

NURSING ADULT ASSESSMENT

PATIENT NAME _____ PT. # _____ HEIGHT _____ MALE
DOB _____ WEIGHT _____ FEMALE
VITAL SIGNS: BP _____ TEMP _____ RESP _____ PULSE APICAL _____ PULSE RADIAL _____ BS _____

HISTORY OF PRESENT ILLNESS: (INCLUDE DATES) _____

HOSPITALIZATION/SURGERIES (REASONS & DATES) _____

PREVIOUS MEDICAL HISTORY (INCLUDE ONSET DATES):

CARDIAC _____ ANGINA ARRHYTHMIA CAD CHF HTN M.I. ALLERGIES _____
 D.M. _____ INSULIN ORAL AGENT DIET CONTROLLED _____
 RESPIRATORY _____ ASTHMA COPD _____
 CANCER _____ ULCERS _____ ETOH USE _____
 OTHER _____

PRINCIPAL DIAGNOSIS: _____ SECONDARY DIAGNOSIS: _____
HOMEBOUND _____

EENT:

VISION: NORMAL IMPAIRED BLIND CONTACT LENSES
 GLASSES CATARACTS
HEARING: GOOD POOR HEARING AID DEAF TINNITUS
MOUTH: GINGIVITIS BLEEDING LESIONS
TEETH: OWN DENTURES UPPER LOWER PARTIAL
THROAT: HOARSE SORE BURNING PAIN
MUCOUS MEMBRANES: MOIST DRY PINK
COMMENTS: _____

MENTAL STATUS:

ALERT ORIENTED X 3 COOPERATIVE CONFUSED
 ANXIOUS FORGETFUL DEPRESSED ISOLATED
 WITHDRAWN LETHARGIC COMATOSE OTHER
COMMENTS: _____

FUNCTIONAL LIMITATIONS:

ADL: SELF-CARE MODERATE ASSISTANCE MAX. ASSISTANCE
ACTIVITY: AMBULATORY BRP ASSIST TO TRANSFER
 RESTRICTIONS: _____
NEEDS ASSISTANCE WITH: _____

RESPIRATORY:

BREATH SOUNDS: EQUAL CLEAR COARSE WHEEZING
 RALES RHONCHI ABSENT
 ORTHOPNEA PAIN HEMOPTYSIS TACHYPNEA SOB
 APNEA COUGH NON-PROD. COUGH PROD. COUGH
DESCRIBE COLOR _____ AMOUNT _____
SMOKE _____ PACKS/DAY YEARS SMOKING _____
OXYGEN AT _____ LITERS/Min. VIA _____
 IPPB SAN OTHER _____
COMMENTS: _____

NUTRITION:

DIET _____ PO NG GT
APPETITE _____ GOOD POOR FAIR
 WEIGHT LOSS _____ (TIME FRAME)
 WEIGHT GAIN _____ (TIME FRAME)
 FLUID INTAKE _____ CUPS/DAY OTHER _____
COMMENTS: _____

GASTRO/ABDOMINAL

BOWEL SOUNDS: PRESENT ABSENT HYPERACTIVE HYPOACTIVE
LAST BM DATE _____ NAUSEA INDIGESTION
 GAS VOMITING HEMATEMESIS DIARRHEA CONSTIPATION
LAXATIVE/ENEMA USE FREQ. _____ PAIN DISTENTION
 HERNIA _____ (LOCATION) MASSES _____ (LOCATION)
 OSTOMY TYPE _____ (LOCATION)
COMMENTS: _____

SOCIAL ENVIRONMENT:

CAREGIVER: _____
RELATIONSHIP: _____
CAREGIVER: _____ CAREGIVER LIMITATIONS:
 LIVES IN RESIDENCE AGE PHYSICAL
 AVAILABLE AT ALL TIMES WORK ILLNESS
 AVAILABLE SOMETIMES OTHER RESPONSIBILITIES
 UNWILLINGNESS
SUPPORT SYSTEM ADEQUATE: YES NO
LANGUAGE SPOKEN: _____
MEANS OF TRANSPORTATION: _____
NEED FOR ANCILLARY SERVICES: YES NO
TYPE: _____
COMMENTS: _____

HOME ENVIRONMENTAL SAFETY:

HOUSE APARTMENT STAIRS GOOD LIGHTING PHONE
 PETS CLEAR PATHS OBSTACLES FIRE ALARM
PATIENT/CAREGIVER ORIENTED TO:
OBSTACLES TO MOBILITY? YES NO SAFETY DEVICES? YES NO
FIRE/ELECTRIC SAFETY? YES NO
COMMENTS: _____

GU/GYN:

BLADDER: CONTINENT INCONTINENT FREQUENCY URGENCY
 PAIN ODOR BURNING RETENTION HESITANCY
 HEMATURIA, URINE: COLOR _____ CLOUDY
 OUTPUT. VOIDS _____ X/DAY OR _____ cc NOCTURIA X _____
 FOLEY SIZE _____ LAST CHANGED _____
 BYN: LAST MENSES _____ LAST PAP _____
 VAGINAL BLEEDING DISCHARGE OTHER _____
 COMMENTS: _____

CARDIOVASCULAR

HEART RATE: REG. IRREG. PALPITATIONS CHEST PAIN
 EDEMA _____ LOCATION (CIRCLE) 1+, 2+, 3+, 4+
 NECK VEIN DISTENTION DIMINISHED PULSE FAINTING
 PACEMAKER _____ /MIN MURMER GALLOP
 FLUID RESTRICTION _____ ML/DAY
 COMMENTS: _____

IV/CATHETER/TUBE ASSESSMENT:

TYPE _____ LOCATION _____ N/A
 EVIDENCE OF: REDNESS SWELLING DRAINAGE PAIN
 COMMENTS: _____
 IMPLANTABLE PORT OTHER _____
 COMMENTS: _____

 N IMPLANTABLE PORT OTHER
 ACCESSED _____ GAUGE _____ INCH _____ (DEVICE)
 INSERTION SITE _____
 REASON FOR RESTART _____
 NEEDLE/CATHETER D/E'D INTACT: YES NO (IF NO, EXPLAIN)
 COMMENTS: _____

NEURO/MUSCULAR:

PUPILS: REACTIVE R L HEADACHE WEAKNESS
 SYNCOPE VERTIGO NUMBNESS TINGLING STIFFNESS
 COORDINATION PROBLEMS CONTRACTURES LETHARGIC
 ROM LOSS PAIN UNSTEADY ARTHRITIS TREMORS
 APHASIA PARALYSIS HEMIPARESIS: R L
 SEIZURES COMATOSE OTHER
 COMMENTS: _____

INTEGUMENTARY:

SKIN: PINK PALE FLUSHED JAUNDICE WARM
 COOL DRY DIAPHORETIC ECCHYMOSIS PETECHIE
 RASH ITCHING POOR TURGOR HAIR LOSS WOUNDS
 LESIONS
 WOUND ADDENDUM COMPLETED: YES NO
 COMMENTS: _____

WOUND ADDENDUM

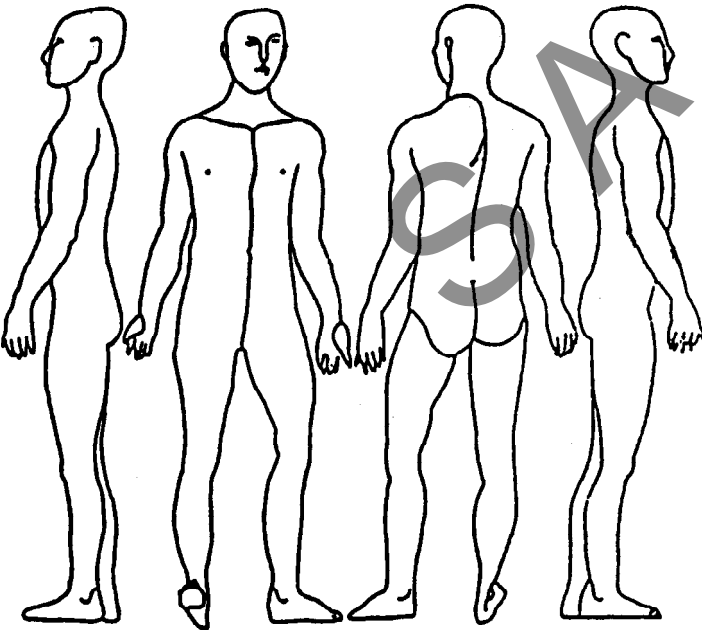


DIAGRAM CODES B - BURN C - CONTUSION D - DECUBITUS
 E - ERYTHEMIA I - INCISION L - LACERATION
 P - PETECHIA R - RASH S - SCAR
 T - TUBES W - WOUNDS

WOUND DESCRIPTION:

	#1	#2	#3
LENGTH			
WIDTH			
DEPTH			
DRAINAGE			
COLOR			
ODOR			
AMOUNT			
RESULTS OF LAST C & S			

COMMENTS: _____

