Midwifery Case Book I and II

FOR BASIC B.SC NURSING SEMESTER VI AND VII NURSING STUDENTS AS PER INC SYLLABUS

Laxmi Agnihotri Rajeshwari Kambi



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PREFACE

Nursing education aims to prepare the standardised and register nurses who are capable for providing standard nursing care to sick individual. And also mothers who go through the physiological processes like conception, pregnancy, and childbirth.

This midwifery case book is a practical record book of midwifery for 6th and 7th semester nursing students as per INC. As the theory and practical examination held on the 7th semester for the both normal and high risk cases, so this practical record book is organised to learn students from simple to complex.

SALIENT FEATURES

- ✓ It is modified and expanded according to the *INDIAN NURSING* COUNCIL (INC)SYLLABUS
- \checkmark It includes basic terminologies which aid students in clinical set up.
- ✓ It contains adequate number of cases and care plans for the antenatal, postnatal and intranatal mothers etc...
- ✓ It also helps in documenting the needs and nursing care to high risk mothers.

AUTHORS



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Mrs. Rajeshwari kambi M.sc (N) is Assistant Professor, Department Of OBG Nursing, and BLDEAS College of Nursing Jamakhandi. Completed B.Sc Nursing in 2009 and M.Sc Nursing in 2021 in Obstetrics and Gynaecology speciality from Rajiv Gandhi University Health Sciences. 3 Years of Clinical Experience and 10 years of Teaching Experience in Nursing Profession. Published many more research articles and scientific papers in national and international journals.

CLINICAL RECORD BOOK

Name of the student:	
Registration number:	Photograph
Age and date of birth:	
Name of the institution:	
Address:	

Signature of Student

Signature of Teacher

Signature of Principal

Signature Internal Examiner

Signature of External Examiner

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TERMINOLOGIES

- Gravida: The total number of pregnancies a woman has had, regardless of their outcome.
- **Para:** The number of pregnancies that have resulted in a birth (living or dead).
- Nulligravida: A woman who has never been pregnant.
- **Primigravida:** A woman pregnant for the first time.
- Multigravida: A woman who has been pregnant more than once.
- Fetal presentation: The part of the fetus that is leading the way during delivery (e.g., head, breech).
- Lie: The position of the fetus in the uterus (e.g., longitudinal, transverse).
- Attitude: The position of the fetus's body (e.g., flexed, extended).
- Engagement: When the presenting part of the fetus enters the pelvic inlet.
- Stations: The position of the presenting part in relation to the pelvic ischial spines during labor.
- Amniotic fluid: The fluid that surrounds the fetus in the uterus.
- Placenta: The organ that supports fetal development during pregnancy.
- Cesarean section (C-section): Surgical delivery of a baby through an incision in the abdomen and uterus.
- VBAC: Vaginal birth after cesarean.
- Amniocentesis (amnio): A test used to diagnose chromosome problems and spina bifida.
- Antepartum (AP): Before birth.
- Antibodies: Proteins that protect your body from bacteria and toxins. During pregnancy and breastfeeding,
- (AROM): Artificial rupture of membranes
- V/V: Vulva/Vagina
- **BUS** :Bartholdi's glands, Urethra, Skene's gland
- **RV:** Extroverted
- **AV** : Anteverted

- **RF** : Retroflexed
- **AF** : Anteflexed
- **MP** : Midplane
- TAH: Total Abdominal Hysterectomy
- **TVH:** Total Vaginal Hysterectomy
- **BSO:** Bilateral Salpingo Oophorectomy
- IA : Incidental Appendectomy
- **BTL/BPS** : Bilateral Tubal Ligation/Bilateral Partial Salpingectomy
- **TL:** tubal ligation
- LTL :laparoscopic tubal ligation
- **PID** :pelvic inflammatory disease
- GC :gonococcus, Gonorrhea
- **CKC :**cold knife conization of the cervix
- **D&C:** dilation and curettage of the uterus
- Cx Bx :cervical biopsy
- ECC :endocervical curettage
- ENDO BX :endometrial biopsy
- LPD: luteal phase defect
- **PMS:** premenstrual syndrome
- **CIN:** cervical intraepithelial neoplasia
- **PCO**: polycystic ovarian disease
- **ERT:** estrogen replacement therapy
- **STD** :sexual transmitted disease
- GTN: gestational trophoblastic neoplasia
- **SAB:** spontaneous abortion
- **EAB:** elective abortion
- SUI :stress urinary incontinence

Antenatal History

Baseline Data

- Name: •
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address: •
- Religion: •
- Obstetrical score: •
- Diagnosis: •

Socio economic history

Educational status: Husband

Wife:

Occupation

: Husband Wife:

- Income:_____

- Type of house:_____
- Standard of living:_____
- Lighting facility:_____
- Toilet facility:_____
- Water facility:_____ Drainage /gardening:______
- Pet animals:

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	Sexual History:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Consang	uineous:
Contraceptive history:	_
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	_ Date of Lightning :
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	NO of TT Inj:
Medications in Pregnancy:	

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise		Living children
1					
2					
3					
4					
5					

Past medical History: _____

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

Body built:

Weight:

Respiration: BP:

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student

Signature Of Supervisor

Antenatal History

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- Religion: •
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- Diagnosis: •

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Educational status: Husband

Wife:

Occupation

: Husband Wife:

- Income:_____

Type of house:_____

Toilet facility:_____

- Standard of living:_____
- Lighting facility:_____
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Educational status: Husband

Wife:

Occupation

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Type of house:_____

Toilet facility:_____

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- Obstetrical score: •
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation

: Husband Wife:

- Income:_____

Type of house:_____

Toilet facility:_____

- Standard of living:_____
- Lighting facility:_____
- Water facility:_____
- Drainage /gardening:______
- Pet animals:

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1							
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ANTENATAL EXAMINATION-8

Antenatal History

Baseline Data

- Name: •
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue: •
- Address: •
- Religion: •
- Obstetrical score: •
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation

: Husband Wife:

- Income:_____

Type of house:_____

Toilet facility:_____

- Standard of living:_____
- Lighting facility:_____
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- Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
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PERSONEL HISTORY:

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- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

Respiration: BP:

Weight: Body built:

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student

Signature Of Supervisor

ANTENATAL EXAMINATION-9

Antenatal History

Baseline Data

- Name: •
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue: •
- Address: •
- Religion: •
- Obstetrical score: •
- Diagnosis: •

Socio economic history

Educational status: Husband

Wife:

Occupation

: Husband Wife:

- Income:_____

Type of house:_____

Toilet facility:_____

- Standard of living:_____
- Lighting facility:_____
- Water facility:_____
- Drainage /gardening:______
- Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	Sexual History:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Consangu	ineous:
Contraceptive history:	
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	Date of Lightning :
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	_ NO of TT Inj:
Medications in Pregnancy:	_

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise		Living children
1					
2					
3					
4					
5					

Past medical History: _____

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

Respiration: BP:

Weight: Body built:

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student

Signature Of Supervisor

ANTENATAL EXAMINATION-10

Antenatal History

Baseline Data

- Name: •
- Age: •
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue: •
- Address: •
- Religion: •
- Obstetrical score: •
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation

: Husband Wife:

- Income:_____

Type of house:_____

Toilet facility:_____

- Standard of living:_____
- Lighting facility:_____
- Water facility:_____
- Drainage /gardening:______
- Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	_ Sexual History:
• Habits:	_ Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Consa	nguineous:
Contraceptive history:	
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	Date of Lightning :
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	NO of TT Inj:
Medications in Pregnancy:	

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise		Living children
1					
2					
3					
4					
5					

