State of Illinois
Department of Human Services - Rushville Treatment & Detention Facility

Nursing Assessment

Name: _____ Date: _____

DHS Number: _____

Birth Date: _____ AGE _____ HT _____ WT _____ BP _____

Temp _____ Pulse _____ Allergies _____

Current Medications and Dosages:

Chief Complaint:

MEDICAL HISTORY	YES	NO	COMMENTS
ALERT/ORIENTED			
GLASSES			
DENTURES			
HEARING AID			
HARD OF HEARING			
PACEMAKER			
PROSTHESIS			
TB			
STD			
HEPATITIS			
HIV			

Nurse Signature: _____ Date: _____

MD Signature: _____ Date: _____

Nursing Assessment

Name: _____ Date: _____

DHS Number: _____

MEDICAL HISTORY CONTINUED	YES	NO	COMMENTS
SMOKER			
ALCOHOL			
DRUGS			
HEART DISEASE/HYPERTENSION			
ASTHMA			
SICKLE CELL			
BLOOD DISORDER			
THYROID			
LIVER DISEASE			
KIDNEY DISEASE			
PSYCH HISTORY			
SUBSTANCE ABUSE HISTORY			
SI			
HI			
COOPERATIVE			

SEIZURES: ◯ Yes ◯ No IF YES LAST SPELL _____

DIABETES: ◯ Yes ◯ No IF YES TYPE: _____

CANCER: ◯ Yes ◯ No IF YES TYPE: _____

SURGERY: ◯ Yes ◯ No IF YES TYPE: _____

Nurse Signature: _____ Date: _____

MD Signature: _____ Date: _____

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Nursing Assessment

Name: _____ Date: _____

DHS Number: _____

MAJOR INJURIES: ◯ Yes ◯ No IF YES TYPE: _____

ANY SPECIAL DIET: ◯ Yes ◯ No IF YES TYPE: _____

VISION: _____BLIND _____CATARACT _____GLAUCOMA _____CONTACTS

NEURO: HEADACHES: ◯ Yes ◯ No DIZZINESS: ◯ Yes ◯ No

RESPIRATORY: _____SOB _____COPD _____COUGH

CARDIOVASCULAR: _____ANGINA _____EDEMA

GI: _____N & V _____HEARTBURN _____ULCERS _____DIARRHEA _____CONSTIPATION

URINARY: _____URGENCY _____FREQUENCY _____PAIN

WEIGHT CHANGE: _____GAIN _____LOSS _____APPETITE CHANGE

SLEEPING DISTURBANCES: ◯ Yes ◯ No

IF YES TYPE: _____

GAIT: _____STEADY _____UNSTEADY

Other Significant Family History

Comments:

Nurse Signature: _____ Date: _____

MD Signature: _____ Date: _____