

Contraction Self-Assessment Record



Name _____

PATIENT INSTRUCTIONS :

1. Try to self-monitor at the same times each day, or in the same part of your daily routine.
2. If you palpate more than **4** contractions in one hour (or more than your usual pattern):
EMPTY your bladder, **DRINK** 2 large glasses of water, and **REMONITOR** for another hour.
3. If there are still more contractions than your usual pattern in the second monitoring, or if you have any of the other symptoms listed on the chart, **CALL YOUR DOCTOR.**
4. At any time, if there is leaking or discharge of fluid from your vagina, **CALL YOUR DOCTOR.**
5. Always trust your instincts: if something "just doesn't feel right", it may not be. **CALL YOUR DOCTOR.**
6. Contact your doctor or nurse as often as needed, even if just for reassurance.
7. Bring this form with you to each prenatal visit and any time you come to the hospital.
8. Other: _____

Symptom	Date		Date		Date		Date		Date		Date		
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
# CTX /hr													
Fetal Movements	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	
Backache													
Pressure													
Intestinal Upset													
↑ Vaginal Discharge													

Week _____

Symptom	Date		Date		Date		Date		Date		Date		
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
# CTX /hr													
Fetal Movements	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	
Backache													
Pressure													
Intestinal Upset													
↑ Vaginal Discharge													

Week _____

Symptom	Date		Date		Date		Date		Date		Date		
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
# CTX /hr													
Fetal Movements	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	
Backache													
Pressure													
Intestinal Upset													
↑ Vaginal Discharge													



Doctor's Office _____
 Answering Service _____
 Pharmacy _____

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Symptom	Date		Date		Date		Date		Date		Date		Date	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
# CTX /hr														
Fetal Movements	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/
Backache														
Pressure														
Intestinal Upset														
↑ Vaginal Discharge														

Week

Symptom	Date		Date		Date		Date		Date		Date		Date	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
# CTX /hr														
Fetal Movements	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/
Backache														
Pressure														
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	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
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Fetal Movements	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/
Backache														
Pressure														
Intestinal Upset														
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Week

Symptom	Date		Date		Date		Date		Date		Date		Date	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
# CTX /hr														
Fetal Movements	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/	A/B	/
Backache														
Pressure														
Intestinal Upset														
↑ Vaginal Discharge														

Week

NOTICE This form is only for the purpose of recording information and is not a substitute for regular prenatal care. In no way does this form guarantee the identification of preterm labor or the outcome of pregnancy or medical treatment. Consult your physician before using this form.