

## **PRENATAL SOAP NOTE**

Student Name  
Date of Clinic Visit  
Patient's Name  
Preceptor's Name

### **S (SUBJECTIVE)**

Information related to the physician from the patient directly. This would include the chief complaint with history and pertinent questions related to the complaint. For the prenatal visit this would include such things as symptoms that have occurred since the previous visit. Also, questions that the physician may want to know – Have you been having nausea/vomiting?-Have you had any vaginal bleeding?- Have you felt any movement from the baby?

Example: 25 year old Gravida I Para 0-0-0-0 female complains of nausea in the morning for the past 2 weeks. She has been able to tolerate the nausea because it usually subsides by 10 am. She is very active with a full-time legal aid position, but has noted more fatigue at the end of the day. She has not had any vaginal bleeding. She has not felt fetal movement as of this time.

### **O (OBJECTIVE)**

Clinical data such as vital signs and physical findings (Uterine size, Fetal Heart Tones, Urinalysis –done at each visit). Laboratory results, Ultrasound findings.

Example: B.P. 120/80 P 72 Weight 130  
Uterine Size about 2cm below the umbilicus FHT 120  
Urinalysis – negative

### **A (ASSESSMENT)**

Diagnosis/Opinion of the patient at this visit (may be more than one diagnosis)

Example: 12 weeks gestation with nausea

### **P (PLAN)**

What actions you want the patient to do and what actions you will do in the future (further testing and visits)

Example:

1. Continue taking prenatal vitamins
2. Supportive care for nausea – to notify me if increased problems
3. Offer childbirth classes in the future.
4. Appointment in 4 weeks with UA

# Ob Prenatal Soap Note

**Debra D Sullivan**

A red circular graphic with a gradient, appearing as a stylized arrow or a partial circle, located to the right of the author's name.

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## **Table of Contents Ob Prenatal Soap Note**

1. Understanding the eBook Ob Prenatal Soap Note
  - The Rise of Digital Reading Ob Prenatal Soap Note
  - Advantages of eBooks Over Traditional Books
2. Identifying Ob Prenatal Soap Note
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Ob Prenatal Soap Note
  - User-Friendly Interface
4. Exploring eBook Recommendations from Ob Prenatal Soap Note
  - Personalized Recommendations

- Ob Prenatal Soap Note User Reviews and Ratings
- Ob Prenatal Soap Note and Bestseller Lists
- 5. Accessing Ob Prenatal Soap Note Free and Paid eBooks
  - Ob Prenatal Soap Note Public Domain eBooks
  - Ob Prenatal Soap Note eBook Subscription Services
  - Ob Prenatal Soap Note Budget-Friendly Options
- 6. Navigating Ob Prenatal Soap Note eBook Formats
  - ePub, PDF, MOBI, and More
  - Ob Prenatal Soap Note Compatibility with Devices
  - Ob Prenatal Soap Note Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Ob Prenatal Soap Note
  - Highlighting and Note-Taking Ob Prenatal Soap Note
  - Interactive Elements Ob Prenatal Soap Note
- 8. Staying Engaged with Ob Prenatal Soap Note
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Ob Prenatal Soap Note
- 9. Balancing eBooks and Physical Books Ob Prenatal Soap Note
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Ob Prenatal Soap Note
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Ob Prenatal Soap Note
  - Setting Reading Goals Ob Prenatal Soap Note
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Ob Prenatal Soap Note
  - Fact-Checking eBook Content of Ob Prenatal Soap Note

- Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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