

ADMISSION OBSTETRICAL ASSESSMENT

Allergies including food allergies or intolerances:	Medications, herbal products, or over-the-counter drugs you are currently taking or use on a regular basis:
Last Meal: _____ Date/ Time: _____	Age: _____ Marital Status: _____ Is adoption planned? <input type="checkbox"/> No <input type="checkbox"/> Yes

Part I: Past Medical History and Anesthesia Risk Factors	Part II: Social and Environment	Part III: Nursing Obstetrical Assessment
Have you ever had: <input type="checkbox"/> Y <input type="checkbox"/> N	Cognitive/Perceptual/Relationships <input type="checkbox"/> Y <input type="checkbox"/> N	Obstetrical History
A. High blood pressure	1. Is English your primary language?	Date of admission: _____ Time: _____
B. Heart Disease/Heart Attack	2. What is the highest level of education _____ yr.	FPC or OBC _____ HT: _____ WT: _____
C. Chest Pain/Angina	3. Do you have an advanced directive?	G: _____ P: _____ EGA: _____
D. Heart Failure	a. If "YES," where is it located?	Reason for admission: _____
E. Heart Murmur / heart valve problems	b. If "NO," would you like one after reading the Advance Directive brochure?	Weight gain= _____ Normal= 25-35lbs.
F. Swelling	Relationships/Roles <input type="checkbox"/> Y <input type="checkbox"/> N	Contractions: Intensity: _____
G. Breathlessness	1. Do you have someone to help during labor?	Membranes ruptured: yes no
H. Lung Disease/Pneumonia	2. Will you have help at home after discharge	Fluid: Clear Thin mec. Thick mec.
I. Emphysema/Chronic Bronchitis	3. Is your spouse deployed?	Odor: None Foul
J. Asthma/Wheezing/Inhaler use	4. Do you have other children?	Ant: Scant Mod. Copious
K. Alcohol or Drug Dependency	If so how many: _____ ages: _____	Date and time ruptured: _____
L. Jaundice/Hepatitis	5. Do you have help if you are unable to care for the children?	Bleeding: none normal show bleeding
M. Rheumatic Fever	6. Do you have experience with infant care?	Headaches: yes no
N. Bleeding Tendency	Coping/Stress <input type="checkbox"/> Y <input type="checkbox"/> N	Visual disturbances: yes no
O. Anemia	1. Do you have any fears about labor&delivery?	Epigastric pain yes no
P. Stroke	2. Do have any experience with childbirth?	Edema: None Feet Generalized
Q. Epilepsy/Convulsions	3. What did you do for pain in previous labors?	Physical Assessment
R. Head Injury	Fill in: _____	Pain level (0-10): _____
S. Diabetes	4. Do you have any major stresses or changes in your life, other than pregnancy?	Onset: _____ Duration: _____
T. Thyroid gland disorder	5. Have you ever been emotionally or physically abused?	Character:
U. Hemorrhoids	Dietary <input type="checkbox"/> Y <input type="checkbox"/> N	Temp: _____ Pulse: _____ Resp: _____ BP: _____
V. Stomach/Duodenal Ulcers	1. Do you have a special diet?	SSE fern: _____ pool: _____ nitrazine: _____
W. Hiatal Hernia	If so what: _____	SVE Dil: _____ Eff: _____ Sta: _____
X. Burning on Urination	2. How do you plan to feed your baby?	Presenting part: vertex breech
Y. Blood in urine	Breast Bottle Mixed	Skin: Normal other: _____
Z. Kidney Disease	3. How is your appetite: Good Fair Poor	Lungs: Clear throughout Wheezes Rhonchi Rales
AA. Glaucoma	4. Are you able to prepare food for yourself?	Neuro: DTR +1 +2 +3 +4 Clonus - +
BB. Mental illness	5. Do you have difficulty swallowing?	GI: Bowel sounds Present Absent
CC. Scoliosis	Spiritual/Cultural <input type="checkbox"/> Y <input type="checkbox"/> N	Nausea/ Vomiting Yes No
DD. Nerve or muscle disease	1. Do you have any spiritual concerns?	CV: Cap. Refill <3 sec. Yes No
EE. Back problems/ slipped discs/etc	2. Would you like to see a chaplain?	Labs:
Do you smoke?	3. Do you have any cultural concerns?	Blood type/Rh GBS Neg / Pos
How many cigarettes/day? _____	Functional <input type="checkbox"/> Y <input type="checkbox"/> N	Rubella Imm / Non-imm Hep B Neg / Pos
Do you drink alcohol? _____	1. Do you use a cane, walker or other assistive device?	HSV Pos / Neg GC Neg / Pos
If so how much? _____	2. Do you have any special needs?	UA 1*GTT
Have you ever had a blood transfusion? <input type="checkbox"/> Y <input type="checkbox"/> N	Surgical History: Have you or anyone in your family had problems with any anesthetics Yes No	Pregnancy Complications:
Comments/Other:	Please list any surgeries and type of anesthesia (General, Spinal, Epidural)	RN signature: _____

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PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN	
RELATIONSHIP TO SPONSOR		