Company Name

Nursing Assessment

Page 1

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

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

Activities of Daily Living (ADL)		Instrumental Activities of Daily Living (IDAL)	
___Bathing	___Transferring	___Telephone	___Money management
___Dressing	___Locomotion	___Meal preparation	___Shopping
___Grooming	___Eating	___Housework	___Manage appointments
___Toileting		___Laundry	___Access resources
___Other: _____		___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: _____
_____

Company Name

Nursing Assessment
Page 2

Patient's Name _____
Date _____

Psycho-Social Profile: ❑No problems (leave blank) S-subjective problem D-objectively assessed problem

___Hx of previous psych. Illness
___Memory loss-short term/long term
___Disorientation time/place/person
___Communication barriers
___Interpersonal relationships
___Mood-depression/mania/liability
___Poor judgment
___Hallucinations/delusions
___Emotional response to illness and care, body image
___Socialization
___Anxiety/agitation
___Behavior problems
___Learning disabilities
___Growth and development
___Ethnicity

Comments: _____
_____

Review of System/Physical Assessment: ❑No problems (leave blank)

S-subjective problem O-objectively assessed problem DNA- for did not assess

Head
___Dizziness
___Headache

Eyes
___Vision loss (chose one)
___Minimal
___Moderate
___Severe
___Blind
___Not Determined
___Glasses
___Bluffed/double vision
___Change in vision (1 year)
___Glaucoma
___Cataracts
___PERRL

Ears
___Hearing loss (circle one)
___Minimal
___Moderate
___Severe
___Deaf
___Hearing aid
___Tinnitus

Mouth
___Gum problems
___Chewing problems
___Dentures upper – lower - both

Nose
___Epistaxis

Neck and Throat
___Hoarseness
___Difficulty Swallowing

Comments: _____
_____

Cardiovascular

❑Palpitations
❑Varicosities
❑Chest pain
❑Murmurs
❑Pacemaker
❑Dyspnea on exertion
❑Claudication
❑Fatigues easily
❑Edema
❑BR problems
❑Paroxysmal nocturnal dyspnea
❑Orthopnea; # pillows_____
❑Cyanosis

❑WNL ❑DNA

Comments: _____
_____

Respiratory

❑Shortness of breath
❑Shape and symmetry
❑Wheezing
❑Cough
❑Sputum
❑Breath sounds
❑Oxygen
❑Other

❑WNL ❑DNA

Comments: _____
_____

Gastrointestinal Track

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

❑WNL ❑DNA

Comments: _____
_____

Company Name

Nursing Assessment
Page 3

Patient's Name _____
Date _____

Nutritional Status

❑Weight loss or gain last 3 months (amount_____) Height _____ Fluid intake amt/frequency_____
❑Change in appetite Weight (actual)_____ (reported)_____

Diet _____ meals prepared by _____ _____ times per day/wk
Comments: _____
_____

Genitourinary Tract

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

❑WNL ❑DNA
Comments: _____
_____

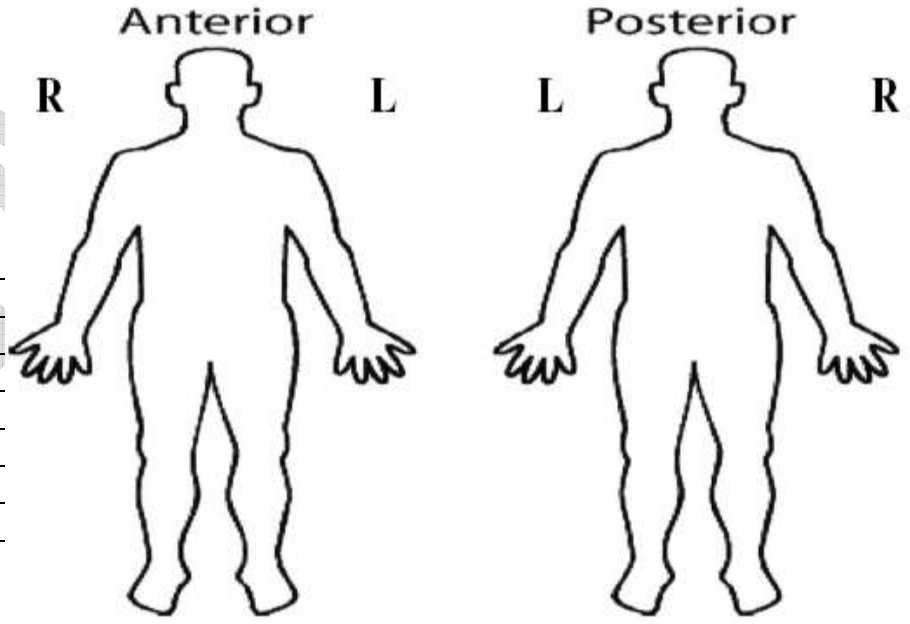
Breasts (for both male and female)

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

❑WNL ❑DNA
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

❑WNL ❑DNA
Comments: _____
_____
_____

Musculoskeletal, Neurological

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

❑WNL ❑DNA
Comments: _____
_____

Company Name

Nursing Assessment
Page 4

Patient's Name _____

Date _____

Endocrine and Hematopoietic

❑Polyuria ❑Excessive bleeding or bruising ❑Intolerance to heat and cold
❑Polydipsia ❑Skin texture ❑Excessive perspiration

❑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.

Intensity
0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Moderate Severe

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_____