Nursing Assessment for Pneumonia

Patient Information
Name:
Age:
Date of Assessment:
ID Number:

History Taking
☐ Recent Respiratory Infections:
☐ Exposure to Illness / Environmental Risks:
☐ Previous Lung Diseases / Surgeries:
☐ Immunization History (e.g., Pneumococcal, Flu):

Physical Examination
☐ Breaths Per Minute:
☐ Breath Sounds (Normal / Crackles / Wheezes):
☐ Signs of Respiratory Distress (e.g., use of accessory muscles, cyanosis):
☐ General Appearance of Consciousness Level:

Diagnostic Test

- **Chest X-Ray**

- [ ] Structural Distribution (Lobar, Bronchial):
- [ ] Abscesses / Infiltrates:
- [ ] Empyema:
- [ ] Types of Infiltration (Scattered / Localized):

- **Fiberoptic Bronchoscopy**

- [ ] Diagnostic Findings:
- [ ] Therapeutic Actions Taken:

- **ABGs and Pulse Oximetry**

- [ ] Blood Oxygen Level (SpO2):
- [ ] ABG Abnormalities:

- **Gram Stain and Cultures**

- [ ] Identified Causative Organisms:
- [ ] Sputum Culture:
- [ ] Blood Culture:

- **Complete Blood Count (CBC)**

- [ ] Leukocytosis:
- [ ] Low WBC (if applicable):
- [ ] ESR Level:

Serologic Studies

- [ ] Specific Titers (Viral Legionella):
- [ ] Cold Agglutinins:

Pulmonary Function Studies

- [ ] Volume Measurements:
- [ ] Airway Pressure:
- [ ] Lung Compliance:

Additional Tests
☐ Electrolytes (Sodium, Chloride):
☐ Bilirubin Level:
☐ Percutaneous Aspiration / Open Biopsy:

Additional Notes
(Additional observations, patient notes, and interventions)
☐ Observations:
☐ Interventions:

Signature

Nurse Signature:
Date:

Patient Signature:
Date: