SHIUSH CLINICS - ANTENATAL CARE CARD

Patient Information

Patient Name: _____ Age: _____

Husband's Name: _____

Address: _____

Phone No.: _____

Date of Registration: _____

Gravida / Para / L / A: G__ P__ L__ A__

LMP: _____ EDD: _____

Initial Investigations

Test	Result	Date
Hemoglobin		
Blood Group / Rh		
VDRL		
HBsAg		
HIV		
Urine Routine		
Blood Sugar		
USG (Dating)		

Medication Record

Date	Iron-Folic Acid	Calcium	TT / Td Dose

Follow-Up Visits Record

Visit No.	Date	Weight	BP	FHS	Fundal Height	Remarks
1						

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3						
4						
5						
6						
7						
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