NURSING ASSESSMENT FORM

Information provided by ☐ Patient ☐ Other…….Telephone Number..... ☐ Transferred from: ……..

Personal Data:

Admission Date.....Time..... ☐ Admitted from: ……..……..

1. **Mode of Arrival:** ☐ Walk ☐ Wheel chair ☐ Stretcher ☐ Other.....
2. **Chief Complaint (CC):**.....
3. **General Appearance (GA)**

   Level of Conscious: ☐ Good Conscious ☐ Confuse ☐ Drowsiness ☐ Stuporous ☐ Unconscious (Coma)

   Vital signs: Body Temperature.....°C. Pulse rate.....bpm. Respiratory rate.....bpm. O_2Sat……%

   Blood pressure.....mmHg Body weight.....Kgs. Height.....cms. BMI..... Kg/m^2
4. **Present Illness / Pregnancy:** .....

   .....
5. **Past Illness History:**

5.1 Underlying disease	○ No	☐ Yes: ☐ DM ☐HT ☐ DLD ☐Other .....
5.2 Past hospital admitted (Hospitalizations)	○ No	☐ Yes: Reasons.....
5.3 Operation history	○ No	☐ Yes: .....
6. History of allergy & reactions	○ No	☐ Yes: ☐Medicine……., ☐Food……., ☐Other.....
7. Current medications	○ No	☐ Yes: .....
8. Family medical history	○ No	☐ Yes: .....
9. Follow-Up	○ Always	☐ Sometimes ☐ Never
10. Drugs/Substances:	○ No	☐ Yes: Tobacco.....piece/day Alcohol ...../day Other.....
11. Physical Checkup	○ No	☐ Yes: .....
12. Immunizations	○ Completed	☐ In completed: .....

Health Assessment

Nutrition /Metabolism

Assistance with feeding:	**Diet:**	**Therapeutic diet:**	**Problem:**	**Nutrition Screening:**
○ Self	☐ NPO	☐ DM	○ None	○ Normal
☐Assisted ☐ NG/OG	☐ Ordinary diet	☐ Low Na	☐ Appetite: ○ Normal	☐Abnormal:
☐Gastrostomy/Jejunostomy tube	☐ Liquid diet	☐ Low Protein	☐ Increased ☐ Decreased	☐ Over nutrition
☐ Parenteral Nutrition	☐Breast feeding/Breast milk	☐ High Protein	☐ Nausea ☐ Vomiting	☐ Unintentional weight loss over 6 months
	☐ Other type of formula….. ……..	☐ Other…….…	☐ Swallowing Difficulty ☐Other…….……	☐ Decrease nutritional intake (more than 7 day)

Skin

Dermal Assessment:	**Color:**	**Turgor:**	**Pressure Ulcer :** ○ No
○ Normal	○ Normal	○ Good	☐ Stage 1; intact skin with non-blanch able redness of location
☐Abnormal; ☐ wound at ……..……	☐ Pale	☐ Poor	☐ Stage 2; skin loss: abrasion, blister or shallow crater
☐ Abrasion ☐ Burn ☐ Contusion ☐ Dermatitis	☐ Jaundice		☐ Stage 3; Shallow/deep crater: not extend down through underlying fascia
☐ Ecchymosis ☐ Hematoma ☐ Laceration ☐ Mass	☐ Cyanosis		☐ Stage 4; Deep crater: exposed bone, tendon or muscle
☐ Petechiae ☐ Rash ☐ Suture ☐ Other…..…..			☐ Unstageble; Slough (yellow, gray, green or brown) or eschar wound bed
			☐ Deep tissue injury

Respiratory

Rate:	**Rhythm/Depth:**	**Effort:**	**Cough:**	**Sputum:**	**Breath sound**	**Current Treatment:**
○ Eupnea	○ Regular	○ Easy	○ None	○ None	○ Normal	○ None
☐ Tachypnea	☐ Irregular	☐ Dyspnea	☐ Dry	☐ Yes;	☐Abnormal;	☐ Oxygen therapy……...……..
☐Bradypnea	☐ Deep	☐ Orthopnea	☐ Productive	☐ Hemoptysis	☐ Wheeze	☐Tracheostomy ☐ Endotracheal Tube
☐ Apnea	☐ Shallow	☐ Other…….....	☐ Other……...	☐ Frothy	☐ Rhonchi	☐ Ventilator ☐ Chest tube
				☐ Color……	☐ Crepitation	☐ Other…….……..……..
					☐ Other……..	

Ward……

Name……...Age…….....

HN……..... AN ……..……...…..

Cardiovascular

Pulse Rhythm:	Pulse Amplitude:	Pulse Rate:	Neck Vein Engorged:	Edema:	Chest Pain:
○ Regular ☐ Irregular	○ Strong ☐ Weakness ☐ Absent	○ Normal ☐ Tachycardia ☐ Bradycardia	○ No ☐ Yes	○ None ☐ Generalized ☐ Location……..… ☐ Pitting……	○ No ☐ Yes; ☐ Location……...…… ☐ Referred Pain…… ☐ Duration…… ☐ Frequency……..……

Neurological

Glascow Coma Scale:	Vision:	Hearing:	Speech:	Smell:	Sensation:
Eye opening (E) = ….. Motor response(M) = …… Verbal response(V) = ……. Total score ☐	○ Normal ☐ Impaired; ☐ Right ☐ Left	○ Normal ☐ Impaired; ☐ Right ☐ Left	○ Normal ☐ Impaired	○ Normal ☐ Impaired	○ Normal ☐ Numbness: …….. ☐ Tingling: …….

Musculoskeletal

Musculoskeletal (Structure/Motor power)**:**
○ Normal
☐ Abnormal;
☐ Movement; ☐ Normal ☐ Abnormal
☐ Weakness; ……..……..……
☐ Deformity; ……..……..……..……
☐ Fracture; ……..……..……

EENT

Eyes:	Ears:	Nose:	Oral Cavity:	Pharynx & Tonsil:
○ Normal ☐ Abnormal; ……..	○ Normal ☐ Abnormal; ……..…..	○ Normal ☐ Abnormal; ……..……..	○ Normal ☐ Abnormal; ☐ Moist ☐ Dry ☐Abrasion ☐Tumor ☐ Dentures ☐Other…..…	○ Not injected ☐ Injected... ……

Gastrointestinal

Abdomen:	Elimination Problem:
○ Soft ☐Tenderness ☐Other……	○ None ☐ Diarrhea ☐ Constipation ☐ Incontinent ☐ Ostomy ☐ Other……

Renal/Urinary

Bladder:	Voiding:	Urine:
○ Full ☐ Empty ☐ Other……	○ Continent ☐ Incontinent ☐ Dysuria ☐ Anuria ☐ Catheter ☐ Other……	○ Clear ☐ Cloudy ☐ Bloody ☐ Other……

Genital

Genital Organ:	Breast:	Nipple :	Sexual function:
○ Normal ☐ Abnormal.. ……	○ Normal ☐ Abnormal … …..……	○ Normal ☐ Abnormal … …..……	○ Normal ☐ Abnormal..… ……..…… ☐ Anxiety: …. ……..…

Menstrual : (Female Only)
○ **Not required** ☐ **Required:**
Age of first period……..……LPM…….
Interval……..days Duration……..…….days
Age of Menopause ……
Reproductive tract:
Fundus (consistency, height, position)……..…….
Lochia; ○ Normal ☐ Abnormal ……
Perineum; ☐ Intact ☐ Episiotomy ……..……
Contraception: ○ No
☐ Yes; ☐ pill ☐ injection ☐ other…..……..

Pain Assessment

Pain: ○ No
☐ Yes: Location: ……..

Intensity (pain score): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

อายุมากกว่า 5 ปี No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

(เด็ก 1-5 ปี) ☐ CHEOP (score) ……..……..……..…

(ทารกแรกเกิด-1 ปี) ☐ NIPS (score) ……..……..……..……..…

Pattern:
☐ Intermittent
☐ Constant
☐ Other……

Pain description
☐ Burning pain
☐ Dull pain
☐ Sharp pain
☐ Electrical pain
☐ Other……

Support Cultural Need / Emotional Support

Religion:	Anxiety:	Support System:	Does the patient require end-of-life care?
☐ Buddhism ☐Christianity ☐ Islamism ☐ Other…… ……	○ None ☐ Yes; ☐ Illness ☐ Family ☐ work ☐ Finance ☐Other…….....	☐ None ○ Yes; ☐Parents ☐ Family ☐Friends ☐Other…..…	☐ No ☐ Yes ☐ Not Required

Discharge Planning Supportive Care

1. Does the patient need post discharge assistance with activity daily living?
○ No
☐ Yes: 1) Does patient have family capable to provide assistance post discharge? ☐ No ☐Yes; ……..……..……...……
2) Is assistance needed that family can't provide? ☐ No ☐Yes; ……..……..……..……

2. Are there financial concerns regarding this hospitalization? ☐ No ☐ Yes; ……

3. Information/Teaching/Learning Needs
☐ Orientation ☐ Disease Process ☐ Medication ☐ Activity ☐ Wound/ Ostomy care ☐ Diet ☐ Safety ☐ Pre/Post-Op Teaching ☐ Infection Control ☐ Self - Care
☐Signs/Symptoms to report ☐ Test/Process Treatment ☐ Appointment ☐ Other ……..……..……..……..

4. Possible Referral Need: ☐ Wound Care/Burn care ☐ Social Service ☐ Rehabilitation/PT ☐ Speech ☐ Ostomy ☐Other……..
☐ Refer to……..……..……..……

Assessment Initiated by RN……...Date……..……Time……..……...

(To be completed by the admitting nurse within 48 hours)

Ward……
Name……..Age…….....
HN……..... AN ……..…….…..