NURSING NOTE EXAMPLE

CATEGORY	DESCRIPTION	EXAMPLE DETAILS
Subjective:	Patient's reported symptoms and experiences	[Patient states they are experiencing shortness of breath and rates pain as 6/10]
	Relevant medical, family, and social history	[Patient has a history of asthma and a family history of hypertension]
	Patient's concerns or questions	[Patient expresses concerns about managing their asthma and asks about treatment options]
Objective:	Vital signs and physical assessment findings	[BP: 135/85 mmHg, HR: 88 bpm, RR: 22 breaths/min, SpO2: 95%, Temp: 98.6°F (37°C)]
	Results of diagnostic tests or lab work	[Chest X-ray: no infiltrates or consolidation; ABG: pH 7.42, PaCO2 37 mmHg, PaO2 88 mmHg]
	Observations of patient behavior or appearance	[Patient appears anxious, uses accessory muscles to breathe, and has audible wheezing]
Assessment:	Analysis of patient's condition and needs	[Patient experiencing an asthma exacerbation with moderate respiratory distress]
	Potential problems or complications	[Potential risks include worsening respiratory distress and hypoxia]
Plan:	Interventions to address patient's needs	[Administer prescribed short-acting bronchodilator via nebulizer; monitor vital signs]
	Patient education or referrals	[Educate patient on proper inhaler technique and self-management of asthma symptoms]
	Evaluation and follow-up	[Reassess patient's respiratory status and vital signs after treatment; notify provider if no improvement or worsening occurs]

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