Los Angeles Harbor College

Associate Degree Registered Nursing Program

NURSING HISTORY & ASSESSMENT FORM

Nursing 339 – Nursing Practice & Process in the Care of the Gerontological Client

Circle or fill in appropriate responses.

Highlight all normal changes of aging in one color ____ *Highlight all ineffective behaviors using a second color* ____

Student: _____ Date(s) of care: _____ Clinical Instructor: _____

Instructions: This history and assessment is to be completed on an individual who is 75 years of age or older. He/she is to be a resident at a long-term care facility to which you are assigned. You must have repeated contact with resident for observation/interviewing/and assessment purposes.

Data sources and data collection strategies: Interviews with or observations of older clients and physical examination may be used to obtain most of the assessment data. For older clients who are cognitively impaired, information may be obtained in interviews with significant others and/or medical records.

Source of info: □ Resident □ Significant Other □ Caretaker □ Medical Record □ Physical exam

Resident Profile: Resident's Initials: ___ Room # _____ Age: ___ Gender: ___ Religion: _____ Admit date: _____

Does the resident have Advanced Directives? □ No □ Yes □ Living will □ DNR □ Do not hospitalize □ Organ donation

□ Feeding restrictions □ Medication Restrictions □ Other treatment restrictions (list)_____

Primary Language: English Y N If no_____ Interpreter needed? Y N

Who is legally responsible: □ Self □ Family member _____ □ Legal guardian _____

Perception of health status: ____ good ____ average ____ poor

Stated positive health habits / strengths:

Prompt with the following & document client response above: ____ Balanced diet ____ Yearly physicals

____ Immunizations: ____ Tetanus ____ Diptheria ____ PPD ____ Influenza ____ Pneumovax

Sleep habits: _____hours of sleep/24 hours

Difficulty falling asleep Y / N _____ Awaking during the noc and unable to go back to sleep Y / N _____

Exercise routine:

Compliance with prescribed medications and treatments: Y / N _____

List preventive health behaviors:

Stated negative past and present health behaviors / weaknesses:

Prompt with the following & document client responses above:

____ Smoking ____ Excessive use of caffeine ____ Alcohol use / abuse ____ Drug use / abuse ____ Limited/no exercise

___ noncompliant with prescribed diet ____ Un-balanced diet ____ Loves junk food

Medical/Surgical Diagnoses
PMH: (Indicate whether medical diagnosis is an acute or chronic problem.)
Previous Hospitalization(s) / PSH: [List procedure and date (year) performed]
Allergies – Medications / Food / Tape / Latex / Dyes / etc...[If yes, include reaction(s)]
Supplements / Herbal Remedies
Medication Reconciliation – Assess medication list for potential polypharmacy / interactions

Current Medication	Indications for this Resident	Active Side Effects

hysiological Modes – General Assessment: Cognitive / Sensation

SUBJECTIVE BEHAVIORS
Pain level ___/10 Location: _____
Aching__ Burning__ Numb__ Piercing__ Pulling__ Sharp__
Shooting___ Tingling__ Stabbing__ Throbbing__ Dull__
Other_____
Is pain always there? Y N Does it come and go? Y N
What makes it better? _____ Worse?_____

OBJECTIVE BEHAVIORS
General appearance: _____
Communication:
□ Speech □ Writes messages to clarify needs □ Points to words to clarify needs □ Unable to communicate □ Other

Score on Physical / Behavioral Assessment:
Language – Conversation _____ Social Interaction _____
Neuro check/Orientation: _____
Affect: _____

Oxygenation Needs [Pulmonary/Cardiovascular/Peripheral Vascular]

SUBJECTIVE BEHAVIORS
Smoking:
Family: N Y
Resident: N Y Pk/yrs: _____
Quit date: _____
Number of pillows / sleep? ___
Dyspnea: N Y _____
Dizziness/Weakness: N Y
Chest pain: N Y Palpitations: N Y
Bleeding: N Y Bruising: N Y

OBJECTIVE BEHAVIORS
T: _____ PR:_____ RR:_____ BP: _____ SpO_2_____ O_2 via ____ @_____
Orthostatic/postural BP: Supine _____ Sitting _____ Standing _____

Heart sounds: _____ P.M.I _____ Peripheral Pulses: _____
Temp:_____ Color_____ Sensation: _____ Movement: _____
Capillary Refill Time: _____ Peripheral Edema: _____

Activity Tolerance – Prior to activity: HR ___ RR___ After activity: HR ____ RR ___

Respirations:
Regular / irregular / symmetrical / unlabored / shortness of breath (SOB) at rest / DOE
A-P diameter_____ B/L breath sounds noted in all lung fields _____
Cough: Y/N □ productive □ nonproductive Sputum amount _____
Consistency: □liquified □thick □other _____ Color: _____

Fluid and Electrolytes Needs

SUBJECTIVE BEHAVIORS
Usual Intake: _____ Output:_____
Likes/Dislikes:_____
Weakness/Cramping: _____

OBJECTIVE BEHAVIORS
Fluid Limit: _____ Hemodialysis access N Y If yes, describe site_____ Bruit: present: Y N Thrill: present Y N

Nutritional Needs: Gastrointestinal

SUBJECTIVE BEHAVIORS
Usual Diet / Cultural Preferences: _____
Dining: Location_____ Company_____
□ Nausea / Vomiting □ Difficulty chewing □ Oral pain
□ Change in Appetite □ GERD If yes to any of the above, describe: _____
Nutritional supplements: Y N _____
Weight loss > 5% in past 30 days Weight loss > 10% in last 180 days Weight loss/gain – amount:____ over what period of time:_____

OBJECTIVE BEHAVIORS
Height:_____ Weight:_____(kg) Usual Weight:_____
Diet: _____
Estimated fluid intake in past 24 hours: _____
Difficulty Swallowing: Y N If dysphagia present, describe type:_____ Dental caries: Y N
Dentures: Y N Are they available? Y N Do they fit? Y / N
Abdomen Shape / Size: _____ Bowel Sounds: Y / N
Score on Physical / Behavioral Functional Assessment Tool:
Eating and Nutrition_____

ertinent lab/tests: Serum albumin:_____

Elimination Needs: Genitourinary / Gastrointestinal

SUBJECTIVE BEHAVIORS	OBJECTIVE BEHAVIORS
Usual pattern/frequency:_____ Dysuria/ Polyuria/ Oliguria/ Anuria/ History of frequent UTI Voiding-Continent: Y / N Control/ Awareness: Y / N _____ Defecation-Continent: Y / N Control/ Awareness: Y / N _____ Last B.M ____ Laxative Use: Y N Type/Frequency: _____	Urine Color/Clarity: _____ _____ Genital edema / discharge N Y If yes, describe: _____ Dressings / Incisions: _____ Ostomy type / Stoma appearance: _____ Self care with ostomy: Y N Hemorrhoids: Y N Rectal Bleeding: Y N
Pertinent lab/tests: Urinalysis_____ C&S (urine):_____	

Rest & Activity Needs/ Sleep/ Orthopedic

SUBJECTIVE BEHAVIORS	OBJECTIVE BEHAVIORS
Needs Assistance to: _____ □ Pain/Discomfort □Fatigue □Weakness Usual Sleep Pattern: _____ Meds/Rituals: _____ Hrs. Slept/Disruptions: _____ Usual Activity/ Exercise:_____	Activity Level: _____ Posture/Position: _____ Impaired gait / strength: Steady / Unsteady / Shuffles / Short steps / Not ambulatory / Other _____ Motor deficits: _____ ROM/ PT/ RNA / ADL/ Exercise _____

SAFETY: Risk for Falls – Circle appropriate number

Previous fall	5	Nocturia or urgency	2
Impaired gait or strength	3	Arrhythmia or postural hypotension	2
Confusion or impaired judgment	5	Decreased vision or hearing	1
Sedative / hypnotic or dizzy	3	TOTAL	

Risk Level: 0-2 = No Risk. 3-4 = Moderate Risk. 5 or greater = High Risk. Fall Precautions initiated Yes / No / NA
RESTRAINTS: N Y MD order _____ Restraint type_____ Reason_____
Circulation/Mobility Assessed: Q___H.___ Provided Nutrition___Hydration___Elimination___Hygiene___Mobility___

