Respiratory Assessment

Date:

Patient's Name:

Examiner's Name:

QUESTIONS

Do you have a respiratory condition?
☐ Yes ☐ No
If yes, what is it, and what's the treatment, if any?
Do you use respiratory assistive devices or take any medication to help with your respiratory concerns?
☐ Yes ☐ No
If yes, please elaborate.
Have you been experiencing any shortness of breath?
☐ Yes ☐ No
If yes, please elaborate on when it began, the level of discomfort when it happens, how it goes away, what triggers it, etc.

Do you have a cough?
☐ Yes ☐ No
If yes, please elaborate on how long you've had the cough, if it's accompanied by sputum or blood, the triggers, and any treatment plan you followed that worked, if any.

Do you smoke or vape?
☐ Yes ☐ No
If yes, please elaborate on what you smoke/vape, how often and how much, whether you have attempted to quit, and the most effective strategies that helped you quit.

OBSERVATION

Respiration Rate:

Pulse:

Blood Pressure:

Oxygen Saturation:

Patient's position:

Patient's level of consciousness:

Skin color:

Presence of clubbing:

Presence of labored breathing:

Breathing pattern:

Breathing level (shallow, deep, “normal”):

Sputum assessment results (if the patient is coughing):

Additional Notes if the patient is a newborn/infant/child:

Additional Notes if the patient is an older adult:

AUSCULTATION NOTES:

PALPATION NOTES:

BREATH AND VOICE SOUND NOTES:

PERCUSSION NOTES:

OTHER NOTES: