Medical surgical nursing sheet

Assessment: A- History

1- Personal history:

-patient's name …… -Age …….
- Bed no …… - Room no …… - Address ……..
- Date of admission …… - Date of discharge ……..
-Medical diagnosis: ……..

2- Present history:

-chief complaint and duration ……
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-History of present illness (HPI):……
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Hospital course:(what happened since admission)
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Systemic review: any abnormality……..
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Allergy . medication history:……..
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Past history: (previous illness):
-medical history……..
-surgical history……
-family history……

Brief description about disease – procedure:

Definition: ……

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Character	In book	In patient
Causes or indication		
Signs and symptoms or Contraindications		
Complication		
Treatment		

-**Assessment** : -B- **physical examination**:

- general appearance: ……
-measurements : weight (BMI)…… - position……
-skin (color – CRT)……
-mental state:(GCS – AVPU)……
-vital signs:

RR …….. Depth…….. Rhythm……
PR…….. Site…….. Rhythm…… Strength/ Volume……..
TMP……Site……
BP……..Site……..Pulse Presure……

Head to toes assessment (any abnormality)

inspection : hair – scalp – face – eye – ear – mouth – nose – neck – chest – abdomen – limbs)

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Palpation: (neck – chest – abdomen)

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Percussion: (chest – abdomen)

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Auscultation (heart sound , breath sound , peristalsis)

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-**Assessment** : c- **investigation**

1 – laboratory : (test indicate abnormality)

Type of test	Result of test	Normal value

2- Radiology (note result)

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Medication:

Name of drug	dose	rout	time	Action of drugs	Side effect

Nursing process

NSG diagno	NSG. planning	NSG intervention	NSG evaluation

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Health education: