

Nurse Assessment Sheet

Patient Information

Name: _____

Date of Birth: _____

Medical Record Number: _____

Date/Time of Assessment: _____

Vital Signs

Blood Pressure: _____

Heart Rate: _____

Respiratory Rate: _____

Temperature: _____

Oxygen Saturation: _____

Allergies

Known Allergies: _____

Reactions: _____

Current Medications

Medication Name: _____

Dosage: _____

Frequency: _____

Route: _____

Medical History

Previous Illnesses: _____

Surgeries: _____

Chronic Conditions: _____

Family Medical History: _____

Current Symptoms/Chief Complaint

Subjective Information: _____

Pain Level (if applicable): _____

Any Changes Since Last Assessment: _____

Physical Examination

General Appearance: _____

Neurological Assessment: _____

Cardiovascular Assessment: _____

Respiratory Assessment: _____

Gastrointestinal Assessment: _____

Musculoskeletal Assessment: _____

Skin Assessment: _____

Psychosocial Assessment

Mental Status: _____

Emotional Well-being: _____

Social Support: _____

Nursing Diagnoses/Concerns

Clinical Observations: _____

Nursing Diagnoses: _____

Interventions/Plans: _____

Additional Notes