UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS, Secretary
CHILDREN'S BUREAU
KATHARINE F. LENROOT, Chief

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Standards of Prenatal Care

An Outline for the Use of Physicians

Bureau Publication No. 153

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LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, April 19, 1940.

MADAM: Transmitted herewith is the pamphlet, Standards of Prenatal Care, with a revised Maternity Record Form.

The pamphlet, first published in 1925, was the work of a committee, headed by Robert L. DeNormandie, M. D., which was appointed at the suggestion of directors of State bureaus of child hygiene to draw up standards of prenatal care for the use of physicians.

Both the revision of 1939 and the present revision were made by Edwin F. Daily, M. D., Director of the Maternal and Child Health Division of the Children's Bureau, with the assistance of the Bureau's advisory committee of obstetricians: Fred L. Adair, M. D., Robert L. DeNormandie, M. D., and James R. McCord, M. D.

Respectfully submitted.

KATHARINE F. LENROOT,
Chief.

Hon. FRANCES PERKINS,
Secretary of Labor.

Standards of Prenatal Care

Prenatal care is that part of maternal care which has as its object the complete supervision of the pregnant woman in order to preserve the life, health, and happiness of the mother and child. All pregnant women should be under medical supervision during their entire pregnancy, at the time of delivery, and during the puerperium. It is only by thorough prenatal care that diseases which may cause death or disability of either the mother or the child may be avoided, arrested, or cured, and that the woman may maintain a physical condition that will enable her to withstand the unavoidable strain associated with labor and delivery.

The physician at the first visit should obtain and record the facts concerning the patient's past history and present pregnancy.

Past History

Illnesses, particularly the following:
- Tuberculosis or exposure to tuberculosis.
- Scarlet fever.
- Tonsillitis or other focal infections.
- Rheumatic fever.
- Cardiovascular and renal disease (including hypertension).
- Venereal disease.

Operations and accidents, especially those of the abdomen and pelvis (date, attendant, and results).

Menstrual history (cycle, amount of flow, duration, and pain).

Previous pregnancies and labors. Pertinent data regarding each previous pregnancy should be recorded:
- Date of termination.
- Period of gestation.
- Complications during pregnancy (including abortion).
- Labor.
  - Onset—normal or induced.
  - Character.
  - Duration.
  - Termination of labor.
    - Normal or artificial.
    - If artificial, what method was used?
  - Other complications.
- Puerperium.
  - Infection.
  - Hemorrhage.
  - Other complications.
  - Treatment or operations as a result of these complications.
- Infant.
  - Live born or stillborn.
  - Weight.
  - If live born:
    - Breast fed—yes or no.
    - Alive now? If dead, give cause and age at death.

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History of Present Pregnancy

Date of last normal menstruation.
Estimated date of delivery.
Symptoms or complaints:
- Dizziness.
- Headaches. Persistent?
- Disturbed vision.
- Palpitation or dyspnea.
- Cough and sputum.
- Nausea and vomiting.
- Diarrhea or constipation.
- Vaginal discharge.
- Bleeding.
- Dysuria (frequency, amount).
- Edema (site).
- Cramps in extremities.

Physical Examination

The physician should then proceed to the physical examination and record the following:

Systolic and diastolic blood pressure.
Temperature.
Pulse rate.
Weight. Record whether dressed or undressed. Relation of present weight to usual weight.
Height.
General appearance and nutrition of patient.
Skin.
Ears and hearing.
Eyes and vision.
Nose and throat.
Mouth (teeth and gums).
Neck (lymph nodes and thyroid).
Breasts.
Heart (auscultation, percussion).
Lungs (auscultation, percussion).
Abdomen (inspection, palpation, fetal heart rate).
Spine and posture.
Extremities.
Vaginal examination:
- To determine the existence of a pregnancy (and whether it is uterine or ectopic).
- To determine the size and position of the uterus.
- To determine the size of the birth canal and type of pelvis—
  - By measuring the diagonal conjugate (distance from sacral promontory to lower margin of symphysis pubic.)
  - By measuring the transverse diameter of the outlet (the distance between the ischial tuberosities).
- To discover any pelvic disease or tumor.
- To find any evidence of venereal disease, and if suspected to take smears.
- Speculum examination of the cervix and vagina is essential in early pregnancy as a routine procedure.
- ***In case of vaginal bleeding or impending labor at any period of gestation only rectal or aseptic vaginal examination should be made.***

MATERNITY RECORD FORM

NAME _____ AGE _____ RACE _____

ADDRESS AND TELEPHONE NO. _____ Married ☐ Single ☐ Date of first visit _____ Date of last period _____ Estimated date of delivery _____

Referred by _____ Plans to be delivered by _____ Home ☐ Hospital ☐

Previous illnesses and operations _____

Previous pregnancies and deliveries (date, complications, results) _____ No. born alive { Now living / Now dead } No. born dead { Under 7 mos. / 7 mos. or more }

Present pregnancy: Symptoms and complaints _____

PHYSICAL EXAMINATION: Date _____ Examiner _____

General appearance _____ Skin _____ Height _____

Ears and hearing _____ Eyes and vision _____

Nose and throat _____ Mouth (teeth, gums) _____

Neck (lymph nodes and thyroid) _____ Breasts _____

Heart _____

Lungs _____

Abdomen (inspection, palpation, fetal heart rate) _____

Spine and posture _____ Extremities _____

Vaginal examination: _____

Pelvic measurements: Outlet (bi-isch. tub.) _____ Inlet (diag. conj.) _____ Type of pelvis _____

	INITIAL EXAMINATION	RETURN EXAMINATIONS							
Date									
Week of gestation									
Weight									
Blood pressure									
Temperature									
Pulse rate									
Urine: Sp. gr									
Albumin									
Date to return									
Examiner									

LABORATORY TESTS:

Wassermann: Date _____ Result _____ Hemoglobin _____ Vaginal smear _____

Other: _____

FOLLOW-UP HISTORY—Prenatal and postpartum periods:

Date	Symptoms and complaints	Findings and treatment (including diet instructions)

DELIVERY:

Date Week of gestation Doctor or midwife Place

Normal ☐ Oper. (specify) Complications {labor or puerp.

Birth wt. Birth registered ☐ Eye prophylaxis Abnormalities of child (specify)

If stillbirth: Death {before labor ☐ during labor ☐ Cause

If neonatal death: Age days If less than 1 day hr. min. Cause

If maternal death: Date Cause

POSTPARTUM EXAMINATION (AT ABOUT 6 WEEKS):

Date Blood press. Gen. cond. mother

Perineum Cervix

Uterus Adnexa

Infant—Under care of private M. D. ☐ Other medical care ☐ No medical care ☐ Dead ☐

Remarks:

Examiner

Laboratory Examination

Taking of blood:

For Wassermann or other serologic test of the blood for syphilis at the first visit during pregnancy. Repeat this test if the result is doubtful.

For hemoglobin determination and erythrocyte and leukocyte count.

Urinalysis (specific gravity, albumin, sugar). A microscopic examination of the sediment is advisable as a matter of routine. If albumin is present a 24-hour specimen should be obtained.

X-ray:

Of chest if pulmonary tuberculosis or cardiac disease is suspected.

Of abdomen or pelvis if there is question of multiple pregnancy, monstrosity, disproportion, or other complications.

Hygiene of Pregnancy

If pregnancy is determined, minute instructions in the hygiene of pregnancy should be given to the patient. Points covered should include:

Diet, including fluids.
Exercise, rest, sleep, and recreation.
Clothing, including shoes.
Baths and care of the skin.
Regulation of bowel movements.
Care of the teeth.
Care of the breasts.
Intercourse during pregnancy.
Hygiene of the home and preparation of home for delivery.
Mental hygiene.

NOTE.—Refer to publications of the United States Children's Bureau, Washington, D. C.—Prenatal Care, Publication No. 4, and What Builds Babies, Folder No. 4—to publications of State departments of health, and to other publications on this subject.

Return Visits

The patient should be examined by a physician at least once a month during the first 6 months, then every 2 weeks or oftener as indicated, preferably every week in the last 4 weeks. A properly qualified public-health nurse can be of assistance to the physician by stressing to the patient the value of medical care early in pregnancy; by interpreting the physician's findings; and by giving nursing supervision, care, and instruction to the patient throughout pregnancy. At each visit to the physician the patient's general condition must be investigated, blood pressure taken and recorded, urinalysis done, pulse and temperature recorded, and weight taken. The symptoms and complaints should be discussed in detail with the patient. If the result of the test for syphilis is positive, treatment should be started immediately and continued without interruption throughout pregnancy. The diet of the patient should be discussed at each visit, and sudden increases in weight should be watched for. The total gain in weight during pregnancy averages between 20 and 25 pounds, but this gain of weight should be gradual from the third to the ninth month.

External pelvimetry is only suggestive and by itself does not determine

whether any disproportion is present. Abdominal examination should be made as indicated. Abdominal palpation in the eighth and ninth months will show whether there is any obvious disproportion between the size of the fetal head and the pelvis. The fetal heart rate should be noted. The fetal position can be determined and sometimes malpositions may be corrected. Further information regarding descent and fixation can be obtained by rectal examination.

In a primigravida, if the presenting part is not engaged in the pelvis 2 weeks before the estimated date of delivery, the physician in charge should determine, so far as possible, whether any disproportion or malposition exists. If a disproportion is diagnosed, special care must be taken to avoid unsterile, and definitely to limit sterile, vaginal examinations immediately prior to or after the onset of labor. This precaution must be observed because of the danger of serious infection should operative procedures later become necessary.

The place of delivery must be planned. If the prospective labor offers a probable chance of being a difficult one, the patient should be sent to a well-equipped hospital for delivery. Early and competent consultation should be obtained for complicated cases.

Pregnancy is a physiologic condition, but there is no condition which so quickly may become pathologic. It is therefore necessary to instruct each patient at her first visit to report at once to the physician anything that may affect her well-being, especially the following symptoms:

1. Obstinate constipation.
2. Shortness of breath.
3. Acute illnesses, especially colds, sore throat, and persistent cough.
4. Persistent or recurring headache.
5. Recurring nausea or vomiting.
6. Visual disturbances.
7. Dizziness.
8. Pain in the epigastrium.
9. Edema, especially of the face, hands, and ankles.
10. Changes in frequency of urination, oliguria, dysuria, and so forth.
11. Severe pain in the lower abdomen.
12. Vaginal bleeding, even the slightest (spotting).

In case of vaginal bleeding or low abdominal pain the patient must be instructed to go to bed at once and to send for her physician. When bleeding from the vagina occurs, its source must be determined by examination, and the patient, if possible, should be removed to a hospital. Vaginal examinations must be made under aseptic technique, and whether they are made in the home or in a hospital means must be at hand to control possible severe bleeding.

If the patient develops toxemia in the course of her pregnancy, it is only by careful medical supervision and treatment that an eclamptic condition may be prevented. Eclampsia (convulsions) can in the majority of cases

be prevented but only by constant vigilance combined with cooperation between the patient and the physician.

If the patient is to be delivered by a licensed midwife, she should have a complete physical examination and laboratory tests made by a physician as early in pregnancy as possible. If there is any doubt whether the patient will have a normal pregnancy and delivery, arrangements should be made for regular supervision and delivery by a physician.

Only by careful study of each case is it possible to determine whether the patient should be delivered at home or in a hospital. Medical, social, and economic factors should be taken into consideration in making the decision.

It is only by the early and repeated examination and treatment of prospective mothers that premature termination of pregnancies, stillbirths, and many diseases and deaths of newborn infants can be prevented. By the same methods the mothers can be spared much distress and disease and many lives can be saved which would otherwise be lost from toxemia, accidents of pregnancy and labor, and infection.

The accompanying form is suggested for use by the physician in his own practice as well as at prenatal clinics. For his convenience space has been given for entries in regard to the delivery and the postpartum period.