Patient Assessment

Patient information		
Name: Johnny Miller		
Date of birth: February 3, 1985	**Gender:** NB	
Occupation: Creative director	**Mobile number:** XXX-XXX-XX	
Height: 6'1"	**Weight:** 170lbs	**Race/ethnicity:** Caucasian
Reason for visit:		
Annual exam		

Social habits			
Alcohol: ○ No ◉ Yes (frequency): Twice a week			
Cocaine: ◉ No ○ Yes		**Narcotics/drug use:** ○ No ○ Yes	
Smokes tobacco: ○ No ◉ Yes			
If yes, # of years: 15	**# of packs/days:** 1	**When stopped:** N/A	
Cultural/religious beliefs that may affect care:			
None that I am aware of.			
Do you prefer to learn by (please check all that applies):			
☑ Seeing (TV, Video, Written) ☑ Hearing (Audio) ☑ Doing (Hands on)			
Do you have any barriers to learning (please check):			
☐ Physical ☐ Emotional ☐ Vision ☐ Financial ☐ Hearing ☐ Cognitive			

Medical history		
Past medical history:	**Current medical conditions:**	**Relevant family medical history:**
Hypertension, allergic rhinitis	Hypertension, allergic rhinitis	Father - Heart disease Mother - Diabetes

Allergies:	**Current medications:**
Penicillin, pollen	Lisinopril 10mg daily, Claritin as needed

Hospitalization/surgery/major illness			
Problem	**Year**	**Where treated**	**Days in hospital**
Tonsillectomy	1995	General Hospital	2 days

Vital signs		
Temperature: 98.6°F	**Blood pressure:** 125/80 mmHg	**Heart rate:** 72 bpm
SpO2: 98%	**Respiratory rate:** 16 breaths per minute	

General appearance:
Well-nourished, no visible distress, alert, oriented

Body systems	
Respiratory system:	**Cardiovascular system:**
Clear to auscultation, no wheezes or crackles	Regular heart rhythm, no murmurs
Gastrointestinal system:	**Musculoskeletal system:**
Abdomen soft, non-tender, bowel sounds normal	Full range of motion, no tenderness
Neurological system:	**Skin & integumentary:**
Alert and oriented, normal reglexes	No rashes or lesions, skin warm and dry

Signs of illness and injury
No visible signs of injury or acute illness.

Nutritional data
Are you following a special diet? ◉ No ○ Yes (please specify):
Unintentional weight: ○ Over/Under 5 lbs in 1 month ○ Over/Under 10 lbs in 3-6 months
Appetite: ◉ Good (eat 3+ meals/day) ○ Fair (1-2 meals/day) ○ Poor (less than 1 meal/day)

Laboratory test results

Test type	Result	Remark
Blood test	Normal	

Mental status assessment
Alertness/Orientation (Person, place, time): ◉ Normal ○ Impaired
Memory (short-term and long-term): ◉ Normal ○ Impaired
Emotional state:
Calm and cooperative during assessment
Behavioral observations:
No abnormal behavior observed

Psychosocial assessment

Social support system

Family	Friends	Caregivers	Others
Supportive, lives with spouse and two children	Good social network, meets weekly for activities	N/A	N/A

Living environment:
Lives in a two-story house, safe neighborhood
Stressors:
Work-related stress due to deadlines
Mental health concerns:
None at present
Coping mechanisms:
Regular exercise, meditation
Additional notes
Patient appears in good health with stable vitals. No new complaints or concerns raised.
Assessor's name and signature: Betty Whitman, RN 
Date: April 12, 2024