

Student Name: Holly Clarke

Date: 11/3/20

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)

Admit diagnosis is alzheimers. Pt has no family at bedside & is confused.

Neurological-sensory (LOC, sensation, strength, coordination, speech, pupil assessment)

Pt is alert, confused, anxious, crying, restless, hostile, angry, & doesn't follow simple commands. expressions are round & soft. Grips & pushers are weak.

Comfort level: Pain rates at 5 (0-10 scale) Location: all over

Psychological/Social (affect, interaction with family, friends, staff)

Pt. interacts w/ staff but is confused.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) pupils are PERRLA, Pt. has hearing aides & is hard of hearing. No nasal drainage or sclera edema. On regular diet. Mouth is coated & dry. Pt. can swallow.

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)

Chest is even. breath sounds are labored & diminished. Pt. has tachypnea. depth is normal.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)

Generalized edema. No abnormal heart sounds. radial rate is strong & able to occlude. pedal pulse is weak but palpable. Capillary refill in fingers is brisk but < 3 sec, in toes its slow but < 3 sec.