

# FACULTY OF PHARMACY, NURSING AND HEALTH PROFESSIONS

# Women's and Maternal Health-Clinical (NURS3231)

#### **Clinical Data Sheet Form Guideline**

Date of nursing care:

Student's Name:

Pat	ient's Initial:	Room Number:	
Bir	th Date (woman):	Hospital/Ward:	
Ge	nder	Admission date	
Ma	rital Status	Diagnosis:	
Chief Compla	aints:		
••••••			
History of pro	esent illness:		
			•••••
			•••••
Past Medical	History:		
•••••			
•••••			•••••
			•••••

Past Surgical History:	
Nutritional History:	
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Allergies:	
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# **Obstetric History**

No	Date of birth	Alive/dead	Sex	Weight	Method of delivery	Place of birth	Complications

Menstrual F	History (Age of menarche, cycle interval,	length of cycle, regular/I	rregular)
Gynecologic	ynecological History: (Any gynecological problems)  ontraceptive history:  No methods used in the past Duration Reason for stopping  renatal Care: (First visit @ how many weeks gestation, number of visits, total weight gain throughout pregnancy, complications)  istory of present Pregnancy: (Gravida, Para, L.M.P, Expected Date of delivery, Gestation, complications, weight, current status)		
Contracepti	ve history:		
No	methods used in the past	Duration	Reason for stopping
Prenatal Ca	re: (First visit @ how many weeks gestati	ion, number of visits, tot	al weight gain throughout pregnancy, complications)
History of p	resent Pregnancy: (Gravida, Para, L.M.F	P, Expected Date of delive	very, Gestation, complications, weight, current status)

# Physical exam

### Review of systems; subjective and objective data:

Skin:
17 J.
Head:
Face:
Neck:
E
Eyes:

Ears:	
Nose:	
11056.	
Mouth and Throat:	
Chest and Lungs:	
Heart and Circulatory System	
Abdomen: (Include Fundal height, lie, presentation, fetal heart sounds, quickening)	

### Pelvic exams:

No	Date/Time	Dilation	Effacement	Station	Membran e status	Color of amniotic fluid	Indication

Skeletal System:
Neurological System:
Social Environmental:

De	escription of labour and delivery events and outcomes: (First stage, second stage, Third stage, newborn status):

# **Diagnostic procedures and laboratory tests with interpretations**

	liology
EC	${f G}$
Oth	ners( ultrasound, gastro scope, colonoscopy, biopsiesetc )

#### **Laboratory Data:**

Test	Date	Patient's Value	Normal Value	Meaning of Abnormal Value

 	 	 uring labour or del	 probien
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### **Medications:**

Name/ Dosage	Action	Rational	Evaluation	Side Effects	

# Nursing care plan

Nursing diagnosis	Planning (Short term goal)	Intervention	Rational	Evaluation
( subjective/Objective data)	(Onor term Sour)			

Uama health tooghing and	continuing care ( specific fo	on this woman)	
monte nearth teaching and	continuing care ( specific to	or this woman)	

	Gained experience (Reflect briefly on what did you learn from this case?)
`it:	ation of the reference (List all references you used while writing this case).
<i>)</i> 10	ation of the Terefence (Dist an Terefences you used winte witting time cuse).