# Pediatric Nursing Assessment

|  |  |
| --- | --- |
| PATIENT NAME |  |
| DATE OF BIRTH |  | SSN |  |
| INSURANCE PROVIDER |  |
| POLICY NUMBER |  | DATE |  |
| PARENT/GUARDIAN NAME |  |
| RELATIONSHIP TO PATIENT |  | TELEPHONE |  |
| ADDRESS |  |
|  |

## MEDICAL HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the patient have any allergies? | Yes | No | Has the patient recently had surgery? | Yes | No |
| If yes, please list all allergies: | If yes, please note when and what surgery: |
|  |  |
|  |  |
| Does the patient have a history of seizures? | Yes | No | Does the patient currently have any medical implants? | Yes | No |
| If yes, please describe history: | If yes, please explain: |
|  |  |
|  |  |
| Is the patient currently taking any form of medication? | Yes | No | Does the patient have any long-term medical conditions? | Yes | No |
| If yes, please note all medications: | If yes, please explain: |
|  |  |
|  |  |
| Is there a history of mental illness? | Yes | No | Is there a history of heart conditions? | Yes | No |
| If yes, please detail: | If yes, please explain: |
|  |  |
|  |  |

## PATIENT CHECK-IN INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| experiencing nausea? | Yes | No | currently on any medication? | Yes | No |
| experiencing dizziness? | Yes | No | able to communicate the illness/pain? | Yes | No |
| experiencing pain? | Yes | No | Does the patient have any visible marks, bruises, or cuts? | Yes | No |
| If yes, please describe: | If yes, please detail: |
|  |  |
|  |  |
| Please attempt to rate the pain on a scale of 1 to 5, with 5 being the most painful | 1 | 2 | 3 | 4 | 5 |

|  |  |
| --- | --- |
| Please note any unusual or out of character behavior of the patient | Please describe the patient’s last 24 hours, leading up to the doctor's visit |

|  |
| --- |
|  |
| PARENT/GUARDIAN SIGNATURE |

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

|  |  |  |  |
| --- | --- | --- | --- |
| NURSE ON CALL |  | TIME |  |
| PATIENT DATE OF BIRTH |  | PATIENT SSN |  |
| NOTES |  |
|  |
| HEARTRATE |  | WEIGHT |  | TEMPERATURE |  |
| COMMENTS | [The child seems grumpy and out of sorts.] |
|  |
| EVALUATION | [The patient is suffering from constipation. The patient has not had a bowel  |
| movement in 48 hours.] |

**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