Clinical Assessment Form

Patient Information

Name:		**Date of Birth:**	
Medical Record #:		**Date/Time of Assessment:**	
Ward/Unit:		**Room #:**	

Vital Signs

Temperature (Â°C/Â°F)	Pulse (bpm)	Respiratory Rate (bpm)	Blood Pressure (mmHg)	SpOâ„ (%)

Assessment

General Appearance	
Neurological Status (e.g., orientation)	
Cardiovascular	
Respiratory	
Gastrointestinal	
Genitourinary	
Musculoskeletal	
Skin (color, turgor, wounds, etc.)	
Pain (Location/Scale 0-10)	

Nursing Interventions / Observations

Plan/Recommendations

Nurse's Signature

Name:		**Signature:**		**Date/Time:**	