
THE NATIONAL ARCHIVES OF THE UNITED STATES
LITTERA
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MANET
1934

OB-51 Admission Examination, Part I; OB-52 Admission Examination, Part II

Form OB-51 was used to record the results of the general examination on every admission to the hospital service. First implemented in April 1962, form OB-51 replaced the general examination findings reported on form OB-31.

Form OB-52, also implemented in April 1962, was used to record the results of the abdomino-pelvic examination after admission and to record all diagnostic impressions made immediately following admission. This form replaced that portion of OB-31 where results of the obstetric examination were reported.

Findings from form OB-51 and OB-52 were combined onto three cards in the master file: 1351, 2351, and 3351 (Table OB-51.1). Slight changes were made in the forms in September 1962; revision affected layout only.

TABLE OB-51.1 Cards and Data Records by Revision for Forms OB-51 and OB-52

Card Name	Card Number	Rev. No.	Number Records
OB-51: Weight, Pulse, Temperature, General Exam	1351	0	38,070
OB-51: General Exam OB-52: Abdomen, Uterus	2351	0	38,069
OB-52: Pelvic, Membranes, Fetal Observations	3351	0	38,060
	total for form		114,199

Data Items Referencing Form OB-51, Admission Exam, Pt. 1

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
1558.....		1351	1	5	Card number (sequence, form type, form number, revision number)
1559.....		1351	6	14	NINDB case number
1560..OB-51	2	1351	15	16	Form OB-51 date (mo)
1561..OB-51	2	1351	17	18	Form OB-51 date (day)
1562..OB-51	2	1351	19	20	Form OB-51 date (yr)
1563..OB-51		1351	21	21	Admission exams, total
1564..OB-51		1351	22	22	Admission exam, number
1565..OB-51	10	1351	23	25	Weight (lbs)
1566..OB-51	10	1351	26	26	Weight, attire worn while
1567..OB-51	11	1351	27	30	Temperature
1568..OB-51	12	1351	31	33	Pulse
1569..OB-51	13	1351	34	36	Blood pressure, systolic
1570..OB-51	13	1351	37	39	Blood pressure, diastolic
1571..OB-51	14	1351	40	40	Appearance, acutely ill
1572..OB-51	14	1351	41	41	Appearance, chronically ill
1573..OB-51	14	1351	42	42	Appearance; obese
1574..OB-51	14	1351	43	43	Appearance; dehydrated
1575..OB-51	14	1351	44	44	Appearance, other abnormality
1576..OB-51	15	1351	45	45	Skin lesion
1577..OB-51	15	1351	46	46	Skin scars, operative
1578..OB-51	15	1351	47	47	Skin pigmentation abnormal
1579..OB-51	15	1351	48	48	Skin; hirsutism
1580..OB-51	15	1351	49	49	Skin; rash
1581..OB-51	15	1351	50	50	Skin, other abnormality
1582..OB-51	15	1351	51	51	Edema, face
1583..OB-51	15	1351	52	52	Edema, hands
1584..OB-51	15	1351	53	53	Edema, abdominal wall
1585..OB-51	15	1351	54	54	Edema, presacral
1586..OB-51	15	1351	55	55	Edema, pretibial
1587..OB-51	15	1351	56	56	Edema, ankle/feet
1588..OB-51	17	1351	57	57	Lymph nodes, enlarged locally
1589..OB-51	17	1351	58	58	Lymph nodes, enlarged generally
1590..OB-51	17	1351	59	59	Lymph nodes, tenderness
1591..OB-51	17	1351	60	60	Lymph nodes, other abnormality
1592..OB-51	18	1351	61	61	ENT and mouth; pharynx inflammation
1593..OB-51	18	1351	62	62	ENT and mouth; inflammation, other
1594..OB-51	18	1351	63	63	ENT and mouth; hearing impairment
1595..OB-51	18	1351	64	64	ENT and mouth; gums abnormal
1596..OB-51	18	1351	65	65	ENT and mouth; teeth carious or missing
1597..OB-51	18	1351	66	66	ENT and mouth, other abnormality
1598..OB-51	19	1351	67	67	Eyes, papillary reflexes nonormal
1599..OB-51	19	1351	68	68	Eyes, inflammation

Data Items Referencing Form OB-51, Admission Exam, Pt. 1

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
1600..OB-51	19	1351	69	69	Eyes: jaundice
1601..OB-51	19	1351	70	70	Eyes: visual impairment, severe
1602..OB-51	19	1351	71	71	Eyes, other abnormality
1603.....		1351	72	80	Blank
1604.....		2351	1	5	Card number (sequence, form type, form number, revision number)
1605.....		2351	6	14	NIMOB case number
1606..OB-51	2	2351	15	16	Form OB-51 date (mo)
1607..OB-51	2	2351	17	18	Form OB-51 date (day)
1608..OB-51	2	2351	19	20	Form OB-51 date (yr)
1609..OB-51	4	2351	21	21	Admission exams, total
1610..OB-51	5	2351	22	22	Admission examination, number
1611..OB-51	20	2351	23	23	Thyroid and thyroid function, signs of disfunction at exam
1612..OB-51	20	2351	24	24	Thyroid abnormal to palpation
1613..OB-51	20	2351	25	25	Thyroid, other abnormality
1614..OB-51	21	2351	26	26	Breasts: palpable mass
1615..OB-51	21	2351	27	27	Breasts: inflammation
1616..OB-51	21	2351	28	28	Breasts: nipples, inverted
1617..OB-51	21	2351	29	29	Breasts, other abnormality
1618..OB-51	22	2351	30	30	Lungs, auscultation abnormal
1619..OB-51	22	2351	31	31	Lungs, percussion abnormal
1620..OB-51	22	2351	32	32	Lungs: dyspnea at rest
1621..OB-51	22	2351	33	33	Lungs, other abnormality
1622..OB-51	23	2351	34	34	Heart murmur
1623..OB-51	23	2351	35	35	Heart rhythm, irregular
1624..OB-51	23	2351	36	36	Heart: organic heart disease suspected
1625..OB-51	23	2351	37	37	Heart, other abnormality
1626..OB-51	24	2351	38	38	Extremities: varicosities, moderate
1627..OB-51	24	2351	39	39	Extremities: varicosities, severe
1628..OB-51	24	2351	40	40	Extremities: ulcers
1629..OB-51	24	2351	41	41	Extremities, other abnormality (not edema)
1630..OB-51	25	2351	42	42	Neurological: reflexes abnormal
1631..OB-51	25	2351	43	43	Neurological, other evidence of disorder
1632..OB-51	26	2351	44	44	Funduscopic: vessel changes
1633..OB-51	26	2351	45	45	Funduscopic: retinal changes
1634..OB-51	26	2351	46	46	Funduscopic: disc changes
1635..OB-51	26	2351	47	47	Funduscopic: hemorrhage
1636..OB-51	26	2351	48	48	Funduscopic: exudate
1637..OB-51	26	2351	49	49	Funduscopic, other abnormality
1638..OB-51	27	2351	50	50	Abnormalities, anomalies, other
1657..OB-51	2	3351	15	16	Form OB-51 date (mo)
1658..OB-51	2	3351	17	18	Form OB-51 date (day)
1659..OB-51	2	3351	19	20	Form OB-51 date (yr)
1660..OB-51	4	3351	21	21	Admissions examination, total

Data Items Referencing Form OB-51, Admission Exam, Pt. 1

DATA ITEM ID		ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4997....VAR	10			86	88	weight gain (lbs)
5273....VAR	10			341	343	weight, prior to delivery, final (lbs)

Data Items Referencing Form OB-52, Admission Exam, Pt. 2

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
1655.....		3351	1	5	Card number (sequence, form type, form number, revision number)
1656.....		3351	6	14	NIMDB case number
1661..OB-52	5	3351	27	32	Admission examination, number
1662..OB-52	13	3351	23	24	Gestational age, estimated by examination (wks)
1663..OB-52	14	3351	25	27	Fetal weight, estimated
1664..OB-52	15	3351	28	28	Pelvic examination type
1665..OB-52	16	3351	29	29	Pelvic examination; presentation
1666..OB-52	17	3351	30	32	Pelvic examination; position
1667..OB-52	18	3351	33	34	Pelvic examination; effacement (percent)
1668..OB-52	19	3351	35	36	Pelvic examination; dilation
1669..OB-52	20	3351	37	38	Pelvic examination; station
1670..OB-52	21	3351	39	39	Pelvic examination; membranes
1671..OB-52	22	3351	40	40	Pelvic examination; vaginal bleeding
1672..OB-52	23	3351	41	45	Pelvic examination; vaginal bleeding, amount (cc)
1673..OB-52	23	3351	46	46	Heart rate
1674..OB-52	24	3351	47	47	Pelvic examination; speculum exam
1675.....		3351	48	80	Blank

COLR-[illegible]
4-62
(Changed [illegible])

1. PATIENT IDENTIFICATION

OB-51 ADMISSION EXAMINATION, PART 1

2. DATE — Mo. | Day | Year
3. TIME (24 Hr. Clock)
4. EXAMINED BY
5. TITLE OR POSITION
6. THIS EXAM WAS
- ☐ 1 CONDUCTED USING THIS FORM
- ☐ 2 OTHER (See Manual)
7. RE-EXAMINED BY
8. TITLE OR POSITION
9.
- ☐ 1 ABNORMAL FINDINGS REVIEWED
- ☐ 2 NORMAL FINDINGS REVIEWED

(Initial All Changes)

10. WEIGHT ☐ STREET CLOTHES ☐ GOWN
11. TEMP.
12. PULSE
13. BLOOD PRESSURE /

GENERAL EXAMINATION ☐ NOT DONE ☐ DONE AFTER DELIVERY

Mark (X) all appropriate boxes and describe any positive findings to right

14. GENERAL APPEARANCE
- ☐ NORMAL ☐ NOT EVAL.
- ☐ ACUTELY ILL ☐ CHRONICALLY ILL
- ☐ OBESE ☐ DEHYDRATED ☐ OTHER

15. SKIN
- ☐ NORMAL ☐ NOT EVAL.
- ☐ LESION ☐ SCARS—OPERATIVE ☐ ABNORMAL PIGMENTATION
- ☐ ERUPTION ☐ RASH ☐ OTHER

16. EDEMA
- ☐ NONE ☐ NOT EVAL.
- ☐ FACE ☐ HANDS ☐ ABDOMINAL WALL
- ☐ PRESACRAL ☐ PRETIBIAL ☐ ANKLE AND/OR FEET

17. LYMPH NODES
- ☐ NORMAL ☐ NOT EVAL.
- ☐ ENLARGED LOCALLY ☐ ENLARGED GENERALLY
- ☐ TENDERNESS ☐ OTHER

18. ENT AND MOUTH
- ☐ NORMAL ☐ NOT EVAL.
- ☐ INFLAMMATION OF PHARYNX ☐ OTHER INFLAMMATION ☐ HEARING IMPAIRMENT
- ☐ ABNORMAL GUMS ☐ CARIOUS OR MISSING TEETH ☐ OTHER

19. EYES
- ☐ NORMAL ☐ NOT EVAL.
- ☐ ABNORMAL PUPILLARY REFLEXES ☐ INFLAMMATION ☐ JAUNDICE
- ☐ SEVERE VISUAL IMPAIRMENT ☐ OTHER

20. THYROID AND THYROID FUNCTION
- ☐ NORMAL AT CLINICAL EXAM ☐ NOT EVAL.
- ☐ SIGNS OF THYROID DYSFUNCTION AT EXAM.
- ☐ ABNORMAL TO PALPATION ☐ OTHER

21. BREASTS
- ☐ NORMAL ☐ NOT EVAL.
- ☐ MASS ☐ INFLAMMATION
- ☐ INVERTED NIPPLES ☐ OTHER

22. LUNGS
- ☐ NORMAL ☐ NOT EVAL.
- ☐ ABNORMAL TO AUSCULTATION ☐ ABNORMAL TO PERCUSSION
- ☐ DYSPNEA AT REST ☐ OTHER

23. HEART
- ☐ NORMAL ☐ NOT EVAL.
- ☐ MURMUR ☐ IRREGULAR RHYTHM
- ☐ ORGANIC HEART DISEASE — SUSPECTED ☐ OTHER

24. EXTREMITIES
- ☐ NORMAL ☐ NOT EVAL.
- ☐ VARICOSITIES, MODERATE ☐ VARICOSITIES, SEVERE
- ☐ ULCERS ☐ OTHER (not edema)

25. NEUROLOGICAL
- ☐ NORMAL ☐ NOT EVAL.
- ☐ ABNORMAL REFLEXES
- ☐ OTHER EVIDENCE OF NEUROLOGICAL DISORDER

26. FUNDUSCOPIC (If done)
- ☐ NORMAL ☐ NOT EVAL.
- ☐ VESSEL CHANGES ☐ RETINAL CHANGES ☐ DISC CHANGES
- ☐ HEMORRHAGE ☐ EXUDATE ☐ OTHER

27. OTHER ABNORMALITIES AND ANOMALIES
- ☐ NONE

28. LAY. [illegible]

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MD.

