**Name of Evaluator**:

Age:

**Name**:

**Address**:

**NURSING HEALTH AND SAFETY ASSESSMENT**

**FORM A**

**Section I: Identifying Information**

1.

DOB: (mm/dd/yyyy )

Male

Female

2.

City

State

Zip Code

3.

Date of Report (mm/dd/yyyy):

4.

**Purpose of Evaluation**:

Annual

Change in Status

Other

5.

**Living Situation**:

ICF

Waiver

Family Home

Host Home

Other (specify)

6.

**Race**:

African American

Native American

Asian

Other (specify)

Hispanic

White

8.

**Communication**:

Verbal

Sign

Assistive Technology

Nonverbal (Comments: )

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9. **Activities of Daily Living** Self Care Ability: (Please score each area with the following scale) 0=Independent; 1=Assistive Device; 2=Assistance from Others; 3=Assistance from Person and Device; 4=Totally Dependent

Eating/Drinking:

Transferring:

Bathing/Personal Hygiene:

Ambulation:

Dressing:

Bed Mobility:

7. **DSM AXIS**

***CURRENT DIAGNOSES***

I

II

III

10. **Adaptive equipment**:

None

(If yes, list all)

11. **Medical equipment**: (*include glucose monitoring, enteral feeding, respiratory supplies, medical*

*alert device, etc*)

None

Indicate type and frequency of use:

12. **History of Falls**:

No

Yes (specify frequency & follow-up)

**Section II: Brief Health History**

15. **Significant Family History**





Information obtained from health record

Information obtained from family member: (If Yes, give name: )

Relationship to individual:

Date: (mm/dd/yyyy)

Yes

Yes

No

No





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19. **Family History of Cancer**

18. **Family History of Seizures**

17. **Family History of Diabetes**

16. **Family History of Cardiac Problems/Hypertension**

14. **Illnesses during the past year**: (include dates)

13. **Hospitalizations and ER visits during the past year**: (Dates and Reasons)

Toileting:

Stair Climbing:

Ambulation Status (describe):

**Section III: Health Data**

22. **Allergies**:

Food

Environmental

Medication Reaction

No Known Allergy

If any reaction, identify antigen & clinical reaction:

EpiPen:

Yes

No

23.

**Current Medical Information**:

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Medical Problem

Date Diagnosed (mm/dd/yyyy)

Date Resolved

(mm/dd/yyyy)

21. **Other Family History**

20. **Family History of Known Genetic Disorders**

24. **Consent Procedures**

25. **Individual’s Health Concerns**

*Individual’s Perspective:*

*Care Provider’s Perspective (give name/title)*:

*Family Member’s perspective (give name/relationship):*

26. **Seizure Disorder**: Type

Summary of seizure data:

Frequency

N/A

27**. Current Medications**

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Date Started mm/dd/yy

Medication

Dosage

Times

Route

Reason

Date to be Discontinued mm/dd/yy

Individual has the capacity to make medical decisions: Yes No

Individual has a substitute health care decision maker:

Yes No

To obtain consent contact:

Name: Phone:

**In a medical emergency two physicians may agree to proceed with medical intervention.**

Advance Directives/DNR None

29. **Medication regimen** (indicate one):

no changes over past 3 months

changes over past 3 months

Describe changes:

30. **Medication concerns:**

31. Is a self administration program utilized for any of the above listed medications?

If Yes, summarize the data sheet:

Yes

No

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28. **Describe best approach for administering medication including: whether tablet should be crushed, given with liquids or food, or liquid form of medication should be used**. (Include individual’s usual response to taking medications)

32. **Date of most recent self administration assessment**: (mm/dd/yyyy)

33. **Sexuality**

**Section IV: Review of Systems**

\***INSTRUCTIONS: Place an X on document findings WNL (within normal limits/negative); NWNL (not**

**within normal limits). Further explanation is needed for all NWNL findings. Please note that the words marked in *italics* below require physical assessment by the nurse.**

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**System**

**WNL**

**NWNL**

**Description**

35. **GENERAL**

a. Appearance

b. Hygiene/Grooming

36**. SKIN**

*a. Dryness, itching*

34. Date: / / B/P: T: P: R: Ht: Wt Ideal Body Weight: Not determined

Diet:

Food supplementation: (Indicate type and frequency) Food restrictions/allergies: Recommendations/comments:

Date of last visit with primary care practitioner (mm/dd/yyyy):

Is sexually active? Yes No Comments:

Masturbation: Appropriate Behavior Inappropriate Behavior Comments:

Describe briefly current sex education programs: None

History of abuse: Yes No Comments:

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*b. Rash*

*c. Wounds/Scars*

*d. Acne*

*e. Breakdown/Pressure ulcer*

*f. Braden Scale*

Date of last dermatology exam (mm/dd/yyyy): None indicated

37. **HEAD/SCALP**

a. c/o Headache, Dizziness

b. Hx: Head Injury

*c. Scalp: Dandruff*

38. **THROAT/MOUTH**

*a. Gums/Mucosa: swollen/ bleeding/discoloration*

*b. Teeth: missing teeth/ Dentures (indicate use)*

*c. Oral Hygiene*

*d. Daily Dental Rx Regimen*

Date of last dental exam(mm/dd/yyyy): Results:

39. **EYES**

a. Gross Vision

*b. Annual Vision Screen*

c. Glaucoma Screen (every 3- 5 yrs in high risk persons)

*d. C/o Itch/Pain/Tearing*

*e. Sclera: red*

f. Presence/hx of cataracts/ glaucoma

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Date of last ophthalmology exam (mm/dd/yyyy) : None indicated Results:

40. **NOSE**

a. Allergies

b. Hx Sinus problems Hx Nose bleeds

*c. Nasal discharge*

Date of last allergy exam (mm/dd/yyyy): None indicated Results:

41. **EARS**

a. History of ear aches Tinnitus/vertigo/infection

b. Wax build-up/discharge

*c. Exam of external ears and ear canal*

*d. Annual hearing screen*

Date of last audiological exam (mm/dd/yyyy): None indicated Results:

Date of last otolaryngology (ENT) exam (mm/dd/yyyy): None indicated Results:

42. **FEET**

*a. Nail Care*

*b. Nails-fungal/ingrown*

*c. Calluses/bunions/corns/ deformities*

*d. Edema*

Date of last podiatry exam (mm/dd/yyyy): None indicated Results:

43. **CARDIOVASCULAR**

*a. Auscultation results*

b. Hx chest pain/PRN RX

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c. Hx Palpitations

d. Hx Hypertension

e. Hx Heart disease

Date of last cardiology exam(mm/dd/yyyy) : None indicated Results:

Pertinent lab/diagnostic results:

44. **RESPIRATORY**

*a. Auscultation results*

*b. Chronic cough*

*c. Dyspnea/Cyanosis*

*d. Chronic congestion*

e. Hx Asthma/Bronchitis

f. Hx Aspiration pneumonia

g. Sleep Apnea

h. Oxygen use

i. Suctioning

j. Postural drainage

*k. Tracheostomy*

Date of last medical exam(mm/dd/yyyy): Give specialty : Results:

Pertinent lab/diagnostic results:

45. **GASTROINTESTINAL**

a. Dysphagia

b. c/o Nausea/Heartburn

c. Hx Vomiting/Dehydration

d. Hx GERD

e. G/J/NG Tube

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f. Recent Weight ↑ or ↓

g. Bowel Patterns

h. Hx Anal/Rectal bleeding

i. Colostomy/Ileostomy

*j. Abdominal exam*

*- Visual*

*- Auscultation*

*- Palpitation*

Date of last gastroenterology exam (mm/dd/yyyy): None indicated Results:

Pertinent lab/diagnostic results:

46. **PERIPHEROVASCULAR**

*a. Extremities: edema/cold*

b. c/o Pain/cramps/ numbness

*c. Varicosities*

47. **TACTILE/KINESTHETIC**

*a. Sensitivity to light/touch/ Sound/smell (specify)*

48. **SLEEP PATTERNS**

a. Able to sleep through the night

b. Measures used to aid sleep

c. Bed wetting/incontinence (specify)

49. **GENITOURINARY**

a. Voiding pattern

b. Incontinence; catheter

c. Kidney disease; Dialysis

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d. Hernia

e. Hx UTI/hematuria,stones

Date of last urology exam (mm/dd/yyyy): None indicated Results:

Pertinent lab/diagnostic results:

50. **NEUROSENSORY**

a. Hx Fainting

*b. Tremors*

*c. Dementia screen*

d. Seizures/concerns

*e. TD/ EPS*

f. Parkinson’s

Date of last neurology exam (mm/dd/yyyy): None indicated Results:

Pertinent lab/diagnostic results:

51. **MUSCULOSKELETAL**

a. c/o Pain/stiffness/cramps

*b. Range of motion*

*c. Gait/coordination/balance*

*d. Joint stiffness/arthritis*

*e. Back problems/scoliosis*

f. Hx Fracture/Osteoporosis

Date of last physical therapy assessment (mm/dd/yyyy): None indicated Results:

Date of last orthopedic exam (mm/dd/yyyy): None indicated Results:

1. **ENDOCRINE/HEMOTOLOGIC**
   1. Heat/cold tolerance

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b. Excessive sweating/ thirst/ hunger/urination

c. Hx Thyroid/ diabetes/ anemia

*d. Bruising/bleeding pattern*

e. Compromised immune system/Autoimmune

Date of last endocrinology exam (mm/dd/yyyy): None indicated Results:

Pertinent lab/diagnostic results:

53. **FEMALE HEALTH ISSUES [N/A FOR MALES]**

a. Menses: pattern/nature

b. Menopause: peri/post

c. Hormonal therapies

d. Birth control: specify method

e. Hysterectomy

*f. Breasts: lumps/discharge/*hx

g. Self-exam skills

h. Pregnancy/miscarriage/ abortion

*i. STD/sores*

Date of last mammogram (mm/dd/yyyy): Results:

Date of last gynecology exam (mm/dd/yyyy): Results:

Pertinent lab/diagnostic results:

54. **MALE HEALTH ISSUES [N/A FOR FEMALES]**

a. Prostate: recent exam/hx

*b. Testicular exam*

57. **Other pertinent information/comment**:

**\*Prevention and relief of distress (Choose one of the following numbers and prompt levels)**

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*c. Scrotum/penis*

d. Vasectomy

e. STD

Date of last urology exam(mm/dd/yyyy): None indicated Results:

Pertinent lab/diagnostic results:

55. **EMOTIONAL MENTAL STATUS**

a. Functional Orientation

**(Indicate frequency,duration,precipitators)**

b. Nervousness/anxiety

c. Sadness/loneliness

d. Fearful/withdrawn

e. Irritable/angry

Date of last psychological exam (mm/dd/yyyy): None indicated Results:

56. **MALADAPTIVE BEHAVIOR**

a. Aggressive/ Assaultive

**(Indicate frequency,duration,precipitators)**

b. Destructive

c. Self-injurious

d. PICA

e. Running away

f. Verbal abuse

Psychotropic medications: Yes No

If Yes, date of consent (mm/dd/yyyy): , provided by whom?

Date of last Behavior Support Plan (BSP) (mm/dd/yyyy): None indicated Results:

Date of consent for BSP (mm/dd/yyyy):

63. **Immunization Status**:

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**IMMUNIZATIONS/VACCINATIONS**

Date of last TETANUS: (mm/dd/yyyy)

Date of last INFLUENZA: (mm/dd/yyyy)

Date of PNEUMOVAX: (mm/dd/yyyy)

Date of PPD/Chest X-Ray: (mm/dd/yyyy) Results:

HEPATITIS B Surface Antigen:

HEPATITIS B Immunity:

**Category: Pain Control**

**Independent**

**Verbal Prompts Needed**

**Assistance Needed**

**Completely Dependent**

**Comments**

58. Pain free. Self caring in the management of pain.

59. Experiences pain which they are able to manage and can ask when treatment is required.

60. Experiences regular or protracted pain which cannot be managed unsupported, although needs can be expressed. Needs assistance, supervision or support in controlling the pain.

61. Able to express verbally protracted pain, but unable to specify the type of pain or its effects. Requires a range of interventions to control pain.

62. Unable to describe needs in respect of pain. The level of pain experienced can only be seen through behavior, facial or bodily expression and emotional state. Requires complex interventions.

For information regarding specific areas of concern and expected outcomes, see the attached Health

Management Care Plan. Also, note that there may be other assessments as appropriate to the nursing care of the individual attached to the Nursing Assessment, i.e. Braden scale, fall risk assessment, dementia screening assessment.

Name of Evaluator & Title

Signature of Evaluator

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64. **Summary of Findings**:

Other: (Give name and date)

Date HEP B Vaccine Series Completed: (mm/dd/yyyy)