Health Assessment in Nursing

PATIENT INFORMATION

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

Gender: _____

Address:

Phone Number: _____ Emergency Contact: _____

Insurance Information:

HEALTH INFORMATION

Chief Complaint:

Present Illness:

Past Medical History:

Medications:

Allergies:

Family History:

Social History:

VITAL SIGNS

Blood Pressure: _____ Heart Rate: _____

Respiratory Rate: _____ Temperature: _____

Oxygen Saturation: _____

PHYSICAL EXAMINATION

General Appearance:

Skin:

HEENT:

Cardiovascular:

Respiratory:

Gastrointestinal:

Musculoskeletal:

Neurological:

FUNCTIONAL ASSESSMENT

ADLs (Activities of daily living):

IADLs (Instrumental activities of daily living):

Cognitive Function:

Psychosocial:

DIAGNOSTIC TESTS AND RESULTS

Laboratory Tests:

Imaging Studies:

Other Diagnostic Tests:

Nurse's Signature:

Date: _____ dd / mm / yyyy Nurse's Name: _____