**NEU FACULTY OF NURSING**

**PUBLIC HEALTH NURSING DATA COLLECTION FORM**

**District……**

**Village……**

**Street……**

**House number……**

**Phone number……**

## SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE FAMILY

| Name | Surname | Date of Birth | Gender | Status of Kinship | Marital Status | Occupation | Education Status | Blood Type | Social Security Status |
|---|---|---|---|---|---|---|---|---|---|
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**Medical history:**

**Family history:**

**SOCIO-CULTURAL CHARACTERISTICS**

Who makes decisions within the family?.....

Do you buy newspapers or magazines for the house?.....

Do you read books?.....

How do you spend your free time?.....

Are there any traditional beliefs and attitudes?.....

Are there any religious beliefs related to health?.....

**SLEEP PATTERN**

How many hours do you sleep each day?.....

Do you take naps during the day? ..... How many hours?.....

Do you have nightmares? .....

Do you feel rested when you wake up in the morning?.....

**RELATIONSHIPS**

Mother and Father: Problem Present( ) Absent( ) Problem?.....

Mother and Children: Problem Present( ) Absent( ) Problem?.....

Father and Children: Problem Yes( ) No( ) Problem?.....

Relationships between children: Problem Yes( ) No( ) Problem?.....

Work Environment Relationships Problem: Yes( ) No( ) Problem?.....

Neighborhood Relationships Problem: Yes( ) No( ) Problem?.....

Relationships with relatives: Problem: Yes( ) No( ) Problem?.....

Friendship relationships: Problem: Yes( ) No( ) Problem?.....

Are there any activities they participate in? Yes( )..... No( )

**ECONOMIC CHARACTERISRICS**

Total income.....(Turkish Lira) per month/year ( ) sufficient ( ) insufficient

Type of additional income: ( ) Money ( ) Food ( ) Clothing ( ) Other.....

Expenses: ( ) Money ( ) Installments ( ) Other.....

How do expenses compare to income? ( ) Low ( )High ( ) Equal

Do you have any investments? .....

Who decides on spending?.....

**THE FAMILY'S NUTRITIONAL CHARACTERISTICS**

Monthly kitchen expenses:.....TL

Number of daily meals..... ( ) Regular ( ) Irregular

Number of daily snacks: ..... ( ) Regular ( ) Irregular

Skipped meals: .....( ) Yes ( ) No

Type of plates and pots used:.....

Habit of eating from a shared pot: ( ) Yes ( ) No

Meal eating style: ( )At the table ( ) On the floor

Places where food is purchased:.....

Considerations when purchasing food:.....

Frequently consumed food items and how often they are consumed:

Meat, Chicken, Fish.....

Milk and dairy products.....

Vegetables and fruit.....

Prepared foods.....

Frying..... .

What do you pay attention to when preparing food:

Washing-chopping-soaking in water

Other……..

Cooking methods:

( ) Frying ( ) Sautéing ( ) Boiling ( ) Steaming Other( ) Specify…….
Food storage methods……

Daily fluid intake…….

**CLEANING CONDITIONS**

Bath frequency:..... .....

Hand and face washing ……

Tooth brushing frequency: …….. times per day

**ENVIRONMENT AND HOUSING TYPE**

The area where the house is located.....

Waste disposal: ( )Municipality ( )Random

Noise: ..... Air pollution:.....

Transportation: ( )Taxi ( )Car ( ) Bus

Animal feeding Status: Species: Shelter:

House type: ( ) Rent.....TL ( )Own

Number of rooms in the house.....

Number of beds.....

Lighting: ( )Problem.....( )No

Humidity: ( )Problem.....( )No

Cleanliness and order: ( )Problem.....( )No

Heating method used:.....

Ventilation:…… ( )Problem.....( )No

Storage of household waste:.....( )Healthy ( )Unhealthy

Drinking water source: ( )Tap water ( )Well water ( )Other

Water source:.....

Type of toilet used: ( )Turkish style ( )Western style

Is the toilet inside the house?.....

Appliances used in the home:

Refrigerator ( ) Washing machine( ) Iron( ) ( )TV, Radio

Vacuum cleaner( ) Other.....

**HEALTH STATUS (elderly parents, children, and other household members)**

Use of healthcare organizations: Adequate( ) Inadequate( )

In what circumstances do you go to the hospital?.....

Have you had any previous hospital experience?.....

If so, what was the reason for your hospitalization?.....

When were you hospitalized?.....

What illnesses have you had?.....

Have you ever had any injuries or accidents?.....

Do you have a surgical history?.....

If yes; type of surgery……..

Date of surgery…….

Do you have any allergies? (yes) specify ……(no)

Habit of using non-prescription drugs (yes) specify……..(no)

Medications used regularly:

| Name of the Medication | Medication Dosage | Medication Time (appropriate, inappropriate) | Method of Administration | Reasons for Admission |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Substance addiction:

• Do you smoke? Yes( ) No( )

• If you smoke, how many years have you been smoking?

• If you don't smoke, are you exposed to smoking environments? Yes( ) No( )

• Do you consume alcohol? Yes( ) No( )

• If you do, how many years have you been drinking? .....

• Substance of dependence……

• Amount and frequency…….

**COMPLAINTS EXPRESSED BY INDIVIDUALS (for each individual)**

HEAD

a-condition of hair…….

b-condition of ears…….

c-condition of the nose……..

d-condition of the mouth……

e-condition of the eyes……

SENSES (decrease or loss of the five senses)……

RESPIRATION SYSTEM

a-Cough, phlegm, etc. complaints……

b-Wheezing, difficulty breathing……..

c-other……

DIGESTION SYSTEM

a-nausea- ……..

b-vomiting……

c-pain related to the digestive system…….

d-tooth loss…….

e-other……

EXCRETORY SYSTEM

a-Frequency of defecation…….

b-Color and consistency of stool…….

c-urination frequency…….

d-urine color……

e-incontinence…….

f-diarrhea……

g-constipation……..

h-other……..

MUSCULOSKELETAL SYSTEM

a-Bel ağrısı…….

b-Boyun ağrısı……

c-Eklem ağrılar…….

d-Skolyoz-lordoz-kifoz…….

e-diğer……

SKIN

a-color……

b-turgor……

c-skin deterioration……..

d-bruising, paleness, coldness …….

e-other…….

CIRCULATORY SYSTEM

a-palpitations…….

b-heart rhythm disorder……

c-varicose veins-vascular occlusion……..

d-edema…….

**FOR OTHER PEOPLE NOT AT HOME**

HEAD

| | | | | |
|---|---|---|---|---|
| People | | | | |
| Condition of hair | | | | |
| Condition of ears | | | | |
| Condition of nose | | | | |
| Condition of mouth | | | | |
| Condition of eyes | | | | |
| Other | | | | |
| | | | | |

RESPIRATORY SYSTEM

| | | | | |
|---|---|---|---|---|
| People | | | | |
| Cough | | | | |
| Phlegm | | | | |
| Wheezing | | | | |
| Difficulty breathing | | | | |
| Others | | | | |

DIGESTION SYSTEM

| | | | | |
|---|---|---|---|---|
| People | | | | |
| Nausea | | | | |
| Vomiting | | | | |
| Pain | | | | |
| Tooth loss | | | | |
| Other | | | | |

EXCRETORY SYSTEM

| | | | | |
|---|---|---|---|---|
| People | | | | |
| Back pain | | | | |
| Neck pain | | | | |
| Joint pain | | | | |
| Scoliosis-lordosis-kyphosis | | | | |

SKIN

| | | | | |
|---|---|---|---|---|
| Individuals | | | | |
| Color | | | | |
| Turgor | | | | |
| Skin deterioration | | | | |
| Bruising, coldness | | | | |
| Others | | | | |

CIRCULATORY SYSTEM

| | | | | |
|---|---|---|---|---|
| People | | | | |
| Palpitations | | | | |
| Arrhythmia | | | | |
| Varicose veins | | | | |
| Vascular occlusion | | | | |
| Edema | | | | |
| Others | | | | |

SENSES (Decreases and Losses)

| | | | | |
|---|---|---|---|---|
| People | | | | |
| Sight | | | | |
| Hearing | | | | |
| Feeling | | | | |
| Taste | | | | |
| Smell | | | | |

**PAST GYNEOECOLOGICAL HISTORY**

Previous gynecological infections (vaginal, cervical, tubal).....

