AIA SINGAPORE

OBSTETRICS & GYNAECOLOGY REPORT

(To be completed by the Attending Obstetrician & Gynaecologist)

Full Name of Expectant Mother:	Date of last follow-up:
Current gestational age (weeks):	Natural conception or otherwise (e.g. IVF):
Estimated Date of Delivery: DD MM YYYY	Number of Foetus:

1. Details of Current and/or Previous Pregnancy	**Yes**	**No**	**If any of the questions answered as "Yes", please give details below, quoting the relevant question number(s). Please include diagnosis, dates, duration and results of all tests done.**
a. Pre-eclampsia or eclampsia?	☐	☐	
b. Gestational trophoblastic disease?	☐	☐	
c. Proteinuria or any other abnormality in urine?	☐	☐	
d. Glycosuria or gestational diabetes?	☐	☐	
e. History of antepartum haemorrhage or PV bleeding?	☐	☐	
f. Any placental abnormalities?	☐	☐	
g. Significant anaemia (Hb < 8 mg/dL) in pregnancy?	☐	☐	
h. Evidence of fatty liver due to pregnancy?	☐	☐	
i. Abnormal weight change which is not in proportion to pregnancy week.	☐	☐	
j. Evidence of cervical incompetence?	☐	☐	
k. Repeated UTI or intra-uterine infection or leakage of liquor?	☐	☐	
l. Evidence of premature uterine contraction?	☐	☐	
m. Pre-term labour or still birth?	☐	☐	
n. Hospitalisation during current pregnancy?	☐	☐	
o. Any relevant medical history or congenital or genetic disorders which may impact the current pregnancy?	☐	☐	
p. Any previous pregnancy complications or abnormalities or abnormalities not mentioned above?	☐	☐	

2. Foetal Assessment: Is there any abnormality noted on the following?	**Yes**	**No**	**If any of the questions answered as "Yes", please give details below, quoting the relevant question number(s). Please include diagnosis, dates, duration and results of all tests done.**
a. Foetal position/presentation?	☐	☐	
b. Foetal size in relation to gestational age?	☐	☐	
c. Foetal heart rate?	☐	☐	
d. Foetal movement?	☐	☐	
e. Evidence of polyhydramnios or oligohydramnios?	☐	☐	
f. Intra uterine growth retardation?	☐	☐	
g. Any other abnormalities which are not mentioned above?	☐	☐	

3. Others: Has the Expectant Mother been found to have the following?	**Yes**	**No**	**If any of the questions answered as "Yes", please give details below, quoting the relevant question number(s). Please include diagnosis, dates, duration and results of all tests done.**
a. Tested positive for Rubella or HIV?	☐	☐	
b. Required to undergo chorionic villous sampling or amniocentesis?	☐	☐	
c. Any medical conditions diagnosed prior to pregnancy?	☐	☐	
d. Any other tests required or abnormalities detected not mentioned above?	☐	☐	

Note: Please attach copies of all investigation reports (including blood test, urine test, ultrasound etc).

_____	_____	_____
Signature & Name of Doctor	Date	Doctor Stamp