Health Assessment Form Nursing

Title: Nursing Health Assessment Form

Patient Details:

- **Full Name:** ____
- **Date of Birth:** ___________________
- **Gender:** [ ] Male [ ] Female [ ] Other
- **Contact Number:** ____
- **Address:** ____

Medical History:

- **Past Surgeries:** ____
- **Chronic Illnesses:** ____
- **Allergies:** ____
- **Family Medical History:** ____________________________________

Current Symptoms:

- **Primary Complaints:** ____
- **Duration of Symptoms:** ______________________________________
- **Associated Symptoms:** _______________________________________

Physical Examination Findings:

System	Normal	Abnormal	Comments
Cardiovascular	[ ]	[ ]	
Respiratory	[ ]	[ ]	

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Neurological	**[ ]**	**[ ]**	
Musculoskeletal	**[ ]**	**[ ]**	
Gastrointestinal	**[ ]**	**[ ]**	
Skin/Derma	**[ ]**	**[ ]**	
Vision/Hearing	**[ ]**	**[ ]**	
General Condition	**[ ]**	**[ ]**	

Nurse Notes:

- **Observations: ____**
- **Recommendations: ____**

Nurse's Name and Signature: _______________________________________

Date: ____________________

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