## Medical History

<table>
<thead>
<tr>
<th>Previous Hospitalizations:</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Blood Transfusion:</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>Reason</td>
</tr>
<tr>
<td>Recent Exposure to Communicable Disease:</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>Reason</td>
</tr>
<tr>
<td>Herpes (History of):</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>Reason</td>
</tr>
<tr>
<td>Last Outbreak:</td>
<td>Yes</td>
<td>No</td>
<td>Current Lesion?</td>
<td>Yes</td>
</tr>
<tr>
<td>STD:</td>
<td>Yes</td>
<td>No</td>
<td>Type</td>
<td>Date</td>
</tr>
<tr>
<td>Chicken Pox (Recent Exposure):</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>Reason</td>
</tr>
<tr>
<td>HIV (Drawn in Pregnancy):</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>Reason</td>
</tr>
<tr>
<td>HBSAg (Drawn):</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>Result</td>
</tr>
<tr>
<td>Alcohol:</td>
<td>Yes</td>
<td>No</td>
<td>Type / Class</td>
<td>Amount</td>
</tr>
<tr>
<td>GBS (Group Beta Strep) Culture:</td>
<td>Yes</td>
<td>No</td>
<td>TX</td>
<td>Pos</td>
</tr>
<tr>
<td>RPR / STS Testing:</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>Result</td>
</tr>
<tr>
<td>Rubella Titer Drawn:</td>
<td>Yes</td>
<td>No</td>
<td>Immune</td>
<td>Yes</td>
</tr>
<tr>
<td>Chlamydia:</td>
<td>Yes</td>
<td>No</td>
<td>Date</td>
<td>TX</td>
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</tbody>
</table>

## Cardiovascular

<table>
<thead>
<tr>
<th>Skin:</th>
<th>Warm, Dry</th>
<th>Cold</th>
<th>clammy</th>
<th>Pale</th>
<th>Cyanotic</th>
<th>Flushed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radial Pulse:</td>
<td>PULSE</td>
<td>Rhythm</td>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edema:</td>
<td>Location</td>
<td>Amount</td>
<td></td>
<td></td>
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</tbody>
</table>

## Respiratory

| Dyspnea: | Yes | No |
| Breath Sounds: | Clear | Wheeze | Rales | Others (Explain): |
| Cough: | Yes | No | Productive | Non-Productive |
| Sputum: | Yes | No | Color |

## Neurological

| LOC: | Alert | Oriented | Confused | Lethargic |
| Reflexes: | | |
| Motor Activity: | Full | Partial | Absent |

* If "Yes", request Physician's Order for NUTRITIONAL CONSULT
### Gastro-Intestinal

<table>
<thead>
<tr>
<th>Special Dietary Needs:</th>
</tr>
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<tbody>
<tr>
<td>* Nausea:</td>
</tr>
<tr>
<td>* Obesity:</td>
</tr>
<tr>
<td>* Vomiting:</td>
</tr>
<tr>
<td>* Diarrhea:</td>
</tr>
<tr>
<td>* Constipation:</td>
</tr>
<tr>
<td>If daily for 3 days or unexplained, initiate Nutritional Consult.</td>
</tr>
</tbody>
</table>

Last BM: ___

### Personal Belongings / Assistive Devices

<table>
<thead>
<tr>
<th>None</th>
<th>W/ Pt</th>
<th>Home</th>
<th>Hosp. Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasses:</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Contacts:</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Dentures:</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Hearing Aid:</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Valuables:</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

(List Valuables)

### Genito-Urinary

<table>
<thead>
<tr>
<th>Urine Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Burning:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Voiding QS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Catheter:</th>
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</thead>
</table>

### Breasts

<table>
<thead>
<tr>
<th>Breasts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nipples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Filling:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lactating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inverted</td>
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</tbody>
</table>

### Psycho-Social

<table>
<thead>
<tr>
<th>Marital Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
</tr>
</tbody>
</table>

| Widowed  | Divorced  | Separated |

<table>
<thead>
<tr>
<th>Father of Baby:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support System:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGHEST GRADE COMPLETED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT SCHOOL GRADE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you learn best?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Videos</td>
</tr>
<tr>
<td>Books</td>
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<table>
<thead>
<tr>
<th>Childhood upon returning to school / work</th>
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<tr>
<th>Help at home:</th>
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<tbody>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>Others</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Source of Financial Support:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
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<td>Others</td>
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<table>
<thead>
<tr>
<th>Immunization current?</th>
</tr>
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<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If "No", hand-out given? | Yes  | No |

### Discharge Planning

**Adolescent 12 - 19 Years Old**

<table>
<thead>
<tr>
<th>Adolescent - Initiate Nutritional &amp; Social Services Consults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current School Grade</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you learn best?</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Immunization current?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
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</tbody>
</table>

If "No", hand-out given? | Yes  | No |

### Physical Disabilities

<table>
<thead>
<tr>
<th>Physical Disabilities:</th>
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<tbody>
<tr>
<td>NO</td>
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### Learning Disabilities

<table>
<thead>
<tr>
<th>Learning Disabilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
</tr>
</tbody>
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### Hearing Impaired

<table>
<thead>
<tr>
<th>Hearing Impaired:</th>
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<tbody>
<tr>
<td>NO</td>
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### Sight Impaired

<table>
<thead>
<tr>
<th>Sight Impaired:</th>
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</thead>
<tbody>
<tr>
<td>NO</td>
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### Substance Use

<table>
<thead>
<tr>
<th>Substance Use:</th>
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<tbody>
<tr>
<td>NO</td>
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### Other (Describe Below)

<table>
<thead>
<tr>
<th>Other (Describe Below):</th>
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</thead>
<tbody>
<tr>
<td>NO</td>
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</table>
### LEARNING NEEDS ASSESSMENT

<table>
<thead>
<tr>
<th>Topic</th>
<th>Initial</th>
<th>Review</th>
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</thead>
<tbody>
<tr>
<td>Relaxation Techniques</td>
<td></td>
<td></td>
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<tr>
<td>Labor Process</td>
<td></td>
<td></td>
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<tr>
<td>Comfort Measures</td>
<td></td>
<td></td>
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<tr>
<td>Fetal Movement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contractions</td>
<td></td>
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<tr>
<td>Diversional Activities</td>
<td></td>
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<tr>
<td>Electronic Fetal Monitoring</td>
<td></td>
<td></td>
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<tr>
<td>Maternal Self Care</td>
<td></td>
<td></td>
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<tr>
<td>Nutritional Needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membranes Rupture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PLAN OF CARE / STANDARD IMPLEMENTATION

<table>
<thead>
<tr>
<th>Topic</th>
<th>IM</th>
<th>D</th>
<th>IN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Standard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily Care - Antenatal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia NSG MGMT</td>
<td></td>
<td></td>
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<tr>
<td>Electronic Fetal Monitoring</td>
<td></td>
<td></td>
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<tr>
<td>Gestational Diabetes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Placenta Previa</td>
<td></td>
<td></td>
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<tr>
<td>Hyperemesis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incompetent Cervix</td>
<td></td>
<td></td>
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<tr>
<td>Premature Membranes Rupture</td>
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<td></td>
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<tr>
<td>Pain Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent PT Care Standard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

**IM** = Implemented  **D** = Demonstrated  **IN** = Initials

### COMMENTS

**RN / LDR SIGNATURE / TITLE**  **DATE / TIME**  **RN / LDR SIGNATURE / TITLE**  **DATE / TIME**

**RN / LDR SIGNATURE / TITLE**  **DATE / TIME**
## Discharge Planning - Patient Plans After Discharge

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
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