Nurse Assessment Sheet

Patient Information

Name: John Doe

Date of Birth: 05/10/1975

Medical Record Number: 123456

Date/Time of Assessment: 02/15/2023, 10:00 AM

Vital Signs

Blood Pressure: 120/80 mmHg

Heart Rate: 72 bpm

Respiratory Rate: 18 breaths per minute

Temperature: 98.6°F

Oxygen Saturation: 98%

Allergies

Known Allergies: None

Reactions: N/A

Current Medications

Medication Name: Lisinopril

Dosage: 10 mg

Frequency: Once daily

Route: Oral

Medical History

Previous Illnesses: Hypertension

Surgeries: Appendectomy (2005)

Chronic Conditions: Hypertension

Family Medical History: Father - Hypertension, Mother - Diabetes

Current Symptoms/Chief Complaint

Subjective Information: The patient reports mild headache and occasional dizziness.

Pain Level (if applicable): 2/10

Any Changes Since Last Assessment: No significant changes were reported.

Physical Examination

General Appearance: Alert and oriented, skin warm and dry.

Neurological Assessment: Cranial nerves intact, no focal deficits.

Cardiovascular Assessment: Regular rhythm, no murmurs.

Respiratory Assessment: Clear breath sounds bilaterally.

Gastrointestinal Assessment: Soft, non-tender abdomen.

Musculoskeletal Assessment: Full range of motion.

Skin Assessment: No lesions or rashes.

Psychosocial Assessment

Mental Status: Oriented to person, place, and time.

Emotional Well-being: The patient expresses concern about managing hypertension.

Social Support: Lives with spouse, family nearby.

Nursing Diagnoses/Concerns

Clinical Observations: Elevated blood pressure.

Nursing Diagnoses: Risk for ineffective therapeutic regimen management related to lack of understanding of hypertension management.

Interventions/Plans: Provide education on medication adherence, lifestyle modifications, and follow-up with a primary care provider.

Additional Notes

Scheduled follow-up appointment for blood pressure reassessment in one week.