4-62
(Changed [illegible])

OB-51

[illegible]

OB-52 ADMISSION EXAMINATION, PART II

1. PATIENT IDENTIFICATION

2. EXAMINED BY

6. RE-EXAMINED BY

3. TITLE OR POSITION

7. TITLE OR POSITION

4. DATE

Mo. | Day | Year

8. ☐ ABNORMAL FINDINGS REVIEWED (1) ☐ NORMAL FINDINGS REVIEWED (4) INITIAL ALL CHANGES

5. TIME

(24 Hr. Clock)

9. THIS EXAMINATION WAS ☐ CONDUCTED USING THIS FORM (1) ☐ OTHER (2) (See manual)

ABDOMINO-PELVIC EXAMINATION

(Do not record results of Postpartum Exam. on this form)

Mark (X) All appropriate boxes and describe any positive findings at right.

10. ABDOMEN (except uterus)
☐ NORMAL (0)
☐ NOT EVAL. (9)
☐ ABNORMAL MASS
☐ HERNIA
☐ ABDOMINAL TENDERNESS
☐ CVA TENDERNESS
☐ OTHER

11. UTERUS
☐ NORMAL FOR WEEKS GESTATION (0)
☐ NOT EVAL. (9)
☐ SIZE NOT COMPATIBLE WITH DATES
☐ TUMOR
☐ MULT. PREGNANCY
☐ UTERINE TENDERNESS
☐ POLYHYDRAMNIOS
☐ OTHER

12. OTHER ABNORMALITIES
☐ NONE (0)
☐ VULVA
☐ VAGINA
☐ ADNEXA
☐ OTHER

13. ESTIMATED WKS GESTATION BY PALPATION

14. ESTIMATED FETAL WEIGHT

PELVIC

15. ☐ NOT DONE (0) ☐ RECTAL (1) ☐ VAGINAL (2)

16. PRESENTATION

17. POSITION

18. EFFACEMENT %

19. DILATATION CMS

20. STATION ☐ ON PERINEUM

21. MEMBRANES
☐ INTACT (0)
☐ NOT EVAL. (9)
☐ QUESTIONABLE (1)
☐ RUPTURED, MECONIUM (2)
☐ RUPTURED, NO MECONIUM (3)

22. VAGINAL BLEEDING AT EXAMINATION
☐ NONE (0)
☐ NOT EVAL. (9)
☐ SHOW ONLY (1)
☐ FREE BLEEDING (2)
☐ VISIBLE EVIDENCE OF RECENT BLEEDING (3)
_____ cc.

23. FETAL HEART RATE _____ /MIN.
☐ NOT HEARD (000)
☐ NOT EVALUATED (999)

24. SPECULUM EXAMINATION
☐ NOT DONE (0)

ADMISSION LABORATORY DATA
(Optional on this form—must appear on OB-48)

HCT _____
HGB _____
NITRAZINE TEST _____

URINE
☐ VOIDED
☐ CLEAN CATCH
☐ CATHETERIZED
☐ CENTRIFUGED
☐ UNCENTRIFUGED

ALBUMIN _____ CASTS _____
GLUCOSE _____ BACTERIA _____
ACETONE _____ OTHER _____
SP. GRAV. _____
WBC _____
RBC

25. DIAGNOSTIC IMPRESSIONS (Record all, including abnormal)

26. APPROPRIATE DATA BY [illegible]

27. LAY EDIT BY

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MD.

[illegible] (CHANGED [illegible])

OB-52

Form Item Numbers linked to Data Items on OB-51, Admission Exam, Pt. 1

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	1564..OB-51	1351	22	22	Admission exam, number
	1563..OB-51	1351	21	21	Admission exams, total
2	1561..OB-51	1351	17	18	Form OB-51 date (day)
2	1658..OB-51	3351	17	18	Form OB-51 date (day)
2	1607..OB-51	2351	17	18	Form OB-51 date (day)
2	1560..OB-51	1351	15	16	Form OB-51 date (mo)
2	1657..OB-51	3351	15	16	Form OB-51 date (mo)
2	1606..OB-51	2351	15	16	Form OB-51 date (mo)
2	1659..OB-51	3351	19	20	Form OB-51 date (yr)
2	1608..OB-51	2351	19	20	Form OB-51 date (yr)
2	1562..OB-51	1351	19	20	Form OB-51 date (yr)
4	1609..OB-51	2351	21	21	Admission exams, total
4	1660..OB-51	3351	21	21	Admissions examination, total
5	1610..OB-51	2351	22	22	Admission examination, number
10	1565..OB-51	1351	23	25	Weight (lbs)
10	4997....VAR		86	88	Weight gain (lbs)
10	1566..OB-51	1351	26	26	Weight, attire worn while
10	5223....VAR		341	343	Weight, prior to delivery, final (lbs)
11	1567..OB-51	1351	27	30	Temperature
12	1568..OB-51	1351	31	33	Pulse
13	1570..OB-51	1351	37	39	Blood pressure, diastolic
13	1569..OB-51	1351	34	36	Blood pressure, systolic
14	1571..OB-51	1351	40	40	Appearance, acutely ill
14	1572..OB-51	1351	41	41	Appearance, chronically ill
14	1575..OB-51	1351	44	44	Appearance, other abnormality
14	1574..OB-51	1351	43	43	Appearance; dehydrated
14	1573..OB-51	1351	42	42	Appearance; obese
15	1584..OB-51	1351	53	53	Edema, abdominal wall
15	1587..OB-51	1351	56	56	Edema, ankle/feet
15	1582..OB-51	1351	51	51	Edema, face
15	1583..OB-51	1351	52	52	Edema, hands
15	1585..OB-51	1351	54	54	Edema, presacral
15	1586..OB-51	1351	55	55	Edema, pretibial
15	1576..OB-51	1351	45	45	Skin lesion
15	1578..OB-51	1351	47	47	Skin pigmentation abnormal
15	1577..OB-51	1351	46	46	Skin scars, operative
15	1581..OB-51	1351	50	50	Skin, other abnormality
15	1579..OB-51	1351	48	48	Skin; hirsutism
	1580..OB-51	1351	49	49	Skin; rash
17	1589..OB-51	1351	58	58	Lymph nodes, enlarged generally
17	1588..OB-51	1351	57	57	Lymph nodes, enlarged locally
17	1591..OB-51	1351	60	60	Lymph nodes, other abnormality

Form Item Numbers linked to Data Items on OB-51, Admission Exam, Pt. 1

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
17	1590..OB-51	1351	59	59	Lymph nodes, tenderness
18	1597..OB-51	1351	66	66	ENT and mouth, other abnormality
18	1595..OB-51	1351	64	64	ENT and mouth; gums abnormal
18	1594..OB-51	1351	63	63	ENT and mouth; hearing impairment
18	1593..OB-51	1351	62	62	ENT and mouth; inflammation, other
18	1592..OB-51	1351	61	61	ENT and mouth; pharynx inflammation
18	1596..OB-51	1351	65	65	ENT and mouth; teeth carious or missing
19	1599..OB-51	1351	68	68	Eyes, inflammation
19	1602..OB-51	1351	71	71	Eyes, other abnormality
19	1598..OB-51	1351	67	67	Eyes, papillary reflexes abnormal
19	1600..OB-51	1351	69	69	Eyes; jaundice
19	1601..OB-51	1351	70	70	Eyes; visual impairment, severe
20	1612..OB-51	2351	24	24	Thyroid abnormal to palpation
20	1611..OB-51	2351	23	23	Thyroid and thyroid function, signs of disfunction at exam
20	1613..OB-51	2351	25	25	Thyroid, other abnormality
21	1617..OB-51	2351	29	29	Breasts, other abnormality
21	1615..OB-51	2351	27	27	Breasts; inflammation
21	1616..OB-51	2351	28	28	Breasts; nipples, inverted
21	1614..OB-51	2351	26	26	Breasts; palpable mass
22	1618..OB-51	2351	30	30	Lungs, auscultation abnormal
22	1621..OB-51	2351	33	33	Lungs, other abnormality
22	1619..OB-51	2351	31	31	Lungs, percussion abnormal
22	1620..OB-51	2351	32	32	Lungs; dyspnea at rest
23	1622..OB-51	2351	34	34	Heart murmur
23	1623..OB-51	2351	35	35	Heart rhythm, irregular
23	1625..OB-51	2351	37	37	Heart, other abnormality
23	1624..OB-51	2351	36	36	Heart; organic heart disease suspected
24	1629..OB-51	2351	41	41	Extremities, other abnormality (not edema)
24	1628..OB-51	2351	40	40	Extremities; ulcers
24	1626..OB-51	2351	38	38	Extremities; varicosities, moderate
24	1627..OB-51	2351	39	39	Extremities; varicosities, severe
25	1631..OB-51	2351	43	43	Neurological, other evidence of disorder
25	1630..OB-51	2351	42	42	Neurological; reflexes abnormal
26	1637..OB-51	2351	49	49	Funduscopic, other abnormality
26	1634..OB-51	2351	46	46	Funduscopic; disc changes
26	1636..OB-51	2351	48	48	Funduscopic; exudate
26	1635..OB-51	2351	47	47	Funduscopic; hemorrhage
26	1633..OB-51	2351	45	45	Funduscopic; retinal changes
26	1632..OB-51	2351	44	44	Funduscopic; vessel changes
27	1638..OB-51	2351	50	50	Abnormalities, anomalies, other

Form Item Numbers linked to Data Items on OB-52, Admission Exam, Pt. 2

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
5	1661..OB-52	3351	22	22	Admission examination, number
13	1662..OB-52	3351	23	24	Gestational age, estimated by examination (wks)
14	1663..OB-52	3351	25	27	Fetal weight, estimated
15	1664..OB-52	3351	28	28	Pelvic examination type
16	1665..OB-52	3351	29	29	Pelvic examination; presentation
17	1666..OB-52	3351	30	32	Pelvic examination; position
18	1667..OB-52	3351	33	34	Pelvic examination; effacement (percent)
19	1668..OB-52	3351	35	36	Pelvic examination; dilation
20	1669..OB-52	3351	37	38	Pelvic examination; station
21	1670..OB-52	3351	39	39	Pelvic examination; membranes
22	1671..OB-52	3351	40	40	Pelvic examination; vaginal bleeding
22	1672..OB-52	3351	41	43	Pelvic examination; vaginal bleeding, amount (cc)
23	1673..OB-52	3351	44	46	Heart rate
24	1674..OB-52	3351	47	47	Pelvic examination; speculum exam

DEFINITION OF CODES
ADMISSION EXAMINATION (PARTS I AND II)
FORMS OB-51 AND 52 CARD 1351

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 351	2-4
3.	Revision Number * Code: 0 - Forms Dated: 4/62 and 4/62 changed 9/62	5
4.	NIMDB # Nine-digit number for Patient Identification Code: As given	6-14
5.	Date of Examination Item 2 (OB-51) Six-digit code for: Month (cols. 15-16) Day (cols. 17-18) Year (cols. 19-20) Code: As given 99 - Month, day and/or year unknown	15-20
6.	Total Number of Admission Examinations Code: 1-8 - As given	21
7.	Admission Examination Number Code: 1-8 - As given	22
8.	Weight Item 10 (OB-51) Four-digit code for: Weight (cols. 23-25) Code:**050-350 - As given in pounds 999 - Unknown **Additional codes reviewed and approved: 357, 370, 372 Attire (col. 26) Code: 1 - Street clothes 2 - Gown 9 - Unknown	23-26

* Item numbers refer to Form Dated: 4/62 changed 9/62

FIELD

9. Temperature
Item 11 (OB-51)
Four-digit code for Fahrenheit temperature including tenths
Code: 0920-1079 - 92.0° to 107.9° as given
9999 - Unknown

10. Pulse
Item 12 (OB-51)
Code: *050-938 - As given
999 - Unknown
* Additional codes revised and approved: 048

11. Blood Pressure
Item 13 (OB-51)
Six-digit code for:
Systolic (cols. 34-36)
Code: 040-280 - As given
999 - Unknown
Diastolic (cols. 37-39)
Code: 010-200 - As given
999 - Unknown

GENERAL EXAMINATION

12. General Appearance
Item 14 (OB-51)
Five-digit code for:
Acutely Ill (col. 40)
Code: 0 - Normal
1 - Abnormal
9 - Unknown
Chronically Ill (col. 41)
Obese (col. 42)
Dehydrated (col. 43)
Code for each column:
Same as in col. 40

Other (col. 44)
Code: 0 - Normal
1 - Underweight
2 - Depressed
3 - Combination of codes 1 and 2
4 - Agitated
5 - Combination of codes 1 and 4
6 - Combination of codes 2 and 4
7 - Combination of codes 1, 2 and 4
9 - Unknown

FIELD		CARD COLUMN
13.	Skin Item 15 (OB-51) Six-digit code for: Lesion (col. 45) Scars Operative (col. 46) Abnormal Pigmentation (col. 47) Hirsutism (col. 48) Rash (col. 49) Code for each column: Same as in Field 12, col. 40 Other (col. 50) Code: 0 - Normal 1 - Abnormalities other than scars, traumatic 4 - Scars, traumatic 5 - Combination of codes 1 and 4 9 - Unknown	45-50
14.	Edema Item 16 (OB-51) Six-digit code for: Face (col. 51) Hands (col. 52) Abdominal Wall (col. 53) Presacral (col. 54) Pretibial (col. 55) Ankle and/or Foot (col. 56) Code for each column: Same as in Field 12, col. 40	51-56
15.	Lymph Nodes Item 17 (OB-51) Four-digit code for: Enlarged Locally (col. 57) Enlarged Generally (col. 58) Tenderness (col. 59) Other (col. 60) Code for each column: Same as in Field 12, col. 40	57-60
16.	Ent and Mouth Item 18 (OB-51) Six-digit code for: Inflammation of Pharynx (col. 61) Other Inflammation (col. 62) Hearing Impairment (col. 63) Abnormal Gums (col. 64) Carious or Missing Teeth (col. 65) Other (col. 66) Code for each column: Same as in Field 12, col. 40	61-66

DEFINITION OF CODES (Continued)

FORM OB-51-52
Card 1351

FIELD		CARD COLUMN
17.	Eyes Item 19 (OB-51) Five-digit code for: Abnormal Pupillary Reflexes (col. 67) Inflammation (col. 68) Jaundice (col. 69) Severe Visual Impairment (col. 70) Other (col. 71) Code for each column: Same as in Field 12, col. 40	67-71

FIELD		CARD COLUMN
1.	Card Number Code: 2	1
2.	Basic Data Code: Same as in cols. 2-22 of Card 1	2-22

GENERAL EXAMINATION (continued)

3. Thyroid and Thyroid Function — 23-25

Item 20 (OB-51)

Three-digit code for:

Signs of Thyroid Disfunction at Exam (col. 23)

Code: 0 - Normal
1 - Abnormal
9 - Unknown

Abnormal to Palpation (col. 24)

Code: Same as in col. 23

Other (col. 25)

Code: 0 - Normal
1 - Abnormalities other than thyroidectomy
2 - Thyroidectomy
3 - Combination of codes 1 and 2
9 - Unknown

4. Breasts — 26-29

Item 21 (OB-51)

Four-digit code for:

Mass (col. 26)
Inflammation (col. 27)
Inverted Nipples (col. 28)

Code: Same as in Field 3, col. 23

Other (col. 29)

Code: 0 - Normal
1 - Abnormalities other than ectopic breast tissue
4 - Ectopic breast tissue
5 - Combination of 1 and 4
9 - Unknown

5. Lungs — 30-33

Item 22 (OB-51)

Four-digit code for:

Abnormal to Auscultation (col. 30)
Abnormal to Percussion (col. 31)
Dyspnea at Rest (col. 32)
Other (col. 33)

Code for each column:
Same as in Field 3, col. 23

DEFINITION OF CODES (Continued)

FORM OB-51 52
Card 2351

FIELD		CARD COLUMN
6.	Heart Item 23 (OB-51) Four-digit code for: Murmur (col. 34) Irregular Rhythm (col. 35) Organic Heart Distress - Suspected (col. 36) Code for each column: Same as in Field 3, col. 23 Other (col. 37) Code: 0 - Normal 1 - Abnormalities other than abnormal rate 2 - Abnormal rate 9 - Unknown	34-37
7.	Extremities Item 24 (OB-51) Four-digit code for: Varicosities, Moderate (col. 38) Varicosities, Severe (col. 39) Ulcers (col. 40) Other (col. 41) Code for each column: Same as in Field 3, col. 23	38-41
8.	Neurological Item 25 (OB-51) Two-digit code for: Abnormal Reflexes (col. 42) Other Evidence of Neurological Disorder (col. 43) Code for each column: Same as in Field 3, col. 23	42-43
9.	Fundoscopic Item 26 (OB-51) Six-digit code for: Vessel Changes (col. 44) Retinal Changes (col. 45) Disc Changes (col. 46) Hemorrhage (col. 47) Exudate (col. 48) Other (col. 49) Code for each column: Same as in Field 3, col. 23	44-49
10.	Other Abnormalities and Anomalies Item 27 (OB-51) Code: Same as in Field 3, col. 23	50

DEFINITION OF CODES (Continued)

FORM OB-51-52
Card 2351

FIELD		CARD COLUMN
	ABDOMINO-PELVIC EXAMINATION	
11.	**Abdomen** Item 10 (OB-52) Five-digit code for: Abnormal Mass (col. 51) Hernia (col. 52) Abdominal Tenderness (col. 53) CVA Tenderness (col. 54) Other (col. 55) Code for each column: Same as in Field 3, col. 23	51-55
12.	**Uterus** Item 11 (OB-52) Six-digit code for: Size not Compatible with Dates (col. 56) Tumor (col. 57) Multiple Pregnancy (col. 58) Uterine Tenderness (col. 59) Polyhydramnios (col. 60) Other (col. 61) Code for each column: Same as in Field 3, col. 23	56-61
13.	**Other Abnormalities** Item 12 (OB-52) Four-digit code for: Vulva (col. 62) Vagina (col. 63) Adnexa (col. 64) Other (col. 65) Code for each column: Same as in Field 3, col. 23	62-65

DEFINITION OF CODES (Continued)

FORM OB-51-52
Card 3351

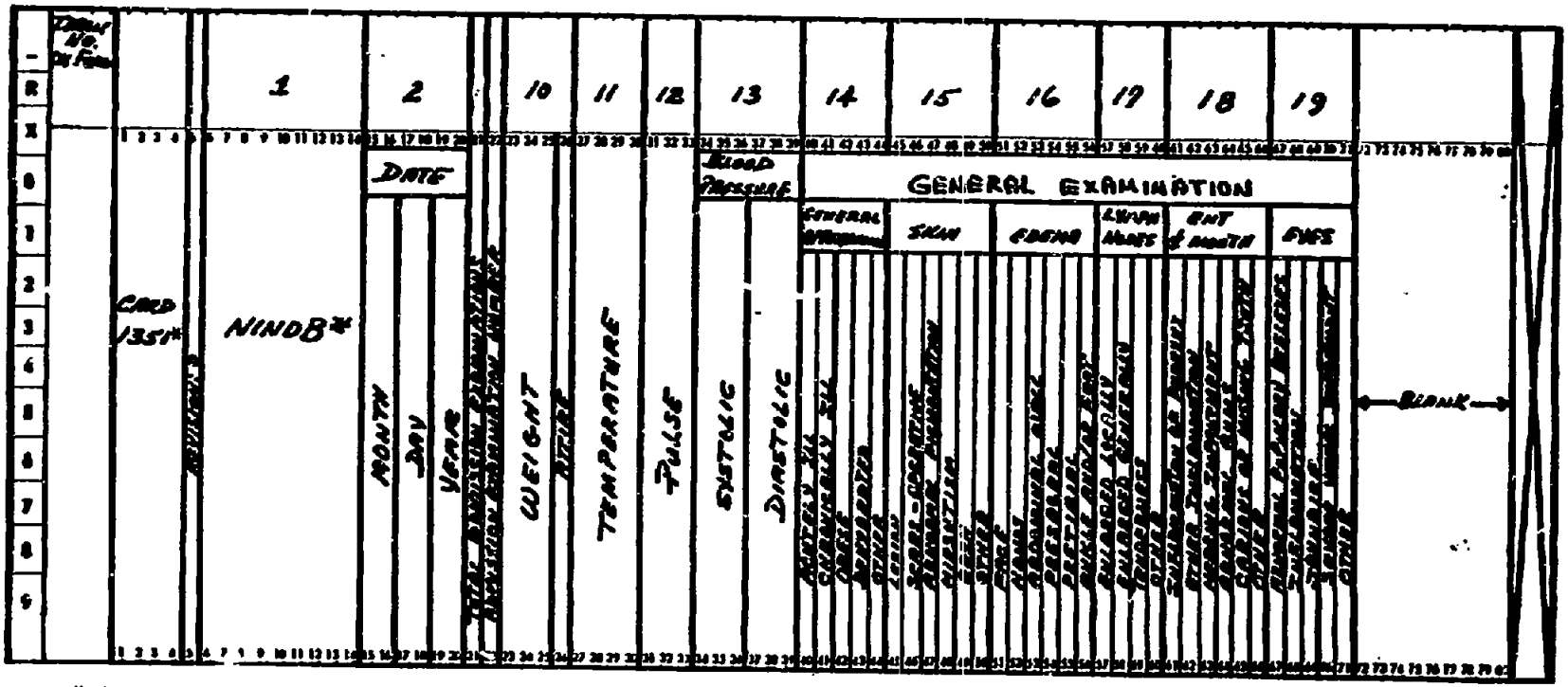
FIELD		CARD COLUMN
1.	**Card Number** Code: 3	1
2.	**Basic Data** Code: Same as in cols. 2-22 of Card 1	2-22
3.	**Estimated Weeks Gestation by Palpation** Item 13 (OB-52) Code: 01-50 - As given 88 - Term 99 - Unknown	23-24
4.	**Estimated Fetal Weight** Item 14 (OB-52) Code: 001-915 - 1 oz. to 9 lbs. 15 oz. as given 988 - 10 lbs. and over 999 - Unknown	25-27
5.	**Type of Pelvic Examination** Item 15 (OB-52) Code: 1 - Rectal 2 - Vaginal 3 - Combination of codes 1 and 2 9 - Unknown	28
6.	**Presentation** Item 16 (OB-52) Code: 0 - Vertex 1 - Breech 2 - Transverse lie, oblique, shoulder 3 - Compound 4 - Multiple pregnancy 9 - Unknown	29

FIELD		CARD COLUMN
7.	**Position** Item 17 (OB-52) Code: 011 - OA, 012 - OT, 013 - OP, 020 - Chin, face, 021 - MA, 022 - MT, 023 - MP, 030 - Brow, 031 - Brow Anterior, 061 - SA, 062 - ST, 063 - SP, 080 - Shoulder, 111 - LOA, 112 - LOT, 113 - LOP, 121 - LMA, 122 - LMT, 123 - LMP, 161 - LSA, 162 - LST, 163 - LSP, 181 - LAA, 183 - LAP, 211 - ROA, 212 - ROT, 213 - ROP, 221 - RMA, 222 - RMT, 223 - RMP, 231 - R brow Ant, 261 - RSA, 262 - RST, 263 - RSP, 281 - RAA, 283 - RAP, 777 - Multiple pregnancy, 888 - Oblique, 999 - Unknown	30-32
8.	**Effacement** Item 18 (OB-52) Code: 00 - No effacement 01-97 - As given in percent 98 - 98% or more 99 - Unknown	33-34
9.	**Dilatation** Item 19 (OB-52) Code: 00 - Not dilated, 05 - 1/2 cm., 10 - 10 cms., 11 - 1 cm., 15 - 1 1/2 cm., 21 - 2 cm., 25 - 2 1/2 cm., 31 - 3 cm., 35 - 3 1/2 cm., 41 - 4 cm., 45 - 4 1/2 cm., 51 - 5 cm., 55 - 5 1/2 cm., 61 - 6 cm., 65 - 6 1/2 cm., 71 - 7 cm., 75 - 7 1/2 cm., 81 - 8 cm., 85 - 8 1/2 cm., 91 - 9 cm., 95 - 9 1/2 cm., 99 - Unknown	35-36

FIELD		CARD COLUMN
10.	**Station** Item 20 (OB-52) Code: 61 = -1 62 = -2 63 = -3 64 = -4, -5 70 = zero 71 = +1 72 = +2 73 = +3 74 = +4, +5 99 = Unknown	37-38
11.	**Membranes** Item 21 (OB-52) Code: 0 - Intact 1 - Questionable 2 - Ruptured, meconium 3 - Ruptured, no meconium 9 - Unknown	39
12.	**Vaginal Bleeding at Examination** Item 22 (OB-52) Four-digit code for: **Bleeding** (col. 40) Code: 0 - None 1 - Show only 2 - Free bleeding 3 - Visible evidence of recent bleeding 9 - Unknown **Amount of Bleeding in cc.** (cols. 41-43) Code: 000 - None 001-997 - 1 to 997 cc. as given 998 - 998 cc. or more 999 - Unknown	40-43
13.	**Fetal Heart Rate** Item 23 (OB-52) Code: 000 - Not heard 020-300 - As given 777 - Heard (rate unknown) 888 - Multiple pregnancy 999 - Unknown	44-46
14.	**Speculum Examination** Item 24 (OB-52) Code: 0 - Not done 1 - Done 9 - Unknown	47

AIMISSION EXAMINATION

PART I



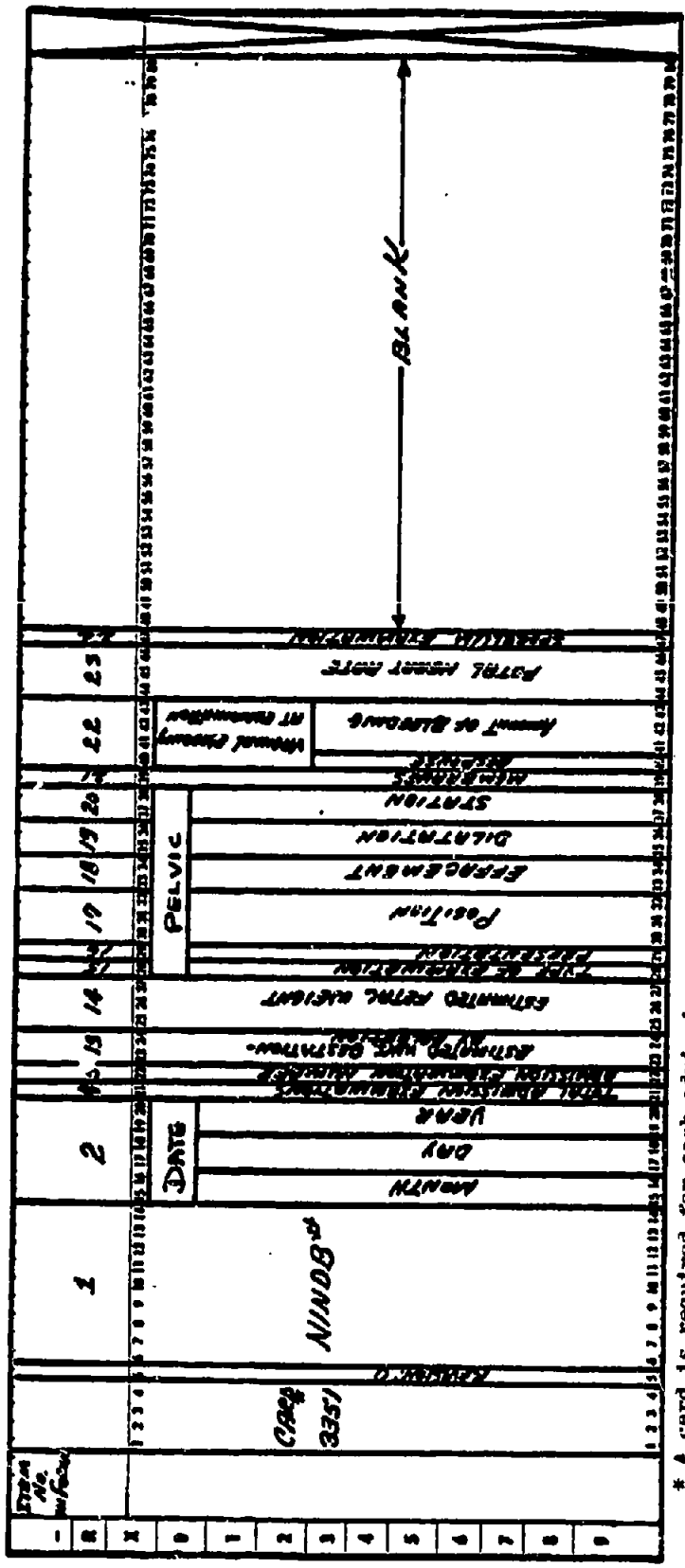
* A card is required for each admission.

ADMISSION EXAMINATION

* A card is required for each admission.

OB-51-52 - 12

ADMISSION EXAMINATION



* A card is required for each admission.

OB-51-52 - 13

OB-51 ADMISSION EXAMINATION, PART I

I. Purpose of form To record the results of the general examination on every admission to the hospital service.

II. Specific Instructions

Item Number

2. Date. Record the date of the examination.

3. Time. Record the time when the general physical examination was performed.

4, 5. Examined by. Print the first initial and last name, and title or position of the examining physician.

6. This exam was.

   a. Mark the box "completed using this form" when the examination findings are recorded directly on this form.

   b. Mark the box "other" if this examination is initially recorded on non-Study forms. In this case, abstract the findings on this form and stamp "Not according to protocol."

7-9. Re-examination.

   a. Print the first initial and last name and title or position of the re-examining physician if findings are re-evaluated by a more senior physician.

   b. Mark the appropriate box(es) if findings are re-evaluated.

   c. The senior examiner is to initial any changes made in the original report.

10. Weight. Record the admission weight the patient, in pounds. Mark the appropriate box to indicate the amount of clothing with which the patient was weighed. When the patient's condition contraindicates this observation, record "NE" (not evaluated).

11. Temperature. Record in Fahrenheit degrees.

12. Pulse. Record.

Item Number

13. Blood pressure. Record.

GENERAL EXAMINATION. Mark the one appropriate box.

14. General appearance. Mark all boxes which describe the general state of the patient.

15. Skin. Mark boxes applicable to skin of any area of the body. Operative scars, wherever present on the patient, are reported only here. Scars other than operative are not considered important unless indicative of major trauma, in which case record under "other."

16. Edema. If edema is present, designate the location by marking the appropriate box(es). In the space to the right, describe the degree of edema in each location, designating it +1 to +4; pitting or non-pitting.

17. Lymph nodes. If any lymph nodes are enlarged, specify whether they are a single local group or all the superficial nodes by marking the appropriate box. If any lymph nodes are tender, mark the appropriate box. Describe the abnormal nodes and their location in the space provided.

18. ENT and mouth. Mark the appropriate boxes. Inflammation of the pharynx includes pharyngitis and tonsillitis. "Other inflammation" includes rhinitis and otitis, and abscessed teeth.

19. Eyes. Severe visual impairment is described as any impairment which prohib the patient, correctly fitted with glasses, from reading unmagnified newsprint. Description should include the degree of impairment of vision. Include under "other" such difficulties as tunnel-vision, color-blindness, etc.

20. Thyroid and thyroid function. Report here physical signs of thyroid dysfunction, e.g. hypo- or hyperthyroidism, by marking the appropriate box, and describing in the available space. This includes findings in other systems (e.g., eyes, skin, neurological). Do not mark "Signs of thyroid dysfunction" when the thyroid gland is abnormal only to palpation.

OB-51 ADMISSION EXAMINATION, PART I (Continued)

Item Number

21. Breasts. If an inflammatory mass is present, mark both boxes, "mass" and "inflammation."

22. Lungs. Report findings of physical examination. Record markedly reduced vital capacity under "other," and describe.

23. Heart. If any findings lead to consideration of organic heart disease, always mark the box so labeled, in addition to marking any other appropriate boxes. If a murmur is considered physiological for pregnancy, or functional, mark "murmur" and describe as "normal for pregnancy," etc.

Item Number

24. Extremeties. Record all findings pertaining to extremities here, other than edema or scars, which are reported in items #16 and 15 respectively.

25. Neurological. Mark all appropriate boxes. Neurological disorders should include muscular abnormalities secondary to neurological involvement.

26. Funduscopic. A funduscopic examination is optional.

27. Other abnormalities and anomalies. Record here any abnormalities discovered during the general examination not recorded elsewhere on the form. Especially note skeletal and congenital abnormalities, other than pelvic. If no abnormalities or anomalies are found, mark the box "none."

OB-52 ADMISSION EXAMINATION, PART II

I. Purpose of form

A. To record the results of the abdomino-pelvic examination after admission.

B. To record all diagnostic impressions made immediately following admission.

II. Specific Instructions

Item Number

2,3. **Examined by.** Print the first initial and last name, and title or position of the examining physician.

4. **Date.** Record the date of the examination.

5. **Time.** Record the time when this part of the examination is initiated.

6-8. **Re-examination.**

a. Print the first initial and last name and title or position of the re-examining physician if findings are re-evaluated by a more senior physician.

b. Mark the appropriate box(es) if findings are re-evaluated.

c. The senior examiner is to initial any changes made in the original report.