Past medical History: _____

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

Respiration: BP:

Weight: Body built:

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student

Signature Of Supervisor

ANTENATAL CARE PLAN

ANTENATAL CARE PLAN-1

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: ______
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•	Dietary Pattern:	Bowel and Bladder Elimination Pattern:					
•	Sleeping Pattern:		Sexual History:				
•	Habits:						
Menstru	ual History:						
	Age at menarche:		Duration of c	ycle in days:			
	Regularity:		Problems:				
	LMP:		EDD:				
Marital	history						
	Age at marriage:						
	Type Of marriage: Consangui	neous/ Non Consan	guineous:				
	Contraceptive history:						
Present	obstetrical history						
	Date of booking:		No of ANC visits:				
	Date of Quickening:		Date of Lightning:				
	Any history of disorders in Pre	gnancy:					
	Weight gain in Pregnancy:		NO of TT Inj:				
	Medications in Pregnancy:						
	stetrical history						
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children	
1							
2							
3							
4							

Past medical History:

Past surgical History: _____

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN-2

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: ______
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•]	Dietary Pattern:		Bowel and Bladder Elimination Pattern:				
• ;	Sleeping Pattern:		Sexual History:				
	Habits:		Drug History:				
Menstru	al History:						
	Age at menarche:	Duration of c	ycle in days:				
]	Regularity:						
]	LMP:		EDD:				
Marital l	history						
	Age at marriage:						
,	Type Of marriage: Consangui	neous/ Non Consang	guineous:				
	Contraceptive history:						
Present o	obstetrical history						
]	Date of booking:		No of ANC visits:				
]	Date of Quickening:		Date of Lightning:				
1	Any history of disorders in Pre	gnancy:					
,	Weight gain in Pregnancy:		NO of TT Inj:				
]	Medications in Pregnancy:						
Past Obs	stetrical history						
SL.NO	2.NO Year of last pregnancy No of Abortion			Term	Mode of delivery	Living children	
1							
2							
3							
4				İ			

Past medical History:

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility
1				

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN-3

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: ______
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•	Dietary Pattern:	Bowel and Bladder Elimination Pattern:						
•	Sleeping Pattern:	Sexual History:						
•	Habits:	Drug History:						
Menstru	ual History:							
	Age at menarche:		Duration of cycle in days:					
	Regularity:							
	LMP:			EDD:				
Marital	history							
	Age at marriage:							
	Type Of marriage: Consanguineous/ Non Consanguineous:							
	Contraceptive history:							
Present	obstetrical history							
	Date of booking:			No of ANC visits:				
	Date of Quickening:			Date of Lightning:				
	Any history of disorders in Preg	nancy:						
	Weight gain in Pregnancy:			NO of TT Inj:				
	Medications in Pregnancy:							
	stetrical history							
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children		
1								
2								
3								
4								

Past medical History:

Past surgical History: _____

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:
Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility
1				

Nursing Diagnosis:

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN -4

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: ______
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•	Dietary Pattern:			Bowel and Bladder Elimination Pattern:			
•	Sleeping Pattern:		Sexual History:				
•	Habits:	Drug History					
Menstru	ual History:						
	Age at menarche:		Duration of c	ycle in days			
	Regularity:		Problems:				
	LMP:						
Marital	history						
	Age at marriage:						
	Type Of marriage: Consangui	neous/ Non Consan	guineous:				
	Contraceptive history:						
Present	obstetrical history						
	Date of booking:		No of ANC v	/isits:			
	Date of Quickening:		Date of Lightning:				
1	Any history of disorders in Pre	gnancy:					
	Weight gain in Pregnancy:		NO of TT Inj:				
	Medications in Pregnancy:						
	stetrical history						
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children	
1							
2							
3							
4							

Past medical History:

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN -5

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: _____
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•]	Dietary Pattern:	Bowel and Bladder Elimination Pattern:					
•	Sleeping Pattern:		Sexual History:				
•	Habits:		Drug History:				
Menstru	al History:						
	Age at menarche:		Duration of c	ycle in days:			
]	Regularity:		Problems:				
]	LMP:	EDD:					
Marital	history						
	Age at marriage:						
,	Type Of marriage: Consanguin	eous/ Non Consan	guineous:				
(Contraceptive history:	<u></u>					
Present o	obstetrical history						
]	Date of booking:		No of ANC visits:				
	Date of Quickening:		Date of Lightning:				
1	Any history of disorders in Preg	nancy:					
	Weight gain in Pregnancy:		NO of TT Inj:				
	Medications in Pregnancy:						
Past Obs	stetrical history						
SL.NO	NO Year of last pregnancy No of Abortion			Term	Mode of delivery	Living children	
1							
2							
3							
4							

Past medical History:

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN -6

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: ______
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•	Dietary Pattern:		Bowel and Bladder Elimination Pattern:				
•	Sleeping Pattern:		Sexual History:				
•	Habits:		Drug History:				
Menstru	al History:						
	Age at menarche:		Duration of c	ycle in days: _			
	Regularity:		Problems:				
	LMP:		EDD:				
Marital	history						
	Age at marriage:						
	Type Of marriage: Consanguin	eous/ Non Consang	guineous:				
	Contraceptive history:						
Present	obstetrical history						
	Date of booking:		No of ANC v	/isits:			
	Date of Quickening:		Date of Lightning:				
	Any history of disorders in Preg	nancy:					
	Weight gain in Pregnancy:		NO of TT Inj:				
	Medications in Pregnancy:						
	stetrical history						
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children	
1							
2							
3							
4					1		

Past medical History:

Past surgical History: _____

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN -7

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: ______
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•	Dietary Pattern:	Bowel and Bladder Elimination Pattern:				
٠	Sleeping Pattern:	Sexual History:				
•	Habits:	Drug History	^{re}			
Menstru	ual History:					
	Age at menarche:		Duration of c	ycle in days		
	Regularity:		Problems:	· · · · · · · · · · · · · · · · · · ·		
	LMP:		EDD:			
Marital	history					
	Age at marriage:					
	Type Of marriage: Consangui	neous/ Non Consang	guineous:			
	Contraceptive history:					
Present	obstetrical history					
	Date of booking:		No of ANC visits:			
	Date of Quickening:		Date of Lightning:			
	Any history of disorders in Prea	gnancy:				
	Weight gain in Pregnancy:		NO of TT Inj	:		
	Medications in Pregnancy:		· · · ·			
	stetrical history					
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
1						

Past medical History:

Past surgical History: _____

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Assessment	Diagnosis	Interventions	Evaluation

	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor
ANTENATAL CARE PLAN -8

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: _____
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•]	Dietary Pattern:	Bowel and Bladder Elimination Pattern:				
•	Sleeping Pattern:		Sexual History:			
•	Habits:		Drug History	•		
Menstru	al History:					
	Age at menarche:		Duration of c	ycle in days:		
]	Regularity:		Problems:			
]	LMP:	EDD:				
Marital	history					
	Age at marriage:					
,	Type Of marriage: Consanguin	eous/ Non Consan	guineous:			
(Contraceptive history:					
Present o	obstetrical history					
]	Date of booking:		No of ANC visits:			
	Date of Quickening:		Date of Lightning:			
1	Any history of disorders in Preg	nancy:				
	Weight gain in Pregnancy:		NO of TT Inj:			
	Medications in Pregnancy:					
Past Obs	stetrical history					
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						

Past medical History:

Past surgical History: _____

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN -9

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: ______
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•	Dietary Pattern:	Bowel and Bladder Elimination Pattern:					
•	Sleeping Pattern:		Sexual History:				
•	Habits:		Drug History	*			
Menstru	ual History:						
	Age at menarche:		Duration of c	ycle in days	:		
	Regularity:		Problems:				
	LMP:						
Marital	history						
	Age at marriage:						
	Type Of marriage: Consangui	neous/ Non Consan	guineous:				
	Contraceptive history:						
Present	obstetrical history						
	Date of booking:		No of ANC visits:				
	Date of Quickening:		Date of Lightning:				
1	Any history of disorders in Pre	gnancy:					
	Weight gain in Pregnancy:		NO of TT Inj:				
	Medications in Pregnancy:						
	stetrical history						
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children	
1							
2							
3							
4							

Past medical History:

Past surgical History: _____

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility
1				

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

ANTENATAL CARE PLAN -10

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____
- Standard of living: ______
- Water Facility: _____
- Drainage /Gardening: ______

Type of house: ______ Lighting facility: _____ Toilet facility: _____

Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

5

•	Dietary Pattern:			Bowel and Bladder Elimination Pattern:		
•	Sleeping Pattern:	Sexual History:				
•	Habits:			*		
Menstru	ual History:					
	Age at menarche:		Duration of c	ycle in days	:	
	Regularity:		Problems:			
	LMP:					
Marital	history					
	Age at marriage:					
	Type Of marriage: Consangui	neous/ Non Consan	guineous:			
	Contraceptive history:					
Present	obstetrical history					
	Date of booking:		No of ANC visits:			
	Date of Quickening:		Date of Lightning:			
1	Any history of disorders in Pre	gnancy:				
	Weight gain in Pregnancy:		NO of TT Inj:			
	Medications in Pregnancy:					
	stetrical history					
SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						

Past medical History:

Past surgical History: _____

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

Respiration:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT /CONDUCTION OF NORMAL DELIVERY

INTRANATAL ASSESSMENT-1

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Mi	n		At 5 Mi	Min			
		0	1	2	0	1	2		
1	Respiratory Effort								
2	Heart Rate								
3	Musle Tone								
4	Reflexes								
5	Colour								

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-2

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min		At 5 Min			
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH


Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-3

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Min		
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-4

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Min		
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-5

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min		At 5 Min			
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-6

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Sex	Weight at birth	Health status
1								
2								
3								
4								

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min		At 5 Min			
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:______
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-7

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Min		
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-8

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Min		
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH


Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-9

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Mi		At 5 Mi	At 5 Min			
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-10

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Mi		At 5 Mi	At 5 Min			
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-11

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min		At 5 Min			
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-12

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min		At 5 Min			
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:______
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-13

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Mi		At 5 Mi	At 5 Min			
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-14

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Min			
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH


Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-15

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Mi		At 5 Mi	At 5 Min			
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-16

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Min		
		0	1	2	0	1	2
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-17

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Mi	n		At 5 Min			
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-18

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Mi	n		At 5 Min			
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:_____
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-19

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Mi	At 5 Min		
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH



Third Stage of Labour

- Placenta and membranes:______
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

INTRANATAL ASSESSMENT-20

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous: _______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on: _____ Commencement of contraction: _____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: ______ at _____am/pm
- Vital signs T____ P___ R ____ BP Fetal Heart Rate _____,
- Duration of Ist stage:______

Second Stage of Labour

Membranes ruptured spontaneously at _____ / artificially Ruptured at ______

Medications given_____

Cervix fully dilated at

Type delivery_____

- Color of the liquor ______
- Duration of II stage ______
- Type of Episiotomy ______
- Baby Born at _____ Sex_____
- Caput formation yes / No
- Resuscitation details of baby______
- Medications given ______

APGAR SCORING

Sl.No	Sign	At 1 Min			At 5 Mi	At 5 Min		
		0	1	2	0	1	2	
1	Respiratory Effort							
2	Heart Rate							
3	Musle Tone							
4	Reflexes							
5	Colour							

Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH


Third Stage of Labour

- Placenta and membranes:______
- Duration of III stage_____
- Cord insertion_____
- Weight_____

Fourth stage:

- Condition of uterus: ______
- Any congenital Abnormalities: ______
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Delivered at _____

Type of placenta _____

Cord Length_____

Approximate blood loss_____

Breast feeding initiated : _____

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN

POSTNATAL AND NEONATAL CARE PLAN -1

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	М	E	М	Ε	М	E	M	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
		 						
	40 39.5 39 38.5 38 37.5 37 36.5	о _С 40 39.5 39 38.5 38 38.5 37.5 37.5 37.5 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 37.5 36.5 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 36.5	°C	°C	°C	°C Image: Constraint of the second secon

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -2

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Sex	Weight at birth	Health status
1								
2								
3								
4								

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	M	E	M	E	M	E	М	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
<i>y</i>								
	40 39.5 39 38.5 38 38 37.5 37 37 36.5	°C 40 39.5 39 39 38.5 38 37.5 36.5 36 1	°C 40 39.5 39.5 39 38.5 38 38 37.5 36.5 36 1 36 1 1 1	°C	°C	°C 40 39.5 39.5 39 38.5 38 38.5 37.5 31 36.5 36.5 36 1 1 1	°C	°C Image: Constraint of the second secon

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	E	Μ	E	М	Ε	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -3

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	М	E	М	Ε	М	E	M	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
		 						
	40 39.5 39 38.5 38 37.5 37 36.5	о _С 40 39.5 39 38.5 38 38.5 37.5 37.5 37.5 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 37.5 36.5 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 36.5	°C	°C	°C	°C Image: Constraint of the second secon

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -4

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Sex	Weight at birth	Health status
1								
2								
3								
4								

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	M	E	M	E	M	E	М	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
<i>y</i>								
	40 39.5 39 38.5 38 38 37.5 37 37 36.5	°C 40 39.5 39 39 38.5 38 37.5 36.5 36 1	°C 40 39.5 39.5 39 38.5 38 38 37.5 36.5 36 1 36 1 1 1	°C	°C	°C 40 39.5 39.5 39 38.5 38 38.5 37.5 31 36.5 36.5 36 1 1 1	°C	°C Image: Constraint of the second secon

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		M	E	М	Е	M	Е	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation
Assessment	Diagnosis	Interventions	Evaluation
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HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -7

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	М	E	М	Ε	М	E	M	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
		 						
	40 39.5 39 38.5 38 37.5 37 36.5	о _С 40 39.5 39 38.5 38 38.5 37.5 37.5 37.5 36.5	°C 40 39.5 39 38.5 38 37.5 37 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 36.5	°C 40 39.5 39 39 38.5 38 37.5 37 36.5	°C	°C	°C Image: Constraint of the second secon

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -5

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	
• LMP:	

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	M	E	M	E	M	E	М	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
<i>y</i>								
	40 39.5 39 38.5 38 38 37.5 37 37 36.5	°C 40 39.5 39 39 38.5 38 37.5 36.5 36 1	°C 40 39.5 39.5 39 38.5 38 38 37.5 36.5 36 1 36 1 1 1	°C	°C	°C 40 39.5 39.5 39 38.5 38 38.5 37.5 31 36.5 36.5 36 1 1 1	°C	°C Image: Constraint of the second secon

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	E	Μ	E	М	Ε	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -6

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Sex	Weight at birth	Health status
1								
2								
3								
4								

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

Date									
Temprature		Μ	E	Μ	E	M	Ε	М	E
^o F	oC								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -7

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug
History:	
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

E	M	E	M	E	M	E
				1		
	1					

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	E	Μ	E	М	Ε	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Assessment	Diagnosis	Interventions	Evaluation
Assessment	Diagnosis	Interventions	Evaluation
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HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -8

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

Date									
Temprature		M	E	M	E	M	E	М	Е
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -9

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	M	E	M	E	M	E	М	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
<i>y</i>								
	40 39.5 39 38.5 38 38 37.5 37 37 36.5	°C 40 39.5 39 39 38.5 38 37.5 36.5 36 1	°C 40 39.5 39.5 39 38.5 38 38 37.5 36.5 36 1 36 1 1 1	°C	°C	°C 40 39.5 39.5 39 38.5 38 38.5 37.5 31 36.5 36.5 36 1 1 1	°C	°C Image: Constraint of the second secon

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	E	Μ	E	М	Ε	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -10

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	М	E	М	Ε	М	E	M	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
		 						
	40 39.5 39 38.5 38 37.5 37 36.5	о _С 40 39.5 39 38.5 38 38.5 37.5 37.5 37.5 36.5	°C 40 39.5 39 38.5 38 37.5 37 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 36.5	°C 40 39.5 39 39 38.5 38 37.5 37 36.5	°C	°C	°C Image: Constraint of the second secon

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -11

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

E	M	E	M	E	M	E
				1		
	1					

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	E	Μ	E	М	Ε	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Assessment	Diagnosis	Interventions	Evaluation
Assessment	Diagnosis	Interventions	Evaluation
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HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -12

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Sex	Weight at birth	Health status
1								
2								
3								
4								

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

Date									
Temprature		Μ	E	Μ	E	M	Ε	М	E
^o F	oC								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -13

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug
• History:	
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Sex	Weight at birth	Health status
1								
2								
3								
4								

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	M	E	M	E	M	E	М	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
<i>y</i>								
	40 39.5 39 38.5 38 38 37.5 37 37 36.5	°C 40 39.5 39 39 38.5 38 37.5 36.5 36 1	°C 40 39.5 39.5 39 38.5 38 38 37.5 36.5 36 1 36 1 1 1	°C	°C	°C 40 39.5 39.5 39 38.5 38 38.5 37.5 31 36.5 36.5 36 1 1 1	°C	°C Image: Constraint of the second secon

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		Μ	E	М	Е	M	Ε	М	Е	
°F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality				[[

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -14

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

Date								
Temprature		E	М	Ε	М	E	M	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
		 						
	40 39.5 39 38.5 38 37.5 37 36.5	40 39.5 39 38.5 38 37.5 37 36.5	°C 40 39.5 39 38.5 38 37.5 37 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 36.5	°C	°C	°C	°C Image: Constraint of the second secon

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH E	DUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -15

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug
• History:	
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

E	M	E	M	E	M	E
				1		
	1					

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	Е	М	Ε	М	Е	Μ	Ε	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Assessment	Diagnosis	Interventions	Evaluation
Assessment	Diagnosis	Interventions	Evaluation
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HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -16

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
• History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Sex	Weight at birth	Health status
1								
2								
3								
4								

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

Date									
Temprature		Μ	E	Μ	E	M	Ε	М	E
^o F	oC								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -17

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	M	E	M	E	M	E	М	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
<i>y</i>								
	40 39.5 39 38.5 38 38 37.5 37 37 36.5	°C 40 39.5 39 39 38.5 38 37.5 36.5 36 1	°C 40 39.5 39.5 39 38.5 38 38 37.5 36.5 36 1 36 1 1 1	°C	°C	°C 40 39.5 39.5 39 38.5 38 38.5 37.5 31 36.5 36.5 36 1 1 1	°C	°C Image: Constraint of the second secon

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	E	Μ	E	М	Ε	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -18

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History: _____

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

	М	E	М	Ε	М	E	M	E
°C								
40								
39.5								
39								
38.5								
38								
37.5								
37								
36.5								
36								
		 						
	40 39.5 39 38.5 38 37.5 37 36.5	о _С 40 39.5 39 38.5 38 38.5 37.5 37.5 37.5 36.5	°C 40 39.5 39 38.5 38 37.5 37 36.5	°C 40 40 39.5 39 38.5 38 38.5 37.5 36.5	°C 40 39.5 39 39 38.5 38 37.5 37 36.5	°C	°C	°C Image: Constraint of the second secon

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -19

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged _____

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

E	M	E	M	E	M	E
				1		
	1					

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		М	E	Μ	E	М	Ε	М	Е	
o _F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Assessment	Diagnosis	Interventions	Evaluation
Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

POSTNATAL AND NEONATAL CARE PLAN -20

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation: Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug
History:	
Menstrual History:	
• Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

- Admitted on:_____
- Presentation :_____
- Head engaged/not engaged ______

commencement of contraction:_____

position :_____

FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
• Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min at 5min	
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF NEWBORN

Date									
Temprature		Μ	E	Μ	E	M	Ε	М	E
^o F	oC								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Date Fundus in cm Temprature Μ Е Μ E Μ E Μ Е ^oF oС 104 40 103 39.5 102 39 38.5 101 100 38 99 37.5 98 37 97 36.5 96 36 Pulse Respiration BP Lochia Bowel Bladder Any other abnormality

CLINICAL CHART OF PUEPERIUM

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK ANTENATAL EXAMINATION

HIGH RISK ANTENATAL CARE PLAN -1

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____
- Standard of living:_____
- Water Facility:_____
- Drainage /Gardening: P

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Type of house:_____

Lighting facility:_____

Toilet facility:_____

Pet animals:_____

Personel history:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	Sexual History:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Cons	sanguineous:
Contraceptive history:	
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	Date of Lightning:
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	NO of TT Inj:
Medications in Pregnancy:	

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise		Living children
1					
2					
3					
4					
5					

Past medical History: _____

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

DATE:										
NAME :		AGE:								
OBSTETRICA	L SCORE:		GESTATION AGE :							
Date										
Temprature		М	E	Μ	E	М	E	М	Е	
°F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Heart rate										
Respiration										
BP										
Bowel										
Bladder										
Weight		I	L	1	1	I	L	<u> I I </u>	I	
Any other abnormality										

ANTENATAL CLINICAL CHART

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation
	1	1	I

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH E	DUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK ANTENATAL CARE PLAN -2

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____ Type of hou
- Standard of living:_____
- Type of house:______ Lighting facility:_____
- Standard of fiving._____ Lig
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	Sexual History:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Consangui	ineous:
Contraceptive history:	
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	Date of Lightning:
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	NO of TT Inj:
Medications in Pregnancy:	

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise		Living children
1					
2					
3					
4					
5					

Past medical History:

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

DATE:									
NAME :			AGE:						
OBSTETRICAL SCORE:		GESTAT		TION AG	Е:				
Date									
Temprature		М	E	Μ	E	М	E	М	Е
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight			<u> </u>		<u> </u>	 	<u> </u>	 	
Any other abnormality									

ANTENATAL CLINICAL CHART

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK ANTENATAL CARE PLAN -3

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____
- Standard of living:_____
- Water Facility:_____
- Drainage /Gardening:_____ P

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

455

Type of house:_____

Lighting facility:_____

Toilet facility:_____

Pet animals:

Personel history:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	Sexual History:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Consa	anguineous:
Contraceptive history:	
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	Date of Lightning:
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	NO of TT Inj:
Medications in Pregnancy:	

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Mode of delivery	Living children
1					
2					
3					
4					
5					

Past medical History: _____

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

DATE:									
NAME :			AGE:						
OBSTETRICAL SCORE:			GESTATION AGE :						
Date									
Temprature		М	E	Μ	Е	М	E	М	Е
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight		I	L	1	1	I	L	<u> I I </u>	I
Any other abnormality									

ANTENATAL CLINICAL CHART

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:
Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK ANTENATAL CARE PLAN -4

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____
- Lighting facility:
- Standard of living:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	Sexual History:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Consangui	ineous:
Contraceptive history:	
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	Date of Lightning:
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	NO of TT Inj:
Medications in Pregnancy:	

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise		Living children
1					
2					
3					
4					
5					

Past medical History:

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

DATE:									
NAME :		AGE:							
OBSTETRICA	L SCORE:		GESTAT		Е:				
Date									
Temprature		М	E	Μ	E	М	E	М	Е
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight			<u> </u>		<u> </u>	 	<u> </u>	 	
Any other abnormality									

ANTENATAL CLINICAL CHART

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK ANTENATAL CARE PLAN -5

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____
- Standard of living:_____
- Water Facility:_____
- Drainage /Gardening: P

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Type of house:_____

Lighting facility:_____

Toilet facility:_____

Pet animals:_____

Personel history:

Dietary Pattern:	Bowel and Bladder Elimination Pattern:
Sleeping Pattern:	Sexual History:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
LMP:	EDD:
Marital history	
Age at marriage:	
Type Of marriage: Consanguineous/ Non Consa	anguineous:
Contraceptive history:	
Present obstetrical history	
Date of booking:	No of ANC visits:
Date of Quickening:	Date of Lightning:
Any history of disorders in Pregnancy:	
Weight gain in Pregnancy:	NO of TT Inj:
Medications in Pregnancy:	

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Mode of delivery	Living children
1					
2					
3					
4					
5					

Past medical History: _____

Past surgical History:

General Examination:

- Appearance:
 - Height:
 - Gait:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth:
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs:
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Weight:

Body built:

BP:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

Right lateral:

Left lateral:

- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

DATE:									
NAME :			AGE:						
OBSTETRICA	L SCORE:		GESTA	TION AG	Е:				
Date									
Temprature		М	E	Μ	Е	М	E	М	Е
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight		I	L	1	1	I	L	<u> I I </u>	I
Any other abnormality									

ANTENATAL CLINICAL CHART

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH E	DUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK POSTNATAL CARE PLAN

HIGH RISK POSTNATAL CARE PLAN-1

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation : Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

Admitted on:_____

commencement of contraction:_____

- Presentation :_____
- position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
• Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
Apgar score at 1min	at 5min
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
Treatment at birth:	

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		M	Ε	М	E	М	Е	М	E	
^o F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality			<u> </u>	<u> </u>	<u> </u>					

TREATMENT GIVEN:_____

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK POSTNATAL CARE PLAN-2

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation : Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
• Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

Admitted on:_____

commencement of contraction:_____

Presentation :_____

position :_____

Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour					
Commencement of contraction on:	atam/pm				
• Vital signs T P R BP	Fetal Heart Rate				
Duration of Ist stage:	Medications given				
Second Stage of Labour					
• Membranes ruptured spontaneously at	/ artificially Ruptured at				
Color of the liquor	Cervix fully dilated at				
Duration of II stage	Type delivery				
Type of Episiotomy					
Baby Born at	Sex				
Apgar score at 1min	at 5min				
• Caput formation – yes / No					
Resuscitation details of baby					
Medications given					
Third Stage of Labour					
Placenta and membranes:	Delivered at				
Duration of III stage	Type of placenta				
Cord insertion	Weight				
Approximate blood loss					
Fourth stage:					
Condition of uterus:	Breast feeding initiated :				
Any congenital Abnormalities:					
• Treatment at birth:					

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		Μ	E	Μ	E	М	E	M	E	
^o F	oC									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

Assessment	Diagnosis	Interventions	Evaluation
Assessment	Diagnosis	Interventions	Evaluation
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HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK POSTNATAL CARE PLAN-3

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation : Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
• Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

Admitted on:_____

commencement of contraction:_____

- Presentation :_____
- position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
• Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
Apgar score at 1min	at 5min
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
• Treatment at birth:	

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		Μ	E	Μ	E	M	E	M	E	
^o F	oC									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality			<u> </u>							

TREATMENT GIVEN:_____

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK POSTNATAL CARE PLAN-4

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation : Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Mode of delivery	Weight at birth	Health status
1							
2							
3							
4							

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

Admitted on:_____

commencement of contraction:_____

- Presentation :_____
- position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
• Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min	at 5min
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
• Treatment at birth:	

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		Μ	E	M	E	M	E	Μ	E	
^o F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK POSTNATAL CARE PLAN-5

BASELINE DATA

• Name:	Age :
• IP No:	Date of Admission :
• LMP:	EDD :
• Mother tongue :	
• Address :	
• Religion :	
• Obstetrical score :	
• Date of Delivery:	
• Diagnosis :	
Socio Economic History	
Educational status: Husband	Occupation : Husband
Wife	Wife:
• Income:	Type of house:
Standard of living:	Lighting facility:
• Water Facility:	Toilet facility:
Drainage /Gardening:	Pet animals:
Family history:	
Type of Family:	No Of Family Members:
Personnel history:	
Dietary Pattern:	Sleeping Pattern:
• Habits:	Drug History:
Menstrual History:	
Age at menarche:	Duration of cycle in days:
• Regularity:	Problems:
• LMP:	EDD:

Marital history

- Age at marriage: ______
- Type Of marriage: Consanguineous/ Non Consanguineous:______
- Contraceptive history: ______

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History:

Past surgical History:

PRESENT PREGNANCY:

Admitted on:_____

commencement of contraction:_____

- Presentation :_____
- position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour	
Commencement of contraction on:	atam/pm
• Vital signs T P R BP	Fetal Heart Rate
Duration of Ist stage:	Medications given
Second Stage of Labour	
• Membranes ruptured spontaneously at	/ artificially Ruptured at
Color of the liquor	Cervix fully dilated at
Duration of II stage	Type delivery
Type of Episiotomy	
Baby Born at	Sex
• Apgar score at 1min	at 5min
• Caput formation – yes / No	
Resuscitation details of baby	
Medications given	
Third Stage of Labour	
Placenta and membranes:	Delivered at
Duration of III stage	Type of placenta
Cord insertion	Weight
Approximate blood loss	
Fourth stage:	
Condition of uterus:	Breast feeding initiated :
Any congenital Abnormalities:	
• Treatment at birth:	

CLINICAL CHART OF PUEPERIUM

Date										Fundus in cm
Temprature		Μ	E	M	E	M	E	Μ	E	
^o F	°C									
104	40									
103	39.5									
102	39									
101	38.5									
100	38									
99	37.5									
98	37									
97	36.5									
96	36									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK NEONATAL EXAMINATION

HIGH RISK NEONATAL CARE PLAN-1

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis
- Breast feeding at:_____
- Passed urine at:_____
- Congenital anomaly if any specify:______

APGAR score at birth:

Eye Discharge: Yes/ no

Passed Meconium at:

• Ty	pe of feed: breast/artificial, if artificial specify	/:
• Me	ethod of feeding: bottle/ Paladai/Spoon/Any O	ther, Specify:
• Sle	eep Pattern: Sleep Hours During Day:	Hours During Night:
• Bo	owel Pattern: No Of Stools:	/Day
• Ty	pe Of Stool: Meconium/ Transitional, Any Ot	her, Specify
Voiding P	attern: Normal/Abnormal, If Abnormal Specif	fy.
PHYSICA	AL EXAMINATION	
Anthropo	ometric measurements	
• Bii	rth weight:	head to heel length:
• He	ead circumference	chest circumference:
Vital sign	S	
• Te	mperature:	Heart rate:
• Re	spiration:	General appearance:
• Po	sture:	
Skin		
• Co	olor: Normal/ Pale/Cyanosed/Jaundiced/Any C	Other, Specify
• La	nugo :Present/Absent	Milia: Present/Absent
• Ve	ernix: Present/Absent	Mangolian Spots: Present/Absent
• Tu	rgor: Normal/Lost	Texture: Normal /Dry/Edematous
• Ra	sh: Present/Absent. If Present, Specify	Erythema Toxicum: Present/ Absent
Head		
• Siz	ze: Normal/Microcephalus/Hydrocephalus	
• Fo	ntanelle: Flat And Soft/Depressed/Bulged/Pul	satile
• Su	tures: Normal/Widened/Overlapping	
• Ca	put Succedaneum: Present/ Absent	Cephalohematoma: Present/ Absent
• An	ny Other:	
Eyes		
• Bli	ink Reflex: Present/Absent	
• Co	onjunctiva: Normal/Yellow/Red/Brown/Blue T	Tinged

