Initial Nursing Assessment Form

Date/Time of Admission

Admitted By (Nurse)

Patient Name

Medical Record Number

Date of Birth

Sex

Contact Number

Chief Complaint/Reason for Admission

Medical & Surgical History

Allergies

Medications (Current)

Vital Signs

Temperature (Â°C)

Pulse (bpm)

Blood Pressure (mmHg)

Respiratory Rate (per min)

Oxygen Saturation (%)

Height (cm)

Weight (kg)

Pain Assessment

Pain Score (0-10)

Location/Description

Functional Assessment

Mobility

Activity Tolerance

Speech

Hearing

Vision

Elimination

Bowel

Urine

Nutritional Assessment

Diet Type

Appetite

Feeding Assistance

Sleep/Rest

Sleep Pattern

Psychosocial/Cultural Assessment

Initial Nursing Assessment/Plan

Nurse Signature

Date