**NURSING NOTE**

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| **Category** | **Description** | **Notes** |
| **Subjective** | Patient’s reported symptoms and experiences | **[Patient’s subjective complaints and concerns]** |
|  | Relevant medical, family, and social history | **[Patient’s medical, family, and social history]** |
|  | Patient’s concerns or questions | **[Patient’s questions or concerns]** |
| **Objective** | Vital signs and physical assessment findings | **[Vital signs and physical assessment findings]** |
|  | Results of diagnostic tests or lab work | **[Diagnostic test results and lab work]** |
|  | Observations of patient behavior or appearance | **[Patient’s appearance and behavior]** |
| **Assessment** | Analysis of patient’s condition and needs | **[Assessment of patient’s condition and needs]** |
|  | Potential problems or complications | **[Potential problems or complications]** |
| **Plan** | Interventions to address patient’s needs | **[Interventions to address patient’s needs]** |
|  | Patient education or referrals | **[Patient education or referrals as needed]** |
|  | Evaluation and follow-up | **[Evaluation and follow-up plan]** |