9. This exam was.

a. Mark the box "completed using this form" when the examination findings are recorded directly on this form.

b. Mark the box "other," if this examination is initially recorded on non-Study forms. In this case, abstract the findings on this form and stamp "Not according to protocol."

ABDOMINO-PELVIC EXAMINATION

a. Complete all items listed whenever appropriate to the period of gestation and/or the condition of the patient. Record prepartum findings only.

b. When any part of the examination is not performed, mark the box "not evaluated," or record "NE."

Item Number

c. In the event of a postpartum [illegible] nation, do not complete items [illegible] and write "postpartum [illegible] form. Complete items #25 and [illegible] agnostic impressions).

10. Abdomen. Mark all boxes which [illegible] the findings on abdominal examin[illegible] other than of the uterus. If there [illegible] unusual findings, mark "normal. If [illegible] bomen is not evaluated, mark [illegible] labeled.

11. Uterus. As a result of abdominal [illegible] vaginal examination:

a. Mark "normal for weeks gest[illegible] of uterine size is compatible with [illegible] and no other abnormality is present.

b. Mark "not evaluated" only if no [illegible] is made to evaluate, either abdom[illegible] or vaginally.

c. Denote the findings of any other [illegible] normality of the uterus by marking [illegible] appropriate box(es). If the size of [illegible] uterus is larger or smaller than [illegible] be expected for the calculated [illegible] of gestation, mark the box so [illegible] and explain at the right.

12. Other abnormalities. If, by abdo[illegible] pelvic examination, no other abnormal[illegible] are noted, mark "none." Mark other [illegible] as appropriate, describing findings [illegible] right.

13. Estimated weeks gestation by palp[illegible] On the basis of the **clinical findings**, estimate the duration of pregnancy [illegible] record in weeks.

14. Estimated fetal weight. On the basis of clinical findings, estimate the fetal weight at the time of admission and record in pounds or grams. If impractical (early pregnancy), record "NE."

15. Pelvic examination.

a. Mark whether an examination performed is rectal or vaginal. If both are performed on admission, mark both boxes and record the findings of **vaginal** examination.

OB-52 ADMISSION EXAMINATION, PART II

I. Purpose of form

A. To record the results of the abdomino-pelvic examination after admission.

B. To record all diagnostic impressions made immediately following admission.

II. Specific Instructions

Item Number

2, 3. Examined by. Print the first initial and last name, and title or position of the examining physician.

4. Date. Record the date of the examination.

5. Time. Record the time when this part of the examination is initiated.

6-8. Re-examination.

a. Print the first initial and last name and title or position of the re-examining physician if findings are re-evaluated by a more senior physician.

b. Mark the appropriate box (es) if findings are re-evaluated.

c. The senior examiner is to initial any changes made in the original report.

9. This exam was.

a. Mark the box "completed using this form" when the examination findings are recorded directly on this form.

b. Mark the box "other," if this examination is initially recorded on non-Study forms. In this case, abstract the findings on this form and stamp "Not according to protocol."

ABDOMINO-PELVIC EXAMINATION

a. Complete all items listed whenever appropriate to the period of gestation and/or the condition of the patient. Record prepartum findings only.

b. When any part of the examination is not performed, mark the box "not evaluated," or record "NE."

Item Number

c. In the event of a postpartum examination, do not complete items #10-24, and write "postpartum" across the form. Complete items #25 and 26 (diagnostic impressions).

10. Abdomen. Mark all boxes which describe the findings on abdominal examination, other than of the uterus. If there are no unusual findings, mark "normal." If abdomen is not evaluated, mark box so labeled.

11. Uterus. As a result of abdominal and/or vaginal examination:

a. Mark "normal for weeks gestation" if uterine size is compatible with dates, and no other abnormality is present.

b. Mark "not evaluated" only if no attempt is made to evaluate, either abdominally or vaginally.

c. Denote the findings of any other abnormality of the uterus by marking the appropriate box(es). If the size of the uterus is larger or smaller than would be expected for the calculated period of gestation, mark the box so labeled and explain at the right.

12. Other abnormalities. If, by abdomino-pelvic examination, no other abnormalities are noted, mark "none." Mark other boxes as appropriate, describing findings at the right.

13. Estimated weeks gestation by palpation. On the basis of the clinical findings, estimate the duration of pregnancy and record in weeks.

14. Estimated fetal weight. On the basis of clinical findings, estimate the fetal weight at the time of admission and record in pounds or grams. If impractical (early pregnancy), record "NE."

15. Pelvic examination.

a. Mark whether an examination performed is rectal or vaginal. If both are performed on admission, mark both boxes and record the findings of vaginal examination.

October 1962

OB-52 ADMISSION EXAMINATION, PART II (Continued)

Item Number

b. If no examination is performed, mark "not done"; the remaining items #16-20 will be blank.

c. If an examination is performed, but one or more components of the examination are not evaluated, record available findings and record "NE" in other spaces.

16. Presentation. Record the presenting part as vertex, breech, transverse lie, etc. If a multiple pregnancy is diagnosed, record the presentation of each twin and indicate which is the leading twin.

17. Position. Utilizing standard terminology, record the position of each fetus as exactly as possible. Do not change this recording of position, even though later findings are in disagreement.

18. Effacement. Express as a percentage.

19. Dilatation. Record the dilatation of the cervix to the nearest centimeter.

20. Station. Station refers to the relationship of the leading bony portion of the presenting part to the ischial spines. It is recorded as centimeters above (minus) or below (plus) the level of the ischial spines. The term "floating" may be used to designate that the presenting part is 3 or more centimeters above the ischial spines (-3). If the presenting part is on the perineum, mark the box so labeled.

21. Membranes. From examination findings, report whether membranes are ruptured or intact. If ruptured, report the presence or absence of meconium-stained amniotic fluid. If status of membranes is questionable or is not evaluated, mark the appropriate box. Whenever the determination of membrane status is aided by use of nitrazine test, note this fact.

Item Number

22. Vaginal bleeding at examination. From examination findings, indicate the presence or absence of vaginal bleeding by marking the one appropriate box. "Free bleeding" is active bleeding other than normal "show", regardless of amount. If there is no longer free active bleeding but there is visible evidence of recent bleeding, mark the box so labeled. Report in estimated cc's the amount of bleeding observed (active or recent).

23. Fetal heart rate. After counting (between contractions), report the rate in beats/minute. If, after a thorough attempt, the fetal heart cannot be heard, mark the box labeled "not heard." If for any reason (including early pregnancy) there is no attempt to obtain a fetal heart rate on admission, mark "not eval." Report any abnormalities in rhythm heard.

24. Speculum examination. If speculum examination is performed as part of the admission examination, record the results here. If not done, mark box. (Examination is optional for Study purposes.)

    Admission laboratory data: This space provides for the optional recording of admission laboratory data for the convenience of the Study hospital. Regardless of whether this space is utilized, all laboratory data is reported on form OB-45.

25. DIAGNOSTIC IMPRESSIONS: Following completion of the admission history and physical examination (OB-50, OB-51, OB-52), record in the spaces provided all diagnostic impressions made or considered at the time.

26. Approximate date of onset. When appropriate, record opposite each diagnostic impression the date of onset, especially of acute infectious processes and toxemia. The date of onset represents the physician's best estimate of the date on which the disease process began.

COLR-3082-51
4-62

OB-51 ADMISSION EXAMINATION, PART 1

1. PATIENT IDENTIFICATION

superseded by OB-51 (4-62) (changed 9-62)

2. DATE	3. TIME	4. THIS EXAM WAS	7. RE-EXAMINED BY
Mo. Day Year	(24 Hr. Clock)	☐ 1 CONDUCTED USING THIS FORM	8. TITLE OR POSITION
4. EXAMINED BY		☐ 2 OTHER (See Manual)	9. ☐ 1 ABNORMAL FINDINGS REVIEWED ☐ 2 NORMAL FINDINGS REVIEWED (Initial All Changes)
5. TITLE OR POSITION			

10. WEIGHT ☐ STREET CLOTHES ☐ GOWN	11. TEMP.	12. PULSE	13. BLOOD PRESSURE /

GENERAL EXAMINATION ☐ NOT DONE ☐ DONE AFTER DELIVERY

Mark (X) all appropriate boxes and describe any positive findings in detail

14. GENERAL APPEARANCE
☐ NORMAL OR ☐ NOT EVAL. OR
☐ ACUTELY ILL ☐ CHRONICALLY ILL
☐ OBESE ☐ DEHYDRATED ☐ OTHER

15. SKIN
☐ NORMAL OR ☐ NOT EVAL. OR
☐ LESION ☐ SCARS—OPERATIVE ☐ ABNORMAL PIGMENTATION
☐ ERUPTION ☐ RASH ☐ OTHER

16. EDEMA
☐ NONE OR ☐ NOT EVAL. OR
☐ FACE ☐ HANDS ☐ ABDOMINAL WALL
☐ PRESACRAL ☐ PRETIBIAL ☐ ANKLE AND/OR FOOT

17. LYMPH NODES
☐ NORMAL OR ☐ NOT EVAL. OR
☐ ENLARGED LOCALLY ☐ ENLARGED GENERALLY
☐ TENDERNESS ☐ OTHER

18. ENT AND MOUTH
☐ NORMAL OR ☐ NOT EVAL. OR
☐ INFLAMMATION OF PHARYNX ☐ OTHER INFLAMMATION ☐ HEARING IMPAIRMENT
☐ ABNORMAL GUMS ☐ CARIOUS OR MISSING TEETH ☐ OTHER

19. EYES
☐ NORMAL OR ☐ NOT EVAL. OR
☐ ABNORMAL PUPILLARY REFLEXES ☐ INFLAMMATION ☐ JAUNDICE
☐ SEVERE VISUAL IMPAIRMENT ☐ OTHER

20. THYROID AND THYROID FUNCTION
☐ NORMAL AT CLINICAL EXAM OR ☐ NOT EVAL. OR
☐ SIGNS OF THYROID DYSFUNCTION AT EXAM.
☐ ABNORMAL TO PALPATION ☐ OTHER

21. BREASTS
☐ NORMAL OR ☐ NOT EVAL. OR
☐ MASS ☐ INFLAMMATION
☐ INVERTED NIPPLES ☐ OTHER

22. LUNGS
☐ NORMAL OR ☐ NOT EVAL. OR
☐ ABNORMAL TO AUSCULTATION ☐ ABNORMAL TO PERCUSSION
☐ DYSPNEA AT REST ☐ OTHER

23. HEART
☐ NORMAL OR ☐ NOT EVAL. OR
☐ MURMUR ☐ IRREGULAR RHYTHM
☐ ORGANIC HEART DISEASE — SUSPECTED ☐ OTHER

24. EXTREMITIES
☐ NORMAL OR ☐ NOT EVAL. OR
☐ VARICOSITIES, MODERATE ☐ VARICOSITIES, SEVERE
☐ ULCERS ☐ OTHER (not edema)

25. NEUROLOGICAL
☐ NORMAL OR ☐ NOT EVAL. OR
☐ ABNORMAL REFLEXES
☐ OTHER EVIDENCE OF NEUROLOGICAL DISORDER

26. FUNDUSCOPIC (if done)
☐ NORMAL OR ☐ NOT EVAL. OR
☐ VESSEL CHANGES ☐ RETINAL CHANGES ☐ DISC CHANGES
☐ HEMORRHAGE ☐ EXUDATE ☐ OTHER

27. OTHER ABNORMALITIES AND ANOMALIES
☐ NONE

28. LAY OUT BY

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MD.

