Emergency Room Nursing Assessment Sheet

Patient Name

Date

Time

MRN/ID

Chief Complaint

Allergies

Vital Signs

Temperature	Pulse	Respiratory Rate	Blood Pressure	SpO_2	Pain (0-10)

History

Present Illness/Injury

Medical History

Medications

Assessment

Airway	Breathing	Circulation	Disability (Neuro)	Exposure

Physical Exam Findings

Interventions / Treatment Given

Response to Treatment

Primary RN

Signature

Time Completed