Israa University
Faculty of Health Professions
Nursing Department
Department of Clinical Training

جامعة الاسراء
كلية المهن الصحية
قسم التمريض
قسم التدريب الميداني

Maternity Nursing Assessment and Care Plan Form

Student's Name: ______________________________ _________**Student's No.** ___________________
Semester/year:_________________ Departments:______________________________________
Training from: ______________to _______________ Total Training Days/hours :________________
Student Mark: ___________________________Clinical instructor: ______________________________

Initial name: Age: Admission date:

Marital status: Employment: Education level

Chief complaint:…….

Confirmed diagnosis:………..

- Past obstetrics medical history :
  ……
- History of other chronic diseases:
  ……
- Previous surgeries
  ……
- Family history
  ……

Functional Health Patterns Assessment

1. Health Perception Health Management Pattern

a. How has general health been?...

………

b. Do you smoke any type of tobacco ??...

c. Accidents (home, work, driving)?

………

……

d. Do you follow suggestions from physicians or nurses?

…….

e. Do you have regular follow-ups with your physician or specialist? If yes, specify

………

……

2. **(Objective Data)** Examination—General health appearance

………

……

2. NUTRITIONAL-METABOLIC PATTERN

a. Describe your typical daily food intake? Supplements (vitamins, type of snacks)?

………

……..

b. Describe your typical daily fluid intake? (Describe.)……………………………………………………………………….

c. Weight loss or gain last 6 months? ❑Yes ❑No (Amount…………………………………………) ,

d. Height loss or gain? ❑Yes ❑No (Amount) ………………………………….

e. Appetite? ❑Good ❑normal ❑poor

f. Food or eating: Diet restrictions (Describe.)………………………………………………………………….

g. Discomfort? Nausea ❑Yes ❑No , Vomiting ❑Yes ❑No,

Stomatitis ❑Yes ❑No, Swallowing (Dysphagia) ❑Yes ❑No Dental problems: ❑Dentures ❑Partial

h. Healing? ❑well ❑poorly , Skin problems: ❑Lesions ❑Dryness

2. **(Objective Data)** Examination:

a. Skin: Bony prominences? ❑Yes ❑No Lesions? ❑Yes ❑No Color changes? ❑Yes ❑No

Moistness? ❑Yes ❑No ❑Edema

b. Oral mucous membranes: Color changes? ❑Yes ❑No Moistness? ❑Yes ❑No

Lesions? ❑Yes ❑No

c. Teeth: General appearance and alignment? ……………………………………………………………………………….

Cavities? ❑Yes ❑No Missing teeth? ❑Yes ❑No

d. Actual weight,………………………Kg , height………………………. cm e. Temperature………………C^{o}

f. Intravenous feeding–parenteral feeding (specify)? ❑Yes ❑No

3. ELIMINATION PATTERN

1. History

a**. Bowel elimination pattern?** (Describe)……………………………………………………………………………….

Frequency?...

Discomfort? Constipation ❑No ❑Yes(Describe)…………………………………………….

Diarrhea ❑No ❑Yes (Describe)……………………………………………… Incontinency ❑No ❑Yes

Bleeding ❑No ❑Yes(Describe)……………………………….Painful defecation ❑Yes ❑No

Ostomy ❑No ❑Yes (Describe)……………………………………………………………………………….

Using of laxatives ? ❑No ❑Yes (Describe)……………………………………………………………………………….

b. **Urinary elimination pattern**? (Describe.)…………………………………………………………………….

Frequency? ……

Problem in control?

Retention ❑Yes ❑No, Hematuria ❑Yes ❑No, Dysuria ❑Yes ❑No, Urgency ❑Yes ❑No,

Incontinency ❑Yes ❑No, Nocturia ❑Yes ❑No, Anuria ❑Yes ❑No, Burning ❑Yes ❑No

Assistive devices : ❑No ❑external condom ❑folly's catheter❑ umbilical cath.

c. Excessive perspiration (sweat)? ………………………………… Odor problems? ❑Yes ❑No

2. **(Objective Data) Examination :** Bowel sounds : Present ❑No ❑Yes , Distention ❑Yes ❑No, Tenderness ❑Yes ❑No, Masses : ❑No ❑Yes(describe) ……………………………………………………………….,

4. ACTIVITY-EXERCISE PATTERN

1. History

a. Sufficient energy for desired or required activities? ❑Yes ❑No

b. Exercise pattern? …………………………………… Regularity? ……………………………………………………………….

c. Perceived ability (use codes : 1= independent, 2 = needs assistance, 3 = dependent)

Feeding …… Bathing ……Toileting …… Dressing………Grooming………Bed mobility…………

General mobility……… Shopping………… Cooking……….. Home maintenance…………..

