NEAR EAST UNIVERSITY
NURSING FACULTY
20…/20… ACADEMIC YEAR …… SEMESTER
NUR 302 CHILD HEALTH AND DISEASES NURSING COURSE
CHILD PATIENT ASSESSMENT FORM

Student Nurse's name and surname:

Student number:

Patient Name and Surname:
Place of Birth:
Year of Birth/Age:
Gender:
Clinic/Department:
Person to be contacted for information/emergencies:
TELEPHONE:
ADDRESS:

Date of Consultation:
Person interviewed: Blood type:
Infectious disease:
Medical diagnosis/diagnoses:

TIME OF ARRIVAL AT THE HOSPITAL:

PLACE OF ARRIVAL: ……Home: …… Another healthcare facility ……Other service

…….Emergency unit …….Other

METHOD OF ARRIVAL AT THE HOSPITAL: …..Wheelchair ……Ambulance …..Stretcher

…..On foot ….. Other

REASON FOR HOSPITALISATION (MAIN COMPLAINT):……

……

When did the complaint/complaints begin?.....

Factors that triggered or accompanied the complaint/complaints?.....

Characteristics of the complaint/complaints (type, severity, duration, and frequency)……

Home remedies used to alleviate the complaint/complaints……

……
….. CURRENT ILLNESS (CHARACTERISTICS):

PERCEPTION OF HEALTH STATUS:

PREVIOUS HOSPITALISATION: …..YES (Please explain) ……NO

- Hospital and department where previously admitted:
- Reason and date of admission:
- Length of stay and outcome:

PHYSICAL ASSESSMENT

1-GENERAL

Pulse: ……/min Respiration: ……./min Blood pressure:……./…….mmHg Temperature: C

Body weight:

Weight percentile:

Height:

Height percentile:

2-RESPIRATION/CIRCULATION

Respiratory rate:

Quality :….NSI … Superficial …..Rapid ….Laboured ….Other

Cough: ….No ….Yes (Please specify)

Secretion: ….No ….Yes (Describe)

Auscultation Findings:

Right upper lobes ….NSI ….Decrease ….None ….Abnormal sounds

Left upper lobes ….NSI ….Decrease ….None ….Abnormal sounds

Right lower lobes ….NSI ….Decrease ….None ….Abnormal sounds

Left lower lobes ….NSI ….Decrease ….None ….Abnormal sounds

Right pedal pulse: ….Strong ….Weak….None

Left pedal pulse: ….Strong ….Weak….None

3- METABOLIC-SKIN

SKIN

Colour ….NSI ….Pale ….Cyanotic ….Ashy ….Jaundice ….Other

Temperature ….NSI ….Hot ….Cold

Turgor ….NSI ….Weak

Oedema ….None ….Present/ Location and characteristics

Lesions ….None ….Present/ Location and characteristics

Bruises ….None ….Present/ Location and characteristics

Redness ….None ….Present/ Location and characteristics

Itching ….None ….Present/ Location and characteristics

MOUTH

Teeth …No …NSI …Decayed …Missing …Filling

Gums …NSI ….White plaques ….Lesions …Other

Tongue …NSI ….Other

ABDOMEN

Bowel Sounds ….Present ….Absent

4-NEUROLOGICAL-EMOTIONAL

Mental Status ….Alert ….Emotional blunting …. Agitated …..Unresponsive

….Letargic …. Memory impairment …. Confusion ….Orientation

Reflexes:

Pupils …. Equal ….Unequal

….Right ….Left

Light reaction

Left ….Present ….Absent (Please specify)

Right ….Present ….No (Please specify)

Eyes ….Clear ….Discharge ….Redness ….Other

Speech ….Normal …Stuttering ….Impaired ….Motor Aphasia

Language spoken ……. Interpreter:……..

5-MUSCULOSKELETAL

ROM ….Complete ….Other

Walking and balance ….Balanced ….Unbalanced

Hand grip ….Equal/Strong ….Weakness/paralysis (….right ….left)

Leg muscles …. Equal/Strong ….Weakness/paralysis (….right ….left)

MEDICATIONS

DESIRED MEDICATIONS	**Administration Frequency/Route/Dose**	**Effect of the Medication**	**Points to Note During Use**	**Safe Dosage Range**
1-				
2-				
3-				
4-				
5-				
6-				

TESTS PERFORMED	**DATE***	**RESULT**

***** For repeat tests, please indicate the most recent date.

Laboratory Findings	**Date**	**Comment**	**Date**	**Comment**
Biochemistry				
HEMOGRAM				

PERSONAL HISTORY:

1. Birth history (Prenatal, Natal, Postnatal)
2. Previous illnesses, trauma, operations
3. Medications previously used/currently used:

   ……None ….Yes (Please specify)
4. Allergies:

   ……None ….Yes (Please specify)

FAMILY HISTORY:

1. Family structure:
2. Family members, their ages and roles (Draw a family tree)
3. Home and social environment: (Describe)

- Physical environment (Home and surroundings)
- Opportunities and limitations in the environment:

4. The family's socio-economic status
- Source of income:
- Health insurance:

5. Family Relationships (Provide examples)
- Time spent together:
- Emotional sharing:

6. The family's experience of major situational and/or developmental stress in the past year:

   …No …Yes (please explain)

7. Family members' reactions to death and illness:

8. Major/most important sources of support during stress/crisis situations

GROWTH AND DEVELOPMENT

- Motor development:
- Cognitive development:
- Language development:
- Social development:

ASSESSMENT OF FUNCTIONAL HEALTH PATTERNS

1-HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN

The baby's/child's general health status since birth:

…..Generally very good …..Good ….Frequently ill ….Generally has some health problems Routine health checks …..Performed …..Sometimes performed ….Never performed

Immunisation status:

Vaccination	Date administered	Vaccination	Date of administration
BCG		Measles	
DTP-Polio 1		Mumps	
DTP-Polio 2		Rubella	
DTP-Polio 3		Influenza	
Diphtheria 1 (DBT)		Hepatitis	
Booster 2 (DT)		Other	
Booster 3 (T)		Other	

Previous Infectious Diseases …..NONE …..PRESENT (Please explain)

Dental health:

What do parents do when they notice any signs of illness?

What measures do they take to protect their health?

Do the parents/family members smoke? …..YES ….NO

Is smoking permitted in the child's presence? …..YES ….NO

Has the child experienced any accidents at home or outside? …..NO …..YES (Please specify the number and type)

2

3

4

Are there any toys specifically for the child at home? …..NO …..YES (Please explain)

What is considered when selecting toys?

What precautions are taken for the child's safety?

What is the general health status of the parents?

…..Generally very good …..Good ….Frequently ill ….Generally has some health issues

II- ACTIVITY-EXERCISE PATTERN

-Bath routine (When, where, and how?)

- Parents' assessment of the baby/child's strength?

….. A strong child …. Gets tired easily/is not very resilient ….Normal

-CHILD'S SELF-CARE ABILITY

	Completely independent	Supervision required	Assistance required	Completely dependent
Feeding				
Dressing				
Toileting				
Personal grooming				
Bathing				

Playing characteristics:

5. Preferred games and game type:

6. Preference for playing with others: …..NO …..YES (Please explain)

7. A particular toy/object they are especially fond of: …..NO …..YES (Please explain)

8. Is this toy/object present? …..NO …..YES (Please explain)

III. NUTRITION / METABOLIC

IF INFANT;

Feeding/eating method:

….Breast milk ….Formula ….Breast milk and formula …. Breast milk /formula and complementary foods ….Other

9. Commencement of complementary foods: …..NO …..YES (Please specify)

WHAT WAS GIVEN	HOW IT WAS GIVEN

FOR INFANTS AND CHILDREN;

10. Appetite: ….Very hungry …..Normal appetite …..Poor appetite

11. Food preferences: …..NONE …..PRESENT (Please explain)

12. Conflict regarding feeding: …..NO …..YES (Please explain)

13. The child's typical/usual daily diet (please provide examples)

Parents'/family's nutritional status?

IV- ELIMINATION PATTERN

Bowel habits …../day …..Time of last defecation …../…./… …..NSI

….Constipation ……Diarrhoea …..Encopresis Other ……..

Bladder habits: …..NSI Frequency ……/day …..Odour in urine ….Burning sensation during urination

…..Haematuria ……Retention …..Incontinence …..Enuresis

Nappy changing routine?

Toilet training? …..NO …..IN PROGRESS (Please explain) …..ACQUIRED

- Is there a problem identified by the family? …..NO …..YES (Please explain)

V- SLEEP-REST PATTERN

Sleep duration ……hours/night Bedtime …….. Wake-up time …….

Daytime nap …… Time and duration…….

Any special routines before bedtime? …..NO …..YES (Please explain)

- Sleep problems? …..NO …..YES (Please explain)

  …… Difficulty falling asleep ….Nightmares …..Sleepwalking ….. Other

VI- COGNITIVE - PERCEPTUAL PATTERN

-The infant/child's general responsiveness to stimuli

……. Responds ….. Responds only to strong stimuli ….. Does not respond

-Response to speech/auditory stimuli

…..NSİ ……Minimally responsive. ……Unresponsive

- Response to visual stimuli / object tracking

…..NSI ……Minimally responsive. ……Unresponsive

-Response to tactile/touch stimuli

…..NSİ ……Minimal response. ……No response

- Response to unfamiliar people?
- Words/sentences used or sounds made? …….
- Words and meanings used specifically by the child? ……
- How does the child communicate their needs? ……..
- Number of friends?
- Relationships with friends/others?
- School performance?
- The child's general reactions to being separated from home/parents?
- Parents' and child's major concerns regarding illness and hospitalisation?

VII- SEXUALITY

- Is the child's behaviour consistent with their sexual identity?
- Menstruation and its characteristics?

PATIENT PROFILE/NURSING COMMENT