Nursing Skin Assessment Checklist

PATIENT INFORMATION

Name: _____ Gender: _____

Age: _____ Date and Time of Assessment: _____ dd / mm / yyyy

Medical Number: _____ Assessor: _____

Allergies/sensitivities:

SUBJECTIVE ASSESSMENT

Complaints related to skin

History of skin conditions

Medications affecting the skin

OBJECTIVE ASSESSMENT

Color

Moisture

Temperature

Turgor

Odor/Discharge

Integrity

Palpitation

Texture

Lesions/Wounds/Rashes

Signs of Inflammation

Specific areas assessed

DOCUMENTATION

Description of observed lesions/wounds/rashes

Treatments applied

RISK FACTOR ASSESSMENT

Immobility/mobility status

Incontinence/continence issues

Nutritional status/hydration

Presence of medical devices

History of chronic illnesses

Additional notes

Please attach photographic documentation if allowed.

Name of assessor – signature

Date: dd / mm / yyyy