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** | | | |  | | | | |