2. **(Objective Data)** Examination:

A- Range of motion : Full ❑Yes ❑No. , Other (specify) ……………………………………………………….

B- Balance and gait : Steady ❑Yes ❑No

C- Hand Grasps : Equal ❑Yes ❑No, Strong ❑Yes ❑No,

Weakness: Rt ❑Yes ❑No, Lt ❑Yes ❑No. Paralysis: Rt ❑Yes ❑No, Lt ❑Yes ❑No

D- Leg muscles : Equal ❑Yes ❑No, Strong ❑Yes ❑No,

Weakness: Rt ❑Yes ❑No, Lt ❑Yes ❑No. Paralysis: Rt ❑Yes ❑No, Lt ❑Yes ❑No

5. SLEEP-REST PATTERN

1. History

a. Generally rested and ready for daily activities after sleep? ……………………………………………………………….

b. Sleep onset problems? ❑No ❑Yes, Aids? ❑No ❑Yes (specify)

Dreams (nightmares)? ❑Yes ❑No, Early awakening? ❑Yes ❑No

c. Rest-relaxation periods? ❑No ❑Yes, from……………. to ……………., ……………. (hours)

6. COGNITIVE-PERCEPTUAL PATTERN

1. History

a. Hearing difficulty? ❑No ❑Yes, Hearing aid? ❑Yes ❑No, Tinnitus ❑Yes ❑No

b. Vision

Wear glasses /lenses? ❑No ❑Yes, Last checked? ……………………………………

When last changed? …………………………………..

c. Any change in memory lately? ❑Yes ❑No

d. Important decision easy to make? ❑Yes easy to make ❑No it is difficult

e. Any discomfort? ❑Yes ❑No

Pain? ❑Yes ❑No Pain severity by (pain scale 1-10)…………………………….

When appropriate: How do you manage it?

2. **(Objective Data)** Examination

a. Orientation. ❑Persons ❑Time ❑Place

b. Hears whisper? ❑Yes ❑No

c. Reads newspaper? ❑Yes ❑No

d. Grasps ideas and questions (abstract, concrete)?

e. Language spoken.

f. Attention span.

7. SELF-PERCEPTION—SELF-CONCEPT PATTERN

1. History

a. How describe self? Most of the time, feel good (not so good) about self?

………

b. Changes in body or things you can't do? Problem to you?

………

c. Changes in way you feel about self or body (since illness started)?

………

d. Things frequently make you angry? ❑Yes ❑No

Annoyed? ❑Yes ❑No, Fearful? ❑Yes ❑No, Anxious? ❑Yes ❑No

e. Ever feel you lose hope? ❑Yes ❑No

2. **(Objective Data)** Examination

a. Eye contact ❑Yes ❑No, Attention span (distraction) ❑Yes ❑No

b. Voice and speech pattern. ❑normal ❑abnormal

c. Nervous (5) or relaxed (1); rate from 1 to 5. **Client rate** ………………………….

d. Assertive (5) or passive (1); rate from 1 to 5. **Client rate** ………………………….

8. ROLES-RELATIONSHIPS PATTERN

1. History

a. Live alone? ❑No ❑Yes, Live with Family? ❑Yes ❑No, Family members?..........................

b. Any family problems you have difficulty handling (nuclear or extended)?

……

c. Family or others depend on you for things? How managing?

……

d. When appropriate: How family or others feel about illness or hospitalization?

……

e. When appropriate: Problems with children? Difficulty handling?

……

f. Belong to social groups? Close friends? Feel lonely (frequency)?

……

g. Things generally go well at work? (School?)

……

h. Feel part of (or isolated in) neighborhood where living?

……

2. Examination

a. Interaction with family member(s) or others (if present).

9. SEXUALITY-REPRODUCTIVE PATTERN

History of previous pregnancies:

1. Last menstrual period? …………………………………………..Menstrual problems? ❑Yes ❑No
2. Gravida?…………………..Para?.....................Abortion? …………………… C.S. …………………
3. Still births ……………………………………. Infant death …………………….
4. Place of last birth…………………

5. Birth weight of new born in grams ……………………………..gm.
6. Duration of breast feeding ……………. months
7. History of postpartum hemorrhage ………………………..
8. Complication of pregnancy ……………………………..
9. Hypertension during pregnancy …………………..
10. Complication of delivery ……………………………………………………………………………………………………..
11. Family history of hypertension, diabetic ………………………………………………………………………………….

