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** [specific health issue]**:**
   - Rationale _____
   - Interventions _____
2. **Impaired** [functional health pattern]**:**
   - Rationale _____
   - Interventions _____
3. **Potential for** [complication]**:**
   - 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: