

Student Name: Madison Gage

Date: 11/4/2020

## 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)

Time of assessment is 0830, patient was admitted for acute pancreatitis. Patient appears to be in pain due to rating pain at an 8, and some abdominal guarding when palpating the abdomen.

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

Patient is alert, and oriented to person, place, time and situation. Patient accurately reports touch and pressure on all four extremities and face. Patient grips and pushes strong and equal bilaterally. Ambulation is unsteady, but patient is able to move all extremities. Speech was clear, and pupils equal, round, and reactive.

**Comfort level:** Pain rates at 8 (0-10 scale) Location: abdomen

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

Patient seemed to be very friendly, communicated with staff in a friendly and respectful manner. Patient interacted with wife and was engaged in the conversation.

**EENT** (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing)

Eyes, ears, neck, throat, mouth are symmetrical. No drainage noted with the eyes, ears, nose, throat, or mouth. Sclera was white and without edema bilaterally. No node definition, and swallowing free of dysphagia.

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

Chest configuration was symmetrical and free of scars, wounds, or dressings, and drains. Lung sounds diminished in lower lobes. Respiratory rate 16 bpm, and rhythm was unlabored ~~or tachypneic~~. No alterations in depth.

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

S<sub>1</sub> and S<sub>2</sub> were normal and free from murmurs or extra sounds. Apical and radial rate 93 without deficit. Rhythm was free of bradycardia and tachycardia. Radial and pedal pulses 2+ bilaterally.

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### IM1 Patient Physical Assessment Narrative

**Gastrointestinal** (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Patient's status of NPO changed to clear liquid. No stool observed at time of assessment. Abdomen was symmetric and free of scars, wounds, dressings, and drains. Bowel sounds active x4, Patient reported tenderness with palpation. Last BM unknown

**Genitourinary-Reproductive** (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Patient urinates about once an hour. Patient does not report frequency issues, or urgency issues. Patient is continent, urine is yellow, clear, no odor. Vaginal bleeding and discharge not applicable to patient.

Urine output (last 24 hrs)                      **LMP** (if applicable)                     

**Musculoskeletal** (alignment, posture, mobility, gait, movement in extremities, deformities) Ambulation was not observed. Patient sat up in bed with criss-crossed legs. Patient moved all extremities. The patient did not have any deformities.

**Skin** (skin color, temp, texture, turgor, integrity)

The patient's skin color was appropriate for ethnicity. Skin was warm, smooth, and skin turgor < 3s. Skin was intact.

**Wounds/Dressings**

Dressings on peripheral left and right INTs, the dressings were clean, dry, and skin free of redness.

**Other**