Treatment received: Medical( )..... Received treatment( )

Surgical( )..... Did not receive treatment( )

Gynecological procedures performed;

Characteristic;..... Reason;..... Result;.....

Characteristics of the cycle;..... .....

Age at menarche;..... .....

Menstrual duration, frequency, and regularity;.....

History of dysmenorrhea;..... .

Frequency of pad changes during menstruation……

What do you use to clean the perineal area?.....

**CONTRACEPTIVE METHODS USED**

| Method Used | | Duration of Use | Reason for Discontinuation |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

**LAST GYNECOLOGICAL EXAMINATION AND PAP SMEAR DATE**

Examination time;.....

Frequency of Pap smears;.....

**PAST PREGNANCY HISTORY**

Number of pregnancies;.....

Number of miscarriages;.....

Number of living children;.....

Abortions;.....

**Please fill out the table below starting with the date of your first pregnancy.**

| Date of Coception | Gestational Age | Duration of Delivetry | Type of Delivery | Who delivered the baby and where | Sex of Newborn | Health Status of Newborn |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |

Attendance at prenatal checkups;.....

Frequency of check-ups;.....

**CURRENT PREGNANCY HISTORY**

Last menstrual period,.....

Estimated due date;.....

Current gestational age;.....

Vaccination status;.....

Name of vaccines administered;.....

Date of vaccination;.....

Height-weight;.....

Dietary pattern;.....

**PROBLEMS EXPERIENCED DURING PREGNANCY**

(If you have experienced any of the following problems, please indicate the corresponding feature)

Nausea-vomiting.....

Constipation.....

Burning sensation during urination.....

Headache.....

Abnormal vaginal discharge (odor, amount, color).....

Vaginal bleeding.....

Swelling in the feet and legs.....

Hemorrhoids.....

Varicose veins.....

Other.....

**SOCIO-CULTURAL AND EMOTIONAL CONDITIONS AFFECTING PREGNANCY**

Whether the pregnancy was planned ( )yes ( )no

Reaction to the pregnancy ( )positive ( )negative

Current feelings about the pregnancy ( )positive ( )negative

Number of children planned for the family;.....

**TRADITIONAL PRACTICES DURING PREGNANCY AND THE POSTNATAL PERIOD**

Yes( ) No( )

If yes, please explain……..

**NEWBORN ASSESSMENT**

**PHYSICAL FINDINGS**

Weight:

Height:

Head Circumference:

Chest Circumference:

**NUTRITION**

Feeding / Eating Method:

Breast Milk___ Formula____ Breast Milk ___ Breast Milk / Formula and Solid Foods ___ Other

Starting solid foods NO____ YES____

**COGNITIVE PERCEPTUAL PATTERN**

-The baby/child's general responsiveness to stimuli

Responds___ However, responds to strong stimuli ____ No response____

-Response to speech/auditory stimuli

Normal__ Minimal response ___ No response___

-Response to visual stimuli/object tracking

Normal__ Minimal response___ No response___

Response to unfamiliar people_____

General health status of the infant/child since birth

Generally very good____ Good___ Frequently ill___ Generally has some health problems___

Routine health checks: Performed___ Sometimes performed___ Never performed___

**IMMUNIZATION STATUS**

| VACCINE | DATE ADMINISTERED | VACCINE | DATE ADMINISTERED |
|---|---|---|---|
| BCG | _____ | MEASLES | _____ |
| DBT-POLIO 1 | _____ | MUMPS | _____ |
| DBT-POLIO 2 | _____ | RUBELLA | _____ |
| DBT-POLIO 3 | _____ | H.INFLUENZA | _____ |
| BOOSTER 1(DBT) | _____ | HEPATITIS | _____ |
| BOOSTER2(DT) | _____ | OTHER | _____ |
| BOOSTER3(T) | _____ | OTHER | _____ |

**CHILD HEALTH AGED 0-6 YEARS**

**1. PHYSICAL FUNCTIONS**

**A. Sleep and Rest:**

1. Does he/she have a special object/toy he/she wants next to him/her while sleeping?

2. Daytime nap:…….. Time and duration:……

3. Bedtime:……. Wake-up time:……

4. Do they have any special bedtime routines?:……

5. Do they have any fears? (Darkness, etc.)

6. Nightmares:…….

7. Sleepwalking:……

8. Bedwetting:……

9. What time does he/she go to sleep at night? What time does he/she wake up in the morning?.....

**B. Nutrition:**

1. Eating behavior: Bottle:…… Breast milk:……
Cup:…… Spoon:……..

2. Type and amount of daily fluids:……

3. Solid foods consumed:……

4. Additional vitamins taken:……

5. Are there any dietary restrictions?:……

6. Favorite foods:……

7. Disliked foods:…….

8. Are there any feeding difficulties?..... ....

9. Other……

**C. Discharge:**

1. How many times a day do you have a bowel movement:……

2. Frequency of urination:……

3. Is there any discomfort when urinating (e.g., burning)?:……

4. Toilet training:……

5. If toilet training is ongoing, the method used:……

6. Are there any issues with bowel movements?

Diarrhea:…….
Constipation:……
Incontinence:……..

**D. Behavior and Activities:**

**1. Personal Hygiene**

a) Care provided by others:

Dressing:……

Brushing teeth:…….

Frequency of bathing:……

b) Self-care activities:

Dressing:…….

Brushing teeth:……

Bathing:……

**2. Games and Entertainment Activities**

Playing alone:……

Playing with others…….

Play activities and favorite toys:……

Favorite TV shows:……

Are there any rules regarding TV viewing?.....

**2. EMOTIONAL – SOCIAL FUNCTIONS**

**A. Communication**

Language development according to the child's age:

Are there any communication problems?..... .....

Reaction to unfamiliar people (shy, fearful, etc.):……

The child's relationship with family members:…… ……

**B. Education**

Educational background:……

School stage:……

How is your academic performance?..... ..... .....

Are there any problems at school?..... ..... .....

Are you eager to work?…….

**3. DISABILITIES (IMPAIRMENTS)**

Vision:……Glasses:……

Hearing:…… ……hearing aid:……

Speech:……

Teeth:……..

Walking:……..

**4. HEALTH HISTORY**

Have you had any illnesses, surgeries, accidents, injuries, etc.? ( )yes ( )no

Have you ever been hospitalized? ( ) yes ( ) no

When…… Where ……..Why……

Do you have any allergies to any substances?.....

**HEALTH-PROMOTING BEHAVIORS:**

**Screening tests for women:**

• Mammogram Do you have one done? ( ) Do you not have one done?( )
If yes, how many times a year do you have it done?
• Breast examination by a doctor Do you have one done? ( ) Do you not have one done?( )
If yes, how often do you have it done?.....
• Do you perform breast self-examination?( )Do you not perform breast self-examination? ( )
If you do, how often do you do it?.....
• Pap Smear Do you have one done? ( ) Do you not have one done?( )

If you do, how many times a year do you get it done?.....

• Gynecological examination Do you have one done? ( ) Do you not have one done?( )

**Screening tests for men:**

- Do you have your testicles examined by a doctor? ( ) Do you not have them examined? ( )
- Do you examine your own testicles? ( ) Do you not examine them? ( )

If yes, how often do you do it?.....

**NUTRITION:**

• Do you have healthy and balanced eating habits? Yes( ) No( )

• Which foods do you consume more of?..... ..

• Do you eat 3 main meals a day? Yes ( ) No( )

• Do you eat 3 snacks a day? Yes( ) No( )

• Do you pay attention to vegetables and fruits produced using natural methods? Yes( ) No( )

**EXERCISES:**

• Do you exercise regularly? Yes( ) No( )
• If yes, what are they?..... .....
• How often do you exercise?..... .....
• Do you do Kegel exercises? Yes( ) No( )

**ENVIRONMENT:**

• Do you wear sunglasses to protect yourself from ultraviolet rays? Yes( ) No( )

• Do you use sunscreen when going out in the sun? Yes( ) No( )

• Is there a swamp around your house? Yes( ) No( )

• Is there an animal shelter around your house? Yes( ) No( )

**Student nurse's first and last name:**