



Heartland
Pathology
Consultants, PC

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HISTORY FOR PLACENTAL EXAMINATION

Patient Name: _____ Date & Time of Delivery: _____

Parity: G [] P [] Ab []

Prenatal History: _____

Delivery History: _____

Clinically Evident Placental Abnormality

Foul Smelling Yes No
 Long Cord Yes No
 Short Cord Yes No
 Amnion Nodosum Yes No
 Battledore Yes No
 Velamentous/Marginal
 Insertion Yes No

Succenturiate Lobe Yes No
 Cord Knotting Yes No
 Nuchal Cord Yes No
 Placental Abruption Yes No
 Blood Loss _____
 Other Yes No

Infant History:

Sex(s) Male Female **Twin** No Yes
 Estimated Gestational Age _____
 Weight(s) #1 _____ #2 _____
 Length(s) #1 _____ #2 _____
 APGARs #1 _____ #2 _____
 Fetal Distress No Yes

Maternal History:

Diabetes Yes No
 Pregnancy-Induced Hypertension Yes No
 Stillbirths No Yes (If Yes, Explain) _____
 Congenital Anomalies No Yes (If Yes, Describe) _____
 Suspected Infection No Yes

Why is placenta sent for examination? _____

Date _____

Physician Signature _____