

Maternal Child Assessment Tool

Student Name: _____

Date: _____

CLIENT INFORMATION

Client Initials : _____ Date of Birth: _____ Age: _____

Marital Status

S ? M ? W ? D ? SEP ?

G	T	P	A	L

EDD: _____ Gestational age: _____ wks

Admitting Diagnosis: _____

Height: _____ Weight: _____
Pre-Pregnancy Present

ALLERGIES:

MENSTRUAL HISTORY

LMP: _____ Menses Monthly: Yes ? No ? Frequency: Q _____ days

Menarche _____ (age onset)

Past Pregnancies (Last Six)										
Date Month Year	GA Weeks	Length OF Labor	Birth Weight	Sex M/F	Type Delivery	Anes	Place of Delivery	Preterm Labor Yes/No	Comments/ Complications	
Medical History:										
TOBACCO:	AMT/DAY PRE PREG		AMT/DAY PREG				NUMBER OF YEARS			
ALCOHOL										
ILLCIT/ RECREATIONAL DRUGS										

*Document in nursing notes/report and elaborate on care plan.

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INFECTION & STD HISTORY						
PHYSICAL EXAMINATION						
	Normal	Abnormal*		Normal		
HEENT			Vagina		? Inflammation	? Discharge
Teeth					? Condyloma	? Lesions
Breasts			Uterus Size	Wks:	? Fibroids	
Lungs			Rectum	? Normal	? Abnormal*	
Heart			DTR's	? Normal	? 1+ ? 2+	? 3+ ? 4+
Abdomen			Clonus	? Present	? Absent	
Extremities*			Cervical Dilation/ Station		FHT Variability	
Skin						

LABORATORY						
Initial Labs	Date	Results			Date	Recent Results
		A	B	AB	O	
Blood Type						
D (rh) Type						
Antibody Screen						
HCT/HGB						
PAP test						
Rubella						
VDRL						
Urine culture/screen						
HBsAg						
HIV counseling/testing						
Group B Strep						
Other:						

Medications:

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