|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  | | --- | |  | | KING SAUD UNIVERSITY  NURSING COLLAGE  MATERNITY AND CHILD HEALTH NURSING  DEPARTMENT  MATERNITY SECTION | | aNTE NATAL RECORD  **abNORMAL** ( 325 NUR) | |  |   [ksu-logo](https://www.google.com.sa/url?sa=i&rct=j&q=&esrc=s&frm=1&source=images&cd=&cad=rja&uact=8&ved=0CAcQjRxqFQoTCJ2vguej4scCFQRYFAodATIMgA&url=https://identity.ksu.edu.sa/ar/logo&psig=AFQjCNHvnWKeElu32mOxrr-AQ56Iv0PnGw&ust=1441624470682477) |
| **Hospital name:**  **Report No:**  **Date:**  **Student name:**  **Student ID:**  **Record grade:**  **Clinical instructor name:**  **Signature:**  **Date:** |
|  |

**Antenatal record ( NUR 325 )**

**Student name: ID number:**

**Record number: Record date:**

**Personal data :**

**Mother's name: Age:**

**Occupation: Education level:**

**Nationality: No of family member:**

**Consanguinity**: Yes / No **House helper:** Yes / No

**House condition**: Apartment/ Villa / Tent **No of room:**

**Medical and surgical history:**

**Heart disease:** Yes / No If yes how it treated:

**Hypertension:** Yes / No If yes how it treated:

**Diabetes:** Yes / No If yes how it treated:

**Asthma:** Yes / No If yes how it treated:

**Anemia:** Yes / No If yes how it treated:

**Thyroid problems:** Yes / No If yes how it treated:

**TB:** Yes / No If yes how it treated:

**Mental disorder:** Yes / No **Multiple pregnancy:** Yes / No

**Congenital anomalies:** Yes / No **Malignancies:** Yes / No

**Allergies, Medication sensitivity:** Yes / No **Type:**

**Operations/ Accident: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Blood transfusion: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication taken:** Yes / No **Reason: Type:**

**Others specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family history:**

**Heart disease:** Yes / No  **Hypertension:** Yes / No

**Diabetes:** Yes / No **Asthma:** Yes / No

**Anemia:** Yes / No  **Thyroid problems:** Yes / No

**Mental disorder:** Yes / No **Multiple pregnancy:** Yes / No

**Congenital anomalies:** Yes / No **Malignancies:** Yes / No

**TB:** Yes / No **Others:**

**Menstrual history:**  **Menarche:**  Years.

**Rhythm:** Regular / Irregular **Duration/Period:** Days.

**Cycle/ Interval:** Days. **Quantity:** Pads/Day.

**Associate complaints:** Yes /No **Specify:**

**Family planning history:** Yes / No If Yes

**Method:**\_\_\_\_\_\_\_\_\_\_\_ **Duration:**\_\_\_\_\_\_\_\_\_\_\_

**Cause of termination:** Caused complication / To get pregnant / Pregnant during taken

**Obstetric history:**

**Gravidity: Parity: Abortion:**

**Term: Preterm: Post term:**

**No of living children: No of normal labor:**

**No of abnormal labor: Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Complication during labor:** Yes / No **Specify:**

**Present history:**

**LMP: EDD: GA: weeks Reason of visit:**

**Present complaints:**

**Mother's reaction toward present pregnancy:**

Planned & wanted/ Unplanned & wanted /Unwanted

**Antenatal risk Assessment**

**Antenatal risk Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Part C – Problem in current pregnancy**  Diagnosis of large for date  Diagnosis of small for date  Polyhydramnios or oligohydramnios  Multiple pregnancy  Malpresentation  Membranes ruptured before 37 weeks  Bleeding < 20 weeks  Bleeding > 20 weeks  Gestational hypertension  Proteinuria > 1+  Gestational diabetes  Blood antibodies (Rh, Anti C , Anti K , etc)  Aneamia ( Hgb < 100 g per L)  Pregnancy > 41 weeks  Poor weight gain ( 26 – 36 weeks < 0.5 kg / week or weight loss)  Smoker – any time during pregnancy | **Score**  2  3  2  3  3  2  1  3  2  1  1  3  1  1  1  1 | **Part A Pre – Pregnancy**  Age < 17 at delivery  Age > 35 at delivery  Weight > 91 kg  Weight < 45 kg  Height < 152 cm  **Diabetes**  Controlled be diet only  Insulin used  Retinopathy documented  **Heart disease**  Asymptomatic ( no effect on daily living)  Symptomatic (effects on daily living)  **Hypertension**  140/90 or greater  Antihypertensive drugs  Chronic renal disease  Other medical disorder e.g. epilepsy | **Score**  1  2  1  1  1  1  3  3  1  3  2  3  2  1 |
| **Part D – other risk factor**  Major fetal anomaly  Acute medical disorder ( acute asthma . thyrotoxicosis. UTI, etc)  Cervical surgery  Substance use  Alcohol > 3 drinks during pregnancy  Alcohol > 1 drink per day throughout pregnancy  Drug dependent | **Score**  3  3  3  3  3  3 | **Part B – Past obstetrical history**  Neonatal death (s)  Stillbirths ( s )  Abortion between 12 to 20 weeks and under 500 grams birth weight  Delivery at 20 – 37 weeks  Cesarean section  Small for dates – 5th %  Large for dates – 95 %  RH isoimmunization – unaffected infant  RH isoimmunization – affected infant  Major congenital anomaly e.g. choromosomal , heart , CNS defects | Score  3  3  1  1  2  1  1  1  3  1 |

**Antenatal risk Assessment**

**( Low risk = 0 – 2 ) ( Moderate risk = 3 – 6 ) ( High risk = > 7)**

**Patient score: She is:** Low risk / Moderate risk / High risk

**Physical Examination:**

**Date: Time :**

Weight:\_\_\_\_\_\_\_ kg. Height: \_\_\_\_\_\_ cm.

**Vital signs:**

T: \_\_\_\_\_\_ C. P:\_\_\_\_\_\_\_\_ b/m. R:\_\_\_\_\_\_ b/m B.P :\_\_\_\_\_\_\_\_ mmHg

**Skin:**

**Color:** Even / Discoloration **Location:**

**Edema:** Yes / No **Location:**

**Face:**

**Color:** Even / Discoloration **Location:**

**Edema:** Yes / No **Location:**

**Eyes problems:**

Redness. Pain . Itching. Visual disturbance .None **Location:**

**Others:**

**Ears problems:**

Discharge. Ear ache. Hearing lose. None **Location:**

**Nose problems:**

Discharge.Bleeding. None **Location:**

**Mouth:**

**Lips:** Pink. Moist. Cracks. Fissures

**Gum and Tongue:** Pink. Moist. Bleeding. Lesion.

**Teeth:** Complete. Decay . Missing tooth.

**Neck:**

**Thyroid gland:** palpable / not palpable

**Chest:**

Symmetry expansion . SOB . Cough . Wheezing.

**Heart:**

**Rhythm:** Regular, Irregular **Any abnormality:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Breast :**

Tenderness . Enlargement. Symmetry. Discharge: Yes/No color:\_\_\_\_\_\_\_\_

**Nipple:**  Inverted Flatten Everted

**Abdomen:**

Scars . Striae. Pigmentation. Linea nigra. Tenderness: \_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Fundus**  **palpitation** | **Level of fundus** | **Lie** | **Position** | **Presentation** | **Attitude** | **FHR** |
| Firm  Laxed  Tenderness | **\_\_\_**  **SP**  **\_\_\_**  **U**  **\_\_\_**  **X** | Longitudinal  Oblique  Transverse | (LOL)  (ROL)  (LOA)  (ROA)   (LOP)   (ROP) | Face  Brows  Vertex  Breach  Shoulder | Complete flexion  Moderate Flexion  Poor flexion  Hyperextended. | **+**  **\_\_\_b/m** |

**Extremities:**

Color:\_\_\_\_\_\_\_ Edema: Yes/ No Temp:\_\_\_\_\_\_\_\_ Varicosities: Yes / No

**Genitourinary tract:**

Lesion . Varicosities. Bruise. Bulging. Edematous

Discharge: Color:\_\_\_\_\_\_\_

**Bladder:**

Full. Empty. Heamatouria. Burning sensation.

