Congestive Heart Failure Nursing Care Plan

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____ Address: _____

Contact Information: _____

MEDICAL HISTORY & RELATED QUESTIONS

Previous Cardiac Events:

Comorbid Conditions:

Medications:

Allergies:

Symptom Description:

Symptom Management:

Family History:

ASSESSMENT

Cardiac Status:

Respiratory Function:

Fluid Volume:

Nutrition:

Medication Management:

Emotional and Psychological Support:

Physical Activity:

Patient Education:

DOCTOR'S SIGNATURE

Name: _____ Date: _____ dd / mm / yyyy