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify.....
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
- Any Other:

Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
- Color Of Tongue: Pink/Pale/Coated
- Palate; Normal/Cleft
- Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent

Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
- Breath Sounds: Normal/Abnormal. If Abnormal Specify.
- Apnoea: Present/Absent.
- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
- Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent
- Bowel Sounds: Present/ Absent
- Any Other Abnormality Specify:
- Spine :Normal/Meningocele/Meningomyocele/Spina Bifida

Extremities

- Palmer creases: well formed/single/ not formed
- Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

•	Normal /Hypospadia	sis/ Epispadiasis/ Hydrocele	Testis: Descended/Undescen	ided
•	Ambiguous genitalia	: yes /no	any other:	
Rectu	ım			
•	Anal patency: yes/no)		
•	Anal excoriation: pro	esent/ absent		
Neuro	ological			
•	Reflexes			
•	Moro:		Tonic neck reflex:	
•	Stepping:		Grasping:	
•	Glabellar:		Babinski:	
Feedi	ng reflexes			
•	Rooting :	Sucking:	Swallowing:	Gag:
Prote	ctive reflexes			
•	Blinking :	cough and sneeze:	yawn:	

- Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness
- Seizures: yes/no. if yes specify.....

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation
MEDICATIO				

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		M	E	M	E	M	E	М	Е
^o F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality				 	 				

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor
HIGH RISK NEONATAL CARE PLAN-2

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis Eye Discharge: Yes/ no
- Breast feeding at: _____ Passed Meconium at: _____
- Passed urine at:_____
- Congenital anomaly if any specify:______

APGAR score at birth:

•	Type of feed: breast/artificial, if artificial specify:				
•	Method of feeding: bottle/ Paladai/Spoon/Any Othe	er, Specify:			
•	Sleep Pattern: Sleep Hours During Day:	Hours During Night:			
٠	Bowel Pattern: No Of Stools:	/Day			
٠	Type Of Stool: Meconium/ Transitional, Any Other	, Specify			
Voidin	ng Pattern: Normal/Abnormal, If Abnormal Specify.				
PHYS	ICAL EXAMINATION				
Anthr	opometric measurements				
٠	Birth weight:	head to heel length:			
•	Head circumference	chest circumference:			
Vital s	signs				
٠	Temperature:	Heart rate:			
•	Respiration: General appearance:				
•	Posture:				
Skin					
•	Color: Normal/ Pale/Cyanosed/Jaundiced/Any Othe	er, Specify			
•	Lanugo :Present/Absent	Milia: Present/Absent			
•	Vernix: Present/Absent	Mangolian Spots: Present/Absent			
•	Turgor: Normal/Lost	Texture: Normal /Dry/Edematous			
•	Rash: Present/Absent. If Present, Specify	Erythema Toxicum: Present/ Absent			
Head					
•	Size: Normal/Microcephalus/Hydrocephalus				
•	Fontanelle: Flat And Soft/Depressed/Bulged/Pulsat	ile			
•	Sutures: Normal/Widened/Overlapping				
•	Caput Succedaneum: Present/ Absent	Cephalohematoma: Present/ Absent			
•	Any Other:				
Eyes					
•	Blink Reflex: Present/Absent				

• Conjunctiva: Normal/Yellow/Red/Brown/Blue Tinged

Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify..... ٠ Any Other: • Ears Position: Normal/Abnormal. If Abnormal Specify: • • Recoiling Of Pinna: Slow/Instant Any Other: • If Abnormal Specify: Nose Discharge; Present/Absent Nasal Flaring: Present/Absent ٠ • Any Other: Mouth and throat • Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft • Color Of Tongue: Pink/Pale/Coated • Palate; Normal/Cleft • Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent Neck: Normal /Stiff/Torricelli's • Chest; Normal/ Protruded/Retractions • Breath Sounds: Normal/Abnormal. If Abnormal Specify. • Apnoea: Present/Absent. • Heart Murmur: Present/ Absent Breast • Abdomen: Normal/Distended/Visible Peristalsis • Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent • Bowel Sounds: Present/ Absent • Any Other Abnormality Specify: • Spine :Normal/Meningocele/Meningomyocele/Spina Bifida **Extremities** Palmer creases: well formed/single/ not formed • • Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

•	Normal /Hypospadia	sis/ Epispadiasis/ Hydrocele	Testis: Descended/Undescended		
•	Ambiguous genitalia	: yes /no	any other:		
Rectu	ım				
٠	Anal patency: yes/no				
•	Anal excoriation: pre	esent/ absent			
Neur	ological				
٠	Reflexes				
٠	Moro:		Tonic neck reflex:		
٠	Stepping:		Grasping:		
•	Glabellar:		Babinski:		
Feedi	ng reflexes				
٠	Rooting :	Sucking:	Swallowing:	Gag:	
Prote	ctive reflexes				
٠	Blinking :	cough and sneeze:	yawn:		
•	Other neurological m	anifestations : absent /hypoto	nic/hypertonic opisthotonus/jit	teriness	

• Seizures: yes/no. if yes specify.....

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation
MEDICATIC)NS			

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		М	E	M	E	M	E	M	Е
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality				<u> </u>					

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK NEONATAL CARE PLAN-3

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis
- Breast feeding at:_____
- Passed urine at:_____
- Congenital anomaly if any specify:______

APGAR score at birth:

Eye Discharge: Yes/ no

Passed Meconium at:

• Тур	e of feed: breast/artificial, if artificial specif	fy:
• Met	hod of feeding: bottle/ Paladai/Spoon/Any	Other, Specify:
• Slee	ep Pattern: Sleep Hours During Day:	Hours During Night:
• Bov	vel Pattern: No Of Stools:	/Day
• Тур	e Of Stool: Meconium/ Transitional, Any C	Other, Specify
Voiding Pa	ttern: Normal/Abnormal, If Abnormal Spec	ify.
PHYSICA	L EXAMINATION	
Anthropon	netric measurements	
• Birt	h weight:	head to heel length:
• Hea	d circumference	chest circumference:
Vital signs		
• Ten	nperature:	Heart rate:
• Res	piration:	General appearance:
• Pos	ture:	
Skin		
• Cole	or: Normal/ Pale/Cyanosed/Jaundiced/Any	Other, Specify
• Lan	ugo :Present/Absent	Milia: Present/Absent
• Ver	nix: Present/Absent	Mangolian Spots: Present/Absent
• Tur	gor: Normal/Lost	Texture: Normal /Dry/Edematous
• Ras	h: Present/Absent. If Present, Specify	Erythema Toxicum: Present/ Absent
Head		
• Size	e: Normal/Microcephalus/Hydrocephalus	
• Fon	tanelle: Flat And Soft/Depressed/Bulged/Pu	ılsatile
• Suti	ures: Normal/Widened/Overlapping	
• Cap	ut Succedaneum: Present/ Absent	Cephalohematoma: Present/ Absent
• Any	V Other:	
Eyes		
• Blin	k Reflex: Present/Absent	
• Con	njunctiva: Normal/Yellow/Red/Brown/Blue	Tinged