4-62

OB-51

COLR-2000-54
4-62

OB-52 ADMISSION EXAMINATION, PART II

superseded by OB-52 (4-62) (Changed 9-62)

1. PATIENT IDENTIFICATION

2. EXAMINED BY

3. TITLE OR POSITION

4. DATE — Mo. / Day / Year

5. TIME — (24 Hr. Clock)

6. RE-EXAMINED BY

7. TITLE OR POSITION

8. 1 ☐ ABNORMAL FINDINGS REVIEWED 2 ☐ NORMAL FINDINGS REVIEWED — INITIAL ALL CHANGES

9. THIS EXAMINATION WAS 1 ☐ COMPUTED USING THIS FORM 2 ☐ OTHER (See manual)

ABDOMINO-PELVIC EXAMINATION

Mark (X) All appropriate boxes and describe any positive findings at right.

10. ABDOMEN (Except uterus)
- ☐ NORMAL 01
- ☐ NOT EVAL. 02
- ☐ ABDOMINAL MASS
- ☐ HERNIA
- ☐ ABDOMINAL TENDERNESS
- ☐ EVA TENDERNESS
- ☐ OTHER

11. UTERUS
- ☐ NORMAL FOR WEEKS GESTATION 01
- ☐ NOT EVAL. 02
- ☐ SIZE NOT COMPATIBLE WITH DATES
- ☐ TUMOR
- ☐ MULT. PREGNANCY
- ☐ UTERINE TENDERNESS
- ☐ POLYHYDRAMNIOS
- ☐ OTHER

12. OTHER ABNORMALITIES
- ☐ NONE 00
- ☐ VULVA
- ☐ VAGINA
- ☐ ADNEXA
- ☐ OTHER

13. ESTIMATED WEEKS GESTATION BY PALPATION

14. ESTIMATED FETAL WEIGHT

PELVIC

15. ☐ NOT DONE 00 ☐ RECTAL 1 ☐ VAGINAL 2

16. EFFACEMENT — %

17. PRESENTATION

18. DILATATION — CMS

19. POSITION

20. STATION — ☐ ON PERINEUM

21. MEMBRANES
- ☐ INTACT 0
- ☐ NOT EVAL. 9
- ☐ QUESTIONABLE 1
- ☐ RUPTURED, MECONIUM 2
- ☐ RUPTURED, NO MECONIUM 3

22. VAGINAL BLEEDING AT EXAMINATION
- ☐ NONE 0
- ☐ NOT EVAL. 9
- ☐ SHOW ONLY 1
- ☐ MILD BLEEDING 2
- ☐ VISIBLE EVIDENCE OF RECENT BLEEDING 3

_____ cc.

23. FETAL HEART RATE — /MIN.
- ☐ NOT HEARD
- ☐ NOT EVALUATED

24. SPECULUM EXAMINATION
- ☐ NOT DONE 0

ADMISSION LABORATORY DATA

(Optional on this form—each appears on OB-43)

HCT _____

HGB _____

NITRAZINE TEST _____

URINE
- ☐ VOIDED
- ☐ CLEAN CATCH
- ☐ CATHETERIZED
- ☐ CENTRIFUGED
- ☐ UNCENTRIFUGED

ALBUMIN _____ CASTS _____

GLUCOSE _____ BACTERIA _____

ACETONE _____ OTHER _____

SP. GRAV. _____

WBC _____

RBC

25. DIAGNOSTIC IMPRESSIONS (Record all, including obstetrical)

26. [illegible] LEAVE BLANK

27. LAY EDIT BY

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4-62

OB-52

OB-32 Labor Room Record

Form OB-32 was used to record observations and events during labor and under certain conditions prior to the onset of labor. The form was implemented in January 1959 and revised once in July 1959; revision affected itemization of information. OB-32 is available in microfilm only; however, data from OB-32 such as temperature, blood pressure, fetal heart rate, meconium, pelvic examination and drugs administered were abstracted along with similar data from OB-30, OB-31, OB-33 and OB-34 on ADM-49, ADM-50 and ADM-51 (see Tables ADM-49.1, ADM-50.1 and ADM-51.1).

COLR-[illegible]
REV. 7-[illegible]

LABOR ROOM RECORD

(Observer)

1. PATIENT IDENTIFICATION

INSTRUCTIONS TO OBSERVER:

1) The first time you observe this patient, write your name and title or position (project nurse, resident, etc.) across the sheet on the first unused line.

2) Initial each observation made by you.

2. THIS FORM WAS *(Check One)*

1 FILLED OUT AS EVENTS OCCURRED   2 COPIED FROM OTHER RECORDS

3. Page No. ____ **of** ____

RECORD MEDICATIONS, NUTRIENTS, FLUIDS AND PROCEDURES ACROSS SHEET AFTER INDICATING TIME

							CONTRACTIONS						PELVIC EXAMINATION				
OBSERVER	DAY OF MONTH	TIME (24 Hour Clock)	TEMPERATURE (Optional after First Observation)	PULSE	BLOOD PRESSURE	FETAL HEART RATE	FREQUENCY (Minutes)	DURATION (Seconds)	SENSORIUM (During Contractions)	MEMBRANES	BLEEDING (NONE, SHOW, FREE)	MECONIUM + or 0	V OR R	CERVICAL DILATATION (CM)	EFFACEMENT (%)	PRESENTATION OR POSITION	STATION
4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
(1)																	
(2)																	
(3)																	
(4)																	
(5)																	
(6)																	
(7)																	
(8)																	
(9)																	
(10)																	
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(17)																	
(18)																	
(19)																	
(20)																	

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(REV. 7-60) (OB-32)

OB-32 LABOR ROOM RECORD

I. Purpose of form — For the detailed recording of observations and events during labor and under certain conditions prior to the onset of labor.

II. General Instructions

A. Patients requiring observation

1. Those in active or questionable labor when length of gestation is 20 weeks or more.
2. Those prior to onset of labor when there is:
   a. Attempt at induction of labor with uterotonic agents.
   b. Any apparent fetal distress, as manifested by meconium or abnormal fetal heart.
   c. Any significant obstetrical complication (e.g., vaginal bleeding, severe pre-eclampsia), and the patient is in the labor and delivery area.
3. Those in labor prior to 20 weeks gestation, when there is any reason to suspect the case is other than abortion.

B. Use of form

1. OB-32 is initiated upon admission or transfer to the Study facility for any of the above. All available data for the required period should be recorded whether the patient is directly observed or not.
2. Observations are continued on the same copy of OB-32 upon return of the patient after temporary absence from the labor area (pelvimetry, delivery room procedures, etc.). A narrative note explaining the absence is made on OB-32.
3. OB-32 is terminated when:
   a. OB-33 is initiated for delivery observations.
   b. Observation is no longer required. Note the reason, destination, and time of termination on OB-32.
4. A new OB-32 form is initiated when the patient is returned to the labor or delivery floor after a previous termination of OB-32.

C. Observer's notes

1. General information. Record in "progress note" form all other information, events, complications, consultative decisions, etc., that serve to clarify and expand the information on the patient's course of labor.
2. Medications. Record each time given, the medication, the dosage and route by which given. If intravenous medication is given by drip method, record the times started and stopped, and the total amount of medication added (with oxytocin recorded in international units). That medication lost or presumed not absorbed (vomiting, faulty syringe, breakage of I.V. fluid bottle, etc.) is to be so noted. Include pre-operative medications for surgery, whenever given.
3. Procedures, treatments. Note all procedures and treatments performed, and any unusual reactions or effects. If not explained by events, note the reason for procedures, and opinions or results which are not more appropriately recorded on another type form. Include specifically oxygen therapy, anesthetic agents, transfusions, double set-up examinations.

D. Recommended frequency of observations.

The frequency of observations is determined by the rapidity of progress of labor, the condition of the gravida, signs of fetal distress, and diagnostic and therapeutic measures being performed. The closer the patient is to delivery or the more severe the complication, the more frequent should be the observations. Requirements listed below are intended to serve as guidelines only, and cannot supplant good judgment in determining frequency of observations indicated in a particular situation.

E. Minimal requirements

1. Item #7 (temperature). Record upon admission, and whenever taken consistent with local routine or condition of the patient.

OB-32 LABOR ROOM RECORD (Continued)

2. Items #8 and 9 (pulse and blood pressure). Record hourly whenever the patient is under observation.

3. Item #10 (fetal heart rate).

   a. During labor, questionable labor or induction attempt record:

      (1) Every 1/2 hour to 3 cms. dilatation.

      (2) Every 15 minutes from 3 to 10 cms. dilatation.

      (3) Every 5 minutes during second stage, until delivery room observations begin.

   b. In the presence of a "significant obstetric complication," without labor, record every 1/2 hour.

4. Items #11-16 (contractions, membranes, bleeding, meconium):

   a. During labor, questionable labor, or induction attempt, record every 1/2 hour. (If sudden or significant change in uterine activity occurs, e.g., precipitate labor, tetanic contractions, more frequent observation should be made).

   b. In the presence of a significant obstetric complication without labor, record hourly.

5. Items #17-20 (pelvic examination). Record the findings of all pelvic examinations made.

III. Specific Instructions

Note: Record information (whether direct observation or information from other persons) in the appropriate column. Report explanatory notes, brief consultations, etc., in narrative form across the page. In these notes take care to place no numbers in the fetal heart column, other than fetal heart rates.

Item Number

2. This form was:

   a. Circle (1) if all or part of events recorded on this form are directly observed by Study personnel.

   b. Circle (2) if all or part of the information was obtained without direct observation. Clearly designate that period and the source of data recorded. Stamp the form "Not according to protocol" if data on entire page has been abstracted or obtained without any observation.

3. Page numbers. Number forms chronologically for each period of observation ending in a termination of OB-32.

4. Observer. Each new observer at the time he or she first observes the patient prints name and position across the first available line of the form. Initials of the observer are optionally recorded in item #4.

5. Day of month. Record at top of each sheet, and as additionally indicated.

6. Time. Place the time of event on the line opposite each observation, examination, medication, etc., that is recorded. Be specific to the nearest minute. If a time can only be approximated, note this fact. State patient's arrival time in the hospital, if possible.

7. Temperature. Record.

8. Pulse. Take between contractions and record rate.

9. Blood pressure. Take between contractions and record.

10. Fetal heart rate:

   a. Count for a 15 second period, starting approximately 30 seconds after cessation of a contraction. Record as beats/minute.

   b. If a fetal heart rate recorded was taken during a contraction, state this clearly for each such observation.

   c. If the fetal heart rate is monitored electronically, the observer is responsible for knowledge of the fetal heart rate during the period monitored, and for recording the rate of OB-32 as frequently as is required by the Instruction Manual. Note those fetal heart rates obtained electronically on this form.

OB-32 LABOR ROOM RECORD (Continued)

Item Number

d. If fetal heart is abnormal, take more frequently than ordinarily required. If irregular, write "irreg." in item #10.

e. Take and record the fetal heart rate immediately after membrane rupture.

f. If there is certainty of fetal demise prior to admission, continuous observation of fetal heart is unnecessary — record "NA" and explanation.

g. Record all fetal heart findings in this column. None should be recorded elsewhere on the form.

11. Frequency of contractions. Frequency refers to the time in minutes from the start of one contraction to the start of the following one. Record the average of the last two such intervals.

12. Duration of contractions. Record in seconds. Duration refers to the time interval from the onset of a contraction until complete relaxation of the uterus, and is determined by abdominal palpation.

a. Record in most instances the average duration of the last two contractions.

b. Note comments descriptive of the character of contractions (weak, strong, etc.) whenever appropriate.

13. Sensorium, effect of medication. Observations are not necessary for Study purposes, except for recording unusual effects or reactions to analgesic medication.

14. Membranes. Note the condition of the membranes as "I" (intact), or "R" (ruptured). If there is uncertainty, record "?". Once observation is recorded, do not change that notation even though subsequent events show the original observation to have been erroneous. Any discrepancy in the observation of rupture of membranes should be supplemented by additional comment, or opinion of the obstetrician, and be reported on this form.

15. Bleeding. This refers only to vaginal bleeding. Record in the column "O" for

Item Number

none, "S" for show, and "F" for free bleeding (defined as any amount more than normal show). Whenever free bleeding is noted, describe fully. Note also any opinions expressed by the physician concerning the observation, and any subsequent therapy or decisions.

16. Meconium. If membranes are intact, no entry need be made. Whenever membranes rupture, the presence or absence of meconium in the fluid is immediately evaluated and recorded as "+" (present), or "O" (absent). Thereafter, record the presence or absence of meconium according to the frequency prescribed above. Whenever meconium is judged present, describe as "lightly stained," "heavily stained," "thick."

Pelvic examination (Items #17-21): Record alongside the findings, the title or position of the person actually performing the examination.

17. Vaginal or rectal. Record the type of examination performed.

18. Cervical dilatation. Record in centimeters.

19. Effacement. Record as percentage.

20. Presentation or position. Record the position. Presentation is only recorded when it is not possible to determine the position. If later events prove the position to have been erroneous, do not change the original notation.

21. Station. Station refers to the relationship of the leading bony portion of the presenting part to the ischial spines.

It is recorded as centimeters above (minus) or below (plus) the level of the ischial spines. The term "floating" may be used to designate that the presenting part is 3 or more centimeters above the ischial spines (−3). If the presenting part is on the perineum, write either "on perineum" or "+4". If the presenting part is crowning at the vulva, write "crowning." If the estimate of station is based on abdominal examination only, describe as "floating," "dipping," "fixed," or "engaged."

PHS-3003-12
1-59

LABOR ROOM RECORD
(Observer)

green

INSTRUCTIONS TO OBSERVER:

1) The first time you observe this patient, write your name and title or position (project nurse, resident, etc.) across the sheet on the first vacant line.

2) Initial each observation made by you.

superseded by 7-59 rev.

THIS FORM WAS (CHECK ONE)
☐ FILLED OUT AS EVENTS OCCURRED ☐ COPIED FROM OTHER RECORDS

Page No. ____ of ____

RECORD MEDICATIONS, NUTRIENTS, FLUIDS AND PROCEDURES ACROSS SHEET AFTER INDICATING TIME

OBSERVER	DATE	TIME	TEMPERATURE	PULSE	BLOOD PRESSURE	FETAL HEART RATE	CONTRACTIONS		SENSORIUM	MEMBRANES I OR R	BLEEDING NONE SHOW FREE	MECONIUM + OR 0	PELVIC EXAMINATION				
							FREQUENCY (Minutes)	DURATION (Seconds)					V OR R	CERVICAL DILATATION	EFFACEMENT	PRESENTATION OR POSITION	STATION
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18

Department of Health, Education and Welfare,
Public Health Service

(OB-32)

OB-33 Delivery Room Events

Form OB-33 was used to record events and observations of delivery in detail. The form was first used in January 1959. It was revised once in July 1959, resulting in a renumbering of several items. The 54,952 records generated were recorded on card number 0333 (Table OB-33.1).

Other data from OB-33 combined with data from OB-30, OB-31, OB-32 and OB-34 were abstracted on cards from ADM-49, ADM-50 and ADM-51 (see tables summarizing data records for these forms).

TABLE OB-33.1 Cards and Data Records by Revision for Form OB-33

Card Name	Card Number	Rev. No.	Number Records
OB-33: Type of Delivery and Time of Delivery Events	0333	1	54,952
	total for form		54,952

Data Items Referencing Form OB-33, Delivery Room Events

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
810.....		0333	1	5	Card number (sequence, form type, form number, revision number)
811.....		0333	6	14	NTNDB case number
812..OB-33	5	0333	15	16	Form OB-33 date (mo)
813..OB-33	5	0333	17	18	Form OB-33 date (day)
814..OB-33	5	0333	19	20	Form OB-33 date (yr)
815.....		0333	21	21	Blank
816..OB-33	1	0333	22	23	Delivery procedure begun (hr)
817..OB-33	1	0333	24	25	Delivery procedure begun (min)
818..OB-33	1	0333	26	27	Delivery procedure begun (sec)
819..OB-33	2	0333	28	29	Uterine; incision (hr)
820..OB-33	2	0333	30	31	Uterine; incision (min)
821..OB-33	2	0333	32	33	Uterine; incision (sec)
822..OB-33	3	0333	34	35	Umbilicus at perineum (hr)
823..OB-33	3	0333	36	37	Umbilicus at perineum (min)
824..OB-33	3	0333	38	39	Umbilicus at perineum (sec)
825..OB-33	4	0333	40	41	Forceps blade to head, first (hr)
826..OB-33	4	0333	42	43	Forceps blade to head, first (min)
827..OB-33	4	0333	44	45	Forceps blade to head, first (sec)
828..OB-33	5	0333	46	47	Traction to head begun (hr)
829..OB-33	5	0333	48	49	Traction to head begun (min)
830..OB-33	5	0333	50	51	Traction to head begun (sec)
831..OB-33	6	0333	52	53	Delivery of head (hr)
832..OB-33	6	0333	54	55	Delivery of head (min)
833..OB-33	6	0333	56	57	Delivery of head (sec)
834..OB-33	7	0333	58	59	Delivery completed (hr)
835..OB-33	7	0333	60	61	Delivery completed (min)
836..OB-33	7	0333	62	63	Delivery completed (sec)
837..OB-33	8	0333	64	65	Cord clamped (hr)
838..OB-33	8	0333	66	67	Cord clamped (min)
839..OB-33	8	0333	68	69	Cord clamped (sec)
840..OB-33	9	0333	70	71	Placenta delivered (hr)
841..OB-33	9	0333	72	73	Placenta delivered (min)
842..OB-33	9	0333	74	75	Placenta delivered (sec)
843..OB-33		0333	76	76	Plurality code
844.....		0333	77	90	Blank

COLLABORATIVE RESEARCH
REV. 1-68

DELIVERY ROOM EVENTS

(Observer)

1. PATIENT IDENTIFICATION

2. OBSERVER'S LAST NAME, INITIAL

3. TITLE OR POSITION

4. THIS FORM WAS (Check One)
FILLED OUT AS EVENTS OCCURRED 1
COPIED FROM OTHER RECORDS 2

5. DATE Mo. / Day / Year

SELECT PROPER COLUMN AND RECORD TIMES	6. Version, Breech, or Forceps	7. Breech, or Version and Extraction	8. Caesarean Section	9. Total Number of Times Forceps were applied FOR ALL DELIVERIES
(1) Procedure for Delivery Begun	XXXXXXXX		XXXXXXXX	
(2) Incision of Uterus	XXXXXXXX	XXXXXXXX		
(3) Umbilicus or Perineum	XXXXXXXX		XXXXXXXX	
(4) First Blade to Head				
(5) Traction to Head Begun				
(6) Head Delivered				
(7) Infant Completely Delivered		XXXXXXXX		
(8) Cord Clamped				
(9) Placenta Delivered				

These items are optional on this form but must appear on PED-1

Time of:

10. First Breath _____

11. First Cry _____

12. Tenth Breath _____

13. TIME	14. BLOOD PRESSURE	15. FETAL HEART RATE	16. MEC. CONIUM + or 0	17. BLEEDING None Show Free	18. NOTE: Record Blood Pressure at Least Every 15 Minutes. Record Fetal Heart Rate after Every Contraction. Record All Medications, Procedures, and Events Using Entire Line and Noting Time.
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					

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REV. 1-68 (OB-33)

Form Item Numbers linked to Data Items on DR-33, Delivery Room Events

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	#43..DR-33	0333	74	74	Plurality code
1	#16..DR-33	0333	22	23	Delivery procedure began (hr)
1	#17..DR-33	0333	24	25	Delivery procedure began (min)
1	#18..DR-33	0333	26	27	Delivery procedure began (sec)
2	#19..DR-33	0333	28	29	Uterine: incision (hr)
2	#20..DR-33	0333	30	31	Uterine: incision (min)
2	#21..DR-33	0333	32	33	Uterine: incision (sec)
3	#22..DR-33	0333	34	35	Umbilicus at perineum (hr)
3	#23..DR-33	0333	36	37	Umbilicus at perineum (min)
3	#24..DR-33	0333	38	39	Umbilicus at perineum (sec)
4	#25..DR-33	0333	40	41	Forceps blade to head, first (hr)
4	#26..DR-33	0333	42	43	Forceps blade to head, first (min)
4	#27..DR-33	0333	44	45	Forceps blade to head, first (sec)
5	#13..DR-33	0333	17	18	Form DR-33 date (day)
5	#12..DR-33	0333	15	16	Form DR-33 date (mo)
5	#14..DR-33	0333	19	20	Form DR-33 date (yr)
5	#28..DR-33	0333	46	47	Traction to head began (hr)
5	#29..DR-33	0333	48	49	Traction to head began (min)
5	#30..DR-33	0333	50	51	Traction to head began (sec)
6	#31..DR-33	0333	52	53	Delivery of head (hr)
6	#32..DR-33	0333	54	55	Delivery of head (min)
6	#33..DR-33	0333	56	57	Delivery of head (sec)
7	#34..DR-33	0333	58	59	Delivery completed (hr)
7	#35..DR-33	0333	60	61	Delivery completed (min)
7	#36..DR-33	0333	62	63	Delivery completed (sec)
8	#37..DR-33	0333	64	65	Cord clamped (hr)
8	#38..DR-33	0333	66	67	Cord clamped (min)
8	#39..DR-33	0333	68	69	Cord clamped (sec)
9	#40..DR-33	0333	70	71	Placenta delivered (hr)
9	#41..DR-33	0333	72	73	Placenta delivered (min)
9	#42..DR-33	0333	74	75	Placenta delivered (sec)

DEFINITION OF CODES
DELIVERY ROOM EVENTS
FORM OB-33 CARD 0333

FIELD		CARD COLUMN
1.	**Card Number** Code: 0	1
2.	**Form Number** Code: 333	2-4
3.	**Revision Number** Code: 1 - Form Dated: 1/59 or Rev. 7/59	5
4.	**NNDB Number** Nine-digit number for Patient Identification Code: As given	6-14
5.	**Date** Item 5 Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given	15-20
6.	**Type of Delivery** Code: 6 - Vertex, brow, or face 7 - Breech or Version and Extraction 8 - Cesarean Section and other operative delivery procedures	21

TIME OF EVENT

Fields 7-15: Six-digit code in each field represents time reported in hours, minutes, and seconds based on 24 hour clock. (2401-2979 = Time of event occurs beyond midnight of date reported in Field 5).

7.	**Procedure for Delivery Begun (1)** Code: As given 000000 - Not applicable (vertex, C/S and other operative delivery procedures) 999999 - Unknown	22-27
8.	**Incision of Uterus (2)** Code: As given 000000 - Not applicable (vertex, breech or version and extraction) 888888 - Not applicable (operative delivery procedures other than C/S) 999999 - Unknown	28-33

DEFINITION OF CODES (Continued)

FORM OB-3
Card 0333

FIELD		CARD COLUMN
9.	Umbilicus at Perineum (3) Code: Same as in Field 7	34-39
10.	First Blade to Head (4) Code: As given 000000 - No forceps used 888888 - No forceps used in C/S and other operative delivery procedures 999999 - Unknown	40-45
11.	Traction to Head Begun (5) Code: As given 000000 - No traction 888888 - No traction in C/S and other operative delivery procedures 999999 - Unknown	46-51
12.	Head Delivered (6) Code: As given 888888 - Not applicable (C/S and other operative delivery procedures) 999999 - Unknown	52-57
13.	Infant Completely Delivered (7) Code: As given 000000 - Not applicable (Breech or Version and Extraction) 999999 - Unknown	58-63
14.	Cord Clamped (8) Code: Same as in Field 12	64-69
15.	Placenta Delivered (9) Code: Same as in Field 12	70-75
16.	Plurality Code: 0 - Single birth 1 - First of multiple 2 - Second of multiple 3 - Third of multiple 4 - Fourth of multiple	76

DELIVERY ROOM EVENTS
FORM OB-33

OB-33 - 3,

OB-33 DELIVERY ROOM EVENTS

I. Purpose of form For the detailed recording of events and observations during delivery. To insure detailed recording for research purposes, it is desirable that form OB-33 not be part of the official (legal) hospital record. It is essential that the Study observer be free to report descriptive details without consideration of medical-legal implications.

II. General Instructions

A. Initiation of form

1. When the patient is taken to the delivery room with intent of delivery.
2. When a decision is made to deliver the patient previously taken to the delivery room for another reason.
3. For all other cases delivering in the Study hospital, regardless of where delivery occurs.

B. Recommendations for obtaining and recording observations

1. The Study observer should have no patient care responsibility and should not leave the delivery room during the period of delivery observation.
2. Events recorded should reflect the informed, direct observation of a trained Study observer. Such observations may be modified by editors' comments, but should never be deleted.

C. Termination of observations

1. Following completion of the third stage of labor, unless complications make continued observation appropriate.
2. When delivery is not effected, and the patient is transferred back to the labor room. Resume observations on OB-32 in such a case.

D. Multiple births. Use a separate form to record the events in items #6-9 for each infant.

E. Cesarean section. In event of Cesarean section, record final fetal heart rate as close to the time of abdominal preparation as possible. Record other observations as frequently as appropriate, but at least once.

III. Specific Instructions

Item Number

2, 3. Observer. Record the [illegible] and title or position of the Study ob[illegible] recording data.

4. This form was:

a. Circle (1) if all or part of events recorded on this form are directly observed by Study personnel.

b. Circle (2) if all or part of information is obtained without direct observation. Clearly designate that period, and the source of data recorded. Stamp the form "Not according to protocol," if the entire form is abstracted or completed without any direct observation.

5. Date. Record date of delivery.

6-8. Type of delivery:

a. Make notations in blank spaces of columns, entering as appropriate:

(1) Time of event to the nearest second, if possible.

(2) "UNK" if event occurred at an unknown time.

(3) "NA" if event did not occur.

b. Traction to head:

(1) Record the first time traction to head is begun (including that used for forceps rotation and conversion). If discontinued and later initiated, report in item #18. Note that traction need not necessarily follow application of forceps.

(2) In breech delivery, record the time traction is first applied, whether manually or by forceps.

October 1982

OB-33 DELIVERY ROOM EVENTS (Continued)

Item Number

c. "Procedure for delivery begun" (column #7):

(1) In breech delivery, the time when the obstetrician first takes hold of fetus.

(2) In version and extraction, the time when the obstetrician inserts his hand into the uterus for purposes of performing the procedure.

9. Total times forceps applied.

a. If forceps are not used, record "0."

b. If forceps are used, record the total number of applications attempted. The introduction of one blade past the biparietal diameter of the head is counted as one-half an application.

10-12. Information may be optionally recorded here.

13. Time. Record the time of each event or observation recorded on that line, to the nearest minute.

14. Blood pressure.

a. Record all blood pressures taken prior to delivery.

b. Blood pressure is taken between contractions at least every 15 minutes (more frequently if abnormal).

15. Fetal heart rate.

a. Count for a 15 second period, starting approximately 30 seconds after cessation of a contraction. Record as beats/minute.

b. Record as frequently as is possible, preferably after every contraction but at least every 3-5 minutes. In any event, record all ascertained, and denote those taken during contractions.

c. Inability to record rates:

(1) If there is no attempt to listen to the fetal heart at all or within a 15 minute period, record "NE."

Item Number

(2) If attempt is made but fetal heart cannot be heard, record "NH." Record any reason considered likely, such as surrounding noise, obesity of patient; if none, record opinion of physician concerning event.

(3) If, although heart rate is considered within normal limits, there is insufficient time to count the rate, record appropriate comments such as "regular," "heard," "OK," etc., on the column.

(4) If demise of infant is certain prior to this time, record "NA."

16. Meconium.

a. If membranes are intact, no entry need be made.

b. When membranes rupture, evaluate and record in the column provided the presence or absence of meconium-stained fluid or frank meconium, (+ or 0). Repeat observation at minimum intervals of 15 minutes.

c. Whenever meconium is judged present, describe in item #18 as "lightly stained," "heavily stained," "thick."

17. Bleeding.

a. Record "0" if there is no vaginal bleeding other than from episiotomy.

b. Record "S" if there is show, and "F" if there is free bleeding (defined as anything other than normal show). Repeat observation at minimum intervals of 15 minutes.

c. Whenever free bleeding is observed, describe in item #18 the amount, and the opinion of the physician in charge concerning its probable significance or etiology.

18. Description of events. Record here a detailed and chronological description of events related to delivery in an eye-witness fashion. The following are to be emphasized:

OB-33 DELIVERY ROOM EVENTS (Continued)

Item #18 Cont.

a. Continued observations of the character of labor.

b. Rupture of membranes, including the time and method.

c. Medications, including time, dosage, and route. Intravenous medication drip started prior to bringing the patient to the delivery room and continued in the delivery room should be so noted, as should the time of discontinuation.

d. Oxygen administration unaccompanied by an anesthetic agent.

e. Initiation of anesthetic procedures, including unsuccessful or incomplete attempts at administration.

f. Pelvic examinations. The type and findings, especially that examination performed just prior to the delivery procedure.

g. All events and procedures related to actual delivery of the infant. When a vacuum extractor is used, record size of cup.

h. Observer's opinions; estimates of the difficulty of procedures.

i. Changes in the patient's condition; i.e., shock, convulsions, etc.

j. Any other observations deemed pertinent, including post-delivery observations which may be minimal unless the postpartum course is complicated.

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DELIVERY ROOM EVENTS
(Observer)

green

superseded by 7-59 rev.

OBSERVER'S LAST NAME, INITIAL	TITLE OR POSITION

THIS FORM WAS (Check One)
☐ FILLED OUT AS EVENTS OCCURRED ☐ COPIED FROM OTHER RECORDS

DATE (Mo-Da-Yr)

SELECT PROPER COLUMN AND RECORD TIMES	Vertex, Brow, or Face	Breech, or Version and Extraction	Cesarean Section
1. Preparation for Delivery Begun	XXXXXXXX		XXXXXXXX
2. Incision of Uterus	XXXXXXXX	XXXXXXXX	
3. Umbilicus or Perineum	XXXXXXXX		XXXXXXXX
4. First Blade to Head			
5. Traction to Head Begun			
6. Head Delivered			
7. Infant Completely Delivered		XXXXXXXX	
8. Cord Clamped			
9. Placenta Delivered			

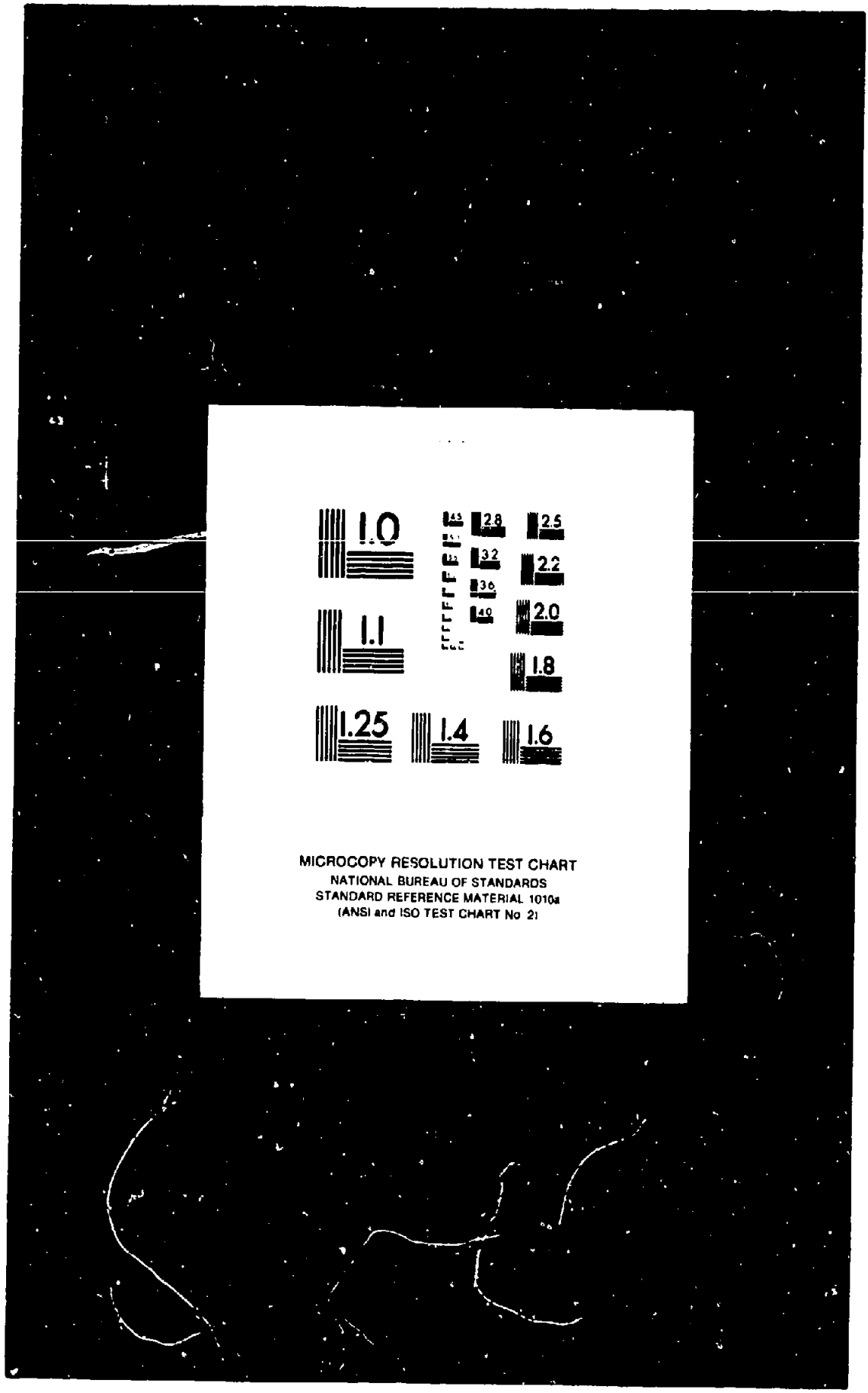
10. Total Number of Times Forceps were applied

TIME OF
First Breath ____ Min. ____ Sec.
First Cry ____ Min. ____ Sec.
Sustained Respiration ____ Min. ____ Sec.

11. TIME	12. BLOOD PRESSURE	13. FETAL HEART RATE	14. ME-CONI-UM + OR 0	15. BLEEDING None Show Free	NOTE: Record Blood Pressure at Least Every 15 Minutes. Record Fetal Heart Rate after Every Contraction. Record All Medications, Procedures, and Events Using Entire Line and Noting Time.

Department of Health, Education and Welfare,
Public Health Service

(OB-33)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MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No 2)

CONTINUED ON NEXT FICHE