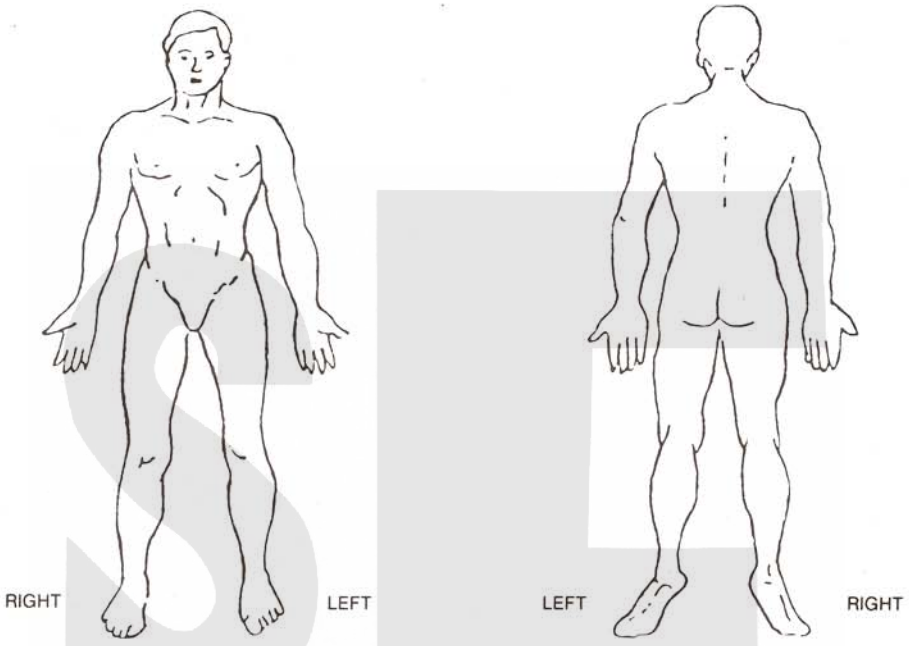
INITIAL NURSING HISTORY AND ASSESSMENT

Age _____ Birth date _____ Sex: M F Weight _____ Height _____

Vital Signs: T _____ P _____ (Reg. ____ Irreg. ____) R _____ BP _____

Dr. _____ Notified of Pt. Admission and Notification of 48 Hr. visit. YES ( ) NO ( ) Init. _____

Indicate on diagram below all body marks such as old or recent scars (including surgical scars), bruises or discolorations (regardless of how slight), lacerations, pressure sores and other ulcerations or questionable markings considered other than normal. Indicate size and depth in cms.



1. **Skin Condition:**

	Reddened	Pale	Jaundiced	Cyanotic	Ashen	Dry	Moist	Oily	Clear
Face									
Upper Ext.									
Lower Ext.									
Trunk									

Medications taken at home prior to admission: _____

Alllergies: Medications _____ Food _____ Other _____

Date of Last chest X-ray or PPD: _____

CURRENT STATUS

2. **Physical Status:** (Describe)
   a. Paralysis/Paresis: _____
   b. Contracture: _____
   c. Congenital anomalies: _____
   d. Traumatic anomalies: _____
   e. Prothesis (excluding dentures): _____
   Hand preference: _____

3. **Functional Status:**
   a. **Transfers — Able to transfer**
      ____ Independently
      ____ With 1 person
      ____ With 2 persons
      ____ Total assist
   b. Ambulation— Able to ambulate:
      ____ Independently
      ____ With 1 person
      ____ With 2 persons
      ____ With device (kind?) _____
      ____ Bedrest
      Comments: _____
   c. *Weight Bearing — Able to bear:*
      ____ Full weight
      ____ Partial weight
      ____ Non-weight bearing
   d. Supportive Device Used:
      Elastic hose ____ Footboard ____
      Bed cradle ____ Air mattress ____ Pillows ____
      Where? _____
      Sheepskin ____ Egg crate ____ Heel protectors ____
      Sling (where) _____
      Hand rolls ____ Side rails (when?) _____
      _____ Trapeze bar _____
      Traction (where? when/) _____
      Other _____

Patient's Name _____ Room # _____ Admission Date ____/____/____
Last First Mo. Day Yr.

4. **Hearing:** (check only)

	Right	Left
Adequate		
Adequate with aid		
Poor		
Deaf		

Comments: _____

5. **Vision:**

	Right	Left
Adequate		
Adequate with glasses		
Poor		
Blind		

Comments: _____

6. **Oral Assesment:**
Wears dentures? ____ Yes ____ No
____ Upper ____ Lower ____ Partial
Do dentures fit? ____ Yes ____ No
Own teeth? ____ Yes ____ No
Condition of teeth (describe):
Condition of mouth (describe): _____

7. **Eating/Nutrition:**
____ Independent ____ Needs assistance
____ Totally dependent
Uses adaptive devices (kind?): _____
Type/consistency of diet _____
Food likes _____
Food dislikes _____
H.S. Snack needed? (Kind?) _____
Comments: _____

8. **Personal Hygiene/grooming:**

	Independent	Needs Assist	Totally Dependent
Bathing:			
Tub			
Shower			
Sponge			
Oral care			
Shave			
Grooming			
Dressing			
Shampoo			

9. **Sleeping:**
Usual bed time: _____
Usual arising time: _____
Usual nap time _____
Night light needed: _____
Gets up during night: _____
Clothing worn at night: _____
Comments: _____

10. **Elimination Habits — B & B Assessment:**
____ Toilet ____ Bedpan
____ Urinal ____ Bedside commode
Bowels:
Pre-admission Habits:
____ Controlled ____ Incontinent ____ Ostomy
____ Constipation problems
Laxatives used _____
Enemas used _____
Suppositories used _____
When was last bowel movement? _____
Bladder:
____ Dribbles ____ Controlled ____ Incontinent
____ Catheter (specify)
____ Time of last voiding _____
Assessment: Patient will ☐ will not ☐ participate in B & B retraining. If not reason: _____

11. **Communication:**
____ Normal ____ Aphasic ____ Slurred
____ Foreign language only

12. **Psychosocial Aspects:**
Family Relationships:
____ Member visit
Closest relationship with _____

Which words describe patient? (check)

____ Alert	____ Fearful
____ Angry	____ Friendly
Answers Question:	____ Lethargic
____ Readily	____ Non-questioning
____ Reluctantly	____ Noisy
____ Inappropriately	Mood:
____ Anxious	____ Passive
____ Agitated	____ Depressed
____ Calm	____ Elevated
____ Cautious	Other _____
____ Comatose	_____
Comprehension:	____ Quiet
____ Slow	____ Questioning
____ Unable to understand	____ Secure
Disoriented to:	____ Seeks support
____ Time	____ Wanders mentally
____ Place	____ Wanders physically
____ Person	____ Homesick
	____ Hyperactive

Patient given explanation of or involved in plans for his/her own care? ____ Yes ____ No
Awareness/understanding of illness _____
Motivation regarding ADL/rehabilitation:
____ Good ____ Fair ____ Poor
Comments: _____

Personal Habits:
____ Smoking ____ Alcohol
Comments: _____

Discharge Evaluation:
Prior living arrangements:
Where? _____
With whom? _____
Still available? _____
Family's plans _____
____ Short term care
____ Long term care with discharge possibility
____ Long term care without discharge possibility
____ Unable to determine at this time
Comments: _____

Orientation of Patient To:

	Yes	No
Call bell		
Bathroom		
Roommate		
Staff		
Facility		
Smoking rules		
Daily Schedules		

____ State reason: _____

Oriented by _____
(Name)

_____ / / _____
Signature Mo. Day Yr.