## Nursing Assessment

### Patient’s Name ________________________________________________

History Given by _______________________________________________

Date ____________________

### Current Diagnosis/Chief Complaints:

#### Past History

### Allergies: (environmental, drugs, food, etc.)

### Immunizations:

- Flu    □ Yes-Date_______ □ No
- Pneumonia □ Yes-Date_______ □ No
- Tetanus    □ Yes-Date_______ □ No □ Other:_________________________

Comments:____________________________________________________________________________________________________________

### Vital Signs:

- Temp.__________  Resp._________  BP (designate position/s)___________________
- Pulse: Apical Rate__________ Radial Rate__________ Rhythm__________ Quality__________

Comments:____________________________________________________________________________________________________________

### Life System Profile

<table>
<thead>
<tr>
<th>5-WNL</th>
<th>4-Not Normal, but w/o help</th>
<th>3-Uses a device</th>
<th>2-With assistance</th>
<th>1-Device and help</th>
<th>0-Dependent</th>
</tr>
</thead>
</table>

### Activities of Daily Living (ADL)

- Bathing
- Transferring
- Telephone
- Money management
- Dressing
- Locomotion
- Meal preparation
- Shopping
- Grooming
- Eating
- Housework
- Manage appointments
- Toileting
- Eating
- Laundry
- Access resources
- Locomotion
- Meal preparation
- Shopping
- Eating
- Laundry
- Access resources
- Medicine management
- Transportation

### Homebound Status (✓ appropriate blanks)

- Outdoors without assistance
- Outdoors with assistance
- Confined to house, not bed disabled
- Bed disabled

Comments:____________________________________________________________________________________________________________

### Financial/Legal (✓ appropriate blank)

- Independent
- Needs assistance from________________________________
- Power of Attorney
- Living Will
- DNR discussed

Comments:____________________________________________________________________________________________________________

### Habits: (✓ and describe)

- Alcohol
- Nicotine
- Sleep disorder
- Caffeine
- Street Drugs
- Other

Comments:____________________________________________________________________________________________________________

### Physical Environment: (✓ appropriate blanks)

- All Adequate
- Interior safety hazards
- Transportation inadequate
- Inadequate space
- Structural hazards
- Private water supply/sewage disposal problem
- Stairs
- Electrical/fire hazards

Comments:____________________________________________________________________________________________________________
**Nursing Assessment**

**Page 2**

<table>
<thead>
<tr>
<th>Psycho-Social Profile:</th>
<th>No problems (leave blank)</th>
<th>S-subjective problem</th>
<th>D-objectively assessed problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hx of previous psych. illness</td>
<td>Mood-depression/mania/liability</td>
<td>Anxiety/agitation</td>
<td></td>
</tr>
<tr>
<td>Memory loss-long term/short term</td>
<td>Poor judgment</td>
<td>Behavior problems</td>
<td></td>
</tr>
<tr>
<td>Disorientation time/place/person</td>
<td>Hallucinations/delusions</td>
<td>Learning disabilities</td>
<td></td>
</tr>
<tr>
<td>Communication barriers</td>
<td>Emotional response to illness and care, body image</td>
<td>Growth and development</td>
<td></td>
</tr>
<tr>
<td>Interpersonal relationships</td>
<td>Socialization</td>
<td>Ethnicity</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

---

<table>
<thead>
<tr>
<th>Review of System/Physical Assessment:</th>
<th>No problems (leave blank)</th>
<th>S-subjective problem</th>
<th>O-objectively assessed problem</th>
<th>DNA- for did not assess</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Head</strong></td>
<td>Dizziness</td>
<td>Vision loss (chose one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minimal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blind</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Determined</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Headache</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mouth**

- Gum problems
- Chewing problems
- Dentures upper – lower - both

**Eyes**

- Glasses
- Blunted/soft vision
- Change in vision (1 year)
- Glaucoma
- Cataracts
- PERRL

**Ears**

- Hearing loss (circle one)
- Tinnitus
- Minimal
- Moderate
- Severe
- Deaf

**Nose**

- Epistaxis

**Neck and Throat**

- Hoarseness
- Difficulty Swallowing

**Comments:**

---

**Cardiovascular**

- Palpitations
- Dyspnea on exertion
- BR problems
- Paroxysmal nocturnal dyspnea
- Pervasive nocturnal dyspnea
- Fatigues easily
- Orthopnea; # pillows

- WNL
- DNA

**Comments:**

---

**Respiratory**

- Shortness of breath
- Wheezing
- Sputum
- Oxygen

- WNL
- DNA

**Comments:**

---

**Gastrointestinal Track**

- Indigestion
- Pain
- Rectal bleeding
- Jaundice
- Nausea, vomiting
- Hernias
- Hemorrhoids
- Tenderness
- Ulcers
- Diarrhea/constipation
- Gallbladder problems
- Ostomy

- WNL
- DNA

**Comments:**

---
## Nursing Assessment

### Patient’s Name _____________________________

### Date __________________

### Nutritional Status

- Weight loss or gain last 3 months (amount ____________)
- Change in appetite
- Height ________
- Fluid intake amount/frequency ____________________________
- Weight (actual) ____________ (reported) ____________

Diet ____________________________ meals prepared by ____________________________ times per day/wk

Comments: ____________________________

---

### Genitourinary Tract

- Frequency
- Nocturia
- Pain
- Urgency
- Hematuria
- Vaginal discharge/bleeding
- Incontinence
- Hx hysterectomy
- Dysmenorrhea
- Lesions
- Prostate disorder
- Gravida/Para
- Date last PAP test
- Contraception

Comments: ____________________________

---

### Breast (for both male and female)

- Lumps
- Tenderness
- Discharge
- Pain
- Does Self-breast exam

Comments: ____________________________

---

### Integumentary

- Hair Changes
- Pruritus
- Color
- Turgor

Skin Condition (Record code # on body area. Indicate size to right of numbered category.)

1. Lesions
2. Bruises
3. Masses
4. Incisions
5. Scars
6. Ulcers
7. Decubiti
8. Pressure areas

Comments: ____________________________

---

### Musculoskeletal, Neurological

- Stiffness
- Swollen joints
- Coordination
- Unequal grasp
- Joint pain
- Gait
- Weakness
- Syncope
- Seizure
- Tenderness
- Deformities
- Temp changes
- Balance
- Paralysis
- Amputation
- Tremor
- Aphasia/inarticulate speech
- Comatose

Comments: ____________________________
Nursing Assessment

Patient’s Name ____________________________________________
Date __________________

Endocrine and Hematopoietic

- Polyuria
- Polydipsia
- Excessive bleeding or bruising
- Intolerance to heat and cold
- WNL
- DNA

Comments: ________________________________________________________________________________________________________________

Pain Status

Frequency of Pain interfering with patient’s activity or movement:

- Patient has no pain or pain does not interfere with activity or movement
- Daily, but not constantly
- Less often than daily
- All of the time

Comments: ________________________________________________________________________________________________________________

Non-Verbal Patient Pain Assessment: (Mark all observed or reported behaviors that may be pain related)

- None Reported/Observed
- Restlessness
- Rigidity
- Crying
- Facial Grimaces
- Guarding
- Moaning
- Other

Comments: ________________________________________________________________________________________________________________

Does pain impact patient’s daily functioning?

- Yes
- No

Comments: ________________________________________________________________________________________________________________

Ask patient if they take any OTC oral or topical meds (such as NSAID’s, Ben-Gay etc.) and/or herbal remedies to obtain pain relief. Add all OTC/Herbal meds to Medication List.

Number each site of the patient’s pain and describe using scales, etc. below.

<table>
<thead>
<tr>
<th>Intensity</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Characteristics: A-Ache (Dull) B-Burning C-Crushing R-Radiating S-Sharp T-Throbbing O-Other (describe)

Location of Pain: ____________________________________________________________

Current Relief Methods (Oral meds, ice, elevation, other) __________________________

Goal: (0-10) ______________

Comments: __________________________________________________________________

Patient Signature________________________________________________________ Date_____________________ Nurse Signature__________________________________________Title:___________ Date_____________________

Nurse Signature________________________________________________________ Title:___________ Date_____________________

Patient Signature________________________________________________________ Date_____________________