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify.....
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
- Any Other:

Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
- Color Of Tongue: Pink/Pale/Coated
- Palate; Normal/Cleft
- Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent

Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
- Breath Sounds: Normal/Abnormal. If Abnormal Specify.
- Apnoea: Present/Absent.
- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
- Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent
- Bowel Sounds: Present/ Absent
- Any Other Abnormality Specify:
- Spine :Normal/Meningocele/Meningomyocele/Spina Bifida

Extremities

- Palmer creases: well formed/single/ not formed
- Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

•	Normal /Hypospadia	sis/ Epispadiasis/ Hydrocele	Testis: Descended/Undescended		
•	Ambiguous genitalia	: yes /no	any other:		
Rectu	ım				
•	Anal patency: yes/no)			
•	Anal excoriation: pre	esent/ absent			
Neuro	ological				
•	Reflexes				
•	Moro:		Tonic neck reflex:		
•	Stepping:		Grasping:		
•	Glabellar:		Babinski:		
Feedi	ng reflexes				
•	Rooting :	Sucking:	Swallowing:	Gag:	
Prote	ctive reflexes				
•	Blinking :	cough and sneeze:	yawn:		

- Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness
- Seizures: yes/no. if yes specify.....

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation
MEDICATIO				

MEDICATIONS

Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility
		Name of the drug & Route & frquency &dose Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug & Image: state of the drug &		

CLINICAL CHART OF NEWBORN

Date									
Temprature		M	E	M	E	M	E	М	Е
^o F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality				 	 				

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK NEONATAL CARE PLAN-4

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis Eye Discharge: Yes/ no
- Breast feeding at: _____ Passed Meconium at: _____
- Passed urine at:_____
- Congenital anomaly if any specify:______

APGAR score at birth:

• Type of feed	: breast/artificial, if artificial specif	y:
• Method of fe	eding: bottle/ Paladai/Spoon/Any (Other, Specify:
Sleep Pattern	n: Sleep Hours During Day:	Hours During Night:
Bowel Patter	rn: No Of Stools:	/Day
• Type Of Stoe	ol: Meconium/ Transitional, Any O	ther, Specify
Voiding Pattern: No	rmal/Abnormal, If Abnormal Spec	ify.
PHYSICAL EXAN	IINATION	
Anthropometric m	easurements	
• Birth weight	:	head to heel length:
Head circum	ference	chest circumference:
Vital signs		
• Temperature	:	Heart rate:
• Respiration:		General appearance:
• Posture:		
Skin		
Color: Norm	al/ Pale/Cyanosed/Jaundiced/Any	Other, Specify
• Lanugo :Pres	sent/Absent	Milia: Present/Absent
• Vernix: Pres	ent/Absent	Mangolian Spots: Present/Absent
Turgor: Norr	mal/Lost	Texture: Normal /Dry/Edematous
• Rash: Presen	t/Absent. If Present, Specify	Erythema Toxicum: Present/ Absent
Head		
• Size: Norma	l/Microcephalus/Hydrocephalus	
• Fontanelle: F	Flat And Soft/Depressed/Bulged/Pu	Isatile
• Sutures: Nor	mal/Widened/Overlapping	
Caput Succe	daneum: Present/ Absent	Cephalohematoma: Present/ Absent
• Any Other:		
Eyes		
• Blink Reflex	: Present/Absent	

• Conjunctiva: Normal/Yellow/Red/Brown/Blue Tinged

Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify..... ٠ Any Other: • Ears Position: Normal/Abnormal. If Abnormal Specify: • • Recoiling Of Pinna: Slow/Instant Any Other: • If Abnormal Specify: Nose Discharge; Present/Absent Nasal Flaring: Present/Absent ٠ • Any Other: Mouth and throat • Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft • Color Of Tongue: Pink/Pale/Coated • Palate; Normal/Cleft • Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent Neck: Normal /Stiff/Torricelli's • Chest; Normal/ Protruded/Retractions • Breath Sounds: Normal/Abnormal. If Abnormal Specify. • Apnoea: Present/Absent. • Heart Murmur: Present/ Absent Breast • Abdomen: Normal/Distended/Visible Peristalsis • Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent • Bowel Sounds: Present/ Absent • Any Other Abnormality Specify: • Spine :Normal/Meningocele/Meningomyocele/Spina Bifida **Extremities** Palmer creases: well formed/single/ not formed • • Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

•	Normal /Hypospadia	sis/ Epispadiasis/ Hydrocele	Testis: Descended/Undescen	ded				
•	Ambiguous genitalia	: yes /no	any other:					
Rectu	ım							
٠	Anal patency: yes/no							
•	Anal excoriation: pre	esent/ absent						
Neur	ological							
٠	Reflexes							
٠	Moro:		Tonic neck reflex:					
٠	Stepping:		Grasping:					
•	Glabellar:		Babinski:					
Feedi	ng reflexes							
٠	Rooting :	Sucking:	Swallowing:	Gag:				
Prote	ctive reflexes							
٠	Blinking :	cough and sneeze:	yawn:					
•	• Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness							

• Seizures: yes/no. if yes specify.....

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation
MEDICATIO				

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		М	E	M	E	M	E	M	Е
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality				<u> </u>					

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH I	EDUCATION
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Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor

HIGH RISK NEONATAL CARE PLAN-5

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis
- Breast feeding at:_____
- Passed urine at:_____
- Congenital anomaly if any specify:______

Eye Discharge: Yes/ no

APGAR score at birth:

Passed Meconium at: _____

• T	ype of feed: breast/artificial, if artificial specify	:		
• M	Iethod of feeding: bottle/ Paladai/Spoon/Any O	ther, Specify:		
• S	leep Pattern: Sleep Hours During Day:	Hours During Night:		
• B	owel Pattern: No Of Stools:	/Day		
• T	ype Of Stool: Meconium/ Transitional, Any Ot	her, Specify		
Voiding 1	Pattern: Normal/Abnormal, If Abnormal Specif	y.		
PHYSIC	CAL EXAMINATION			
Anthrop	ometric measurements			
• B	irth weight:	head to heel length:		
• H	lead circumference	chest circumference:		
Vital sig	ns			
• T	emperature:	Heart rate:		
• R	Respiration: General appearance:			
• P	osture:			
Skin				
• C	olor: Normal/ Pale/Cyanosed/Jaundiced/Any O	ther, Specify		
• L	anugo :Present/Absent	Milia: Present/Absent		
• V	ernix: Present/Absent	Mangolian Spots: Present/Absent		
• T	urgor: Normal/Lost	Texture: Normal /Dry/Edematous		
• R	ash: Present/Absent. If Present, Specify	Erythema Toxicum: Present/ Absent		
Head				
• S	ize: Normal/Microcephalus/Hydrocephalus			
• Fe	ontanelle: Flat And Soft/Depressed/Bulged/Pul	satile		
• S	utures: Normal/Widened/Overlapping			
• C	aput Succedaneum: Present/ Absent	Cephalohematoma: Present/ Absent		
• A	ny Other:			
Eyes				
• B	link Reflex: Present/Absent			
• C	onjunctiva: Normal/Yellow/Red/Brown/Blue T	inged		

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify.....
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
- Any Other:

Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
- Color Of Tongue: Pink/Pale/Coated
- Palate; Normal/Cleft
- Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent

Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
- Breath Sounds: Normal/Abnormal. If Abnormal Specify.
- Apnoea: Present/Absent.
- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
- Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent
- Bowel Sounds: Present/ Absent
- Any Other Abnormality Specify:
- Spine :Normal/Meningocele/Meningomyocele/Spina Bifida

Extremities

- Palmer creases: well formed/single/ not formed
- Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

•	Normal /Hypospadia	sis/ Epispadiasis/ Hydrocele	Testis: Descended/Undescen	ded
•	Ambiguous genitalia	: yes /no	any other:	
Rectu	ım			
•	Anal patency: yes/no)		
•	Anal excoriation: pre	esent/ absent		
Neuro	ological			
•	Reflexes			
•	Moro:		Tonic neck reflex:	
•	Stepping:		Grasping:	
•	Glabellar:		Babinski:	
Feedi	ng reflexes			
•	Rooting :	Sucking:	Swallowing:	Gag:
Prote	ctive reflexes			
•	Blinking :	cough and sneeze:	yawn:	

- Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness
- Seizures: yes/no. if yes specify.....

