Los Angeles Harbor College
Associate Degree Registered Nursing Program

NURSING HISTORY & ASSESSMENT FORM
Circle or fill in appropriate responses. Highlight all ineffective behaviors

<table>
<thead>
<tr>
<th>Student: ___________________________</th>
<th>Patient’s Initials: _________</th>
<th>Room #: _________</th>
<th>Date: ____________</th>
</tr>
</thead>
</table>

**Patient Profile:**
- Age: ___
- Gender: ___
- Primary Language: English Y N
- If no Interpreter needed? Y N

Source of info: ____________________________
Admit date: ____________
Clinical Instructor ________________________

**Medical/Surgical Diagnoses**
- Admitting Diagnosis:

**Past Medical History:**
- Surgical Diagnosis:

**Surgical Diagnosis:**

**Medication Reconciliation**

1. **What is your reason for seeking hospitalization (patient’s own words)?**

2. **Do you understand your medical diagnosis? Yes ___ No ___**

3. **Describe the treatments and medications you have received:**

4. **How often do you go for professional exams? (physical, dental, BP, etc)**

5. **Do you use any assistive devices? Yes ___ No ___ if yes please list:**

6. **How would you rate your health on a scale of 1 to 10 ______**

7. **Does the patient have any physical, psychosocial or cognitive developmental lags that aggravate his/her illness or inhibit self care?**

8. **History of blood transfusion(s) N Y, If yes – reaction________________**

   Allergies to Dyes / Shellfish Y N

9. **Allergies to medication/ food/ tape/ etc…N Y If yes – reaction(s):**

10. **Patient: Tobacco Y N Alcohol Y N Substance Abuse Y N**

11. **Family: Tobacco Y N Alcohol Y N Substance Abuse Y N**

12. **If #10/#11 yes, describe:**

13. **Any concerns you would like to discuss?**

**Nursing Diagnoses to Consider (circle/highlight)**
- Hopelessness
- Altered Health Maintenance
- Altered Thought Process
- Impaired Social Interaction
- Ineffective Coping
- Ineffective Management of Therapeutic Regimen
- Noncompliance
- Other

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<table>
<thead>
<tr>
<th>Nursing Diagnoses to Consider</th>
<th></th>
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<tbody>
<tr>
<td>(circle/highlight)</td>
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<tr>
<td>Therapeutic Regimen</td>
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<tr>
<td>- Noncompliance</td>
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<tr>
<td>- Other</td>
<td></td>
</tr>
</tbody>
</table>
# I. Physiological Modes - General Assessment: Cognitive / Sensation

### Subjective Data

- **Pain level**: _____/10
- **Pain assessment**:
  - Aching
  - Burning
  - Numb
  - Piercing
  - Pulling
  - Sharp
  - Shooting
  - Tingling
  - Stabbing
  - Throbbing
  - Dull
  - Other
- **Location**: ________________________________
- **Duration**: Is pain always there? Y  N
- **Does it come and go?**: Y  N
- **What makes it better?**
- **Worse?**
- **Ability to communicate pain**: Y  N  If no, describe:

### Objective Data

- **General appearance**: Well-nourished / Thin / Obese
- **Alert / Semi-conscious / Unresponsive**
- **Level of activity**: Bed rest / chair / bathroom / as tolerated
- **Ambulatory**: assistance needed Y  N  If yes, describe:
- **Barriers to communication**: Aphasia Y  N  If yes, describe

### Nursing Diagnoses to Consider

- **(circle/highlight)**
  - Impaired Verbal Communication
  - Pain: acute/chronic
  - Self-Care Deficit (be specific)
  - Sensory/Perceptual Alteration
  - Altered Tissue Perfusion: Cerebral
  - Other

### Oxygenation Needs [Pulmonary/Cardiovascular/Peripheral Vascular]

#### Subjective Data

- **Smoking**: N  Y If yes, ____pack years
- **If quit, how long ago**: ______________________
- **Cough**: Y  N  Productive Y  N
- **Dyspnea**: Y  N  DOE: Y  N
- **Dizziness/Weakness**: ______________________
- **Swelling**: ______________________
- **Chest pain**: ______________________
- **Palpitations**: ______________________
- **Bleeding**: ______________________
- **Bruising**: ______________________

#### Pertinent Lab work and tests:

- **RBC_____Hgb_____Hct_______
- **C&S__________________________
- **O₂ Sat________BNP_________
- **Chest X-ray:**

#### EKG:

- ABG’s: pH_____Paco₂________________
  - Pao₂________________
  - Sao₂________________
  - HCO₃________________
  - Base Excess __________
- **Other**: ______________________

#### Objective Data

- **Vital Signs**
  - **T:** _____
  - **PR:** _____
  - **RR:** _____
  - **BP:** ________
  - **Orthostatic/postural BP:** ______________
  - **Pulse Ox:**
  - **Oxygen via** ______________ @_________
  - **Ht.:** _______  **Wt.:** _______ (kg.)

- **Regular heart rate**: Y  N  If no, describe
- **Pulses**: weak / strong  Peripheral pulses equal Y  N
- **Mucus membranes pink/moist**: Y  N  Cyanosis:Y  N
- **Capillary refill**: _______ sec.  Skin temperature________________________
- **Skin color**:_____.Telemetry Y  N  Pacemaker Y  N
- **Edema degree / location**: ______________________

#### Activity Tolerance (must do on all patients):

- **Specify activity**: ______________________
- **Prior to activity:**  PR______ RR______
- **After activity:** PR______ RR______

#### Respirations: regular/irregular/symmetrical/unlabored/shortness of breath (SOB) at rest/DOE

- **Bilateral breath sounds noted in all lung fields**: Y  N
- **Diminished**: Absent ______________
- **Crackles**: ______________
- **Wheezes**: ______________
- **Rhonchi**: ______________
- **Cough**: Y  N  □ productive  □ nonproductive
- **Sputum amount**: ______________________
- **Consistency**: □ liquified  □ thick  □ thin
  - □other: ______________________
  - **Color**: clear, white, yellow, brown, green, gray, other ______

### Nursing Diagnoses to Consider (circle/highlight)

- Ineffective Airway Clearance
- Impaired Gas Exchange
- Ineffective Breathing Pattern
- Knowledge Deficit
- Impaired Skin Integrity
- Alteration in Tissue Perfusion
- Activity Intolerance
- Risk for Infection
- Fatigue
- Cardiac Output: Decreased
  - Other

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Los Angeles Harbor College
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### Fluid and Electrolytes Needs

**Subjective Data**
- Usual Intake: ___________________
- Output: ___________________
- Weakness/Cramping: ____________

**Pertinent Lab Work: Electrolytes**
- **Na**$^+$: _______
- **K**$^+$: _______
- **Cl**$: _______
- **CO$_2$**: _______
- **Ca**$^{++}$: _______
- **PO$_4$**: _______
- **Hct**: _______

**Objective Data**
- All intake (IV, PO, etc.) past 24 hrs: ____________
- All output (urine, emesis, lavage) past 24 hrs: ____________
- Calculate fluid balance: _______ml (positive/negative)
- **IV Solution**: __________________________________
- **Rate**: _______ mL/hr
- **Drop rate**: _______ gtt/min
- **Saline lock site**: Y  N
- **Patency**: Y  N
- **Flushed**: Y  N
- **Condition of Site**: ____________________________
- **Edema/Retention**: ____________________________
- **Hemodialysis access**: N  Y
- **If yes, describe site**: ____________________________
- **Bruit**: present: Y  N
- **Thrill**: present: Y  N
- **Peritoneal Dialysis**: N  Y
- **If yes, describe site**: ____________________________

**Nursing Diagnoses to Consider**
- Fluid Volume: Excess/Deficit
- Risk for Imbalanced Fluid Volume
- Risk for Electrolyte Imbalance

### Nutritional Needs: Gastrointestinal

**Subjective Data**
- Usual Diet / Cultural Preferences: ____________________________
- **Likes**: ____________________________
- **Dislikes**: ____________________________
- **Nausea**: Y  N
- **Vomiting**: Y  N
- **GERD**: Y  N
- **Dysphagia**: Y  N
- **Diarrhea**: Y  N
- **Constipation**: Y  N
- **Change in Appetite**: Y  N
- **Usual Weight**: __________________
- **Recent wt loss/gain**: __________________
- **Nutritional supplements**: Y  N
- **Date last BM**: __________________

**Objective Data**
- **Diet**: ____________________________
- **Nutritional supplements**: ____________________________
- **Gavage formula**: ____________@ _______ mL/hr via NG / PEG / Jejunostomy tube
- **Difficulty chewing**: Y  N
- **Difficulty Swallowing**: Y  N
- **Abdomen Shape**: soft / firm / flat / distended / tender / rigid / other: ____________________________
- **Bowel Sounds**: present / sluggish / hyperactive / absent: ____________________________
- **Masses**: N  Y
- **Hernia**: N  Y
- **Suction**: continuous / intermittent / gravity
- **Ostomy**: N  Y
- **Stoma appearance**: ____________________________
- **Self care with ostomy**: Y  N

**Nursing Diagnoses to Consider**
- Altered Nutrition: Less/More than Body Requirements
- Impaired Swallowing
- Altered Bowel Elimination (Constipation)
- Dysfunctional GI Motility
- Risk for Aspiration

### Elimination Needs: Genitourinary

**Subjective**
- **Usual pattern/frequency**: ____________________________
- **Any difficulty/concerns**: ____________________________

**Objective**
- **Bladder distended**: Y  N
- **Urine**: yellow/amber/dark amber clear / cloudy sediment / odor
- **Urine amount in 24 hr**: __________________
- **Void**: continent / incontinent
- **Foley**: Y  N
- **Condom**: Y  N
- **Suprapubic**: Y  N
- **Dysuria / Polyuria / oliguria / anuria**: ____________________________
- **Genital edema / discharge**: N  Y
- **If yes, describe**: ____________________________
- **Ostomy**: N  Y
- **Stoma appearance**: ____________________________

**Nursing Diagnoses to Consider**
- Impaired Urinary Elimination: Retention
- Incontinence
- Risk for Urinary Incontinence (Stress, Urge, & Overflow)

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### Rest & Activity Needs/ Sleep/ Orthopedic

<table>
<thead>
<tr>
<th>Subjective:</th>
<th>Objective:</th>
<th>Nursing Diagnoses to Consider (circle/highlight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs Assistance to:</td>
<td>Assistance needed: Y N If yes, describe</td>
<td>- Disturbed Sleep Pattern</td>
</tr>
<tr>
<td>Fatigue:</td>
<td>Moves all extremities: Y N If no, describe:</td>
<td>- Sleep Deprivation</td>
</tr>
<tr>
<td>Weakness:</td>
<td>Contractures N Y If yes, where_________________</td>
<td>- Activity Intolerance</td>
</tr>
<tr>
<td>Usual Sleep Pattern:</td>
<td>Joint swelling/tenderness N Y Functional limitations N Y describe:</td>
<td>- Risk for injury</td>
</tr>
<tr>
<td>Meds/Rituals:</td>
<td>Restraints/Casts/Traction/______________________</td>
<td>- Other-</td>
</tr>
<tr>
<td>Usual Activity/ Exercise:</td>
<td>Amputation: _____ROM Y N PT Y N</td>
<td></td>
</tr>
</tbody>
</table>

| SAFETY: Risk for Falls – Circle appropriate number |
|-----------------------------------------------|----------------|
| Previous fall | Nocturia or urgency |
| Impaired gait or strength | Arrhythmia or postural hypotension |
| Confusion or impaired judgment | Decreased vision or hearing |
| Sedative / hypnotic or dizzy | TOTAL |

Risk Level: 0-2 = No Risk. 3-4 = Moderate Risk. 5 or greater = High Risk. Fall Precautions initiated Yes / No / NA

<table>
<thead>
<tr>
<th>RESTRAINTS: N Y MD order</th>
<th>Restraint type</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulation/Mobility Assessed: Q___H._</td>
<td>Provided Nutrition</td>
<td>Hydration</td>
</tr>
</tbody>
</table>

### Sensory Regulation Needs: Neurological / Endocrine / Eyes / Ears

<table>
<thead>
<tr>
<th>Subjective Data</th>
<th>Objective Data</th>
<th>Nursing Diagnoses to Consider (circle/highlight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory changes / deficits:</td>
<td>Awake &amp; oriented: person/place/time/purpose: Y N</td>
<td>- Alteration in Body Temperature:</td>
</tr>
<tr>
<td>Fatigue/Heat-Cold Intolerance:</td>
<td>If no, describe_________________</td>
<td>(Hypo/Hyperthermia)</td>
</tr>
<tr>
<td>LMP:</td>
<td>Follows directions consistently: Y N If no, describe</td>
<td>- Health Maintenance Alteration</td>
</tr>
<tr>
<td>Postmenopausal N Y</td>
<td>Eyes open spontaneously: Y N Drainage Y N Tearing Y N</td>
<td></td>
</tr>
<tr>
<td>Supplementary hormones:</td>
<td>PERRLA / constricted / fixed :________________________</td>
<td>- Knowledge Deficit</td>
</tr>
<tr>
<td>Pertinent lab/tests:</td>
<td>Speech clear &amp; appropriate: Y N If no, describe</td>
<td>- Alteration in Sensory/Perception</td>
</tr>
<tr>
<td>FSBS___________</td>
<td>Spontaneous movement: Upper Y N Lower Y N</td>
<td></td>
</tr>
<tr>
<td>Fasting glucose</td>
<td>Unresponsive: Y N Lethargic: Y N Agitated: Y N</td>
<td></td>
</tr>
<tr>
<td>Thyroid Panel</td>
<td>Aphasic: Y N Confused: Y N Forgetful: Y N</td>
<td></td>
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<tr>
<td>Hair (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision (impaired):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taste (altered):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smell (altered):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touch (altered):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
II. Psychosocial Modes

Role function: Primary (age, gender, ethnicity):________________________
Secondary (husband/wife/widow/widower, etc.):________________________
Tertiary (hobbies, interests):__________________________________________
What is your occupation? ___________________________ Retired: N Y How long
“Sick” role behaviors: Angry Y N Irritable Y N Withdrawn Y N Flat Affect Y N Sad Y N
Anxious Y N Uncooperative Y N Denial Y N Fearful Y N Demanding Y N If yes, describe_____________________________________________________
Stage of Illness:_________________________ Health Practices:
Home environment: resides in home / multifamily home / shelter / SNF other________________
Religion ____________________________ None / refuses to state / not asked
Expected Developed Stage of Life (Cho)________________________
Growth & Developmental tasks (Cho – describe how individualized to patient):
1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________
4. ________________________________________________________________
Self concept:
1. Self-perception: How has your illness affected your appearance?
   ________________________________________________________________
   ...

Subjective: Risk for skin breakdown (Braden Scale) – Circle appropriate number

<table>
<thead>
<tr>
<th>Sensory perception</th>
<th>Moisture</th>
<th>Activity</th>
<th>Mobility</th>
<th>Nutrition</th>
<th>Friction &amp; Shear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely limited 1</td>
<td>Constantly moist</td>
<td>Bedfast 1</td>
<td>Completely immobile 1</td>
<td>Very poor 1</td>
<td>Problem 1</td>
</tr>
<tr>
<td>Very limited 2</td>
<td>Very moist</td>
<td>Chairfast 2</td>
<td>Very limited 2</td>
<td>Prob inadequate 2</td>
<td>Potential problem 2</td>
</tr>
<tr>
<td>Slightly limited 3</td>
<td>Occasionally moist</td>
<td>Walks occasionally 3</td>
<td>Slightly limited 3</td>
<td>Adequate 3</td>
<td>No apparent problem 3</td>
</tr>
<tr>
<td>No impairment 4</td>
<td>Rarely moist</td>
<td>Walks frequently 4</td>
<td>No limitations 4</td>
<td>Excellent 4</td>
<td></td>
</tr>
</tbody>
</table>

Note: Patients with total score of 18 or less are considered to be at risk for developing pressure ulcers. 15-18 = Mild risk. 13-14 = Moderate risk. 10-12 = High risk. 9 or below = Very high risk.

Risk Assessment Total

Nursing Diagnoses to Consider (circle/highlight)
- Altered Role Performance
- Anticipatory Grieving/Loss
- Anxiety
- Disturbed Body Image
- Ineffective Family Coping
- High Risk for Role Strain
- Impaired Adjustment
- Ineffective Denial
- Ineffective Individual Coping
- Impaired Social Interaction
- Powerlessness
- Role Conflict
- Role Strain
2. Alteration in body image: What is different about your body now?

______________________________

Personal self:

1. Self-consistency: How are you managing your life?

2. Self-ideal: What would you like to be or do in your life?

3. Moral-ethical self: Do you have a faith that is important to you?

What do you consider to be your strengths?

What do you consider to be opportunities for improvement (weaknesses)?

Dependent behaviors

Help seeking:

Attention seeking

Affection seeking

Interdependent behaviors (Assistance needed due to constraints of illness / age / etc.)

Independent behaviors (initiative taking)

Obstacle mastery:

III. Discharge Planning

1. Anticipated Date of Discharge: ________________

2. Resources Available: Persons(s): ____________________________ Financial: ____________________________

3. Do you anticipate change in your living situation after discharge? Yes ___ No ___ If yes, describe:

4. How have you managed your health problems prior to admission?

ReQUIRES home assistance: Ambulation Y N Wound & skin care Y N Meds &/or IV therapy Y N Shopping Y N

Transportation Y N Home Health Y N Hospice Y N Other ____________________________

If yes, describe ________________________________________________________________

Teaching / learning needs (current admission) Patient / Family / Other ____________________________

1. ____________________________________________________________________________

2. ____________________________________________________________________________

3. ____________________________________________________________________________

Diet Type ____________________________% taken (1) Breakfast ________ (1) Lunch ________

(2) Breakfast ________ (2) Lunch ________ 1 = day one of care

2 = day two of care

TPN/Tube feeding:

List specific guidelines for special diets, e.g. Low sodium, ADA, Renal:

Is your patient’s diet meeting food pyramid guidelines: Y N If no, include specifics as to what to avoid and what to include to ensure adequate nutrition:

Documentation completed (check when completed day 1 / day 2):

Vital signs (1) _____ (2) _____ Pain assessment (1) _____ (2) _____ Intake & Output (1) _____ (2) _____ Charting (1) _____ (2) _____

Focus note (describe) (1) ___________________ (2) ___________________ If above not completed, instructor notified: Y N