

Focused Nursing Assessment Form

Patient information	
Name:	Gender:
Date of birth:	Date/time of assessment:
Reason for visit:	
Relevant medical history	
Vital signs	
Blood pressure:	Respiratory rate:
Heart rate:	Temperature:
Oxygen saturation:	
Focused area	
<input type="checkbox"/> Neurological system	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Respiratory system	<input type="checkbox"/> Skin
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Eye
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Ear, nose, and throat (ENT)
<input type="checkbox"/> Renal	<input type="checkbox"/> Other:
Subjective data	Objective data
Remarks	
Assessed by:	Signature: