Nursing Patient Assessment Form

Pharmacy _____ **Pharmacy Phone** _____

ASSISTIVE DEVICES (check all that apply)

Hearing aid(s)	_____	Glasses	_____	Contacts	_____
Crutches	_____	Walker	_____	Cane	_____
Wheelchair	_____	Pacemaker	_____	Defibrillator	_____

PSYCHOSOCIAL/COPING

Primary Language _____ Interpreter needed Y / N

With whom do you live? _____

Are there any family members (or others) with whom we ***should not*** share information?

(If YES, please list names) _____

May we leave messages on your answering machine? Y / N

Is there anyone at home willing/able to assist with healthcare, if needed? Y / N

Do you have problems sleeping? Y / N

Would you like information or assistance with: (check all that apply)

Cancer support groups	_____	Complementary therapies	_____
Family counseling/support	_____	Financial concerns	_____
Medical supplies/equipment	_____	Nutrition issues	_____
Meal preparation/household help	_____	Spiritual support	_____
Transportation	_____	Workplace issues/concerns	_____

Referral Made Y / N To Whom _____

EDUCATIONAL ASSESSMENT

Who would you like included in patient education sessions? _____

_____

How do you learn best?

Written	_____	Verbal	_____	Video	_____
Hands on	_____	Demonstration	_____		

Are there any barriers to learning? If yes, describe _____

_____

BASELINE VITALS (nurse to complete)

Ht	_____	Wt	_____	T	_____
Pulse	_____	BP	_____	Resp	_____

Patient/Other Signature _____ **Date** _____

Nurse Signature _____ **Date** _____