# 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 |

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|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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.] | | | | | | | | | | | | |

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