NURSING HEALTH AND SAFETY ASSESSMENT
FORM A

Section I: Identifying Information

1. **Name**:
   Age: DOB: (mm/dd/yyyy) Male ☐ Female ☐

2. **Address**:
   City State Zip Code

3. **Name of Evaluator**: 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 ☐ Asian ☐Hispanic ☐ White
   ☐Native American ☐ Other (specify)

7. **DSM AXIS**	***CURRENT DIAGNOSES***
I	
II	
III	

8. **Communication**: ☐ Verbal ☐Sign ☐Assistive Technology
   ☐ Nonverbal (Comments:_)

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:	

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Toileting:		Stair Climbing:	
Ambulation Status (describe):			

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

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

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

15. **Significant Family History**

- Information obtained from health record ☐ Yes ☐ No
- Information obtained from family member: ☐ Yes ☐ No
  (If Yes, give name: _____)
- Relationship to individual: _____
- Date: (mm/dd/yyyy)_____

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

17. **Family History of Diabetes**

18. **Family History of Seizures**

19. **Family History of Cancer**

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

21. **Other Family History**

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**:

Medical Problem	Date Diagnosed (mm/dd/yyyy)	Date Resolved (mm/dd/yyyy)

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24. **Consent Procedures**

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 ☐	

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 Frequency N/A ☐

Summary of seizure data: _____

27**. Current Medications**

Date Started mm/dd/yy	Medication	Dosage	Times	Route	Reason	Date to be Discontinued mm/dd/yy

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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)

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? ☐Yes ☐No
If Yes, summarize the data sheet: _____

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

33. **Sexuality**

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:

Section IV: Review of Systems

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):

***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.**

System	WNL	NWNL	Description
35. **GENERAL** a. Appearance	☐	☐	
b. Hygiene/Grooming	☐	☐	
36**. SKIN** *a. Dryness, itching*	☐	☐	

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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: _____			
52.**ENDOCRINE/HEMOTOLOGIC** a. 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	☐	☐	

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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):			

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

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

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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.	☐	☐	☐	☐	

63. **Immunization Status**:

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:

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Other: (Give name and date)	Date HEP B Vaccine Series Completed: (mm/dd/yyyy)

64. **Summary of Findings**:

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

**Adapted from CT Department of Developmental Services Nursing Health & Safety Assessment, 2006*

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