

# PATIENT NURSING ASSESSMENT FORM

Comprehensive Initial & Ongoing Evaluation | Confidential Medical Record

## SECTION 1 | ADMINISTRATIVE INFORMATION

Patient Full Name	Date of Birth (DD/MM/YYYY)	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	
Patient ID / MRN	Admission Date	Admission Time	Ward / Unit / Bed No.	Room No.
Attending Physician	Primary Nurse	Nurse ID / Badge No.	Assessment Date	
Admission Diagnosis / Chief Complaint	Admission Type <input type="checkbox"/> Emergency <input type="checkbox"/> Elective <input type="checkbox"/> Transfer			

## SECTION 2 | EMERGENCY CONTACT & NEXT OF KIN

Contact Name	Relationship	Primary Phone	Alternate Phone
Address			Healthcare Proxy / Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION 3 | VITAL SIGNS & MEASUREMENTS

Parameter	Value	Unit	Time	Initials
Blood Pressure (BP)		mmHg		
Heart Rate (HR)		bpm		
Respiratory Rate (RR)		breaths/min		
Temperature (Temp)		degC / degF		
Oxygen Saturation (SpO2)		%		
Blood Glucose (CBG)		mmol/L / mg/dL		
Weight		kg		
Height		cm		
BMI (calculated)		kg/m2		
Pain Score (0-10 NRS)		/10		

Pain Location: \_\_\_\_\_ Character:  Sharp  Dull  Burning  Aching  Throbbing Radiating:  Yes  No Aggravating/Relieving Factors: \_\_\_\_\_

## SECTION 4 | MEDICAL & SURGICAL HISTORY

Past Medical History (PMH) — check all that apply:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Diabetes Mellitus (Type 1) | <input type="checkbox"/> Diabetes Mellitus (Type 2) | <input type="checkbox"/> Asthma / COPD          |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Failure              | <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> Stroke / TIA           |
| <input type="checkbox"/> CKD / Renal Disease     | <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> HIV / AIDS                 | <input type="checkbox"/> Cancer (specify below) |
| <input type="checkbox"/> Thyroid Disorder        | <input type="checkbox"/> Psychiatric Disorder       | <input type="checkbox"/> Epilepsy / Seizures        | <input type="checkbox"/> Autoimmune Disease     |

Sickle Cell Disease       TB (past/current)       Peptic Ulcer Disease       Osteoporosis  
 Anemia       Other (specify)

Specify 'Other' or Cancer Type:

Year of Diagnosis:

Current Status:

Surgical / Procedural History:

Procedure / Surgery	Year	Hospital / Facility	Complications

### SECTION 5 | ALLERGIES & ADVERSE REACTIONS

No Known Drug Allergies (NKDA)  No Known Allergies (NKA)

Allergen (Drug / Food / Environment)	Type	Reaction / Symptoms	Severity	Date Noted
			<input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe	
			<input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe	
			<input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe	
			<input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe	

### SECTION 6 | CURRENT MEDICATIONS & SUPPLEMENTS

Medication Name (Generic / Brand)	Dose	Route	Frequency	Indication	Last Taken

Patient uses herbal / traditional remedies Specify: \_\_\_\_\_  OTC medications Specify: \_\_\_\_\_

### SECTION 7 | REVIEW OF SYSTEMS (ROS)

**Cardiovascular**

Chest pain / tightness       Palpitations       Oedema (swelling)  
 Orthopnoea       Paroxysmal nocturnal dyspnoea       Syncope / near-syncope

**Respiratory**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dyspnoea / SOB | <input type="checkbox"/> Cough (dry)             | <input type="checkbox"/> Cough (productive)      |
| <input type="checkbox"/> Haemoptysis    | <input type="checkbox"/> Wheezing                | <input type="checkbox"/> Pleuritic pain          |
| <b>Gastrointestinal</b>                 |  |  |
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Vomiting                | <input type="checkbox"/> Diarrhoea               |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Haematochezia / Melaena | <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> Dysuria        | <input type="checkbox"/> Haematuria              | <input type="checkbox"/> Frequency / Urgency     |
| <input type="checkbox"/> Incontinence   | <input type="checkbox"/> Oliguria / Anuria       | <input type="checkbox"/> Flank pain              |
| <b>Neurological</b>                     |  |  |
| <input type="checkbox"/> Headache       | <input type="checkbox"/> Dizziness / Vertigo     | <input type="checkbox"/> Weakness                |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Hearing changes         | <input type="checkbox"/> Confusion / Altered LOC |
| <b>Musculoskeletal</b>                  |  |  |
| <input type="checkbox"/> Joint pain     | <input type="checkbox"/> Muscle pain / cramps    | <input type="checkbox"/> Swelling / Redness      |
| <input type="checkbox"/> Limited ROM    | <input type="checkbox"/> Back pain               | <input type="checkbox"/> Gait instability        |
| <b>Skin / Integumentary</b>             |  |  |
| <input type="checkbox"/> Rash / Lesions | <input type="checkbox"/> Wounds / Ulcers         | <input type="checkbox"/> Pruritus                |
| <input type="checkbox"/> Jaundice       | <input type="checkbox"/> Pallor / Cyanosis       | <input type="checkbox"/> Diaphoresis             |
| <b>Endocrine / Metabolic</b>            |  |  |
| <input type="checkbox"/> Polydipsia     | <input type="checkbox"/> Polyuria                | <input type="checkbox"/> Weight gain             |
| <input type="checkbox"/> Weight loss    | <input type="checkbox"/> Heat / Cold intolerance | <input type="checkbox"/> Fatigue / Lethargy      |

## SECTION 8 | PHYSICAL EXAMINATION FINDINGS

<b>General Appearance</b>	Findings / Remarks
<b>Head / Eyes / ENT</b>	Findings / Remarks
<b>Neck / Lymph Nodes</b>	Findings / Remarks
<b>Cardiovascular</b>	Findings / Remarks
<b>Respiratory / Lungs</b>	Findings / Remarks
<b>Abdomen</b>	Findings / Remarks
<b>Genitourinary</b>	Findings / Remarks
<b>Extremities / Peripheral Pulses</b>	Findings / Remarks
<b>Skin / Integument</b>	Findings / Remarks
<b>Neurological</b>	Findings / Remarks
<b>Musculoskeletal</b>	Findings / Remarks
<b>Psychiatric / Behavioural</b>	Findings / Remarks

## SECTION 9 | NEUROLOGICAL & COGNITIVE STATUS

### Level of Consciousness (LOC):

- |                                |  |  |  |
|--------------------------------|--|--|--|
| <input type="checkbox"/> Alert | <input type="checkbox"/> Verbal stimuli response | <input type="checkbox"/> Pain stimuli response | <input type="checkbox"/> Unresponsive (AVPU) |
|--------------------------------|--|--|--|

**Glasgow Coma Scale (GCS):**

Eye Opening (E)	Score	Verbal Response (V)	Score	Motor Response (M)	Score	TOTAL GCS
Spontaneous	4	Oriented	5	Obeys commands	6	
To voice	3	Confused	4	Localises pain	5	
To pain	2	Inappropriate words	3	Withdraws from pain	4	
None	1	Incomprehensible	2	Flexion (Decorticate)	3	
		None	1	Extension (Decerebrate)	2	
				None	1	

**Orientation:**

Person                                       Place                                       Time                                       Event

**Pupil Assessment:**

Right Pupil Size (mm)                      Reaction  Brisk  Sluggish  Fixed                      Left Pupil Size (mm)                      Reaction  Brisk  Sluggish  Fixed

**SECTION 10 | FUNCTIONAL STATUS, FALLS & PRESSURE INJURY RISK**

**Activities of Daily Living (ADLs) — check level of assistance required:**

Activity	Independent	Needs Assistance	Fully Dependent	Comments
Bathing / Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility / Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding / Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transfers (bed-chair)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Braden Scale for Pressure Injury Risk:**

Sensory Perception	Moisture	Activity	Mobility	Nutrition	Friction/Shear	TOTAL
/4	/4	/4	/4	/4	/3	<b>/23</b>

Risk Level:  No Risk (19-23)  Mild Risk (15-18)  Moderate Risk (13-14)  High Risk (10-12)  Very High Risk (<= 9)

**Falls Risk Assessment (Morse Fall Scale):**

Item	Scale	Score
History of falling in past 3 months	No=0 / Yes=25	
Secondary diagnosis	No=0 / Yes=15	
Ambulatory aid	None/bed rest/wheelchair=0 / Crutches/cane/walker=15 / Furniture=30	
IV / IV access	No=0 / Yes=20	
Gait	Normal/bed rest/immobile=0 / Weak=10 / Impaired=20	
Mental status	Oriented to own ability=0 / Overestimates/forgets limitations=15	
<b>TOTAL MORSE SCORE</b>		<b>/125</b>

Risk Level:  Low Risk (0-24)  Medium Risk (25-44)  High Risk (>= 45) Fall Prevention Protocol Initiated:  Yes  No

## SECTION 11 | PSYCHOSOCIAL & SPIRITUAL ASSESSMENT

Marital Status  Single  Married  Divorced  Widowed

Occupation / Employment Status

Primary Language

Interpreter Required  Yes  No Language:

Education Level

Mood / Affect — check all that apply:

Calm

Anxious

Depressed

Agitated

Labile

Flat / Blunted

Euphoric

Irritable

Suicidal ideation

Homicidal ideation

Hallucinations

Delusions

PHQ-2 Quick Screen:

Little interest/pleasure in things  0  1  2  3

Feeling down/hopeless/helpless  0  1  2  3

PHQ-2 Total: \_\_\_/6 (Score >= 3: refer for full PHQ-9)

Social Support System

Spiritual / Religious Preferences

Coping Mechanisms / Concerns:

Discharge Planning Considerations:

## SECTION 12 | NUTRITIONAL & FLUID STATUS

Current Diet / Nutritional Order

Appetite  Good  Fair  Poor  NPO

Nutritional Supplements

Nutritional Risk Screening — MNA Short Form:

Recent significant weight loss  Yes  No

Recent food intake decline  Yes  No

Reduced mobility  Yes  No

Acute illness / stress  Yes  No

BMI < 23  Yes  No

Calf circumference < 31 cm  Yes  No

Swallowing Difficulty  None  Mild  Moderate  Severe

Nausea / Vomiting  None  Mild  Severe Frequency: \_\_\_\_\_

IV Fluids (type / rate)

Fluid Restriction  Yes  No Limit  
(mL/day):

Last Bowel Movement:

Last Urine  
Output:

## SECTION 13 | SOCIAL HISTORY & LIFESTYLE

Substance Use:

Substance	Status	Amount / Frequency	Duration	Last Use	Cessation Interest
Tobacco / Cigarettes	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never				<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never				<input type="checkbox"/> Yes <input type="checkbox"/> No
Cannabis	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other illicit drugs	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never				<input type="checkbox"/> Yes <input type="checkbox"/> No



**Discharge Planning Goals:**

### SECTION 18 | NURSE SIGNATURE & VERIFICATION

Assessing Nurse (Print Name)	Signature	Designation / Title	Date	Time
Countersigned by (Charge Nurse / Supervisor)	Signature	Designation	Date	Time

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