# Nursing Health Assessment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | | | | |
| Address: |  | | | | |
| Telephone: |  | email: | |  | |
| Date: |  | | Apt. Time: | |  |

### MEDICAL HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have allergies? | Yes | No | Have you ever had any surgeries? | Yes | No |
| If so, to what? |  |  | If yes, please list date, type of surgery: |  |  |
| Please list all of the allergies: |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Any history of heart conditions? | Yes | No | Do you have any medical implants? | Yes | No |
| If so, please list: |  |  | If yes, please note: |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Do you have AIDS or HIV? | Yes | No | Please list the name and address of your |  |  |
| If yes, please note medications: |  |  | Primary care physician: |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Are you currently on any medications? | Yes | No | Please list an emergency contact: |  |  |
| If yes, please note medications: |  |  | Name: |  |  |
|  |  |  | Telephone: |  |  |
|  |  |  | Email: |  |  |
|  |  |  | Relation: |  |  |
| Do you have a history of mental illness? | Yes | No | Please list your insurance provider: |  |  |
| If yes, please list history: |  |  | Provider: |  |  |
|  |  |  | Policy Number: |  |  |
|  |  |  | Date: |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PATIENT CHECK-IN EVALUATION** | | | | | |
| Are you currently experiencing pain? | Yes | No | Are you experiencing dizziness? | Yes | No |
| If yes, where is the pain located? |  |  |  |  |  |
|  |  |  | Do you urinate frequently? | Yes | No |
|  |  |  |  |  |  |
| Are you experiencing hallucinations? | Yes | No | Are you experiencing blurred vision? | Yes | No |
| If yes, describe: |  |  |  |  |  |
|  |  |  | Are you presently under the influence of drugs or alcohol? | Yes | No |
|  |  |  | If yes, please note: |  |  |
|  |  |  |  |  |  |
| Are you experiencing nausea? | Yes | No |  |  |  |
|  |  |  | 1 2 3 4 5 |  |  |
| Are you pregnant? | Yes | No | Please describe the pain: |  |  |
| If yes, note due date: |  |  |  |  |  |
|  |  |  | PATIENT SIGNATURE: |  |  |
|  |  |  |  |  |  |

### THE FOLLOWING IS FOR OFFICE USE ONLY. PLEASE DO NOT WRITE BELOW THIS LINE.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | | | Note patient mood: |
| Date: |  | Time: |  |  |
| Notes: | | | | Note patient anxiety: |
|  | | | |  |
|  | | | | Comments: |
|  | | | |  |
|  | | | |  |