Chronic Disease Nursing Assessment Form

Patient Information

Full Name

Date of Birth

Medical Record Number

Contact Number

Gender

Select

Medical History

Chronic Diagnosis

Duration of Disease

Relevant Medical History

Current Medications

Allergies

Assessment

Vital Signs (BP, HR, RR, Temp, SpOâ,,)

Current Symptoms

Physical Assessment

Lifestyle & Social History

Smoking Status

Alcohol Consumption

Dietary Habits

Physical Activity Level

Nursing Plan

Nursing Diagnosis

Goals/Expected Outcomes

Planned Interventions

Evaluation & Follow-Up