PREMATURITY PREVENTION PROGRAM
OFFICE VISIT ASSESSMENT FORM

Patient's Name:____________________ ETA by CrMS:____________

U/S:____________

Physician's Name:____________________ LMP:____________

DIRECTIONS: Please complete the following form at each prenatal visit.

Date												
Gestational Age												
I am experiencing:												
1. Pelvic Pressure (Y or N)												
2. Low Backache (Y or N)												
3. Abdomen Knots up Like a Ball (Y or N)												
4. Cramps or Contractions (Y or N)												
5. Vaginal Bleeding (Y or N)												
6. Vaginal Discharge (Y or N)												
7. Generally not Feeling Right (Y or N)												
Treatment Plan Implemented												

To be completed by the physician or the nurse:

These Symptoms are: (Put number in upper outer triangle of box)

0. Absent
1. Mild
2. Moderate
3. Severe

These Symptoms are: (Put symbol in lower right triangle of box)

New: New since the last visit

NC: The same intensity as the last visit

↑: Increased frequency, intensity or severity since the last visit

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