### Respiratory Assessment – Submit with care plan

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Patient Initials:</th>
<th>Room#:</th>
<th>Clinical Date:</th>
</tr>
</thead>
</table>

#### Assess for Risk Factors: (circle if present)
Positive family history, age, gender, smoking exposure to sidestream cigarette smoking, asthma, tuberculosis, frequent colds, exposure to environmental pollutants, immobility, allergies, communal residence, known or suspected HIV infection.

#### Symptoms: (circle if present)
Persistent cough, shortness of breath at rest or with activity, wheezing, orthopnea, weight loss, fatigue, night sweats, fever, chest pain, activity intolerance.

#### Respirations:
- Rate
- Rhythm
- Depth

#### Chest:
- Symmetry: normal, abnormal
- Excursion: normal, abnormal

Describe if abnormal

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#### Uses accessory muscles:
- no  yes

#### Tactile fremitus:
- present  absent

If absent, describe location

#### Breath sounds:
- normal (clear)  abnormal

If abnormal, locate and describe

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#### Cough:
- absent  present

If present:
- productive  non-productive

If productive, describe amount, color, and consistency of sputum

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#### Skin:
- color: pale, pink, cyanotic
- temperature: cool, cold, warm, hot
- moisture: normal, dry, wet

#### Nailbeds:
- <180 degrees  >180 degrees

#### Emotional, cognitive state:
- calm, restless, irritable, confused, disoriented, drowsy

#### Lab data:
- Hgb
- Hct
- WBC
- SpO₂ (oximetry)
- SaO₂
- PCO₂
- Chest X-ray
- Sputum culture

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#### Nursing Diagnosis (if appropriate):

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