Present pregnancy :

1. Menstruation : LMP (Date) ………………………………………………..

Menstruation Problems : ❑No, ❑Yes (Describe)……………………………………………………………………………

……

2. Expected Day of Delivery ……………………………………………………………

2. Use of contraceptives : ❑No, ❑Yes (Describe)…………………………………………………………………………

……

3. Breast feed at conception ……………………………………………………………………………………

4. Vaginal bleeding / discharge : ❑No, ❑Yes (Describe)………………………………………………………………..

……

5. When appropriate to age and situations: Sexual relationships satisfying?

Changes? ❑Yes ❑No Problems?...

2. **(Objective Data)** Examination

1. Per vaginal examination: ❑Yes ❑No (if yes please give details of indication and results)

……..

2. Abdominal examination: ❑Yes ❑No (if yes please give details of indication and results)

……..

3. Cardiotocography(CTG): ❑Yes ❑No (indication……………………………………………………………………….)

Fetal heart rate: ………… bpm, uterine contraction: ❑Positive ❑Negative

a. **10. COPING-STRESS TOLERANCE PATTERN**

1. History

a. Any big changes in your life in the last year or two?
....

b. Tense or relaxed most of the time? When tense, what helps?
....

c. Use any medicines?
....

d. Coping mechanisms……….

2. **(Objective Data)** Examination: None.

11. VALUES-BELIEFS PATTERN

1. History

a. Generally get things you want from life? ❑Yes ❑No, Important plans for the future? ❑Yes ❑No

b. Religion important in life? ❑Yes ❑No

When appropriate: Does this help when difficulties arise? ❑Yes ❑No

c. When appropriate: Will being here interfere with any religious practices? ❑Yes ❑No

Other Physical Examination (Objective Data)

Respiratory / Circulatory

A- Blood Pressure ……………………………………………………

B- Pulse : Apical rate …………………… , Radial rate …………………………. Rhythm …………………………. .
Heart auscultation : Abnormal sound ❑No ❑Yes(Specify)
……….

C- Respiration : Rate -----------------, Rhythm -------------------
Lung auscultation : Abnormal sounds ❑No ❑Yes(Specify)

Medication Profile

Drug and Classification	For this patient Indications	Dose Frequency	Contraindic ations	Expected side effects	Nursing Implication

Laboratory and Diagnostic Tests

Date	Performed Test		Normal Value	Patient's Value	Interpretations
	Last CBC	*Hgb.*			
		HCT			
		RBCS			
		WBCS			
		PLT			
	Last S. electrolytes	*Na*			
		K			
		Ca			
	KFT	*Urea*			
		Creatinine			

Date	Performed Test		Normal Value	Patient's Value	Interpretations
	Others				

Radiologic studies

X-ray: ❑No ❑Yes(Specify, organ and result)

……

CT: ❑No ❑Yes(Specify, organ and result)

……

MRI: ❑No ❑Yes(Specify, organ and result)

……

Ultrasound: ❑No ❑Yes(Specify, organ and result)

………

………

………

Nursing Care Plan (1)

Functional Health Pattern ……………………………………………………………………

Nursing Problem ………………………………………………………………………………..

Actual Nursing Diagnosis ……

Evidenced By ………

Short - Term Goals ………..

……

Planned intervention with Rationale

1.

Rational/

2.

Rational/

3.

Rational/

4.

Rational/

5.

Rational/

Actual Intervention

1.

2.

3.

4.

Evaluation of outcomes

………

Nursing Care Plan (2)

Functional Health Pattern ………………………………………………………………

Nursing Problem ……………………………………………………………………………..

Actual Nursing Diagnosis …….

Evidenced By ……….

Short - Term Goals ………..

……….

Planned intervention with Rationale

6.

Rational/

7.

Rational/

8.

Rational/

9.

Rational/

10.

Rational/

Actual Intervention

5.

6.

7.

8.

Evaluation of outcomes

……

Nursing Care Plan (3)

Functional Health Pattern ……………………………………………………………………

Nursing Problem …………………………………………………………………………………..

Potential Nursing Diagnosis ……..

Evidenced By ……….

Short - Term Goals ………..

……….

Planned intervention with Rationale

11.

Rational/

12.

Rational/

13.

Rational/

14.

Rational/

15.

Rational/

Actual Intervention

9.

10.

11.

12.

Evaluation of outcomes

………