Your Hospital's Logo Here

ANTENATAL ADMISSION DATABASE

ASSESSMENT PART II

PATIENT IDENTIFICATION

MEDICAL HISTORY

PREVIOUS HOSPITALIZATIONS: ☐ NO ☐ YES DATE: REASON:	PREVIOUS SURGERY:
PREVIOUS BLOOD TRANSFUSION: ☐ NO ☐ YES DATE: REASON: ☐ NO ☐ YES	* HEART DISEASE: ☐ NO ☐ YES * HYPERTENSION: ☐ NO ☐ YES
RECENT EXPOSURE TO COMMUNICABLE DISEASE: ☐ NO ☐ YES	RESPIRATORY PROBLEM: ☐ NO ☐ YES HEADACHE: ☐ NO ☐ YES
HERPES (HISTORY OF): ☐ NO ☐ YES LAST OUTBREAK: CURRENT LESION? ☐ NO ☐ YES	SEIZURE: ☐ NO ☐ YES DIZZINESS: ☐ NO ☐ YES
STD: ☐ NO ☐ YES TYPE: DATE: TX: ☐ NO ☐ YES	* DIABETES: ☐ NO ☐ YES TYPE / CLASS:
CHICKEN POX (RECENT EXPOSURE): ☐ NO ☐ YES	BACK INJURY: ☐ NO ☐ YES
HIV (DRAWN IN PREGNANCY): ☐ NO ☐ YES DATE: RESULT:	UTI: ☐ NO ☐ YES TX: ☐ NO ☐ YES Date: ______ TEST OF CURE: ☐ POSITIVE ☐ NEGATIVE
HBSAG (DRAWN): ☐ NO ☐ YES DATE: RESULT:	ALCOHOL: ☐ NO ☐ YES AMOUNT: LAST USED:
GBS (GROUP BETA STREP) CULTURE: ☐ POS ☐ NEG TX: ☐ NO ☐ YES	SMOKE: ☐ NO ☐ YES AMOUNT:
RPR / STS TESTING: ☐ NO ☐ YES DATE: RESULT:	DRUGS: ☐ NO ☐ YES TYPE: AMOUNT: LAST USED:
RUBELLA TITER DRAWN: ☐ NO ☐ YES | IMMUNE: ☐ NO ☐ YES CHLAMYDIA: DATE: TX: ☐ NO ☐ YES	COMMENTS:

CARDIOVASCULAR

SKIN: ☐ WARM, DRY ☐ COLD ☐ CLAMMY ☐ PALE ☐ CYANOTIC ☐ FLUSHED

RADIAL PULSE: PULSE: ______ RHYTHM: ______ QUALITY: ______

EDEMA: LOCATION: ______ AMOUNT: ______

RESPIRATORY

DYSPNEA: ☐ NO ☐ YES

BREATH SOUNDS: ☐ CLEAR ☐ WHEEZE ☐ RALES ☐ OTHER (Explain): ______

COUGH: ☐ NO ☐ YES ☐ PRODUCTIVE ☐ NON - PRODUCTIVE

SPUTUM: ☐ NO ☐ YES COLOR: ______

NEUROLOGICAL

LOC: ☐ ALERT ☐ ORIENTED ☐ CONFUSED ☐ LETHARGIC

REFLEXES: ______

MOTOR ACTIVITY: ☐ FULL ☐ PARTIAL ☐ ABSENT

* If "YES", request Physician's Order for NUTRITIONAL CONSULT

RN / LDR SIGNATURE / TITLE ______ DATE ______

RN / LDR SIGNATURE / TITLE ______ DATE ______

RN / LDR SIGNATURE / TITLE ______ DATE ______

PART OF THE MEDICAL RECORD

GASTRO-INTESTINAL

SPECIAL DIETARY NEEDS: ____________________

* NAUSEA:	☐ NO	☐ YES	ONSET: ______
* OBESITY:	☐ NO	☐ YES	WEIGHT: ______
* VOMITING:	☐ NO	☐ YES	ONSET: ______
* DIARRHEA:	☐ NO	☐ YES	ONSET: ______
* CONSTIPATION:	☐ NO	☐ YES	ONSET: ______

* IF DAILY FOR 3 DAYS -or- UNEXPLAINED, INITIATE **NUTRITIONAL CONSULT**.

LAST BM: ______

PERSONAL BELONGINGS / ASSISTIVE DEVICES

	NONE	W/ PT	HOME	HOSP. SAFE
GLASSES:	☐	☐	☐	☐
CONTACTS:	☐	☐	☐	☐
DENTURES:	☐	☐	☐	☐
HEARING AID:	☐	☐	☐	☐
VALUABLES: Explain Policy	☐	☐	☐	☐

(List Valuables) ____________________

GENITO-URINARY

URINE FREQUENCY:	☐ NO	☐ YES
BURNING:	☐ NO	☐ YES

VOIDING QS: ____________________

CATHETER: ____________________

BREASTS

BREASTS:	NIPPLES:	
☐ SOFT	☐ NORMAL	☐ CRACKED
☐ FILLING	☐ FLAT	☐ DRAINAGE
☐ LACTATING	☐ INVERTED	

UNIT ORIENTATION

	PP UNIT
VIDEO TAPING POLICY:	☐
ROOM:	☐
NURSE CALL SYSTEM:	☐
BED CONTROL:	☐
PHONE / TV:	☐
VISITING POLICY:	☐
SMOKING POLICY:	☐
SECURITY ISSUES:	☐

PSYCHO-SOCIAL

MARITAL STATUS:	☐ SINGLE	☐ MARRIED
☐ WIDOWED	☐ DIVORCED	☐ SEPARATED
FATHER OF BABY:	☐ INVOLVED	☐ UNINVOLVED
SUPPORT SYSTEM:	☐ AVAILABLE	☐ UNAVAILABLE

HIGHEST GRADE COMPLETED: ____________________

OF CHILDREN AT HOME: ____________________

AGES: ____________________

REFERRALS

BREAST FEEDING NUTRITIONAL CONSULT	☐ NO	☐ YES
ADOLESCENT NUTRITIONAL CONSULT	☐ NO	☐ YES
NUTRITIONAL CONSULT	☐ NO	☐ YES
SOCIAL SERVICES CONSULT	☐ NO	☐ YES
HOME CARE	☐ NO	☐ YES
WIC	☐ NO	☐ YES
ADOPTION	☐ NO	☐ YES
ST ANNS	☐ NO	☐ YES

FALL POTENTIAL / IMPAIRMENT

PHYSICAL DISABILITIES	☐ NO	☐ YES
LEARNING DISABILITIES	☐ NO	☐ YES
HEARING IMPAIRED	☐ NO	☐ YES
SIGHT IMPAIRED	☐ NO	☐ YES
SUBSTANCE USE	☐ NO	☐ YES
OTHER (DESCRIBE BELOW)	☐ NO	☐ YES

____

____

____

____

____

____

DISCHARGE PLANNING

ALL - PREPARATION FOR INFANT HOMECOMING

☐ CRIB ☐ CAR SEAT ☐ CLOTHING ☐ BOTTLES ☐ FORMULA

ADOLESCENT 12 - 19 YEARS OLD

ADOLESCENT - INITIATE NUTRITIONAL & SOCIAL SERVICES CONSULTS

CURRENT SCHOOL GRADE ________ COLLEGE ________

HOW DO YOU LEARN BEST?

☐ VIDEOS	☐ BOOKS	☐ PICTURES
☐ LECTURES	☐ GROUPS	☐ INDIVIDUAL

CHILD CARE UPON RETURNING TO SCHOOL / WORK ______________

HELP AT HOME: ☐ PARENTS ☐ BABY'S FATHER ☐ OTHERS ______________

SOURCE OF FINANCIAL SUPPORT: ☐ PARENTS ☐ BABY'S FATHER ☐ OTHERS ______________

IMMUNIZATION CURRENT? ☐ Yes ☐ No → IF "No", HAND-OUT GIVEN? ☐ Yes ☐ No

RN / LDR SIGNATURE / TITLE	DATE / TIME	RN / LDR SIGNATURE / TITLE	DATE / TIME

RN / LDR SIGNATURE / TITLE	DATE / TIME

Your Hospital's Logo Here

OBSTETRIC ADMISSION DATABASE
ASSESSMENT PART II

PATIENT IDENTIFICATION

LEARNING NEEDS ASSESSMENT

RELAXATION TECHNIQUES	☐ INITIAL	☐ REVIEW
LABOR PROCESS	☐ INITIAL	☐ REVIEW
COMFORT MEASURES	☐ INITIAL	☐ REVIEW
FETAL MOVEMENT	☐ INITIAL	☐ REVIEW
CONTRACTIONS	☐ INITIAL	☐ REVIEW
DIVERSIONAL ACTIVITIES	☐ INITIAL	☐ REVIEW
ELECTRONIC FETAL MONITORING	☐ INITIAL	☐ REVIEW

OTHER (SPECIFY): ____________________

MATERNAL SELF CARE	☐ INITIAL	☐ REVIEW
NUTRITIONAL NEEDS	☐ INITIAL	☐ REVIEW
DIABETIC TEACHING	☐ INITIAL	☐ REVIEW
MEMBRANES RUPTURE	☐ INITIAL	☐ REVIEW
BLEEDING DISORDERS	☐ INITIAL	☐ REVIEW

OTHER (SPECIFY): ____________________

PLAN OF CARE / STANDARD IMPLEMENTATION

	IM	D	IN	COMMENTS
ADMISSION STANDARD				
DAILY CARE - ANTENATAL				
ANESTHESIA NSG MGMNT				
ELECTRONIC FETAL MONITORING				
GESTATIONAL DIABETES				
PLACENTA PREVIA				
HYPEREMESIS				
HYPERTENSION				
INCOMPETENT CERVIX				
PREMATURE MEMBRANES RUPTURE				
PAIN MANAGEMENT				
ADOLESCENT PT CARE STANDARD				
OTHER				

IM = Implemented **D** = Demonstrated **IN** = Initials

RN / LDR SIGNATURE / TITLE **DATE / TIME**

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RN / LDR SIGNATURE / TITLE **DATE / TIME**

PART OF THE MEDICAL RECORD

DISCHARGE PLANNING - Patient Plans After Discharge

NURSING NOTES

DATE:	TIME:	

PART OF THE MEDICAL RECORD