

NURSING PROGRESS NOTES EXAMPLE

PATIENT'S INFORMATION:

Patient's Name: [Full Name]
Age: [55]
Gender: [Male]
Admission Date: [03/03/2040]
Room Number: [123]

VITAL SIGNS:

Date and Time	Temperature	Blood Pressure	Respiratory Rate	Heart Rate
[03/01/2040] [8:00 AM]	[98.6°F]	[120/70 mmHg]	[18 breaths/min]	[80 beats/min]
[03/01/2045] [4:00 PM]	[99.2°F]	[130/80 mmHg]	[20 breaths/min]	[84 beats/min]
[03/02/2040] [8:00 AM]	[98.8°F]	[140/90 mmHg]	[22 breaths/min]	[88 beats/min]

ASSESSMENT:

Date and Time	Assessment	Findings	Interventions
[03/01/2040] [8:00 AM]	Initial assessment	Patient is alert and oriented to person, place, and time. No complaints of pain. Lungs clear to auscultation. Abdomen soft and nontender.	None
[03/01/2045] [4:00 PM]	Follow-up assessment	Patient reports a pain level of [05] out of [10]. Administered [02] tablets of acetaminophen as ordered. Lungs clear to auscultation. Abdomen soft and nontender.	Administered medication as ordered
[03/02/2040] [8:00 AM]	Morning assessment	Patient reports a pain level of [03] out of [10]. Lungs clear to auscultation. Abdomen soft and nontender.	None

Licensed Nursing Progress Notes

RJ Shavelson



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