

STUDENT:  NU:  DATE DUE:   
INSTITUTION:  DATE OF INTERVENTION:

**I. IDENTIFYING DATA**

CLIENT INITIALS:  DATE OF ADMISSION:  AGE:   
GENDER:  RACE:  RELIGION:  LANGUAGE:

SOURCES OF INFORMATION: ( List sources used to obtain information, i.e. , client, family, chart.)

**II. GENERAL HEALTH HISTORY**

MEDICAL DIAGNOSIS: ( Reason for admission )

CO-EXISTING MEDICAL DIAGNOSES:

EXPLANATION OF THE MEDICAL DIAGNOSIS: ( pathophysiology )

RISK FACTORS: ( \* Risk factors if related to the client )

EXPLANATION OF SURGICAL PROCEDURES: ( Include the dates )

CHIEF COMPLAINT: ( Using client's own words, give a brief description of the problem that brought him/her to the institution )

**II. GENERAL HEALTH HISTORY ( cont. )**

**A. ONSET ( When did the problem start ? )**

**B. LOCATION ( Where is the complaint localized ? )**

**C. PRECIPITATING FACTORS ( Were there any factors which hastened the occurrence of the problem ? )**

**D. AGGRAVATING FACTORS (Were there any factors that seemed to make the problem worse ? )**

**E. ALLEVIATING FACTORS ( Were there any factors that seemed to help the problem ? )**

**F. CLIENT'S UNDERSTANDING OF ILLNESS AND THERAPY**

**G. CLIENT'S ACCEPTANCE OF ILLNESS**

**H. CLIENT'S EXPECTATION**

**II. GENERAL HEALTH HISTORY ( CONT . )**

**PAST MEDICAL HISTORY:**

**A. ALLERGIES ( Food, drugs, and other type of reaction )**

**B. IMMUNIZATIONS:**

**C. ILLNESS/INJURIES ( Y= Yes; N = No )**

Anemia	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	STD ( Sexually transmitted diseases )	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	Major trauma	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	Other	<input type="checkbox"/>

If yes to any of the above, explain.

**D. HOSPITALIZATIONS/SURGERIES ( Reason for; dates )**

**FAMILY MEDICAL HISTORY:(Identify age, health problem, living or deceased status of mother, father, grandparents, siblings, aunts and uncles.)**

**III. CLIENT PROFILE:**

**ERIKSON'S DEVELOPMENTAL TASK:**

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**SOCIAL HISTORY:**

Family/Significant others/members of household

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Type of Residence ( Apartment or private house; stairs )

--

Occupation

--

Level of Education

--

Social/Recreational activities

--

Religious practices

--

Ethnicity/Cultural background

--

**HEALTH PRACTICES:**

Smoking ( Amount; duration )

--

Alcohol/Illicit drug use ( Amount; duration )

--

Exercise/Activity ( Describe usual pattern.)

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**SLEEP PATTERN:**

Number of hours usually needed for complete rest

--

Quality of sleep

--

Sedatives taken

--

Naps

--

Sleep habits/rituals

--

**III. CLIENT PROFILE ( CONT . )**

**NUTRITION:**

Height	<input type="text"/>	Current Weight	<input type="text"/>	Usual Weight	<input type="text"/>	Recent Weight Changes	<input type="text"/>
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Usual Appetite	<input type="text"/>	Recent Appetite	<input type="text"/>
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Cultural Eating Habits

Foods liked

Foods disliked

Typical day's menu ( breakfast, lunch, dinner, snacks )

**DRUGS AND REMEDIES:**

Over the counter ( OTC ) ( Include vitamins, minerals )

Folk remedies ( Herbs, herbal teas, health food remedies )

Prescription drugs ( Used at home )

**IV. REVIEW OF SYSTEMS:**

( CLIENT'S STATEMENTS/SUBJECTIVE DATA regarding each system. Write N if client denies presence of response. Give client's description if he/she indicates response is present. If client is unable to verbalize, statements of a significant other can be recorded; If no information is available, write N/A).

**GENERAL:**

Usual state of health

**PSYCHO-SOCIAL:**

Anxiety

Mood changes

Other

**CENTRAL NERVOUS SYSTEM/SENSORY:**

Syncope  Vertigo

Paresthesis

Paralysis

Headaches

Visual problems

Hearing problems

Nasal problems  Other

**BREASTS:**

Pain/tenderness

Lumps/masses

Discharge  Other

**IV. REVIEW OF SYSTEM: ( CONT. )**

( CLIENT'S STATEMENTS/SUBJECTIVE DATA regarding each system. Write N if client denies presence of response. Give client's description if he/she indicates response is present. If client is unable to verbalize, statements of a significant other can be recorded. If no information is available, write N/A).

**RESPIRATORY:**

Dyspnea  Cough

Hemoptysis  Other

**CARDIOVASCULAR:**

Chest pain

Palpitations  Dependent edema

Varicosities  Other

**GASTROINTESTINAL:**

Appetite  Polyphagia

Dysphagia  Abdominal pain

Bowel habits

Dentures  Nausea/Vomiting

Polydipsia  Other

**IV. REVIEW OF SYSTEMS ( CONT. )**

( CLIENT'S STATEMENTS/SUBJECTIVE DATA regarding each system. Write N if client denies presence of response. Give client's description if he/she indicates response is present. If client is unable to verbalize, statements of a significant other can be recorded. If no information is available, write N/A).

**GENITOURINARY:**

Bladder habits

Dysuria  Hematuria

**GYNECOLOGICAL:**

Age of menarche/menopause  Pregnancies

Vaginal discharge/Pruritis

Contraceptives  Other

**MUSCULOSKELETAL:**

Weakness  Joint stiffness

Pain or swelling  Other

**INTEGUMENT:**

Eruptions  Rashes

Pruritis  Ecchymosis

Other

**V. PHYSICAL ASSESSMENT:**

( STUDENT'S OBSERVATIONS/OBJECTIVE ASSESSMENT of client's responses. Physical assessment observations should be appropriate to NU level of student. )

Height  Weight  Temperature  B/P

Pulse ( rate, rhythm, quality )

Respirations ( rate, rhythm, depth )

**A. CENTRAL NERVOUS SYSTEM:**

Level of consciousness

Orientation

Ability to sense touch and temperature

Speech pattern/Impairment

Other

**B. INTEGUMENT:**

Color  Texture  Temperature  Turgor

Cleanliness  Lesions

Scars  Decubiti

Pediculosis  Texture of hair/distribution

Other

**IV. REVIEW OF SYSTEMS ( CONT. )**

( STUDENT'S OBSERVATIONS/OBJECTIVE ASSESSMENT of client's responses. Physical assessment observations should be appropriate to NU level of student. )

**C. EYES:**

Movement  Color of sclerae

Ptosis  Discharge  Blink reflex

Peerla  Other

**D. EARS:**

Discharge  Other

**E. MOUTH, NOSE, THROAT:**

Dental problems

Bleeding gums  Lesions

Gag reflex  Ability to chew

Nasal discharge  Other

**F. NECK:**

ROM  Swollen glands

Neck vein distention  Other

**G. BREASTS AND AXILLA:**

Symmetry  Dimpling

Masses  Discharge

Swollen lymph nodes  Other

**V. PHYSICAL ASSESSMENT: ( CONT. )**

( STUDENT'S OBSERVATIONS/OBJECTIVE ASSESSMENT of client's responses. Physical assessment observations should be appropriate to NU level of student. )

**H. CHEST:**

Symmetry of chest excursion

Breath sounds

Apical pulse  Other

**I. ABDOMEN:**

Distention  Rigidity

Bowel sounds  Fine motor skills

**J. MUSCULOSKELETAL:**

ROM  Muscle tone

Muscle strength  Fine motor skills

Gait  Other

**K. PERIPHERAL VASCULAR:**

Color and temperature of extremities

Varicosities  Edema

Quality of pulses: Femoral   
Popliteal   
Dorsalis pedis

Homan's sign  Other

**PHYSICAL ASSESSMENT: ( Cont. )**

( STUDENT'S OBSERVATIONS/OBJECTIVE ASSESSMENT of client's responses. Physical assessment observations should be appropriate to NU level of student. )

**L. GENITOURINARY:**

Discharge

Character of discharge

Character of urine

**VI. SIGNIFICANT LAB DATA:**

List values for the following tests, any other tests with abnormal results, and any tests which are specific to the client's disease condition.

