Student Name: Keaton Carothers **Date:** 8/25/20

Patient Physical Assessment Narrative

PHYSICAL ASSESSMENT NARRATIVE BY SYSTEMS: (Complete using assessment check list and reminders below).

GENERAL INFORMATION (Time of assessment, admit diagnosis, general appearance)
Pt was admitted August 14th. Patient came in with complaints of low blood pressure and syncope. Admit diagnosis is altered mental status. Patient is alert and oriented at bedside.

Neurological–sensory (LOC, sensation, strength, coordination, speech, pupil assessment)
Patient was alert and oriented. Pupils were equal, round and reactive to light. Pt demonstrated strong hand grips. There was a little bit of a weakness with the Right extremities. Speech was coherent.

Comfort level: Pain rates at 7 **(0-10 scale) Location:** Back of head + (R) extremities

Psychological/Social (affect, interaction with family, friends, staff)
There was no family at the bedside. The patient was responsive and actively participating in conversation with healthcare team.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) Sclera were white. Patient c/o sore throat. There was visible nasal drainage. Symmetrical eyes and ears.

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)
Pt states that there is no SOB. Pt was on room air. Breath sounds are clear to auscultation. Pt had a productive cough with slimy white and yellow secretions

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)
No visible or pitting edema. Patient has Left subclavian pacemaker. It is a 2 lead. No audible heart murmurs, gallops or rubs. Radial pulses wee (2+) Strong to touch. Pedal pulses wee strong. Posterior tibial was weak. (1+)

Student Name: Keaton Carothers **Date:** 8/25/20

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Patient's appetite has been fair. Patient has active Bowel Sounds X 4 quadrants. No tenderness to palpatation. Stool has been a dark brown color with runny consistency. **Last BM** August 25th, 2020

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Urine is clear. Patient has bathroom privileges and is up to void. Stool has been a dark brown with runny diarrhea consistency.

Urine output (last 24 hrs) _____ **LMP** (if applicable) N/A

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) Spine and posterior alignment are straight. Pt. is capable of moving all extremities. Gait is steady. No visible deformities.

Skin (skin color, temp, texture, turgor, integrity) Patient skin was intact. Visible bruising noticeable on Left forearm. Skin was smooth and warm to touch. Turgor of skin test was positive. Immediate skin return on turgor test.

Wounds/Dressings PICC line on left forearm. Dressing surrounding PICC intact, with no visible redness or drainage. Right subclavian line with dressing intact. No redness or drainage noted. VP Shunt at Right parietal has healed.

Other N/A

Adopted: August 2016