

Student Name: Lindsay Lambert

Date: 12/16

### 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 took place at 1235 on SS. Patient is post-op day 1, had Right upper quadrant ileostomy placed. Patient appears healthy and recovering in good spirits.

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

patient is alert & oriented ~~to~~ x3. patient feels dull and sharp pain. Strong HRTW. patient is weak upon exertion but is able to stabilize himself, walker needed at home. pupils PERRLA.

Comfort level: Pain rates at 6 (0-10 scale) Location: abdomen & back

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

patient is in good spirits, interacts with staff, friendly w/ all ~~patients~~ encounters. He jokes around, wife stated that he must be feeling better due to his sense of humor.

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

patient has no drainage of eyes, ears, or nose. Trachea midline. patient is able to swallow. patient has no distention, nodes are not swollen.

options:  
normal  
\*  
excavation  
\*  
exaggerated

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

Respiratory Rate 16, chest configuration is bilaterally symmetrical, breath sounds present but diminished in both lobes. Patient SOB upon exertion. on 2L NC O2 sat 93.

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

patient has ~~regular~~ irregular heart sounds, PPM set at 71 bpm. apical rate & radial rate 70. S1 & S2 audible radial pulse 2+ bilaterally. Pedal pulse 1+ bilaterally. capillary refill < 3 seconds.

Student Name: Vindsey Lambert

Date: 12/10

IM1 Patient Physical Assessment Narrative

**Gastrointestinal** (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) patient has hyperactive bowel sounds. Abdomen is firm and distended but not tender to and slightly tender. Patient rated tenderness a 4/10 (0-10 scale). Patient has irregular bowel habits. Last BM 12/13

**Genitourinary-Reproductive** (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) patient has left foley placed 12/07. urine is yellow without sediment or discharge. Per care completed, NO irritation or odor at site.

**Urine output** (last 24 hrs) 200ml LMP (if applicable) \_\_\_\_\_

**Musculoskeletal** (alignment, posture, mobility, gait, movement in extremities, deformities) patient can move all 4 extremities. Slightly stiff and weak after exertion. ~~Strength was improved from week~~ patient is mobile, assist x2 due to size, unsteady gait. Despite incision on abdomen, there are no other deformities.

**Skin** (skin color, temp, texture, turgor, integrity) patient skin color appropriate with race. extremities warm and dry. Skin turgor tight. patient skin warm to touch. laceration on upper left extremity, dressing dry and intact.

**Wounds/Dressings** patient has a clean 4x4 gauze dressing on left elbow, wound almost healed. 12 inch incision vertically on abdomen, changed packing & dressing with bedside nurse. No signs of irritation or infection.

**Other**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1 emptied foley @ 1400, did not work total output for 24hrs.