DATE	TEST	NORMAL VALUES	CLIENT VALUES	EXPLANATION OF RESULTS (PERTINENT TO CLIENT)
	Hgb			
	Hct			
	Rbc			
	Wbc			
	Platelets			
	Glucose			
	Albumin			
	Na			

**VI. SIGNIFICANT LAB DATA: ( Cont. )**

List values for the following tests, any other tests with abnormal results, and any tests which are specific to the client's disease condition.

DATE	TEST	NORMAL VALUES	CLIENT VALUES	EXPLANATION OF RESULTS (PERTINENT TO CLIENT)
	K			
	Cl			

**VI. SIGNIFICANT LAB DATA: ( Cont. )**

Other significant tests: ( Include x-rays, scans, EKG's, EEG's, etc. )

DATE	TEST	NORMAL VALUES	CLIENT VALUES	EXPLANATION OF RESULTS (PERTINENT TO CLIENT)
	Urinalysis			
	PH			
	Specific gravity			
	Rbc			
	Wbc			
	Glucose			
	Protein			
	Ketones			

**VII. CURRENT MEDICATIONS:**

(Include all medications the client is receiving over a 24 hour period. \*Under the column labeled uses, write use pertinent to your client.)

CLASSIFICATION/NAME (Include dose, route, frequency and dosage range)	ACTION/EFFECT	USES	SIDE EFFECTS	NURSING INTERVENTIONS

**VII. CURRENT MEDICATIONS: ( Cont . )**

CLASSIFICATION/NAME	ACTION/EFFECT	USES	SIDE EFFECTS	NURSING INTERVENTIONS

**VII. CURRENT MEDICATIONS: ( Cont . )**

CLASSIFICATION/NAME	ACTION/EFFECT	USES	SIDE EFFECTS	NURSING INTERVENTIONS

**VIII. ANALYSIS OF DATA: ( See guidelines for explanation and examples. )**

COLUMN 1	COLUMN 2	COLUMN 3
CLINICAL MANIFESTATIONS (objective and subjective data)	HUMAN NEED (human need which is altered)	NURSING DIAGNOSIS (diagnosis which best reflects alterations in human needs)

**IX. NURSING CARE PLAN: (See guidelines for explanation of each column.)**

**COLUMN 1**

**COLUMN 2**

**COLUMN 3**

**NURSING DIAGNOSIS (Number in priority order) # 1**

**OUTCOME CRITERIA (Expected client outcomes)**

**PLANNED NURSING INTERVENTIONS (Nursing orders)**

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**IX. NURSING CARE PLAN: (See guidelines for explanation of each column.)**

COLUMN 4

COLUMN 5

COLUMN 6

ACTUAL NURSING INTERVENTIONS	RATIONALE FOR PLANNED NURSING INTERVENTIONS	EVALUATION OF GOALS

**X. DISCHARGE PLANNING ( NU 315, 416 )**

Health Teaching (about disease, health maintenance, clinical manifestations that require medical attention)

Medication (name, purpose, effect; include client teaching)

Diet (include client teaching)

Level of Activity

Treatments (include teaching related to any treatment or procedure to be continued at home, e.g., blood glucose monitoring, dressing changes, etc.)

