Nursing Patient Assessment Form

Date

Time

Nurse Name

Patient Name

Patient ID/Number

Date of Birth

Gender

Select

Vital Signs

Blood Pressure (mmHg)

e.g. 120/80

Temperature (°C)

Pulse (bpm)

Respiratory Rate (rpm)

SpO_2 (%)

General Assessment

General appearance, hygiene, mobility, etc.

Head-to-Toe Assessment

Neurological

Consciousness, orientation, etc.

Respiratory

Breath sounds, effort, etc.

Cardiovascular

Heart sounds, edema, etc.

Gastrointestinal

Abdomen, appetite, etc.

Genitourinary

Urine output, urinary issues, etc.

Skin

Color, condition, wounds, etc.

Musculoskeletal

ROM, strength, gait, etc.

Other Observations

Pain Assessment

Pain Level (0-10)

0-10

Location / Description

Nursing Diagnosis / Plan

Note clinical impressions and care plan

Nurse Signature

Name / Signature