INITIAL EVALUATION AND NURSING ASSESSMENT

Patient____Age___________Ethnicity______________________________________

Religion______________________________Marital Status_______________________Occupation_____________________________________

Informant____Reliability____

DIAGNOSES: (list all diagnoses, surgical procedures & complications relating to present condition and dates.)		HISTORY OF PRESENT ILLNESS
ENVIRONMENTAL EXPOSURE TO POLLUTANTS/TOXIC AGENTS & DATES		ALLERGIES
CHILDHOOD DISEASE/ IMMUNIZATIONS	MILITARY HX, TRAVEL & DATES	RISK FACTORS(circle all that apply) SMOKING DIETARY OBESITY DRUGS LACK OF EXERCISE ALCOHOL SEXUAL BEHAVIOR
HISTORY OF PERTINENT PAST ILLNESS, HOSPITALIZATIONS, SURGERY, DATES		FAMILY HISTORY – GRANDPARENTS, PARENTS, SIBLINGS

REVIEW OF SYSTEMS	**COMMENTS**
INTEGUMENTARY Rash, pruritus, lesions, dandruff, changes in skin, hair or nails, ulcers, wounds, incisions (describe on wound sheet)	
NEUROLOGICAL Headaches, injuries, fainting, seizures, tremors, numbness, tingling, dizziness, paralysis, changes in memory, touch, taste, smell, hearing, vision, pain and/or sx of infection in eyes or ears, tinnitus, use of glasses, contact lenses, hearing aid	
RESPIRATORY Cough and characteristics, sputum, dyspnea, wheezing, hemoptysis, congestion or discharge from nose, pain in throat, nose or chest, epitaxis, throat infections, asthma, bronchitis, pneumonia, emphysema, upper respiratory infections	
CARDIOVASCULAR Chest pain, edema, dyspnea, palpitations, hypertension, heart condition, phlebitis, trouble with circulation to the extremities	
GASTROINTESTINAL Abdominal pain, nausea, vomiting, diarrhea, constipation, hemorrhoids, indigestion, swallowing, appetite, excessive flatus or belching, changes in stool color, consistency or frequency, mouth, teeth or chewing problems, partial or complete dentures, hepatitis, diverticulitis, gallstones, peptic ulcer, colitis, ostomy.	
RENAL Difficulty in urination, dysuria, dribbling, incontinence, urgency, frequency, infections, stones	
MUSCULOSKELETAL Pain or stiffness in joints, redness, swelling, limited ROM, fatigue, weakness, pain in muscles, arthritis, fractures, deformity, tumor, infection, ambulation, use of assistive devices	
ENDOCRINE Diabetes, thyroid condition, increase in thirst, appetite, urination, heat or cold intolerance, breath odor, changes in weight/stamina, fat distribution	
HEMATOPOIETIC Anemias, bruising, previous transfusions, skin hemorrhages, petechiae, blood dyscrasias, leukemia, immune disorders	
REPRODUCTIVE Lesions on or drainage from penis or vulva, rashes or irritations on penis or vulva, vaginal infections, venereal disease, infertility, birth control, sexual difficulties, age at menarche and menopause, number of pregnancies, abortions, live births, complications during pregnancies, LMP, lumps or pain in genitalia (M or F), date of last PAP and Mammogram	
PSYCHIATRIC Depression, nervousness, mood swings, insomnia, self-concept, effect of stress, thoughts of suicide, substance abuse, ETOH abuse	

NUTRITIONAL STATUS ______Ht. ______Wt. ____________________________Diet o Oral o Enteral o Parenteral

______ Recent Weight Loss ______Over Weight ______Under Weight

Fluid intake/day____Meals prepared by_______________________________

ACTIVITIES OF DAILY LIVING (Check appropriate boxes)

Level of Independence	Without help	Uses a Device	Help of Another	Device & Help	Dependent Does not do	Not Deter
Eating						
Toileting						
Transfers						
Ambulation						
Dressing						
Bathing/Shower						
Shopping						
Housekeeping						
Laundry						
Prepare meals						
Transportation						
Handling Money						
Using Telephone						

APPLIANCE/AIDS/SPECIAL EQUIP

Ambulation aid, other Prosthetic Device	Has	Needs
Tub Stool		
Hospital Bed		
Transferring Equip		
Toileting Equip		
Dressing Equip		
Colostomy Bag		
Cane		
Walker		
Grab Bar		
Commode		
Oxygen		
Wheelchair		
Leg Brace		
Other		

FAMILY/ SUPPORT SYSTEMS:

o family (specify)____ o other (specify)____

o lives alone Informal caregiver(s) is (are) able to receive instructions and provide care? o Yes o No

TREATMENTS Nationwide Medical Waste 1-954-747-8858

SUPPLY NEEDS (check box)	Has	Needs

CLIENT'S COMPREHENSION OF DIAGNOSIS:	**EMERGENCY SAFETY INSTRUCIONS GIVEN?** o YES o NO

MAJOR NURSING DIAGNOSIS/PROBLEMS REQUIRING ATTENTION:

SHORT TERM GOALS

LONG TERM GOALS:

SIGNATURE____DATE_____________________________________