**X. DISCHARGE PLANNING ( NU 315, 416 )**

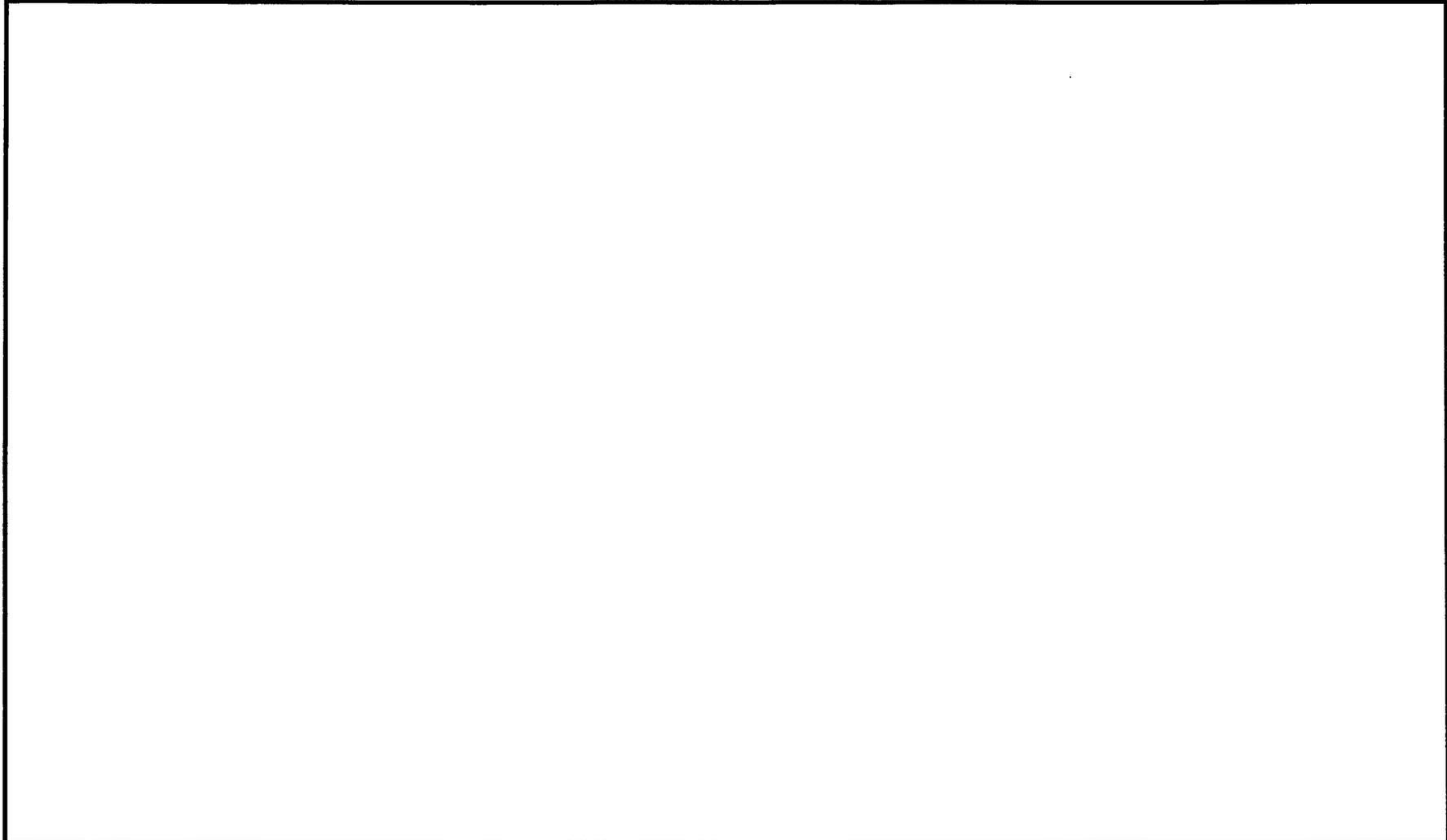
Referrals (to Social Service, Home Care, Visiting Nurse Service, etc.)

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Follow-up Medical Care (include clinic appointments, appointments with private physician, etc.)

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**XI. BIBLIOGRAPHY: (Include at least one journal article as reference. Use APA scholarly form and see Writing Resource Booklet as a reference.)**

A large, empty rectangular box with a black border, intended for the student to write their bibliography entries in APA format.