

**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. O₂Sat.....%
Blood pressure.....mmHg Body weight.....Kgs. Height.....cms. BMI..... Kg/m²
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: ☐ Self ☐ Assisted ☐ NG/OG ☐ Gastrostomy/Jejunostomy tube ☐ Parenteral Nutrition	Diet: ☐ NPO ☐ Ordinary diet ☐ Liquid diet ☐ Breast feeding/Breast milk ☐ Other type of formula.....	Therapeutic diet: ☐ DM ☐ Low Na ☐ Low Protein ☐ High Protein ☐ Other.....	Problem: ☐ None ☐ Appetite: ☐ Normal ☐ Increased ☐ Decreased ☐ Nausea ☐ Vomiting ☐ Swallowing Difficulty ☐ Other.....	Nutrition Screening: ☐ Normal ☐ Abnormal: ☐ Over nutrition ☐ Unintentional weight loss over 6 months ☐ Decrease nutritional intake (more than 7 day)
---	--	--	---	--

Skin

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

Respiratory

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

Ward.....

Name.....Age.....

HN..... AN

Cardiovascular						
Pulse Rhythm: ☐ Regular ☐ Irregular	Pulse Amplitude: ☐ Strong ☐ Weakness ☐ Absent	Pulse Rate: ☐ Normal ☐ Tachycardia ☐ Bradycardia	Neck Vein Engorged: ☐ No ☐ Yes	Edema: ☐ None ☐ Generalized ☐ Location..... ☐ Pitting.....	Chest Pain: ☐ No ☐ Yes; ☐ Location..... ☐ Referred Pain..... ☐ Duration..... ☐ Frequency.....	
Neurological					Musculoskeletal	
Glascow Coma Scale: Eye opening (E) = Motor response(M) = Verbal response(V) = Total score 	Vision: ☐ Normal ☐ Impaired; ☐ Right ☐ Left	Hearing: ☐ Normal ☐ Impaired; ☐ Right ☐ Left	Speech: ☐ Normal ☐ Impaired	Smell: ☐ Normal ☐ Impaired	Sensation: ☐ Normal ☐ Numbness: ☐ Tingling:	Musculoskeletal (Structure/Motor power): ☐ Normal ☐ Abnormal; ☐ Movement; ☐ Normal ☐ Abnormal ☐ Weakness; ☐ Deformity; ☐ Fracture;
EENT					Gastrointestinal	
Eyes: ☐ Normal ☐ Abnormal;	Ears: ☐ Normal ☐ Abnormal;	Nose: ☐ Normal ☐ Abnormal;	Oral Cavity: ☐ Normal ☐ Abnormal; ☐ Moist ☐ Dry ☐ Abrasion ☐ Tumor ☐ Dentures ☐ Other.....		Pharynx & Tonsil: ☐ Not injected ☐ Injected... ..	Abdomen: ☐ Soft ☐ Tenderness ☐ Other.....
Renal/Urinary			Genital			
Bladder: ☐ Full ☐ Empty ☐ Other.....	Voiding: ☐ Continent ☐ Incontinent ☐ Dysuria ☐ Anuria ☐ Catheter ☐ Other.....	Urine: ☐ Clear ☐ Cloudy ☐ Bloody ☐ Other.....	Genital Organ: ☐ Normal ☐ Abnormal..	Breast: ☐ Normal ☐ Abnormal	Nipple : ☐ Normal ☐ Abnormal	Sexual function: ☐ 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): No Worst possible (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: ☐ Buddhism ☐ Christianity ☐ Islamism ☐ Other.....		Anxiety: ☐ None ☐ Yes; ☐ Illness ☐ Family ☐ work ☐ Finance ☐ Other.....		Support System: ☐ None ☐ Yes; ☐ Parents ☐ Family ☐ Friends ☐ Other.....		Does the patient require end-of-life care? ☐ 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

