# Office Visit Assessment Form

**Direction:** Please complete the following form at each prenatal visit.

<table>
<thead>
<tr>
<th>Date</th>
<th>Gestational Age</th>
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**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**

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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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