Nursing Assessment

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

SS #_____

Emergency Contact: (Name and Number) _____

Medical History

Eyes: ___ Change in vision / eye pain, redness, Glaucoma ___ **No problems**
Ears/Nose/Throat: ___ Nosebleeds, trouble swallowing ___ Frequent sore throat, hoarseness ___ Hearing loss / ringing in ears ___ **No problems**
Skin: ___ New or change in mole ___ Rash / itching ___ **No problems**
Cardiovascular: ___ Chest pain / discomfort ___ Palpitations (fast or irregular heartbeat) ___ **No problems**
Respiratory: ___ Cough / wheeze ___ Loud snoring / altered breathing during sleep ___ Short of breath with exertion ___ **No problems**
Gastrointestinal: ___ Heartburn / reflux / indigestion ___ Blood or change in bowel movement ___ Constipation ___ **No problems**
Genitourinary: ___ Leaking urine ___ Blood in urine ___ Nighttime urination or increased frequency ___ Discharge: penis or vagina ___ Concern with sexual function ___ **No problems** **STI Screening:** ___ Hx of Unprotected Sex ___ Sex for drugs ___ Blood Transfusions ___ Shared Needles **Are you aware of your HIV Status?** Y or N **Any Known STI?** Y or N

Neurological: ___ Headache ___ Memory loss ___ Fainting ___ Dizziness ___ Numbness / tingling ___ Unsteady gait ___ Frequent falls **___ No problems**
Musculoskeletal: ___ Neck pain ___ Back pain ___ Muscle / joint pain **___No problems**
Endocrine: **___** Diabetes (Type: ___) ___ Thyroid problems ___ **No problems**
Hematologic/Lymphatic: ___ Swollen glands ___ Easy bruising ___ **No problems**
Allergic/immune: ___ Hay fever / allergies ___ Frequent infections **___ No problems**

IMMUNIZATIONS: Add year, if known Dates Unknown □

Tetanus (Td): _____ With Pertussis (Tdap): _____ Varicella (Chicken Pox) shot *or* illness: _____

Pneumovax (pneumonia): _____ Influenza (flu shot): _____ Hepatitis A: _____

Hepatitis B: _____ MMR: _____ Meningitis: _____ Zostavax (shingles): _____

HPV: _____

Medical / Surgical History:

___ Cancer ___ Kidney ___ Disease ___ Blood Disorders ___ Gout Bladder problems
___ Neurological Disorders ___ High Blood Pressure ___Urinary Tract Infections ___ Stomach Ulcers
___ Stroke ___ Liver Disease ___ MI ___ Hepatitis ___ Tuberculosis ___ Thyroid Problems
___ Heart Disease ___ Emphysema/ COPD ___ Pacemaker ___ Congestive Heart Failure
___ Asthma ___ Diabetes ___ Depression ___ Anxiety ___ HIV/AIDS ___ High Cholesterol
___ Osteoporosis ___ Psychiatric disorder ___ Arthritis Rheumatoid ___ Arthritis Headaches
Other/ Comments_____

Surgical History:

_____
_____
_____

Do you use any alternative therapies? _____

How would you rate your diet - Good ___ Fair ___ Poor ___

Do you restrict what you eat? ___ Do you worry about your weight? ___

Do you think you eat too much? ___ Do you eat a balanced diet? ___

WOMEN'S HEALTH HISTORY: **Are you currently pregnant? _____**

Total number of pregnancies: _____ Number of births: _____

Date of last menstrual period: _____ Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Do you exercise regularly? Yes___ No___ Type _____ How often _____

Safety

Do you use seatbelts consistently? ____ Is violence at home a concern for you? _____ Do you have a working smoke detector? _____

End-of-Life Planning

End-of-Life Planning consists of a legal document (e.g. Living Will, Advanced Directive) that explains your wishes should you become incapacitated and unable to express your wishes regarding life-saving/sustaining medical interventions.

Have you established a Living Will or Advanced Directive? _____Yes _____ No

If you answered "No", would you like more information regarding obtaining end-of-life planning? _____ Yes _____No

Current Medications

Medication Name	Strength	Frequency	Route	Condition for which medication is prescribed

Do Your medications work for you? Yes ___ No ___

Allergies

Allergies to medication/foods/environmental	Reaction

Any Significant family medical History? ___ Y or ___ N

(describe)_____
_____

Vitals:

B/P _____ Pulse _____ Temp _____ R/R _____