ADULT NURSING ASSESSMENT

Client's Name: _____

History Given by: _____ Date: _____

If Active problem, indicate plan of action under "Comments" or address on pathway.	Active	Inactive	Potential
A. **Current Diagnosis (ESI)/Chief Complaints:**			
B. **Past History:**			
C. **Allergies:** (environmental, drugs, food, etc.)			
Immunizations: **Flu:** Yes____ No ____ Date _____ **Pneumonia:** Yes ____ No ____ Date _____ **Tetanus:** Yes ____ No ____ Date_____ **Other:** Comments:			
E. **Vital Signs:** Temp _____ Resp. _____ BP (designate positions/s) _____ Pulse: Apical Rate _____ Radial Rate _____ Rhythm _____ Quality _____ Other Pulses:			
F. Life System Profile: **5-WNL; 4-Not normal, but w/o help; 3-Uses a device; 2-With Assistance; 1-Device and help; 0-Dependent** 1. Activities of Daily Living (ADL) ___ Bathing ___ Transferring ___ Dressing ___ Locomotion ___ Grooming ___ Eating ___ Toileting ___ Other 2. Instrumental Activities of Daily Living (ADL) ___ Telephone ___ Money management ___ Meal Preparation ___ Shopping ___ Housework ___ Manage appointments ___ Laundry ___ Access resources ___ Medicine management			
3. Homeboundness (Check appropriate blanks) ___ Outdoor without assistance ___ Outdoors with assistance ___ Confined to house, not bed disabled ___ Bed disabled Comments: 4. Financial/Legal (check appropriate blank) ___ Independent ___ Needs assistance from _____ ___ Power of Attorney ___ Living Will ___ DNR discussed Comments:			
5. Habits: (check and describe) ___ Alcohol ___Caffeine ___ Nicotine ___ Street drugs ___ other ___ Sleep disorder Comments:			
6. Physical Environment: (Check appropriate blanks) ___ All adequate ___ Inadequate space ___ Electrical/fire hazards ___ Structural hazards ___ Stairs ___ Interior safety hazards ___ Private water supply/sewage disposal problem ___Transportation inadequate Comments:			

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G. Psycho-social Profile: If no problem, leave blank, place S for subjective problem, 0 of objectively assessed ___ Hx of previous psych. Illness ___ Mood-depression/mania/lability ___ Anxiety/agitation ___ Memory loss-short term/long term ___ Poor judgment ___ Behavior problems ___ Disorientation time/place/person ___ Hallucinations/delusions ___ Learning disabilities ___ Communication barriers ___ Emotional response t illness and care, body image ___ Growth and development ___ Interpersonal relationships ___ Socialization ___ Ethnicity Comments:			
H. **Review of Systems/Physical Assessment:** If no problem present leave blank; place S for subjective problem; 0 for objectively assessed problem; DNA for did not assess; A✓ in the DNA box indicates did not assess or system not reviewed. Some blanks may require specific information.			
1. Head: ___ Dizziness ___ Headache 2. Eyes: ___ Vision loss (circle one) Minimal Moderate Severe Blind Not Determined ___ Glasses ___Blurred/Double vision ___ Change in vision over last year ___ Glaucoma ___ Cataracts ___ PERRL 3. Ears: ___ Hearing Loss (circle one) Minimal Moderate Severe Deaf ___ Hearing aid ___ Tinnitus 4. Mouth: ___ Gum problems ___ Chewing problems ___ Dentures (upper/lower) 5. Nose: ___ Epistaxis 6. Neck and Throat: ___ Hoarseness ___ Difficulty swallowing Comments: ❑WNL ❑DNA			
7. Cardiovascular: ___ Palpitations ___ Dyspnea on exertion ___ BP problems ___Varicosities ___ Claudication ___ Paroxysmal nocturnal dyspnea ___ Chest pain ___ Edema ___ Fatigues easily ___ Orthopnea # Pilows _____ ___ Murmurs ___ Cyanosis ___ Pacemaker Comments: ❑WNL ❑DNA			
8. Respiratory: ____ Shortness of Breath ____ Wheezing ____ Sputum ____ Oxygen ____ Shape and Symmetry ____ Cough ____ Breath Sounds ____ Other Comments: ❑WNL ❑DNA			
9. Gastrointestinal Tract: ____Indigestion ____ Pain ____Rectal Bleeding ____ Jaundice ____Nausea, vomiting ____ Hernias ____Hemorrhoids ____ Tenderness ____ Ulcers ____ Diarrhea/constipation ____ Gallbladder problems ____ Ostomy Comments: ❑WNL ❑DNA			
10. Nutritional Status: ____Weight loss or gain last 3 months (amount _____) ___ Change in appetite Diet _____ Fluid intake _____ Height _____ Weight (actual) _____(reported) _____			

Client's Name: _____ Date: _____

Meals prepared by _____

Comments:

❑WNL ❑DNA

11. Genitourinary Tract:

___ Frequency ___ Nocturia ___ Dysmenorrhea ___ Gravida/Para ___ Pain
___Urgency ___ Lesions ___ Date last PAP test ___ Hematuria ___ Vaginal discharge/bleeding
___ Prostate disorder ___ Contraception ___ Incontinence ___ Hx hysterectomy

Comments:

❑WNL ❑DNA

12. **Breasts:** (for both male and female)

___ Lumps ___Tenderness ___ Discharge ___Pain ___Does Self-breast exam

Comments:

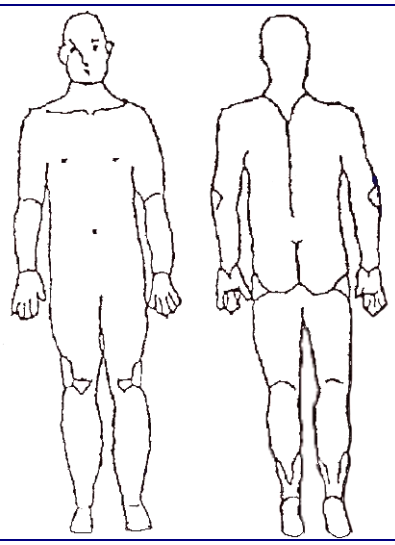
❑WNL ❑DNA

13. **Integument:**

___Hair Changes ___Pruitus ___Color ___Tugor

Skin condition (Record code # on body area. Indicate size to right of numbered category.)

1. Lesions ___ 2. Bruises ___ 3. Masses ___ 4. Scars ___ 5. Ulcers
___ 6. Decubiti ___ 7. Pressure areas ___ 8. Incisions ___ 9. Rash



Comments:

❑WNL ❑DNA

14. **Musculoskeletal Neurological:**

___ Stiffness ___Leg cramps ___ Seizure ___Paralysis ___ PERRL ___Swollen joints
___Numbness ___Tenderness ___Amputation ___Coordination ___Unequal grasp ___Deformities
___Tremor ___Joint pain ___Gait ___Temp changes ___Headache ___Weakness
___Syncope ___Balance ___Hoarseness

Comments

❑WNL ❑DNA

	Active	Inactive	Potential

Client's Name: _____ Date: _____

15. **Endocrine and Hematopoietic:** ___ Polyuria ___ Polydipsia ___ Excessive bleeding or bruising ___ Skin texture ___Intolerance to heat and cold ___ Excessive perspiration ___ Epistaxis Comments: ❑WNL ❑DNA			

Date of Assessment: _____ Signature of Assessor: _____

General Comments: