

Patient Assessment

Patient information			
Name:			
Date of birth:		Gender:	
Occupation:		Mobile number:	
Height:	Weight:	Race/ethnicity:	
Reason for visit:			
Social habits			
Alcohol:	No	Yes (frequency):	
Cocaine:	No	Yes	Narcotics/drug use: No Yes
Smokes tobacco:	No	Yes	
If yes, # of years: _____ # of packs/days: _____ When stopped: _____			
Cultural/religious beliefs that may affect care:			
Do you prefer to learn by (please check all that applies):			
Seeing (TV, Video, Written)	Hearing (Audio)	Doing (Hands on)	
Do you have any barriers to learning (please check):			
Physical	Emotional	Vision	Financial
Hearing	Cognitive		
Medical history			
Past medical history:	Current medical conditions:	Relevant family medical history:	
Allergies:		Current medications:	

Hospitalization/surgery/major illness			
Problem	Year	Where treated	Days in hospital
Vital signs			
Temperature:	Blood pressure:	Heart rate:	
SpO2:	Respiratory rate:		
General appearance:			
Body systems			
Respiratory system:	Cardiovascular system:		
Gastrointestinal system:	Musculoskeletal system:		
Neurological system:	Skin & integumentary:		

Signs of illness and injury			
Nutritional data			
Are you following a special diet?		No	Yes (please specify):
Unintentional weight:		Over/Under 5 lbs in 1 month	Over/Under 10 lbs in 3-6 months
Appetite:		Good (eat 3+ meals/day)	Fair (1-2 meals/day) Poor (less than 1 meal/day)
Laboratory test results			
Test type	Result		Remark
Mental status assessment			
Alertness/Orientation (Person, place, time):		Normal	Impaired
Memory (short-term and long-term):		Normal	Impaired
Emotional state:			
Behavioral observations:			
Psychosocial assessment			
Social support system			
Family	Friends	Caregivers	Others

Living environment:

Stressors:

Mental health concerns:

Coping mechanisms:

Additional notes

Assessor's name and signature:

Date: