

**COMMUNITY COLLEGE OF RHODE ISLAND  
NURSING ASSESSMENT FORM**

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Patient (Initials): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Adm. Date: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Past Medical History: \_\_\_\_\_

Allergies: \_\_\_\_\_ Code Status: \_\_\_\_\_

**FUNCTIONAL HEALTH PATTERNS**

**NURSING DIAGNOSIS**

<p><b>1. <u>Health Perception/Health Maintenance Pattern</u></b></p> <p>Patient Perception of General Health _____</p> <p>Health Practices _____</p> <p>Ability/Willingness to Participate in Care _____</p> <p>Smoking/Tobacco/Alcohol/Drug History _____</p>	
<p><b>2. <u>Nutrition/Metabolic Pattern</u></b></p> <p>Diet: _____ Purpose: _____</p> <p>Appetite _____ % of food eaten at mealtime _____</p> <p>Fluid intake in 24 hrs. _____ IV type, rate, amt. _____</p> <p>Nausea _____ Vomiting _____</p> <p>Weight loss/gain (amt.) _____ Food Intolerances _____</p> <p>Dentures: _____</p> <p>Skin Integrity: dryness, skin turgor, decubiti, bruises, reddened, incision (describe) _____</p>	
<p><b>3. <u>Elimination Pattern</u></b></p> <p>Bowel Patterns _____ Date of Last BM: _____</p> <p>Constipation: _____ Diarrhea: _____ Ostomy (type): _____</p> <p>Abdomen: soft, hard, distended _____ Bowel Sounds: _____</p> <p>Bladder Patterns: _____ Urine Output/24 hrs.: _____</p> <p>Urine (describe color &amp; clarity): _____</p> <p>Foley: _____ Intermittent Catheterization: _____ Incontinent Briefs: _____</p>	

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<p><b>4. <u>Activity/Exercise Pattern (self-care ability)</u></b></p> <p>0 = Independent                      1 = Assistive Devices                      2 = Assistance from others          3 = Assistance from person and equipment                      4 = Dependent/Unable</p> <p>Eating: _____ Dressing/Grooming: _____ Bathing: _____ Bed Mobility: _____</p> <p>Transferring: _____ Ambulating: _____ Drinking: _____ Toileting: _____</p> <p>Assistive Devices: None _____ Crutches _____ Walker _____          Bedside Commode _____ Other _____</p>	
<p><b><u>Activity/Exercise Pattern (mobility)</u></b></p> <p>Range of Motion: Full _____ Other _____</p> <p>Balance &amp; Gait: Steady _____ Unsteady: _____</p> <p>Hand Grasp: Equal _____ Strong _____          Weakness/Paralysis: Right _____ Left _____</p> <p>Leg Muscles: Equal _____ Strong _____          Weakness/Paralysis: Right _____ Left _____</p> <p>Number of people needed to assist with ambulation: _____</p>	
<p><b><u>Activity/Exercise Pattern (respiratory/circulatory status)</u></b></p> <p>Baseline Vital Signs: T _____ P _____ R _____ BP _____          Current Vital Signs: T _____ P _____ R _____ BP _____</p> <p>Resp. Quality: Dyspnea yes no SOB Use of Accessory Muscles</p> <p>Resp. Pattern: Eupnea Tachypnea Bradypnea Cheyne-Stokes</p> <p>Breath Sounds: Clear Abnormal (describe): _____</p> <p>C/O pain with Resp.: yes no</p> <p>Oxygen Therapy: _____ SaO<sub>2</sub> _____</p> <p>Cough yes no</p> <p>Sputum yes no color: _____</p> <p>Clubbing yes no</p> <p>Facial Color pale pink cyanotic other (describe): _____</p> <p>Facial Skin warm cool dry moist</p> <p>Extremities warm cool color (describe): _____</p> <p>Edema yes no pitting (location): _____</p> <p>CRT (lower) &lt;3 sec. yes no CRT (upper) &lt;3 sec. yes no</p> <p>Homan's Sign _____</p> <p>JVD _____</p> <p>Peripheral Pulses: Radial Pulse _____ Pedal Pulse _____</p> <p>Apical Pulse Rate: _____ regular _____ irregular _____</p> <p>Heart Sounds: _____</p>	
<p><b>5. <u>Sleep/Rest Patterns</u></b></p> <p>Usual Hours of Sleep: _____ Last Night (hrs): _____</p> <p>Naps _____ Insomnia _____ Sleep Aids _____</p> <p>Generally rested and ready for daily activities after sleep? _____</p>	



**FUNCTIONAL HEALTH PATTERNS**

**NURSING DIAGNOSIS**

<p><b>10. <u>Coping/Stress Tolerance Pattern</u></b></p> <p>Major loss/change in the past year?</p> <p>What problem/s is the patient trying to deal with now?</p> <p>How does the patient usually deal with these situations?</p> <p>Emotional state of patient:</p> <p>Is patient on any medications to assist in coping?</p>	
<p><b>11. <u>Value/Belief Pattern</u></b></p> <p>Religious or spiritual beliefs which help to give the patient inner strength?</p> <p>Religious/spiritual/cultural practices during hospitalization?</p>	

**NOTE: Prioritize the top three Nursing Diagnoses according to Maslow's Hierarchy of Needs.**

<p><b>ADDITIONAL ASSESSMENT</b></p>	<p><b>LEARNING NEEDS</b></p>
<p><b>DISCHARGE PLANNING</b></p> <p>Lives:        Alone        With Family        Nursing Home        Other</p> <p>Destination Post Discharge:    Home        Nursing Home        Other</p> <p>Support Systems upon Discharge:</p> <p>Previous Use of Community Resources:</p> <p>Needs assistance with one or more of the following: food preparation, wound care, meds, shopping, supplies, ambulation, transportation, other (specify):</p> <p>Community Resources Needed:</p>	