Maternal Health Antepartum Nursing Assessment Form

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| **Client Name:** |  | **Date of Service:** |  |
| **Medical reason for nursing assessment:**  |  |

# Client Physical Assessment

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| **Blood Pressure** |  | **Weight** |  |
| **Headache/visual changes** |  | **Edema** |  |
| **Contractions/cramping** |  | **Vaginal bleeding/leaking of fluid/abnormal discharge** |  |
| **Fetal movement** |  | **Medication use and PNV** |  |
| **New/changed medical diagnosis** |  |