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PRACTICAL RECORD BOOK for General Nursing and Midwifery

As per the INC syllabus

Name of the Candidate: _____

Name of the Institution: _____

_____

SN Nanjunde Gowda



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NURSING CARE PLAN: 1

HISTORY TAKING AND PHYSICAL EXAMINATION

Nursing History

Name of the ward: _____ Student name: _____

Period from: _____ to _____ Name of the hospital: _____

Demographic Data

Name of the patient:	IP No:
Age:	Gender:
Marital status:	Nationality:
Language spoken:	Religion:
Occupation:	Education:
Income:	Address:
Date of admission:	Treatment received on arrival to hospital:
Provisional diagnosis:	Treatment received by patient on arrival:

History of Present Illness

Ask any or all of the following as appropriate and write a summary

Reason for visit: _____

When did the symptoms started: _____

General state of health: _____

Was the onset sudden or gradual: _____

How often the problem occurs: _____

Has the problem occur before: _____

Treatment received on arrival to hospital: _____

Chief Complaint

Eliciting a client's history not only assists with individualizing the plan of care but also help to establish a bond with that client.

Gather specific information regarding:

Onset: _____.

Location: _____.

Duration: _____.

Aggravating factors: _____.

Relieving factors: _____.

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Associated manifestation: _____.

Past surgical history: _____.

Past medical history: _____.

Allergies: _____.

Medication History

Medication prescribed. Use of antihypertensive/diuretics/vasodilator/nitroglycerin/anticoagulant/dioxin/bronchodilators/contraceptive/hormones/steroids/antidepressant/psychotropic/thyroid hormones/over the counter medication/herbs note time and dosage and how often they are taking.

_____.

_____

_____

Allergies: Note and describe any environmental, food or drug allergies

_____

Family History

Type of family: Nuclear/Joint family

Family Composition

Sl. No.	Name	Relationship to the patient	Age	Sex	Education	Occupation	Health status

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Family Tree

Family History of Illness

Is there any family history of: Asthma/cancer/diabetes/epilepsy/hypertension/heart disease/hepatitis/hemophilia/stroke/tuberculosis/mental disorders/thyroid or autoimmune disorders/aged grandparent and siblings alive? If yes, what is their current state of health? If no, state the cause of death and age of death _____

_____

Past Health History

- Previous hospitalization: _____
- Surgery if any: _____
- History of accident or blood transfusion: _____
- Is the client taking any prescription or over-the-counter medications on a regular basis/notice all the medications, how long: _____

_____

Values and Beliefs

- What are the client's attitudes/beliefs about hospitalization?

_____

- Does he/she have any inappropriate perception of illness?

_____

Dietary Habits

Assess excess or deficit caloric intake and client approximate intake of foods, high in sodium, cholesterol, saturated fat, and caffeine.

_____

_____

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PHYSICAL EXAMINATION

Use questioning, observation and examination to gather data. Tick items that apply to the client and comment as needed.

Sensation

Eyes:
- Poor vision/blurred vision/eye infection:
- Blindness R/L/eye pain:
- Itching/prosthesis/glasses/contact lens:

Ears: Ringing in ears/discharge/ear infection/loss of hearing R/L/ear pain/itching/hearing aids.

Tongue: Difficulty of taste**.**

Nose: Frequent colds/nose bleeds/pain/discharge**.**

Touch: Reduced or tactile perception.

Skin and mucus membranes: Excessive dryness/bruising/jaundice/itching/rash/broken skin/wound/pale/flushed/poor turgor/change in pigmentation.

Mouth and throat: Sore throat/coated tongue/dental caries/bad breath (halitosis)/bleeding gums/dentures upper/lower.

Hair: Itchy scalp/hygiene poor/dandruff/hair change/loss/excess.

Nails: Colors changes/biting/splitting/clubbing

Respiration

- Rate: _____
- Cough/dyspnea/wheezing/coughs blood (hemoptysis)/cyanosis/pain on breathing/restlessness—smoke (how many per day): _____

Circulation

- Pulse rate: _____/min
- Blood pressure: _____mm Hg
- Fatigue/Chest pain/nausea—vomiting/anemia/varicose veins/peripheral pulses/leg swelling/ulcers.

