

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)

Assessment performed at 1500. Chief complaint of left shoulder pain, diagnosed with left proximal humerus fracture. Exhibited appropriate posture and facial expressions during interaction. No signs of apparent distress.

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

Alert and oriented to person and place. Pupils 4mm equal, round and reactive to light. Moves all extremities except left arm on command. Hand grasp of right hand is strong, toe wiggle strong and equal bilaterally. Left arm paralysis due to surgical block. Speaks English clearly. Patient states they are in pain but cannot rank their pain on scale because they cannot feel their left arm.

Comfort level: Rates pain at 0 (0-10 scale) **Location:** N/A

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

Interacts appropriately with staff, no family at bedside. Friendly responses to questions. Responsive facial expressions.

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

Sclera clear and white without drainage. Ears symmetrical. Auditory canals without drainage. Hears spoken voice without difficulty. Nasal septum midline, mucosa pink. Oral mucosa membranes pink, moist and intact. Neck supple with no palpable lymph nodes.

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

Chest symmetrical, trachea midline. Breath sounds clear to auscultation in upper lobes, diminished breath sounds in lower lobes. Respirations 22, even and unlabored. Oxygen saturation of 98% on 2L of oxygen nasal canula.

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

Heart sounds audible with regular rate and rhythm. Radial pulses 2+ bilaterally with rate of 84, pedal pulses 2+ bilaterally. Blood pressure of 100/70. No edema noted. Capillary refill <3 seconds. Nailbeds pink. Denies chest pain or discomfort. Apical pulse not assessed.

Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation)

Abdomen soft and nontender upon palpation. Active bowel sounds in all 4 quadrants. Does not remember last bowel movement, states that usual bowel movements occur in the afternoon or after a meal.

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge)

Patient voids on his own with bedside urinal. States that urine is usually yellow or dark yellow. Denies having pain or trouble urinating, denies odor or discharge. Urine output in last 24 hours not assessed.

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

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities)

Exhibited proper posture. Moves all extremities on command, except for left arm due to surgical block. All movements are coordinated and purposeful. No deformities in upper or lower extremities. Makes slight changes in body or extremity position. Gait not assessed at this time.

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

Skin warm, dry and intact. Color appropriate to race. Turgor elastic.

Wounds/Dressings

Skin clean and dry. Dressing present on left shoulder. Dressing is closed to air. Peripheral venous access site present in right hand, without redness or swelling, clean dressing.

Other

[Click or tap here to enter text.](#)