Time In: _____
Time Out: _____

NURSING ASSESSMENT

☐ INITIAL ☐ REASSESSMENT ☐ UPDATE

PATIENT: _____ MR#: _____
DIAGNOSIS: _____ PHYSICIAN: _____
EMERGENCY CONTACT PERSON: NOT RESIDING WITH PATIENT
NAME: _____ **RELATION:** _____ **ADDRESS:** _____
PHONE- (HOME) _____ (Work) _____ (other) _____

PATIENT'S CHIEF COMPLAINT: _____

PERTINENT HISTORY _____

GENERAL APPEARANCE _____

AGE_____ HEIGHT_____ WEIGHT_____ ALLERGIES _____
VITAL SIGNS AP_____ (REG/IRR) RP_____ (REG/IRR) PM_____ RESPIRATIONS_____

BLOOD PRESSURE RIGHT LEFT
SITTING _____
STANDING _____
LYING _____

SENSORY: VISION: NORMAL_____ LIMITED_____ BLIND_____ VISUAL AID (DESCRIBE) _____
HEARING NORMAL_____ HARD OF HEARING_____ DEAF_____
HEARING AID (DESCRIBE) _____ ALTERATIONS TASTE/SMELLS_____

COMMENTS _____

RESPIRATORY: SOB _____ SOB ON EXERTION_____ LUNG SOUNDS_____
COUGH_____ SPUTUM_____ ORTHOPNEA_____ CYANOSIS_____ NIGHT SWEAT _____ DYSPNEA_____
SMOKER(PPD)_____ 02 AT _____ LPM VIA_____ FREQUENCY_____ IPPB\HHA_____
MEDICATION_____ FREQUENCY_____ TRACH_____ PT/FAMILY CARE FOR TRACH _____
SUCTION_____ TYPE_____ FREQUENCY_____

COMMENTS _____

CARDIAC: CHEST PAIN/PRESSURE_____ LAST EPISODE_____, X_____MIN
RADIATING TO_____ RELIEVED BY _____ PALPITATION_____
DIAPHORESIS_____ LEG CRAMPS_____ FAINTING_____ PACEMAKER_____

PEDAL PULSE: (R) YES NO WARM/COLD
(L) YES NO WARM /COLD
EDEMA RLE 0 TR 1+ 2+ 3+ 4+ PITTING
LLE 0 TR 1+ 2+ 3+ 4+ PITTING
PINK___PALE_____CYANOTIC_____
CAPILLARY REFILL GOOD-FAIR___POOR___
AFFECTED AREA_____
HOMAN'S SIGN (R)_____(L)_____

COMMENTS _____

MUSCULOSKELETAL BALANCE _____ FRACTURE_____ RANGE OF MOTION_____
ENDURANCE_____ AMPUTATION_____ PARALYSIS_____ COORDINATION_____ PROSTHESIS_____
UE STRENGTH_____ LE STRENGTH_____ PAIN_____ JOINT STIFFNESS_____
ARTHRITIC CHANGES_____ ASSISTIVE DEVISE_____ TRANSFERS_____

COMMENTS _____

HEADACHE_____ TREMORS_____ VERTIGO_____ SEIZURES_____ SYNCOPE_____ ATAXIA_____
SENSORY LOSS_____ LOC_____ PERLA_____
MENTAL STATUS- ORIENTED TIME_____ PLACE_____ PERSON_____
MEMORY SHORT TERM_____ LONG TERM_____
.COMMENTS _____

PAIN: SITE(s)_____ PRECIPITATING FACTORS_____

INTENSITY AT REST 0 1 2 3 4 5 WITH ACTIVITY 0 1 2 3 4 5
DESCRIPTION _____ ALLEVIATING FACTORS _____
PAIN MED REGIMEN_____ ADEQUATE YES___ NO____

COMMENTS _____

FUNCTIONAL MOBILITY STATUS:

MOBILITY STATUS AMBULATES WITHOUT ASSIST_____ WITH ASSIST_____ CANE_____ WALKER_____ CRUTCHES_____
WHEELCHAIR_____ HOYER LIFT_____ TRANSFERS WITH HELP_____ WITHOUT HELP_____ WALLS/FURNITURE_____
BEDBOUND _____ OUT OF BED EXCEPT TO SLEEP OR REST _____ IN BED PART OF THE DAY_____
IN BED MOST OF DAY_____ UNMOTIVATED TO GET OUT OF BED_____ ABLE TO REPOSITION SELF ___ YES ____ NO
ABLE TO TURN WHILE IN BED ___ YES ___ NO

ACTIVITIES OF DAILY LIVING

	SELF	NEEDS HELP	HAS HELP
BATHING			
DRESSING			
EATING			
COOKING MEALS			

	SELF	NEEDS HELP	HAS HELP
HOUSEKEEPING			
GROOMING			
SHOPPING			

CAREGIVER/SIGNIFICANT OTHER:_____

COMMENTS _____

SOCIAL/BEHAVIORAL:

HOUSEHOLD ALONE _____ **PRIMARY CAREGIVER:** NAME_____
SPOUSE/FAMILY _____ RELATIONSHIP _____
NON-RELATIVE _____ AVAILABILITY _____
RELIGIOUS PREFERENCE_____ CURRENT/PREVIOUS OCCUPATION_____
PATIENT/CAREGIVER EXPECTATION OF CARE_____
PATIENT/CAREGIVER COMPLIANCE WITH HOME MEDICAL REGIME_____
MARITAL STATUS M___ W___ D___ S___
COMMUNICATION: LANGUAGE SPOKEN _____ READING _____ INTERPRETER_____ DIFFICULTY SPEAKING_____
UNDERSTANDING SPOKEN COMMUNICATION_____ _____ WRITING_____

BEHAVIORAL STATUS: ALERT___ WITHDRAWN_____ AGITATED_____ ANXIOUS_____ UNCOOPERATIVE_____
ANGRY/HOSTILE_____ LETHARGIC_____ SAD_____ OTHER_____
APPEARS APPROPRIATE_____ MOTIVATION TO LEARN_____ ABILITY TO LEARN_____ BODY IMAGE_____

FLUID & ELECTROLYTES: FLUID INTAKE: _____ DRY MUCOUS MEMBRANES _____
TREMORS _____ PARASTHESIAS _____ SKIN TURGOR _____ MUSCLE CRAMPS _____ IRRITABILITY _____
WEAKNESS _____ ARRHYTHMIAS _____ CONFUSION _____ OTHER _____

COMMENTS _____

NUTRITION DIET _____ UNDERSTOOD _____ FOLLOWED _____ IF NO WHY? _____
ANOREXIA _____ INDIGESTION _____ WEIGHT CHANGE _____ APPETITTE _____ DYSPHAGIA _____
DIFFICULTY CHEWING _____ NAUSEA _____ VOMITING _____ STOMATITIS _____ MEALS PREPARED BY _____
MEAL ROUTINE _____ ORAL HYGIENE _____ DENTURES _____
GT TUBE _____ PEG TUBE _____ NGT _____ FEEDINGS _____ VIA _____

COMMENTS _____

ELIMINATION: URINE COLOR _____ APPEARANCE _____ ODOR _____ PAIN _____
URINATION FREQUENT _____ NOCTURIA. _____ CATHETER HOSPITAL INSERTION DATE _____ PRESENT _____
SIZE _____ TYPE _____ LAST CHANGED _____ EXTERNAL _____ INDWELLING _____
SUPRAPUBIC _____ HEMATURIA. _____ DIFFICULTY INITIATION _____ IRRIGATION _____
SOLUTION _____ FREQUENCY _____ URGENCY _____ BURNING _____ INCONTINENT _____
DIAPERS _____ OUTPUT _____
OSTOMY TYPE _____ APPEARANCE _____ SELF-MANAGED _____
BOWEL REGULAR _____ LAST BM _____ CONSTIPATION _____ DIARRHEA _____ BOWEL PATTERN _____
BOWEL SOUNDS _____ BLEEDING _____ INCONTINENT _____ HEMORRHOIDS _____
ELIMINATION AID _____ DISTENTION/GIRTH _____

COMMENTS _____

REPRODUCTIVE: (DESCRIBE)
BREAST/NIPPLE _____ GENITALIA _____ PROSTATE _____
DATE OF LAST MAMMOGRAM _____

COMMENTS _____

SLEEP: _____ FAIR _____ POOR _____ HOURS _____ NAPS _____ AIDS TO SLEEP _____

COMMENTS _____

SKIN: Pallor _____ _____ RASH _____ DRY _____ BRUISES _____
JAUNDICE _____ NAIL/HAIR CONDITION _____ TURGOR _____ WARM _____ PALE _____ PINK _____
SCARS _____ INCISIONS _____ OTHER _____

{ } B=BRUISE { } D=DECUBITUS { } L=LACERATION { } R=RASH { } S=SCAR

	SIZE	SIZE L W D	DRAINAGE	DESCRIPTION/STAGE
LACERATION				
WOUND /INCISION				
DERMAL ULCER				
SKIN DESCRIPTION				
2ND WOUND/ULCER				
3RD WOUND/ULCER				

WOUND CARE ORDERS _____

COMMENTS _____

SOCIAL/BEHAVIORAL: (CONT.)

PATIENT CARE MANAGEMENT:	SELF-MANAGED	PCG-MANAGED	DEFICITS NOTED DESCRIBE
MEDICATION			
DIET			
TREATMENT			

POTENTIAL RISK FACTORS:	ACTION RECOMMENDED
ENVIRONMENT	
PHYSICAL	
MEDICATION-RELATED	
EMOTIONAL	

PATIENT MAY BENEFIT FROM MSS____ AIDE____ PT____ OT____ ST____ RT____
INFORMATION SOURCE PATIENT____ SPOUSE____ OTHER (SPECIFY)____

PROCEDURES: LABS

INJECTIONS____ OTHERS____
TOLERATED WELL____ DIFFICULTY ENCOUNTERED____
'COMMENTS

MEDICAL EQUIPMENT

HME COMPANY____ TEL____
PHARMACY NAME____ TEL____

INSTRUCTIONS/RESPONSE

COMMENTS

R.N. NAME____

R N SIGNATURE____ ____

Patient Signature____ DATE____