WOUND CARE OUTPATIENT CLINIC
INITIAL NURSING ASSESSMENT

PATIENT LABEL

Date:______________________________

Latex

Allergies-

Do you have a history of hay fever, asthma, eczema, allergies or rashes? ☐ Yes ☐ No
Are you allergic to any foods, especially bananas, avocados, kiwi, or chestnuts? ☐ Yes ☐ No
Do you experience rash, oral itching, swelling, or wheezing when exposed to these foods? ☐ Yes ☐ No

Occupation-

Are you exposed to any products that contain latex, including gloves, at work? ☐ Yes ☐ No
Have you ever had an allergic reaction to something in your work environment? ☐ Yes ☐ No
Have you ever had a rash on your hands after wearing latex gloves? ☐ Yes ☐ No

If so, how long after putting on the gloves did the rash develop?
☐ < 1 minute ☐ 1 minute ☐ 2-4 minutes ☐ 5-9 minutes ☐ 10-19 minutes ☐ 20-29 minutes
☐ 30-59 minutes ☐ 1-3 hours ☐ 4-24 hours ☐ > 24 hours What did the rash look like?

What did the rash look like: ____

Hidden Reactions to Latex-

Have you ever had swelling, itching, hives, shortness of breath, cough, or other allergic symptoms during or after blowing up a balloon, undergoing a dental procedure, using condoms or diaphragms, or following a vaginal or rectal examination? ☐ Yes ☐ No

Have you ever had an allergic reaction of unknown cause, especially during a medical or dental procedure? ☐ Yes ☐ No

Do you have spina bifida or any urinary tract problem requiring surgery or catheterization? ☐ Yes ☐ No

Educational

Primary Language Spoken: ☐ English ☐ Spanish ☐ Sign ☐ Other ____________________
________________________ Primary Language for Healthcare Communications: ☐ English
☐ Spanish ☐ Sign ☐ Other ___

Learning Preference: ☐ Hearing ☐ Seeing ☐ Both ☐ Other________________________________

Learning Barriers: ☐ None ☐ Unable to read ☐ Language barrier ☐ Cognitive limitations
☐ Hearing impairment ☐ Speaking impairment ☐ Visual impairment ☐ Limited mobility/dexterity
☐ Psychosocial factors ☐ Family issues ☐ Cultural practices ☐ Religious practices ☐ Not willing to learn
☐ Not ready to learn ☐ Other ____________________

Developmental Level: ☐ Child (age 0-17) ☐ Young Adult (age 18-25) ☐ Adult (age 25-40)
☐ Middle aged (age 41-65) ☐ Old (age 66-79) ☐ Frail (age 80 & older)

Learning Participants: ☐ Patient ☐ Family member ☐ Both ☐ Other

Vaccinations/Immunization History

Hepatitis A (Hep A) Vaccine: ☐ No Dose First Dose:__________________Second Dose: __________________
☐ Check here if the patient cannot remember the date of immunization

Hepatitis B (Hep B) Vaccine: ☐ No Dose First Dose:__________________Second Dose: __________________
☐ Check here if the patient cannot remember the date of immunization

Influenza (Flu) Vaccine: ☐ No Dose Last Dose: __________________

Pneumococcal Vaccine: ☐ No Dose Last Dose: __________________

Measles Mumps Rubella Vaccine: ☐ No Dose First Dose:______________Second Dose: __________________
☐ Check here if the patient states he/she acquired the disease prior to 1957.

Tetanus/Diphtheria Vaccine: ☐ No Dose First Dose:__________________Second Dose: __________________
Third Dose:__________________Last Booster: __________________

Chickenpox Vaccine: ☐ No Dose First Dose:______________________Second Dose: __________________
☐ Check here if the patient states he/she had the disease.

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B/P:	Pulse:	Resp:	Temp:	BG:	Ht (in):	Wt (lbs):
Right ABI:			Left ABI:			

Precautions:		Patient Arrival:		Departure Disposition:		Departure Instructions:		Special Needs:		Point of Care Testing:	
Standard Body Fluid		Ambulatory		Without Assistance		Special Needs		Isolation		Orthostatic	
MRSA		Cane		With Assistance		Social Services		Emotional Patient		Hand Held Doppler	
VRE		Crutches		ED		Simple Discharge		Educational Barrier		Beside Glucose Testing	
HIV		Stretcher		Routine Admit		Complex Discharge		Language Barrier		Specimen Collection	
Latex		Wheelchair		Telemetry Admit		Coordination of Care		Altered Mentation		LE Assessment	
		Walker		ICU/OR Admit		Patient Process: Simple		Transfer Assist		ABI	
		Roll About		Transfer to Another Facility or NH		Patient Process: Complex		Communication Deficit		UE Assessment	
		Scooter		Other Physician Office							

Pain

What is the location of your pain? ______________________________________

Pain Levels: Scale used: ☐ FLACC ☐ FACES ☐ (0-10)
Current: _______ Worst: _______ Best: _______ Acceptable: _______

Is your pain: ☐ worsening ☐ stable ☐ improving

Is there any temporal nature to your pain? ☐ occasional ☐ intermittent ☐ continuous

How long have you had pain? ☐ < 1 week ☐ 2 weeks ☐ 3 weeks ☐ 1 month ☐ 2 months ☐ 3 months ☐ > 3 months

Describe the quality of your pain: ☐ throb ☐ stabbing ☐ sharp ☐ prick ☐ dull ☐ cramping ☐ burn ☐ ache

What relieves or alleviates your pain? ☐ relaxation ☐ pharmacological ☐ nothing ☐ heat ☐ exercise ☐ distraction

What causes or increases your pain? ______________________________________

What parts of your life does your pain effect? ☐ sleep ☐ relationships ☐ quality of life physical activity
☐ emotions ☐ concentration ☐ appetite

What is your current pain management regimen? ______________________________________
____

Goals for management of pain:
____
____
____

Nursing Assessment

RN Signature:__________________________Date: ___________ Time: ________

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Nutrition

Unintentional weight change: ◻ no change ◻ loss ◻ gain

Appetite change: ◻ no change ◻ increase ◻ decrease

Difficulties preventing eating: ◻ vomiting ◻ taste ◻ swallowing ◻ purchasing food ◻ nausea ◻ mouth sores ◻ feel full quickly ◻ diarrhea ◻ cooking/obtaining meals ◻ constipation ◻ chewing

Current diet: ◻ tube feeding ◻ soft mechanical ◻ renal ◻ regular ◻ low sodium ◻ low residue ◻ low fat ◻ liquid ◻ diabetic ◻ cardiac

Do you take any vitamin supplements? ◻ Yes ◻ No

Do you drink any meal supplement shakes? ◻ Yes ◻ No

Do you have any cultural, ethnic, or religious restrictions on your diet? ◻ Yes ◻ No

Who feeds you? ◻ self ◻ family member ◻ care giver

Goals for Nutrition: ____

____

____

____

Functional/Activities of Daily Living

I = Independent Mn = Minimum Md = Moderate D = Dependent

Functional Level	Activity of Daily Living
	Ability to dress upper body
	Ability to dress lower body
	Bathing

Functional Level	Activity of Daily Living
	Transferring
	Ambulation
	Toileting

Patient Work

Does the patient work? ◻ Yes ◻ No

What type of work does the patient do? ____

Will this treatment have an impact on the patient's work? ◻ Yes ◻ No

Advanced Directive

Does the patient have an Advanced Directive? ◻ Yes ◻ No

Would you like to share a copy with the clinic? ◻ Yes ◻ No ◻ It is on file with the hospital

Patient Rights

Does the patient understand their Patient's Rights? ◻ Yes ◻ No

Was a copy of the Patient's Rights given to the patient? ◻ Yes ◻ No ◻ Pt. Refused ◻ Pt. already had a copy

Spiritual & Cultural

Does the patient have any spiritual or cultural preferences that could affect their care? ◻ Yes ◻ No

The patient has identified a spiritual or cultural preference that could affect care. The preference is:

____

____

The patient has identified multiple spiritual or cultural preferences that could affect care. Those preferences are:

____

____

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Braden Scale

Please choose the best option as it pertains to the patient in the following categories, then tally the score received in the box provided below.

Sensory Perception (ability to respond meaningfully to pressure related discomfort): ◻ Completely Limited (1) ◻ Very Limited (2) ◻ Slightly Limited (3) ◻ No Impairment (4)

Moisture (degree to which skin is exposed to moisture): ◻ Constantly Moist (1) ◻ Very Moist (2) ◻ Occasionally Moist (3) ◻ Rarely Moist (4)

Activity (degree of physical activity): ◻ Bedfast (1) ◻ Chairfast (2) ◻ Walks Occasionally (3) ◻ Walks Frequently (4)

Mobility (ability to change and control of body position): ◻ Completely Immobile (1) ◻ Very Limited (2) ◻ Slightly Limited (3) ◻ No Limitation (4)

Nutrition (usual food intake pattern): ◻ Very Poor (1) ◻ Probably Inadequate (2) ◻ Adequate (3) ◻ Excellent (4)

Friction & Sheer: ◻ Problem (1) ◻ Potential Problem (2) ◻ No Apparent Problem (3)

Total Score Received: __________

Fall Risk

Please choose the best option as it pertains to the patient in the following categories, then tally the score received in the box provided below.

Confusion/Disorientation/Impulsivity: ◻ Yes (4) ◻ No (0)

Symptomatic Depression: ◻ Yes (2) ◻ No (0)

Altered Elimination: ◻ Yes (1) ◻ No (0)

Dizziness/Vertigo: ◻ Yes (1) ◻ No (0)

Any administered antiepileptics (anticonvulsants): ◻ Yes (2) ◻ No (0)

Any administered benzodiazepines: ◻ Yes (1) ◻ No (0)

Get-up-and-go* Test: ◻ Ability to rise in a single movement, no loss of balance with steps (0) ◻ Pushes up, successful in one attempt (1) ◻ Multiple attempts but successful (3) ◻ Unable to rise without assistance (4)

Total:________** A score of ≥ 5 indicates that the patient is at a high risk for a fall.

Abuse

Have you ever been emotionally or physically abuse by your partner or someone important to you?
◻ Yes ◻ No If yes, by whom______________________________and total Number of times_______.

Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
◻ Yes ◻ No If yes, by whom______________________________and total Number of times_______.

Within the last year, has anyone forced you to have sexual activities?
◻ Yes ◻ No If yes, by whom______________________________and total Number of times_______.

Are you afraid of your partner or anyone you listed above? ◻ Yes ◻ No

Did Patient choose to defer the Abuse Screening? ◻ Yes ◻ No