SINA INSTITUTE OF NURSING AND ALLIED HEALTH SCIENCES QUETTA
DOCTOR SHAIR MUHAMMAD ROAD QUETTA
✉Email: sinahsquetta75@gmail.com
✆PHONE: 0311-8013611

ASSESSMENT FORM

Student Name: _____Batch: _____Session: _____
Faculty Name: _____Date: _____Clinical Area: _____

DEMOGRAPHIC DATA:

Patient's Name: _____ Room/Bed#:_____Age: _____Sex:_____

D.O.A: _____ Religion: _____Occupation:_____

Marital status: _____Medical Diagnosis: _____ Nursing Diagnosis: _____

Surgical Procedure: _____ Address: _____

VITAL SIGNS

Temperature: _____ F°, Pulse Rate: _____/min, Respiratory Rate: _____/min

Blood Pressure: _____, Weight: _____ Kg Do you have any allergies? No ____ Yes ___

What sort of allergy? _____

(Check reactions to medications, foods, cosmetics, insect bites, etc.) Review admission CBC, urinalyses, and chest x-ray. Note any abnormalities here:

_____

_____

CLINICAL PROFILE:

Chief Complain:

_____

_____

_____

1) HEALTH PERCEPTION–HEALTH MANAGEMENT PATTERN

a) Describe your illness or current health problem

_____

_____

b) How do you feel your current daily activities have affected your health?

_____

_____

c) How do you feel your illness should be treated?

_____

_____

d) Do you have or anticipate any difficulties in caring for yourself or others at home? If Yes,

Explain _____

_____

e) Tell me what do you do when you have a health problem?

_____

_____

Genogram (Family History):

2) NUTRITIONAL–METABOLIC PATTERN

a) Describe the type and amount of food you eat at breakfast, lunch and dinner on an average day.

_____

_____

b) Do you attempt to follow any certain type of diet?

_____

_____

c) What type of snacks do you eat? How often?

_____

_____

d) What kind of fluids do you usually drink? How much per day?

_____

_____

e) Have you ever experienced nausea and vomiting? Describe.

_____

_____

f) Describe the condition of your skin.

_____

_____

g) Do you have excessively dry or oily skin?

_____

_____

h) Have you gained recent weight or loss? Describe.

_____

_____

i) Have you taken any measures to gain or lose weight?

Describe _____

_____

3) ELIMINATION PATTERN

a) Describe your bowel pattern. Have there been any recent changes?

_____

_____

b) How frequently are your bowel movements?

_____

_____

c) Do you have any discomfort with your bowel movements? Describe

_____

_____

d) Have you ever had bowel surgery? What type? Ileostomy? Colostomy?

_____

_____

4) SELF- PERCEPTION SELF CONCEPT

a) How do you feel about yourself?

_____

_____

b) Has your illness affected you? Describe yourself:

_____

_____

c) How does your family feel about yourself and your illness?

_____

_____

_____

d) How do you feel about your appearance? If you feel any change then explain

_____

_____

5) ROLE-RELATIONSHIP PATTERN

a) Describe your family

_____

_____

b) What is your major responsibility in family? How do you feel about this responsibility?

_____

_____

c) How is your family coping with your current state of health?

_____

_____

d) Describe your occupation.

_____

_____

e) Are there any major problems you have at work?

_____

_____

f) Who is the most important person in your life? Explain

_____

_____

g) How do you feel about the people in your community?

_____

_____

h) What do you see as your contribution in society?

_____

_____

6) COPING–STRESS TOLERANCE PATTERN

a) What is the problem?

_____

_____

b) What have you tried before?

_____

_____

c) How well did it work?

_____

_____

d) Who is available to help you?

_____

_____

e) Do you use any medication, drugs to help relieve stress?

_____

_____

7) VALUE–BELIEF PATTERN

a) Do you have a religious affiliation? Is this important for you?

_____

_____

b) Are there certain practices (e.g. Prayers, reading scripture) that are important to you to follow while you are ill or hospitalized?

_____

_____

c) Is there a significant person (e.g., minister, priest) from your religious denomination whom you want to be contacted?

_____

_____

d) Is the relationship with God an important part of your life? Explain.

_____

_____

e) How can I help you continue with this source of spiritual strength while you are in hospital?

_____

_____

8) ACTIVITY & EXERCISE PATTERN

a) Describe your activities on a normal day including hygiene activates, eating activities, house activities? _____

_____

b) Do you feel any difficulty with any of these activities? Explain.

_____

_____

c) Do you have time or leisure activities?

_____

_____

d) Describe what you do to make a living?

_____

_____

e) How has your health affected your ability to work?

_____

_____

9) SEXUALITY-REPRODUCTION PATTERN

a) On what date did your last cycle normally last?

_____

_____

b) Have you notice any change in your menstrual cycle?

_____

_____

c) Explain any health problem or concerns you had with each pregnancy?

_____

_____

d) If you have children, what are the ages and sex of each?

_____

_____

10) SLEEP-REST PATTERN

a) Describe your usual sleeping time at home?

_____

_____

b) Do you ever experience difficulty with falling asleep? Do you feel fatigued after a sleep period?

_____

_____

c) What helps you to fall asleep? Medicine? Reading? Relaxation? Watching T.V?

_____

_____

11) COGNITIVE PATTERN

a) Describe any pain you have now? Explain

_____

_____

b) Relate you pain on a scale of 1-10, with 10 being the most severe pain

_____

_____

c) Do you find decision making difficulty, fairly easy, or variable?

_____

_____

IDENTIFIED NURSING DIAGNOSIS

_____

_____

_____

_____

Teacher Sign Student Sign