

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:

Emphyema:

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: