Week 40 of pregnancy: due date and final preparation for labor

Understanding the week 40 due date

The conventional estimated is calculated as 40 weeks, or 280 days, from the first day of the last menstrual period. Johns Hopkins Medicine describes Naegele's Rule, a commonly used method: count back three months from the first day of the last menstrual period, then add one year and seven days. This assumes a relatively standard menstrual cycle, so adjustments may be needed when cycles are shorter, longer, irregular, or when ovulation timing is known to differ.

Due date calculation can also be refined by early ultrasound, especially first-trimester crown-rump length measurement, which is often considered the most accurate ultrasound-based dating method. For pregnancies conceived through in vitro fertilization, dating may be based on embryo transfer and fertilization timing. In practice, clinician integrates menstrual history, ultrasound findings, and assisted reproduction details when relevant.

It is helpful to think of the due date as the center point of a range. Better Health Channel notes that only about 4% of women deliver on their estimated due date, and that full-term occurs between 37 and 42 weeks. This does not mean care team will ignore dates; rather, they use gestational age to guide

monitoring, risk assessment, and conversations about timing of .

What week 40 may feel like physically

At 40 , the uterus is at maximum stretch and the body may be preparing for through hormonal, cervical, uterine, and pelvic . You may notice increased pelvic as the head descends, more frequent Braxton Hicks , backache, disrupted sleep, urinary frequency, leg cramps, and fatigue. Some people experience loose stools, nausea, or a sudden burst of energy often called nesting, although these are not reliable predictors of imminent .

Cervical change can begin before noticeable labor or occur only once labor is established. Your cervix may soften, shorten, move forward, and dilate gradually. If your clinician performs a cervical examination, they may describe effacement, dilation, station, cervical , and consistency. These findings can provide context, but they still cannot precisely predict when labor will begin.

You may also notice an increase in vaginal mucus or the passage of the mucus plug, sometimes tinged with blood. A small amount of pink or brown mucus can occur as the cervix , but heavy bleeding, severe pain, or concern about ruptured membranes prompt immediate contact with your maternity unit.

Your baby at the due date

By week 40, most fetal organ s are mature enough for life outside the , although normal variation remains. The baby continues to accumulate fat, coordinate sucking and swallowing, and maintain sleep-wake cycles. Space is limited, so s may feel different: less flipping and more stretching, rolling, pressing, or pushing. Importantly, the overall pattern of fetal remain reassuring for you.

Do not dismiss reduced fetal as simply being due to the baby running out of room. If you perceive a significant decrease, absence of or a pattern that feels unusual for your baby, contact your healthcare provider or triage promptly. They may recommend assessment such as fetal heart rate monitoring, ultrasound evaluation, or other testing based on your situation.

At this stage, clinicians may also pay close attention to amniotic fluid

volume, fetal heart rate patterns, blood pressure, and any pregnancy-specific risk factors. The goal is to support spontaneous labor when appropriate while identifying situations where closer monitoring or delivery planning may be safer.

Early labor, active labor, and when to call

Labor often begins gradually. Early labor may include irregular contractions that become more patterned over time, lower back discomfort, pelvic pressure, and mild cervical change. Contractions in true labor typically grow stronger, longer, and closer together, and they do not fade with rest, hydration, or a change in position. Your maternity team may give you a specific contraction pattern for when to call or come in, especially if you have had a previous rapid labor, a planned cesarean birth, Group B Streptococcus considerations, or other risk factors.

Rupture of membranes can feel like a gush or a persistent trickle of fluid. If you think your waters have broken, contact your healthcare provider even if contractions have not started. They may ask about the time it happened, fluid color, odor, fetal movement, and whether you have fever or uterine tenderness.

Call urgently or seek immediate care if you have any of the following: vaginal bleeding more than spotting, severe or constant abdominal pain, reduced fetal movement, symptoms of preeclampsia such as severe headache or visual changes, fever, seizures, chest pain, shortness of breath, or fluid that appears green or brown. If something feels wrong, it is appropriate to be assessed; maternity teams prefer that you call early rather than wait in uncertainty.

Final practical preparation for labor

Confirm your route to the hospital or birth center, including where to enter after hours.
Review who will accompany you and how they can be reached at any time.
Install the infant car seat according to local safety guidance before discharge day.
Keep your phone charged and important numbers saved, including maternity triage.
Arrange care for older children, pets, or dependents if labor begins suddenly.

Emotional readiness and communication with your support team

The final days of pregnancy can feel psychologically intense. You may be fielding constant messages asking whether the baby has arrived, while also coping with discomfort and uncertainty. Setting boundaries is reasonable. Some families choose a simple update message such as, "We will let you know when there is news," to reduce pressure.

Discuss preferences with your birth partner or support person before labor begins. Topics may include pain relief options, mobility, hydration, who communicates with family, cultural or spiritual preferences, and what kind of encouragement feels helpful. A birth plan is best viewed as a communication tool rather than a script. Labor can change quickly, and flexibility often reduces distress when clinical recommendations shift.

If anxiety feels overwhelming, or if you have a history of depression, trauma, panic, or perinatal mood symptoms, tell your healthcare professional. Emotional preparation is part of medical care. Support may include counseling, perinatal mental health services, medication review where appropriate, or a more detailed plan for labor and postpartum follow-up.

If pregnancy continues after 40 weeks

Reaching the does not automatically mean something is wrong. Many pregnancies continue beyond 40 and still have healthy outcomes. However, as gestational age advances, your maternity team may recommend additional surveillance or discuss of labor depending on local guidelines, your health, wellbeing, cervical status, prior birth history, and your preferences.

Questions worth asking include: How was my due date established? What do you recommend now? At what gestational age do you usually discuss ? What are the benefits and risks of waiting compared with in my specific situation? What symptoms should prompt immediate ? These conversations should be individualized rather than based solely on the calendar.

If is recommended, your may explain cervical ripening, membrane sweeping, amniotomy, oxytocin infusion, or other methods depending on your circumstances and local practice. This article cannot determine whether is appropriate for

you; that decision belongs in a shared discussion with your obstetrician, midwife, or maternity care team.