Nutrition

- Weight: _____
- Height: _____
- Skin fold thickness: _____
- Appetite change/weight change/nausea/vomiting/dysphasia/heart burn/dentures/normal eating pattern (likes and dislikes): _____

Abdomen

- **Inspection:** Rashes/lesions/scar/striae
- **Distended peristalsis:** Present/absent
- **Palpation:** Pain/tenderness/mass

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Elimination

Urinary/frequency/urgency/dribbling/urinary incontinence/painful urination retention/dysuria/urinary appliance/nocturia/hematuria/anuria/distended bladder

Activity/Exercise

Muscle Pain/muscle weakness/cramps/joint pain/swelling/stiffness of movements/deformities/abnormal gait/fatigue/impaired coordination

Self-care (describe limitation to eating, bathing, dressing, toileting, ambulating) _____

_____

Comfort

Describes the following:

Pain? If yes, how it is relieved?: _____

Sleep pattern and methods/treatment used for sleep: _____

Neurological Responses

Disorientation/unconscious/headache/tremors/paralysis numbness/weakness/seizures (fits)/dizziness/loss of memory/difficult expressing self verbally.

Immune Response

- Temperature: _____
- Allergies: _____
- Fever in last 45 hours: _____
- Swollen glands: _____
- COMMENTS: _____

Sexuality

Female:

- Age of menarche: _____
- LMP: _____
- Duration: _____
- Flow: _____
- Cycle: _____ days)/dysmenorrheal/bleeding between periods/vaginal bleeding.

Male:

Discharge/swelling/masses; comments: _____

Investigation Done

Date	Name of the investigation	Normal values	Patients values/result	Significance

Medical diagnosis (Final): _____

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Drug Management

Name of the drug	Dosage and frequency	Side effect	Nursing intervention

Diet Plan

Type of diet required (snacks, lunch, dinner):

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Nursing Care Plan

ASSESSMENT Subjective Objective	Nursing diagnosis	GOALS Short-term Long-term	Implementation	Evaluation

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Summary/Conclusion

Health Education

Reference

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Date of submission:

Signature of subject In-charge

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Salient Features

- The content has been prepared in accordance with the INC syllabus.
- Presentation of the content is comprehensive to adopt to the needs of the Indian faculty and students.
- Content is based on prescribed clinical learning requirements.
- It includes appendices on various important topics.
- Content is reviewed by experts.
- It is a comprehensive practical record book written in lucid language for easy understanding.
- Content is organized in a logical and reader-friendly order.
- This book is prepared based on nursing process approach.
- This book is a guide for GNM nursing students.

Nanjunde Gowda MSc (N) PhD is Professor and *Former* Principal, Anil Baghi College of Nursing, Ferozepur, Punjab, India and did his GNM and Post BSc Nursing from Victoria Hospital School of Nursing, Bengaluru, and Government College of Nursing, Bengaluru, Karnataka. He started his career in nursing as a Staff Nurse and worked in General Hospital, Tumakuru; KNTB Hospital, Kolar; Sanjay Gandhi Accident Complex, and Victoria Hospital, Bengaluru, Karnataka, India. He continued his education by obtaining master's degree from M.S Ramaiah Institute of Nursing Education and Research, Bengaluru, Karnataka. He has varied experience of over 35 years in nursing including successful innings as a Registered Nurse in Royal Commission Hospital, Yanbu, Saudi Arabia, and Staff Development Officer in Ministry of Health (MOH), Sultanate of Oman. He was a Regional Master Trainer in Eye Health Care and I.V. Therapy program in Nizwa Hospital, Dhakaliya Region, Sultanate of Oman.

He has published books on *Foundation of Nursing, Fundamentals of Nursing, IV Therapy Manual for Nurses, Clinical Practice Diary and Cumulative Record for PC BSc Nursing, A to Z Performance Evaluation in Nursing*. He has presented scientific papers in international, national, and regional conferences and has also conducted and attended many conferences and workshops. He has held various positions in Nursing associations like GNAK and Trained Nurses Association of India (TNAI).

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