Any complication:

**Lab investigation:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **No** | **Test** | **Result** | **Normal range** | **Comments** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |
| **5** |  |  |  |  |
| **6** |  |  |  |  |

**24 – HOUR RECALL FORM AND FOOD GROUP EVALUATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| FOOD AND FLUID INTAKE FROM TIME AWAKENING UNTIL THE NEXT MORNING | | | | | | | |
| TIME | FOOD & DRINK CONSUMED | | NUMBER OF SERVINGS IN THE FOOD GROUPS | | | | |
| MILK GROUP | MEAT GROUP | FRUITS & VEGEATABLE | BREAD & CEREALS | FATS & SWEETS |
| NAME & TYPE | AMOUNT |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |
| TOTALS | | |  |  |  |  |  |

**ONE SERVING IN EACH GROUP**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| BREAD & CEREALS | FRUITS & VEGEATABLE | MEAT GROUP | MILK GROUP | FATS & SWEETS |
| **1** slice of bread  **1/2** cup of rice, cooked cereal or pasta  **1** cup of ready-to-eat cereal  **1** flat tortilla | **1** cup of raw leafy vegetables  **1/2** cup of other vegetables, cooked or raw  **3/4** cup of vegetable juice  One medium apple, orange or banana  **1/2** cup of chopped, cooked or canned fruit  **3/4** cup of fruit juice | One egg  **2** tablespoons of peanut butter  **1/2** cup cooked dry beans  **1/3** cup of nuts | One serving of milk or yogurt is **1** cup  **1** sclid of cheese  **1** pice as big as play cards of meat or chicken | **1** teaspoon of olive oil , butter , margarine. |

**RECOMMENDED NUMBER OF SERVINGS DAILY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **BREAD & CEREALS** | **FRUITS & VEGEATABLE** | **MEAT GROUP** | **MILK GROUP** | **FATS & SWEETS** |
| **PREGNANCY OR LACTATING** | 6 – 11 | 3 – 5 | 2 – 3 | 3 – 4 |  |
| **AMOUNT** |  |  |  |  |  |
| **EVALUATON**  L = LOW  A = ADEQUATE  E = EXCESSIVE  **MOTHER TOTAL:** |  |  |  |  |  |

**Hamilton Anxiety Rating Scale (HAM-A)**

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

**0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

**1 - Anxious mood**

Worries, anticipation of the worst, fearful anticipation, irritability.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

**2- Tension**

Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

**3- Fears**

Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

**4- Insomnia**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

**5 Intellectual**

Difficulty in concentration, poor memory.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

**6 Depressed moods**

Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

**7 Somatic (muscular)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone

**8 Somatic (sensory)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

**9 Cardiovascular symptoms**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

**10 Respiratory symptoms**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Pressure or constriction in chest, choking feelings, sighing, dyspnea.

**11 Gastrointestinal symptoms**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, looseness of bowels, loss of weight, constipation.

**12 Genitourinary symptoms**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

**13 Autonomic symptoms**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

**14 Behavior at interview**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **4** |

Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc

**Scoring**

Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56,

**<17 indicate mild severity,**

**18–24 mild to moderate severity**

**25–30 moderate to severe.**

**Beck's Depression Inventory**

**This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.**

**1.**

0 I do not feel sad.

1. I feel sad
2. I am sad all the time and I can't snap out of it.
3. I am so sad and unhappy that I can't stand it.

**2.**

0 I am not particularly discouraged about the future.

1. I feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel the future is hopeless and that things cannot improve.

**3**

0 I do not feel like a failure.

1. I feel I have failed more than the average person.
2. As I look back on my life, all I can see is a lot of failures.
3. I feel I am a complete failure as a person.

**4.**

0 I get as much satisfaction out of things as I used to.

1. I don't enjoy things the way I used to.
2. I don't get real satisfaction out of anything anymore.
3. I am dissatisfied or bored with everything.

**5**

1. I don't feel particularly guilty
2. I feel guilty a good part of the time.
3. I feel quite guilty most of the time.
4. I feel guilty all of the time.

**6.**

0 I don't feel I am being punished.

1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

**7.**

0 I don't feel disappointed in myself.

1. I am disappointed in myself.
2. I am disgusted with myself.
3. I hate myself.

**8.**

0 I don't feel I am any worse than anybody else.

1. I am critical of myself for my weaknesses or mistakes.
2. I blame myself all the time for my faults.
3. I blame myself for everything bad that happens.

**9.**

0 I don't have any thoughts of killing myself.

1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

**10.**

0 I don't cry any more than usual.

1. I cry more now than I used to.
2. I cry all the time now.
3. I used to be able to cry, but now I can't cry even though I want to.

**11**

0 I am no more irritated by things than I ever was.

1. I am slightly more irritated now than usual.
2. I am quite annoyed or irritated a good deal of the time.
3. I feel irritated all the time.

**12.**

0 I have not lost interest in other people.

1. I am less interested in other people than I used to be.
2. I have lost most of my interest in other people.
3. I have lost all of my interest in other people.

**13.**

0 I make decisions about as well as I ever could.

1. I put off making decisions more than I used to.
2. I have greater difficulty in making decisions more than I used to.
3. I can't make decisions at all anymore.

**14.**

1. I don't feel that I look any worse than I used to.
2. I am worried that I am looking old or unattractive.
3. I feel there are permanent changes in my appearance that make me look unattractive
4. I believe that I look ugly.

**15.**

0 I can work about as well as before.

1. It takes an extra effort to get started at doing something.
2. I have to push myself very hard to do anything.
3. I can't do any work at all.

**16.**

0 I can sleep as well as usual.

1. I don't sleep as well as I used to.
2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3. I wake up several hours earlier than I used to and cannot get back to sleep.

**17.**

0 I don't get more tired than usual.

1. I get tired more easily than I used to.
2. I get tired from doing almost anything.
3. I am too tired to do anything.

**18.**

0 My appetite is no worse than usual.

1. My appetite is not as good as it used to be.
2. My appetite is much worse now.
3. I have no appetite at all anymore.

**19.**

0 I haven't lost much weight, if any, lately.

1. I have lost more than five pounds.
2. I have lost more than ten pounds.
3. I have lost more than fifteen pounds.

**20**

1. I am no more worried about my health than usual.
2. I am worried about physical problems like aches, pains, upset stomach, or constipation.
3. I am very worried about physical problems and it's hard to think of much else.
4. anything else.

**21.**

0 I have not noticed any recent change in my interest in sex.

1. I am less interested in sex than I used to be.
2. I have almost no interest in sex.
3. I have lost interest in sex completely.

**INTERPRETING THE BECK DEPRESSION INVENTORY**

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

**Total Score\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Levels of Depression**

0-10----------------------------These ups and downs are considered normal

11-16\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mild mood disturbance

17-20\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Borderline clinical depression

21-30\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Moderate depression

31-40\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Severe depression

Over 40\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Extreme depression

**MEDICATION RECORD**

**Patient name: Age: Sex: Date:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Nurse Role** | **Side effect** | **Action** | **Time** | **Route** | **Dose** | **Medication name** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**NURSING RECORD**

**Patient name: Age: years. GA: weeks.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Evaluation** | **Nursing intervention** | **Client's goal** | **Client need and / or problem** | **Date / Time** |
|  |  |  |  |  |