# Nursing Patient Assessment

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name of Patient | | | |  | | | | | | Date of Birth | |  |
| Address: | |  | | | | | | | | | | |
| City |  | | | | State |  | | Zip | | |  | |
| Contact Phone | | |  | | | | Email Address | |  | | | |
| Pharmacy | | |  | | | | Pharmacy Phone | |  | | | |

### Vitals

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Temperature** |  | **Height** |  | **Weight** |  | **Body Mass Index** |
|  |  |  |  |  |  |  |
| **Blood Pressure** |  | **Pulse** |  | **Respiratory** |  | **Blood Glucose** |
|  |  |  |  |  |  |  |

### Assistive Devices (check all that apply)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Glasses |  | Contacts |  | Hearing Aid |  | Crutches |  |  |
| Cane |  | Walker |  | Wheelchair |  | Other (specify) |  | |

### Physical/Mental Status (check all that apply)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Obesity |  | Malnutrition |  | Dehydration |  | Loss of Appetite |  |
| Trouble Sleeping |  | Anxiety |  | Depression |  | Unconscious |  |
| Stressed |  | Other (Specify) | |  | | | |

Other notable health conditions

|  |
| --- |
|  |
|  |
|  |

### Psychosocial

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Primary Language |  | | | Translator Required | | Yes | No |
| Names of those who live with you | |  | | | | | |
| Family members willing to assist with healthcare | | |  | | | | |
| Family members with whom we should NOT share information | | | | |  | | |

### Educational Information

|  |  |
| --- | --- |
| Who to include in education sessions |  |

How do you learn best? (Check all that apply)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Written |  | Verbal |  | Video |  | Hands on |  | Demonstration |  |

|  |  |
| --- | --- |
| Obstructions to learning |  |

### Other

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Family counseling |  | Cancer support groups |  | Complementary therapy |  |
| Spiritual support |  | Financial concerns |  | Meal preparation/house help |  |
| Nutritional issues |  | Medical supplies |  | Workplace issues |  |
| Transportation |  |  | | | |

|  |  |  |
| --- | --- | --- |
| May we leave messages on your answering machine? | Yes | No |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Patient/Legal Caretaker Signature |  | Date |
|  |  |  |
| Nurse Signature |  | Date |