

Nursing Assessment

"Confidential- this form must always be saved on a secure network accessible only by Ryan White funded staff"

Client name _____ Client # _____ CM initial _____ Date ____ / ____ / ____

Vitals

Height	Current weight	Ideal weight	Current CD4	Date	Current VL	Date	Lowest CD4	Date	Highest VL	Date
				/ /		/ /		/ /		/ /

Physical appearance

Skin: _____ Posture & position: _____
 Obvious physical deformities: _____ Mobility: _____
 Speech: _____ Hearing: _____
 Personal hygiene: _____ Facial expression: _____

Allergies

Medication/drug Yes No List: _____
 Food Yes No List: _____
 Environmental Yes No List: _____

HIV status

HIV positive (*not AIDS*) dx date: ____ / ____ / ____
 HIV positive (*AIDS unknown*) dx date: ____ / ____ / ____
 CDC – defined AIDS dx date: ____ / ____ / ____

HIV risk factors (*check all that apply*)

MSM Heterosexual IDU Perinatal
 Receipt of blood or tissue
 Hemophilic coagulation disorder
 Unknown or not reported/identified
 Other: _____

HIV Status

None Publicly-funded clinic or HD Private practice Hospital outpatient ER Other

Last medical visit: Provider _____ Date ____ / ____ / ____

Care provider contact information (*name and phone number*):

Primary care provider		-	-
HIV/AIDS provider		-	-
Pharmacy		-	-
Dentist		-	-

Activities of daily living (*self, assistance needed or dependent*):

Activity	Self	Asst.	Dep.	Activity	Self	Asst.	Dep.	Activity	Self	Asst.	Dep.
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meal prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current complaints (*nutritional assessment required if yes):

X = Yes	Description	X = Yes	Description	X = Yes	Description
<input type="checkbox"/>	*Abdominal pain	<input type="checkbox"/>	Changes in headache pattern	<input type="checkbox"/>	Falls
<input type="checkbox"/>	*Changes in eating habits	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Changes in strength
<input type="checkbox"/>	*Nausea/vomiting	<input type="checkbox"/>	Chills	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	*Diarrhea	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Pain
<input type="checkbox"/>	*Unexplained weight loss	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	*Difficulty swallowing	<input type="checkbox"/>	Swollen lymph glands	<input type="checkbox"/>	Cough
<input type="checkbox"/>	*Sores in throat or mouth	<input type="checkbox"/>	Seizures/tremors	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Changes in hearing	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Skin changes/rashes
<input type="checkbox"/>	Changes in vision	<input type="checkbox"/>	Changes in balance	<input type="checkbox"/>	Other:

Comments:

Medical history

Has client ever been diagnosed with opportunistic infections or conditions? (C=current; P=past) None

<input type="checkbox"/> C <input type="checkbox"/> P	ACD (AIDS Dementia Complex)	<input type="checkbox"/> C <input type="checkbox"/> P	Candidiasis	<input type="checkbox"/> C <input type="checkbox"/> P	Cervical Cancer
<input type="checkbox"/> C <input type="checkbox"/> P	Cholesterol - elevated	<input type="checkbox"/> C <input type="checkbox"/> P	Chronic/recurrent sinusitis	<input type="checkbox"/> C <input type="checkbox"/> P	CMV (Cytomegalovirus)
<input type="checkbox"/> C <input type="checkbox"/> P	Coccidioidomycosis	<input type="checkbox"/> C <input type="checkbox"/> P	Cryptococcal meningitis	<input type="checkbox"/> C <input type="checkbox"/> P	Cryptosporidiosis
<input type="checkbox"/> C <input type="checkbox"/> P	Diabetes	<input type="checkbox"/> C <input type="checkbox"/> P	Encephalopathy	<input type="checkbox"/> C <input type="checkbox"/> P	Herpes simplex
<input type="checkbox"/> C <input type="checkbox"/> P	Herpes zoster	<input type="checkbox"/> C <input type="checkbox"/> P	Hepatitis A, B or C	<input type="checkbox"/> C <input type="checkbox"/> P	Histoplasmosis
<input type="checkbox"/> C <input type="checkbox"/> P	Kaposi's sarcoma	<input type="checkbox"/> C <input type="checkbox"/> P	Leukoencephalopathy	<input type="checkbox"/> C <input type="checkbox"/> P	Lymphoma
<input type="checkbox"/> C <input type="checkbox"/> P	MAC (Mycobacterium Avian Complex)	<input type="checkbox"/> C <input type="checkbox"/> P	Myopathy	<input type="checkbox"/> C <input type="checkbox"/> P	Oral hairy leukoplakia
<input type="checkbox"/> C <input type="checkbox"/> P	Parasitic infection	<input type="checkbox"/> C <input type="checkbox"/> P	PCP (Pneumocystis carinii pneumonia)	<input type="checkbox"/> C <input type="checkbox"/> P	Toxoplasmosis
<input type="checkbox"/> C <input type="checkbox"/> P	Bacterial pneumonia	<input type="checkbox"/> C <input type="checkbox"/> P	PML (Progressive multifocal leukoencephalopathy)	<input type="checkbox"/> C <input type="checkbox"/> P	Tuberculosis
<input type="checkbox"/> C <input type="checkbox"/> P	STDs (sexually transmitted diseases)	<input type="checkbox"/> C <input type="checkbox"/> P	Thrombocytopenia	<input type="checkbox"/> C <input type="checkbox"/> P	Other:

Comments:

Has client had **positive results** for any of the following tests: None
 Hepatitis B Hepatitis C Tuberculin skin test Anal pap Last test date: ___/___/___

Has client had any of the following **treatments**:
 Chemotherapy Infusion Radiation
 Hepatitis C Treatment for LTBI (*latent TB*) Treatment for TB disease (*active*)

Has client had any of the following **immunizations**:
 Hepatitis A (HAV) Hepatitis B (HBV) Influenza
 Measles/Mumps/Rubella (MMR) Polysaccharide pneumococcal Other: _____
 Tetanus/diphtheria/pertussis (Tdap) Tetanus/diphtheria (Td)

Comments: _____

Current sexually transmitted disease history

Does the client have any of the following symptoms: None

Genital ulcers, warts, blisters or other lesions Pain with sex Pain in lower abdomen
 Pain/burning with urination Oral lesions New/usual skin rash

Men: Testicular or groin pain Urethral discharge
Women: Increased vaginal discharge Vaginal order Vulvar itching
 Changes in menses Bleeding between periods

Has client been told by a health care provider that they have any of the following in the past year: None

Chlamydia Pelvic Inflammatory Disease (PID) Herpes simplex
 Trichomonasomavirus Lymphogranuloma Verereum (LGV) Syphilis
 Gonorrhea Human Papilloma Virus (HPV)

Has client been treated for any of the above? _____

Current gynecological history

Is client currently pregnant? Yes No Is client currently breastfeeding? Yes No

Type of birth control: _____

Last PAP: ____ / ____ / ____ Results: Normal Abnormal

Last breast exam: ____ / ____ / ____ Results: _____

Last mammogram: ____ / ____ / ____ Results: _____

Comments: _____

Nutritional assessment

Current weight: _____ Ideal weight: _____

X = Yes	Description	Comments
<input type="checkbox"/>	Access to food: is client getting enough to eat?	
<input type="checkbox"/>	Does client have an appetite?	
<input type="checkbox"/>	Does client have abdominal pain?	
<input type="checkbox"/>	Does client have nausea, vomiting, diarrhea?	
<input type="checkbox"/>	Does client have difficulty swallowing?	
<input type="checkbox"/>	Does client have difficulty chewing?	
<input type="checkbox"/>	Has client experienced change in eating habits?	
<input type="checkbox"/>	Does client have dental issues?	See oral health assessment

Visual assessment of client's appearance (*build, underweight, overweight, signs of wasting syndrome*):

Nutritional summary may include: Supplements w/regular wt. checks Referral to RD Referral for dental care
 Referral to dentist Referral to primary HIV care provider Referral for counseling (*eating disorder, MH concern, substance abuse concern*) Nutritional incentive contract Other _____

Liver health assessment

X = Yes	Description	Comments
<input type="checkbox"/>	History of Hep A, B, C or other liver problems?	
<input type="checkbox"/>	Has client seen a doctor in the past 6 months about liver problems?	
<input type="checkbox"/>	Has client had liver function tested in the past 6 months?	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
	Does client have:	
<input type="checkbox"/>	• Jaundice	
<input type="checkbox"/>	• Abdominal pain	
<input type="checkbox"/>	• Gum bleeding & icterus	
<input type="checkbox"/>	• Edema	
<input type="checkbox"/>	• Skin changes	

Liver health summary may include: Referral to HIV care provider Referral to dietician
 Referral for counseling (*A&D concern*) Education about appropriate use of herbs, vitamins, supplements, etc ...
 Education about hepatitis C treatment Education about eating raw or undercooked shellfish Other: _____

Oral health assessment

When was the last time the client saw a dentist? / /

Does client have dental insurance or other access to dental care? Yes No

Does client report practicing daily oral hygiene? Yes No

Does client report oral health problems? Yes No

Dentures need re-alignment.

Episodic pain and/or sensitivity with teeth, gums or mouth

Missing days from work (*or other activities*) because of problems with teeth, gums or mouth

Difficulty interacting with others due to oral health problems that negatively impact self-esteem

Difficulty eating or speaking

Visual exam:

Has few teeth or missing teeth

Has dark, discolored teeth, missing teeth, bleeding red gums or decayed teeth

Has white, hairy growth or creamy bump-like patches or other oral lesions

Oral health summary

Current medication profile

Date prescribed	Medication	Dose	Frequency	Route	Date d/c'd
/ /					/ /
/ /					/ /

Nursing plan

Nurse signature and Credentials _____ DATE ____ / ____ / ____