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation
MEDICATIO				

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		M	E	M	E	М	E	M	E
°F	°C								
104	40								
103	39.5								
102	39								
101	38.5								
100	38								
99	37.5								
98	37								
97	36.5								
96	36								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality			<u> </u>	<u> </u>		<u> </u>	<u> </u>	<u> </u>	

Assessment	Diagnosis	Interventions	Evaluation

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student

Signature of Supervisor
ASSESSED ABNORMAL DELIVERIES

Name of patient:			
IP number:			
Age:			
Obstetrical score:			
Gestational weeks:			
LMP			
EDD			
Presentation			
Position			
Weeks of gestation			
Indication			
Nature of delivery:			
Condition of baby:			
Sex;			
Weight:			
APGAR score:			
Condition of mother: _	 	 	

Signature of Student

Name of patient:
IP number:
Age:
Obstetrical score:
Gestational weeks:
LMP
EDD
Presentation
Position
Weeks of gestation
Indication
Nature of delivery:
Condition of baby:
Sex;
Weight:
APGAR score:
Condition of mother:

Signature of Student

Name of patient:			
IP number:			
Age:			
Obstetrical score:			
Gestational weeks:			
LMP			
EDD			
Presentation			
Position			
Weeks of gestation			
Indication			
Nature of delivery:			
Condition of baby:			
Sex;			
Weight:			
APGAR score:			
Condition of mother: _	 	 	

Signature of Student

Name of patient:
IP number:
Age:
Obstetrical score:
Gestational weeks:
LMP
EDD
Presentation
Position
Weeks of gestation
Indication
Nature of delivery:
Condition of Baby:
Sex:
Weight:
APGAR score:
Condition of Mother:

Signature of Student

Name of patient:			
IP number:			
Age:			
Obstetrical score:			
Gestational weeks:			
LMP			
EDD			
Presentation			
Position			
Weeks of gestation			
Indication			
Nature of delivery:			
Condition of baby:			
Sex;			
Weight:			
APGAR score:			
Condition of mother:	 	 	<u>.</u>

Signature of Student

ASSESSED/WITNESSED CAESAREAN SECTION

Name of patient:	
IP number:	
Age:	
Obstetrical score:	
Gestational weeks:	
LMP	
EDD	
Presentation	
Position	
Weeks of gestation	
Indication	
Nature of delivery:	
Condition of Baby:	
Sex:	
Weight:	
APGAR score:	
Condition of Mother:	

Signature of Student

Name of patient:
IP number:
Age:
Obstetrical score:
Gestational weeks:
LMP
EDD
Presentation
Position
Weeks of gestation
Indication
Nature of delivery:
Condition of Baby:
Sex:
Weight:
APGAR score:
Condition of Mother:

Signature of Student

ame of patient:
number:
ge:
ostetrical score:
estational weeks:
ЛР
DD
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sition
eeks of gestation
lication
ture of delivery:
ondition of Baby:
x:
eight:
PGAR score:
ondition of Mother:

Signature of Student

Name of patient:
IP number:
Age:
Obstetrical score:
Gestational weeks:
LMP
EDD
Presentation
Position
Weeks of gestation
Indication
Nature of delivery:
Condition of Baby:
Sex:
Weight:
APGAR score:
Condition of Mother:

Signature of Student

Signature of Student

EPISIOTOMY PERFORMED

EPISIOTOMY AND SUTURING PERFORMED/ASSISTED

Sl.No	IP Number	Date of Delivery	Obstetric Score	Indication	Type of Episiotomy	No.of Sutures	Condition	Signature of Supervisor
1								
2								
3								
4								
5								

Signature of Student

VAGINAL EXAMINATION PERFORMED

VAGINAL EXAMINATIONS PERFORMED IN LABOUR

S1.	Name	IP	Date of	Age	Obstetric	Cervix		Membranes	Presentation	Station of	Remarks	Signature
No	of the	Number	Examination		score				position	presenting		of
	patient				And GA	Effacement	Dilatation		-	part		supervisor
1												
2												
[
3												
4												
5												

Signature of Student

IUCD AND STERILIZATION PERFORMED

INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD) INSERTIONS ASSISTED

Sl.No	Name of the patient	IP Number	Age	Para	Date of Delivery	No of Living Children
1						
2						
3						
4						
5						

Signature of Student

FEMALE STERLIZATIONS/TUBAL LIGATIONS WITNESSED/ASSISTED

Sl.No	Name of the patient	IP NO.	Age	Para	Date of Delivery	Living	Reason for tubal ligations	Contraceptive used before	LMP	Method of tubal ligation	Remarks
2											
3											
4											
5											

Signature of Student

PLACENTA EXAMINATION

PLACENTA EXAMINATION -1

Name of Mother
Age
Obstetrical Score
Date of Delivery
Nature of Delivery:
Condition of Mother
Condition of Baby:
Expelled Baby At:
Delivery Of Placenta At:
Complete/Incomplete:
Membranes of Placenta:
Weight of Placenta:
Type Of Placenta:
Cord Insertion:
Any Abnormality of Placenta:

Signature of Student

PLACENTA EXAMINATION -2

Name of Mother
Age
Obstetrical Score
Date of Delivery
Nature of Delivery:
Condition of Mother
Condition of Baby:
Expelled Baby At:
Delivery Of Placenta At:
Complete/Incomplete:
Membranes of Placenta:
Weight of Placenta:
Type Of Placenta:
Cord Insertion:
Any Abnormality of Placenta:

Signature of Student

KANGRAOO MOTHER CARE

KANGAROO MOTHER CARE -1

Name of Mother:		
Age:		
IP Number:		
Education status:		
Obstetrical Score		
Date of Delivery		
Nature of Delivery:		
Sex of baby		
Weight of baby		
Apgar score at birth		
Treatment at birth:		
Breast feeding:		
Duration of KMC:		
Technique of KMC:	 	
Remarks:		

Signature of Student

KANGAROO MOTHER CARE -2

Name of Mother:
Age:
IP Number:
Education status:
Obstetrical Score
Date of Delivery
Nature of Delivery:
Sex of baby
Weight of baby
Apgar score at birth
Treatment at birth:
Breast feeding:
Duration of KMC:
Technique of KMC:
Remarks:

Signature of Student

PLANNED PARENTHOOD

PLANNED PARENTHOOD -1

Name of Mother:	
Age:	
IP Number:	
Education status:	
Name of husband:	
Education status:	
Obstetrical score:	
AV AIDS Used:	
Remarks:	

Signature of Student

PLANNED PARENTHOOD -2

Name of Mother:	
Age:	
IP Number:	
Education status:	
Name of husband:	
Education status:	
Obstetrical score:	
AV AIDS Used:	
Remarks:	

Signature of Student