# Nursing Health Assessment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | | | | |
| Address: |  | | | | |
| Telephone: |  | email: | |  | |
| Date: |  | | Apt. Time: | |  |

### MEDICAL HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have allergies? | Yes | No | Have you ever had any surgeries? | Yes | No |
| If so, to what? |  |  | If yes, please list date, type of surgery: |  |  |
| Please list all of the allergies: |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Any history of heart conditions? | Yes | No | Do you have any medical implants? | Yes | No |
| If so, please list: |  |  | If yes, please note: |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Do you have AIDS or HIV? | Yes | No | Please list the name and address of your |  |  |
| If yes, please note medications: |  |  | Primary care physician: |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Are you currently on any medications? | Yes | No | Please list an emergency contact: |  |  |
| If yes, please note medications: |  |  | Name: |  |  |
|  |  |  | Telephone: |  |  |
|  |  |  | Email: |  |  |
|  |  |  | Relation: |  |  |
| Do you have a history of mental illness? | Yes | No | Please list your insurance provider: |  |  |
| If yes, please list history: |  |  | Provider: |  |  |
|  |  |  | Policy Number: |  |  |
|  |  |  | Date: |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PATIENT CHECK-IN EVALUATION** | | | | | |
| Are you currently experiencing pain? | Yes | No | Are you experiencing dizziness? | Yes | No |
| If yes, where is the pain located? |  |  |  |  |  |
|  |  |  | Do you urinate frequently? | Yes | No |
|  |  |  |  |  |  |
| Are you experiencing hallucinations? | Yes | No | Are you experiencing blurred vision? | Yes | No |
| If yes, describe: |  |  |  |  |  |
|  |  |  | Are you presently under the influence of drugs or alcohol? | Yes | No |
|  |  |  | If yes, please note: |  |  |
|  |  |  |  |  |  |
| Are you experiencing nausea? | Yes | No |  |  |  |
|  |  |  | 1 2 3 4 5 |  |  |
| Are you pregnant? | Yes | No | Please describe the pain: |  |  |
| If yes, note due date: |  |  |  |  |  |
|  |  |  | PATIENT SIGNATURE: |  |  |
|  |  |  |  |  |  |

### THE FOLLOWING IS FOR OFFICE USE ONLY. PLEASE DO NOT WRITE BELOW THIS LINE.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | | | Note patient mood: |
| Date: |  | Time: |  |  |
| Notes: | | | | Note patient anxiety: |
|  | | | |  |
|  | | | | Comments: |
|  | | | |  |
|  | | | |  |

**Copyright information - Please read**

© This [**Free Microsoft Office Template**](http://www.hloom.com/more/) is the copyright of Hloom.com. You can download and modify this template for your own personal use. You can (and should!) remove this copyright notice ([click here to see how](http://www.hloom.com/resumes/how-to-format-word/)) before customizing the template.

You may not distribute or resell this template, or its derivatives, and you may not make it available on other websites without our prior permission. All sharing of this template must be done using a link to <http://www.hloom.com/>. For any questions relating to the use of this template please email us - [info@hloom.com](mailto:info@hloom.com)