HMHC INC
Health Med Home Care, Inc.

Time In: _____

Time Out: _____

NURSING ASSESSMENT

Patient: _____ M.R.#: _____ Sex: ____ Male ____ Female

Address: _____ Phone #: ( ) _____

Vital Signs: BP _____ Temp _____ HR _____ Resp. _____ BS _____ Age _____ D.O.B. _____

Height _____ Weight _____ Allergies: _____

Diagnosis _____

Sensory Vision: Normal _____ Limited _____ Blind _____ Glasses _____ Other: _____

Hearing: Normal_____ Poor _____ Hearing Aid (specify): _____ Speech problems: _____

Respiratory Lungs: Clear_____ Dec. BS _____

Cough: Sputum: _____ Ronchi: _____ Wheezing: _____ Rales: _____

Dyspnea: Orthopnea: _____ O2 @ _____ LPM via ____ Frequency: _____ CPAP: _____

Trach: Pt./Family perform tracheostomy care (yes/no)

SOB @ Rest _____ SOB on Exertion _____

Cardiac Heart Rate: Regular ___ Irregular ___ Chest Pain ___ Pacemaker ___

Cramps Legs/Hands ___ Other: _____

Pedal Pulse: Right (yes / no) (Warm / Cold) Edema: RLE (0, 1+, 2+, 3+, 4+ pitting)

Left (yes / no) (Warm / Cold) LLE (0, 1+, 2+, 3+, 4+ pitting)

Musculoskeletal Balance: _____ Range of Motion: _____ Weakness: _____

Fracture: _____ Endurance: _____ Amputation: _____ Paralysis: _____

Hemiplegia (specify): _____ Paraplegia (specify): _____ Hand Deformities: _____

Slow/Unsteady Gait: _____ Assistive Device: Walker / Cane / Wheelchair

Transfer with one person assistance: _____ Other: _____

CNS Tremors: _____ Vertigo: _____

Mental Status: Oriented: Time _____ Place _____ Person _____ Alert ____ Forgetful _____ Confused ____

Memory: Short-Term _____ Long-term _____ Other: _____

Pain Site(s): _____

Intensity: 0 1 2 3 4 5 6 7 8 9 10 Pain Management: _____

_____

_____

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Functional Limitations Mobility: Ambulates with assist. _____ Ambulates without assist. _____

Cane ___ Walker ___ Holds onto walls/furniture for support ____ Transfers with assistance _____

Transfers without assistance ___ Hoyer Lift ___ Bedbound ___ Transfers bed to chair/wheelchair ___ Painful ambulation ___

Nutrition Diet: _____ Appetite: Good / Fair / Poor

Peg tube ___ Other: _____

Elimination Urine: Color: _____ Appearance: _____ Odor:_____

Incontinent (yes / no) Diapers (yes / no) Other: _____

Bowel: Regular: _____ Irregular _____ Last BM _____ Diarrhea _____

Incontinent (yes / no) Bowel sounds: _____ Ostomy type: _____

Other: _____

Skin Warm _____ Dry _____ Turgor: _____

Wound(s) (Specify) _____

Social Environment Lives alone _____ Lives with: _____

Caregiver Name: _____ Relation: _____

Emergency contact; Name: _____

Telephone #: ( ) _____

Caregiver Limitations to Assist Patient with Personal Care and ADL's:

Work Schedule ☐ Physical Limitations ☐ Mental Limitations ☐ Other Responsibilities ☐ _____

_____

Medication Status: ☐ Medication Regimen completed/reviewed ☐ No Change ☐ Order Obtained

Check if any of the following were identified: ☐ Ineffective drug therapy ☐ Significant side effects

☐ Potential adverse effects/drug reactions ☐ Significant drug interactions ☐ Duplicate drug therapy

☐ Non-compliance with drug therapy

Instructions: _____

_____

_____

_____

Comments:

_____

_____

Patient/Cg. Signature: _____ Date: _____

R.N. Name: _____ Date: _____
Print/Signature