Patient Assessment Form For Nurses

Patient Information

- **Full Name: ______________________________**
- **Age: ______________________________**
- **Gender: ______________________________**
- **Contact Number: ______________________________**
- **Address: ______________________________**

Medical History

- **Allergies: ______________________________**
- **Current Medications: ______________________________**
- **Chronic Conditions: ______________________________**
- **Recent Surgeries: ______________________________**

Assessment Details

- **Date of Assessment: ______________________________**
- **Time of Assessment: ______________________________**
- **Nurse's Name: ______________________________**
- **Department: ______________________________**

Vital Signs

- **Temperature: ______________________________**
- **Blood Pressure: ______________________________**
- **Pulse Rate: ______________________________**
- **Respiratory Rate: ______________________________**

Nurse's Observations

- **General Appearance: ______________________________**

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- **Pain Level (1-10): ______________________________**
- **Mobility Issues: ______________________________**
- **Mental Status: ______________________________**

Checkbox for Additional Notes

[ ] Additional Notes: ______________________________

Signature Section

- **Nurse's Signature: ______________________________**
- **Date: ______________________________**

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