NURSING ASSESSMENT FORM

Patient name:_____

PHYSICAL ASSESSMENT (Objective)

1. CLINICAL DATA

Age_____ Height _____ Weight _____ (Actual/Approximate)
Temperature _____
Pulse: _____ Strong _____ Weak _____ Regular _____ Irregular
Blood Pressure: Right Arm _____ Left Arm ____ Sitting ____ Lying _____

2. RESPIRATORY/CIRCULATORY

Rate _____
Quality: ____ WNL ____ Shallow ____ Rapid ____ Labored ____ Other _____
Cough: _____ No _____ Yes/Describe _____

Auscultation:

Upper rt lobes ____ WNL ____ Decreased ____ Absent ____ Abnormal sounds
Upper lt lobes ____ WNL ____ Decreased ____ Absent ____ Abnormal sounds
Lower rt lobes ____ WNL ____ Decreased ____ Absent ____ Abnormal sounds
Lower lt lobes ____ WNL ____ Decreased ____ Absent ____ Abnormal sounds
Right Pedal Pulse: _____ Strong _____ Weak _____ Absent
Left Pedal Pulse: _____ Strong _____ Weak _____ Absent

3. METABOLIC-INTEGUMENTARY

Skin:
Color: ___ WNL ___ Pale ___ Cyanotic ___ Ashen __ Jaundice ___ Other _____
Temperature: ___ WNL ___ Warm ___ Cool
Turgor: ____ WNL _____ Poor

Edema: ____ No _____Yes/Description/Location_____
Lesions: ____ None ____ Yes/Description/Location_____
Bruises: ____ None ____ Yes/Description/Location_____
Reddened: ____ No ___Yes/Description/Location_____
Pruritus: ____ No ____ Yes/Description/Location_____

Tubes: Specify _____

MOUTH:
Gums: ____ WNL _____ White plaque _____ Lesions ____ Other _____
Teeth: ____ WNL _____ Other _____
ABDOMEN:
Bowel Sounds: _____ Hyperactive ____ Normal _____Hypoactive _____ Absent
ELIMINATION:
Bowel Movements: _____ WNL ____ Constipation ____Diarrhea ____Colostomy___
Other:_____
GENITOURINARY:
Voiding: ____WNL Describe: color_____ clarity_____ Other:_____
Incontinence: ___ Present ____Absent _____Dysuria ____Urgency ____Frequency
Catheter: Specifiy:_____ Urinary diversion: Specify_____

4. SENSORINEURAL

Pupils _____ Equal ____ Unequal

If unequal, Left - size in mm.
If unequal, Right - size in mm.

Reactive to light:
Left: _____ Yes _____ No/Specify _____
Right: _____ Yes _____ No/Specify _____
Eyes: ___ Clear ____ Draining _____ Reddened ____ Other _____
Level of Consciousness: Alert: ____Yes ____ No
Oriented to: Person ___Yes ___ No Place: ___Yes ___No Time: ___Yes ___No

5. MUSCULOSKELETAL

Range of Motion: _____ Full ____ Other _____
Balance and Gait: _____ Steady _____ Unsteady
Hand Grasps: ____ Equal ____ Strong ____ Weakness/Paralysis (__ Right ___ Left)
Leg Muscles: ____ Equal ____ Strong ____ Weakness/Paralysis (__ Right ___ Left)

DISCHARGE PLANNING

Lives: Alone _____ With _____ No known residence _____
Intended Destination Post Discharge: ____ Home ____ Long-term care _____ Homeless shelter ____
Boarding home_____ Undetermined ____ Other _____
Previous Utilization of Community Resources:
___ Home Care/Hospice ___ Adult Day Care ___ Church Groups ___ Other _____
___ Meals on Wheels ___ Homemaker/Home Health Aid ___ Community Support Group

Post-discharge Transportation:
_____ Car _____ Ambulance _____ Bus/Taxi
_____ Unable to Determine at this time

Anticipated Financial Assistance Post-discharge? ____ No ____ Yes _____

Anticipated Problems with Self-care Post-discharge? ____ No ____ Yes _____

Self-care abilities: Needs help with: ____feeding ____bathing ____dressing ____ grooming
____transferring ____taking medications ____cooking ____transportation ____using phone
____ shopping
Assistive Devices Needed Post-discharge? ____ No ____ Yes Type: _____

Referrals: (record date)
Discharge Coordinator _____ Home Health _____
Social Service _____ Financial counselor_____

Other Comments: _____

Signature: _____