

Comprehensive Nursing Assessment Template

Patient Information

Name: _____

Age: _____

Gender: _____

Date of Admission: _____

Medical Record Number: _____

Allergies: _____

Primary Language: _____

Next of Kin/Contact Person: _____

Emergency Contact: _____

Vital Signs

Temperature: _____

Pulse: _____

Respiratory Rate: _____

Blood Pressure: _____

Oxygen Saturation: _____

General Health Assessment

A. Health History

1. Presenting Complaint: _____

2. Past Medical History:

3. Family Medical History:

4. Social History:

5. Psychosocial History:

B. Physical Assessment

1. Head-to-Toe Assessment:

2. Pain Assessment:

Nursing Diagnoses

1. Risk for _____:

- Rationale _____
- Interventions _____

2. Impaired _____:

- Rationale _____
- Interventions _____

3. Potential for _____:

- Rationale _____
- Interventions _____

Nursing Interventions

1. Medication Administration:

- Name of medication _____
- Dosage _____
- Route _____
- Frequency _____
- Purpose _____

2. Patient Education:

3. Monitoring and Evaluation:

Care Plan

1. Goals:

- Short-term goals: _____
- Long-term goals: _____

2. Interventions:

Discharge Planning

1. Home Care Instructions:

2. Follow-Up Appointments:

3. Community Resources:

Documentation

Date and Time: _____

Assessment Findings:

Nursing Interventions:

Response to Interventions:

Collaboration with Other Healthcare Providers:

Patient and Family Education:

Discharge Planning: