YOUR COMPANY NAME

NURSING ADUL ASSESSMENT

PT. # _____ HEIGHT _____ ☐ MALE

PATIENT NAME_____ DOB_____ WEIGHT_____ ☐ FEMALE

VITAL SIGNS: BP_____ TEMP_____ RESP _____ PULSE APICAL_____ PULSE RADIAL_____ BS _____

HISTORY OF PRESENT ILLNESS: (INCLUDE DATES) _____

HOSPITALIZATION/SURGERIES (REASONS & DATES) _____

PREVIOUS MEDICAL HISTORY (INCLUDE ONSET DATES):

☐ CARDIAC _____ ☐ ANGINA ☐ ARRHYTHMIA ☐ CAD ☐ CHF ☐ HTN ☐ M.I.

☐ D.M._____ ☐ INSULIN ☐ ORAL AGENT ☐ DIET CONTROLLED

☐ RESPIRATORY _____ ☐ ASTHMA ☐ COPD

☐ CANCER _____ ☐ ULCERS_____ ☐ ETOH USE_____

☐ OTHER _____

ALLERGIES

PRINCIPAL DIAGNOSIS: _____ SECONDARY DIAGNOSIS: _____

HOMEBOUND _____

EENT:

VISION: ☐ NORMAL ☐ IMPAIRED ☐ BLIND ☐ CONTACT LENSES ☐ GLASSES ☐ CATARACTS

HEARING: ☐ GOOD ☐ POOR ☐ HEARING AID ☐ DEAF ☐ TINNITUS

MOUTH: ☐ GINGIVITIS ☐ BLEEDING ☐ LESIONS

TEETH: ☐ OWN ☐ DENTURES ☐ UPPER ☐ LOWER ☐ PARTIAL

THROAT: ☐ HOARSE ☐ SORE ☐ BURNING ☐ PAIN

MUCOUS MEMBRANES: ☐ MOIST ☐ DRY ☐ PINK

COMMENTS:_____

RESPIRATORY:

BREATH SOUNDS: ☐ EQUAL ☐ CLEAR ☐ COARSE ☐ WHEEZING ☐ RALES ☐ RHONCHI ☐ ABSENT

☐ **ORTHOPNEA** ☐ PAIN ☐ HEMOPTYSIS ☐ TACHYPNEA ☐ SOB

☐ APNEA ☐ COUGH ☐ NON-PROD. COUGH ☐ PROD.COUGH

DESCRIBE COLOR _____ AMOUNT _____

SMOKE_____ PACKS/DAY YEARS SMOKING_____

OXYGEN AT _____ LITTERS/Min. VIA_____

☐ IPPB ☐ SAN ☐ OTHER_____

COMMENTS:_____

NUTRITION:

DIET _____ ☐ PO ☐ NG ☐ GT

APPETITE_____ ☐ GOOD ☐ POOR ☐ FAIR

☐ WEIGHT LOSS _____ (TIME FRAME)

☐ WEIGHT GAIN _____ (TIME FRAME)

☐ FLUID INTAKE _____ CUPS/DAY ☐ OTHER _____

COMMENTS:_____

GASTRO/ABDOMINAL

BOWEL SOUNDS: ☐ PRESENT ☐ ABSENT ☐ HYPERACTIVE ☐ HYPOACTIVE

LAST BM DATE _____ ☐ NAUSEA ☐ INDIGESTION

☐ GAS ☐ VOMITING ☐ HEMATEMESIS ☐ DIARRHEA ☐ CONSTIPATION

LAXATIVE/ENEMA USE FREQ. _____ ☐ PAIN ☐ DISTENTION

☐ HERNIA _____ (LOCATION) ☐ MASSES _____ (LOCATION)

☐ OSTOMY TYPE _____ (LOCATION)

COMMENTS:_____

MENTAL STATUS:

☐ ALERT ☐ ORIENTED X 3 ☐ COOPERATIVE ☐ CONFUSED

☐ ANXIOUS ☐ FORGETFUL ☐ DEPRESSED ☐ ISOLATED

☐ WITHDRAWN ☐ LETHARGIC ☐ COMATOSE ☐ OTHER

COMMENTS:_____

FUNCTIONAL LIMITATIONS:

ADL: ☐ SELF-CARE ☐ MODERATE ASSISTANCE ☐ MAX. ASSISTANCE

ACTIVITY: ☐ AMBULATORY ☐ BRP ☐ ASSIST TO TRANSFER

☐ RESTRICTIONS: _____

NEEDS ASSISTANCE WITH: _____

SOCIAL ENVIRONMENT:

CAREGIVER:_____

RELATIONSHIP:_____

CAREGIVER:

☐ LIVES IN RESIDENCE

☐ AVAILABLE AT ALL TIMES

☐ AVAILABLE SOMETIMES

CAREGIVER LIMITATIONS:

☐ AGE ☐ PHYSICAL

☐ WORK ☐ ILLNESS

☐ OTHER RESPONSIBILITIES

☐ UNWILLINGNESS

SUPPORT SYSTEM ADEQUATE: ☐ YES ☐ NO

LANGUAGE SPOKEN:_____

MEANS OF TRANSPORTATION:_____

NEED FOR ANCILLARY SERVICES: ☐ YES ☐ NO

TYPE:_____

COMMENTS:_____

HOME ENVIRONMENTAL SAFETY:

☐ HOUSE ☐ APARTMENT ☐ STAIRS ☐ GOOD LIGHTING ☐ PHONE

☐ PETS ☐ CLEAR PATHS ☐ OBSTACLES ☐ FIRE ALARM

PATIENT/CAREGIVER ORIENTED TO:

OBSTACLES TO MOBILITY? ☐ YES ☐ NO SAFETY DEVICES? ☐ YES ☐ NO

FIRE/ELECTRIC SAFETY? ☐ YES ☐ NO

COMMENTS:_____

YOUR COMPANY NAME

GU/GYN:

BLADDER: ☐ CONTINENT ☐ INCONTINENT ☐ FREQUENCY ☐ URGENCY
☐ PAIN ☐ ODOR ☐ BURNING ☐ RETENTION ☐ HESITANCY
☐ HEMATURIA, ☐ URINE: COLOR _____ ☐ CLOUDY
☐ OUTPUT. VOIDS _____ X/DAY OR _____ cc ☐ NOCTURIA X _____
☐ FOLEY SIZE _____ LAST CHANGED _____
BYN: LAST MENSES _____ LAST PAP _____
☐ VAGINAL BLEEDING ☐ DISCHARGE ☐ OTHER _____
COMMENTS: _____

IV/CATHETER/TUBE ASSESSMENT:

☐ N/A
☐ TYPE _____ ☐ LOCATION _____
EVIDENCE OF: ☐ REDNESS ☐ SWELLING ☐ DRAINAGE ☐ PAIN
COMMENTS: _____
☐ IMPLANTABLE PORT OTHER _____
COMMENTS: _____

N IMPLANTABLE PORT OTHER
ACCESSED _____ GUAGE _____ INCH _____ (DEVICE)
INSERTION SITE _____
REASON FOR RESTART _____
NEEDLE/CATHETER D/E'D INTACT: ☐ YES ☐ NO (IF NO, EXPLAIN)
COMMENTS: _____

CARDIOVASCULAR

HEART RATE: ☐ REG. ☐ IRREG. ☐ PALPITATIONS ☐ CHEST PAIN
☐ EDEMA _____ LOCATION (CIRCLE) 1+, 2+, 3+, 4+
☐ NECK VEIN DISTENTION ☐ DIMINISHED PULSE ☐ FAINTING
☐ PACEMAKER _____ /MIN ☐ MURMER ☐ GALLOP
☐ FLUID RESTRICTION _____ ML/DAY
COMMENTS: _____

NEURO/MUSCULAR:

PUPILS: REACTIVE ☐ R ☐ L ☐ HEADACHE ☐ WEAKNESS
☐ SYNCOPE ☐ VERTIGO ☐ NUMBNESS ☐ TINGLING ☐ STIFFNESS
☐ COORDINATION PROBLEMS ☐ CONTRACTURES ☐ LETHARGIC
☐ ROM LOSS ☐ PAIN ☐ UNSTEADY ☐ ARTHRITIS ☐ TREMORS
☐ APHASIA ☐ PARALYSIS ☐ HEMIPARESIS: ☐ R ☐ L
☐ SEIZURES ☐ COMATOSE ☐ OTHER
COMMENTS: _____

INTEGUMENTARY:

SKIN: ☐ PINK ☐ PALE ☐ FLUSHED ☐ JAUNDICE ☐ WARM
☐ COOL ☐ DRY ☐ DIAPHORETIC ☐ ECCHYMOSIS ☐ PETECHIE
☐ RASH ☐ ITCHING ☐ POOR TURGOR ☐ HAIR LOSS ☐ WOUNDS
☐ LESIONS
WOUND ADDENDUM COMPLETED: ☐ YES ☐ NO
COMMENTS: _____

WOUND ADDENDUM

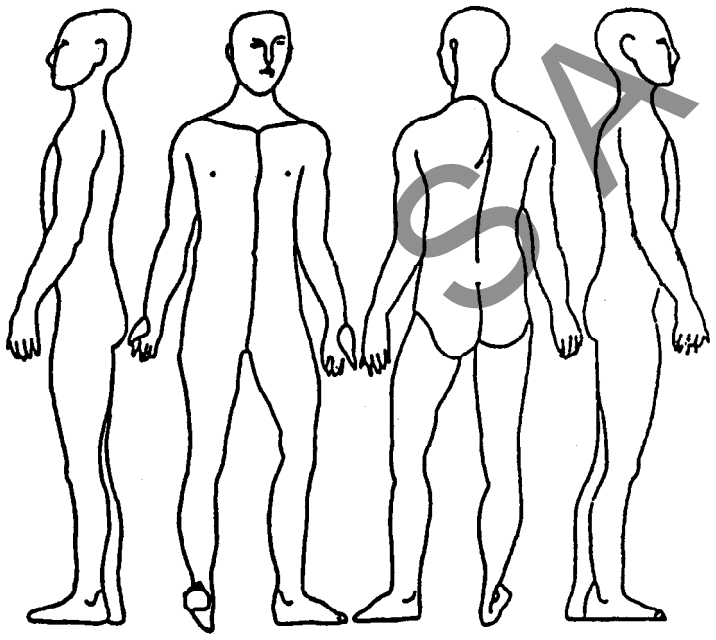

DIAGRAM CODES

B - BURN	C - CONTUSION	D - DECUBITUS
E - ERYTHEMIA	I - INCISION	L - LACERATION
P - PETECHIA	R - RASH	S - SCAR
T - TUBES	W - WOUNDS	

WOUND DESCRIPTION:

	#1	#2	#3
LENGTH			
WIDTH			
DEPTH			
DRAINAGE			
COLOR			
ODOR			
AMOUNT			
RESULTS OF LAST C & S			

COMMENTS: _____

EMPLOYEE SIGNATURE/TITLE _____ DATE _____