Comprehensive Health Assessments in Nursing

Patient information	
Name: Donald Stevens	
Date of birth: May 5, 1970	**Contact information:** (555) 123-4567
Address: 123 Maple Street, Springfield, IL	
Emergency contact person and contact number: (555) 123-5557	
Date of assessment: October 5, 2024	
Vitals	
Temperature: 98.6 °F	**Blood pressure:** 145/85 mmHg
Heart rate: 78 bpm	**Respiratory rate:** 18 breaths/min
SPO2: 97%	
Medical history	
Primary care provider (PCP):	**Date of last PCP visit:**
Dr. Emily Harper	August 20, 2024
Current medications (name, dose, frequency):	**Allergies (medication, food, environmental):**
Lisinopril, 10 mg, once daily Metformin, 500 mg, twice daily Atorvastatin, 20 mg, once daily	Penicillin (rash)
Past medical conditions (chronic or acute):	**Surgeries/hospitalizations (dates, reasons):**
Hypertension (diagnosed in 2015) Type 2 diabetes (diagnosed in 2018)	Appendectomy (2002)
Family history (hereditary conditions):	**Immunizations (check all that apply):**
Father: Heart disease, deceased at 72 Mother: Type 2 diabetes, currently alive at 78	☑ Influenza ☐ Pneumonia ☑ COVID-19 ☑ Tetanus ☐ Others:

Psychosocial assessment

Emotional well-being

How do you feel emotionally most days?	History of mental health concerns (anxiety, depression, etc.):
I feel stressed sometimes, but overall, I ’ m okay. No history of anxiety or depression.	None reported

Support systems

Family, friends, community, etc.:	Does the patient feel supported?
Lives with wife and two adult children.	(•) Yes ( ) No

Living situation

Select one:

- ( ) Lives alone
- (•) With family
- ( ) In ass

Are there any safety concerns at home?

( ) Yes (•) No

Occupation and work environment

Current job: Carpenter

Are there work-related stressors?

(•) Yes ( ) No

Substance use

Tobacco:	Alcohol:
( ) Yes (•) No	( ) Yes (•) No

Recreational drugs:

( ) Yes (•) No

Cultural considerations

Primary language: English

Need for interpreter services:

( ) Yes (•) No

Cultural/religious practices impacting care:
None reported.
Dietary restrictions due to cultural/religious beliefs:
None reported.
Preferred gender pronouns: (●) He ( ) She ( ) They ( ) Other:

Head-to-toe assessment

Head and neck assessment	
Area	**Findings**
Scalp:	Scalp is clean and intact; no lesions noted.
Hair:	Hair is clean, evenly distributed, and without thinning.
Eyes:	Conjunctivae are pink; sclerae are white. Pupils are equal, round, and reactive to light (PERRLA). Vision is 20/20 with correction.
Face:	Symmetrical with no signs of swelling or deformity. No tenderness upon palpation.
Ears:	External ears are symmetrical and without lesions. Hearing is intact to whispered voice test.
Nose and sinus:	Nose is midline with no discharge. Sinuses non-tender upon palpation.
Mouth and throat:	Oral mucosa is pink and moist. No lesions, gums are healthy, and teeth are in good condition. Tonsils are not enlarged.
Chest and lungs assessment	
Area	**Findings**
Chest:	Chest is symmetrical with no deformities. Skin is intact.
Lungs:	Breath sounds clear bilaterally. No wheezes or crackles noted.
Gastrointestinal symptoms:	No reports of nausea or vomiting; appetite is good.
Posterior thorax:	No tenderness or deformities; equal expansion noted.
Breasts:	Breasts are symmetrical, no lumps or discharge noted.
Axillae:	No lymphadenopathy or tenderness noted. Skin is intact.

Cardiovascular system assessment	
Area	**Findings**
Neck vessels:	Carotid pulses are strong and equal bilaterally; no bruits.
Heart:	Heart sounds normal with regular rhythm, no murmurs or extra sounds.
Peripheral pulses:	Radial, brachial, femoral, popliteal, posterior tibial, and dorsalis pedis pulses are 2+ and equal bilaterally.
Lower extremities:	Radial, brachial, femoral, popliteal, posterior tibial, and dorsalis pedis pulses are 2+ and equal bilaterally.
Peripheral vascular system assessment	
Area	**Findings**
Arms:	No edema or lesions; skin warm and dry.
Hands:	Capillary refill less than 2 seconds; no clubbing or cyanosis.
Legs:	Skin is warm, no edema, or varicosities noted.
Abdominal assessment	
Area	**Findings**
Abdomen:	Abdomen is soft, non-tender, no distension or masses.
Bowel sounds:	Active bowel sounds in all quadrants, no signs of obstruction.
Musculoskeletal system	
Area	**Findings**
Gait:	Gait is steady and coordinated, no limp noted.
Joints:	Full range of motion in all joints without pain or swelling.
Cervical, thoracic, lumbar spine:	Spine is straight; no tenderness or deformities noted.
Shoulder and elbows:	No pain or limitations in range of motion.
Wrists and fingers:	Full range of motion, no swelling or deformities.
Hips:	Full range of motion, no pain upon movement.
Knees:	No swelling or pain; full range of motion.
Ankles and feet:	No edema, full range of motion; pulses strong.

Neurological system assessment	
Area	**Findings**
Mental status:	Alert and oriented to person, place, time, and situation.
Cranial nerves:	Intact; pupils equal, round, and reactive; facial sensation intact.
Motor and cerebellar	Strength 5/5 in all extremities; gait is coordinated.

Genitourinary system assessment	
Area	**Findings**
Genitalia:	External genitalia appears normal; no lesions noted.
Anus and rectum:	No hemorrhoids or fissures; rectal tone is normal.
Urine test:	Clear yellow urine; no blood or abnormalities noted.

Additional notes

Patient expressed concerns about managing stress and maintaining healthy blood pressure. Recommendations for lifestyle changes were discussed, including diet and exercise. Follow-up appointment scheduled for next month.

Attending nurse name: Sarah Mitchell

License number: RN-7654321

Signature: SMithell

Date: October 5, 2024