# Pediatric Nursing Assessment

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| --- | --- |
| PATIENT NAME |  |
| DATE OF BIRTH |  | SSN |  |
| INSURANCE PROVIDER |  |
| POLICY NUMBER |  | DATE |  |
| PARENT/GUARDIAN NAME |  |
| RELATIONSHIP TO PATIENT |  | TELEPHONE |  |
| ADDRESS |  |
|  |

## MEDICAL HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the patient have any allergies? | Yes | No | Has the patient recently had surgery? | Yes | No |
| If yes, please list all allergies: | If yes, please note when and what surgery: |
|  |  |
|  |  |
| Does the patient have a history of seizures? | Yes | No | Does the patient currently have any medical implants? | Yes | No |
| If yes, please describe history: | If yes, please explain: |
|  |  |
|  |  |
| Is the patient currently taking any form of medication? | Yes | No | Does the patient have any long-term medical conditions? | Yes | No |
| If yes, please note all medications: | If yes, please explain: |
|  |  |
|  |  |
| Is there a history of mental illness? | Yes | No | Is there a history of heart conditions? | Yes | No |
| If yes, please detail: | If yes, please explain: |
|  |  |
|  |  |

## PATIENT CHECK-IN INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| experiencing nausea? | Yes | No | currently on any medication? | Yes | No |
| experiencing dizziness? | Yes | No | able to communicate the illness/pain? | Yes | No |
| experiencing pain? | Yes | No | Does the patient have any visible marks, bruises, or cuts? | Yes | No |
| If yes, please describe: | If yes, please detail: |
|  |  |
|  |  |
| Please attempt to rate the pain on a scale of 1 to 5, with 5 being the most painful | 1 | 2 | 3 | 4 | 5 |

|  |  |
| --- | --- |
| Please note any unusual or out of character behavior of the patient | Please describe the patient’s last 24 hours, leading up to the doctor's visit |

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| PARENT/GUARDIAN SIGNATURE |

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

|  |  |  |  |
| --- | --- | --- | --- |
| NURSE ON CALL |  | TIME |  |
| PATIENT DATE OF BIRTH |  | PATIENT SSN |  |
| NOTES |  |
|  |
| HEARTRATE |  | WEIGHT |  | TEMPERATURE |  |
| COMMENTS | [The child seems grumpy and out of sorts.] |
|  |
| EVALUATION | [The patient is suffering from constipation. The patient has not had a bowel  |
| movement in 48 hours.] |