Sensory Regulation Needs: Neurological / Endocrine / Eyes / Ears

SUBJECTIVE BEHAVIORS	OBJECTIVE BEHAVIORS
Sensory changes / deficits:_____ Female: Postmenopausal N Y Erectile Dysfunction:_____ Sexual Activity/Practices: ____ Last Physician exam (GU):_____ Supplementary hormones:	□ Eyes open spontaneously □ Drainage □ Tearing PERRLA / constricted / fixed Vision: □ Wears glasses □ Wears contacts □ Adequate: With aid, sees fine detail, including regular print □ Impaired: With aid, sees large print, but not regular print □ Macular degeneration □ Limited vision – not able to see newspaper headlines □ No vision, or can only see light, colors or shapes □ Side vision problems (e.g. leaves food on one side of try, difficulty traveling, bumps into people and objects) □ Sees halos or rings around lights □ Sees flashes of light □ Sees "curtains over eyes" □ Cataracts □ Other_____ Hearing: □ Hears adequately □ Loss of high frequency sounds □ absence of hearing □ Hearing Aides If yes, describe use_____ Taste (altered): N Y If yes, describe_____ Smell (altered): N Y If yes, describe_____ Touch (altered): N Y If yes, describe_____ Hair (describe): _____ Deficits/Excess Hormones: _____
Lab Work Steroids/ Mineral Corticoids: _____ Insulin/ Glucose Balance: _____ Thyroid: _____ X-Ray/ Cat Scan: _____	

rotection Needs: Integumentary

SUBJECTIVE BEHAVIORS	OBJECTIVE BEHAVIORS
Change in typical skin color / temperature / condition: _____	Temperature: hot / warm / cool / cold Jaundice: Y/N Intact _____ Turgor _____ Ecchymosis_____ Petechiae _____ Denuded_____ Rash/Irritation _____
Any recent change with increase of infections (e.g. resp., urinary) N Y If yes, describe: _____	Lesions _____ Incisions _____ Dermal ulcers Y/N Location: _____ Stage____ Size_____ Drainage: Y/N Odor: Y /N Describe_____
Pertinent lab/tests: WBC_____ Serum Albumin____ C&S:	

Psychosocial Mode – Role Function

What was your occupation? _____ How many years in that occupation/Retirement? _____
Does aging and/or chronic health conditions have an effect on your ability to work/perform functional activities? Y N
Hobbies/Interests:_____ Ethnicity/cultural identity: _____ Spirituality/ Religion: _____

Significant other / Spouse □ Living and well □ Poor health □ Deceased Developmental stages of family_____
Is family supportive? Y N Do they visit? Y N Has your role changed because of aging/chronic health conditions? Y N
Describe _____Do you ever feel socially isolated? Y N
: there any indication in this history of problems in:
Role relationship/ social isolation/ Impaired Social Interaction? Y N _____

Psychosocial Mode – Self- Concept (observe facial expressions/Body posture/tone of voice)

Physical self
Self perception: Perception of health status: □ Good □ Average □ Poor Why? _____
Alternative in the body image: Stated negative past and present health behaviors/weaknesses:
Personal Self
Self Consistency:
Self ideal: Life Satisfaction: □ normal, □ mild depression □ severe depression □ unable to assess
Moral –Ethical Self
Do you have a faith that is important to you? _____
What do you consider to be your strengths? _____
Your weakness? _____ _____

Psychosocial Mode – Interdependence

Who is the most important person(s) to you in your life? _____
How do you get along with other people? _____ Do you feel safe in your environment? _____
How do you let your family/significant others know you care for them? _____
Who do you depend on for support when you have a problem(s)? _____
Coping Mechanisms:_____ _____

o you usually use medication, drug or alcohol to help you deal with your problems?_____

	Age-Related Behaviors	Pathological Behaviors
Senses:		
Integumentary System: (Skin integrity, fragility, dryness, itching, lesions, decubiti, bruises, bleeding, skin color, thickened nails, temperature of extremities, contact allergies, decreased perspiration, etc.)		
Respiratory System: (Rate, Effort, Breath sounds, SOB, cough, secretions, etc.)		
Cardiovascular System: (HR, rhythm, heart sounds, BP, venous distention, capillary refill, peripheral pulses, hypertension, effect of activity on HR, edema, fatigue, orthostatic / postural hypotension, varicosities, venous ulcers, etc.)		

Gastrointestinal System: (Flatulence, constipation, heartburn, incontinence, dysphagia, hemorrhoids, etc.) Last colonoscopy:		
Genitourinary System: (Frequency, color of urine, incontinence, nocturia, retention, UTI, etc.) MALE: Last screening for Prostate Specific Antigen: _____ Impotence, other: FEMALE: Last mammogram:_____ Dyspareunia, vaginal bleeding, infection, other:		
Neurological System: (Mental status, reflexes, ataxia, tics, tremors, paralysis, weakness, gait, diminished sense of smell, touch, heat sensation, taste, numbness or tingling, etc.)		
Endocrine System:		
Musculoskeletal System: (Motor coordination, atrophy, weakness, contractures, deformities, etc.)		
Emotional / Spiritual Health:		