Student Name: Brynne Barker **Date: 12/15/2020**

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)

1300, Chronic Obstructive Pulmonary Disease (COPD), general appearance was

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

Alert, oriented X 3. Pupils 5 mm equal, round reactive to light (PERRL). Moves all extremities on command, responded appropriately to sharp and dull sensations. Hand grasp toe wiggle (HGTW) equal and strong bilaterally. Movements purposeful and coordinated. Speech was difficult to understand due to patient being extremely anxious and consistent shaking.

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

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

Patient had family at the bedside. Patient was alert and followed simple commands. Responded to questions slowly but friendly. Patient was anxious and had responsive facial expressions. Acted appropriately towards staff.

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 with difficulty. Nasal septum midline, mucosa pink, oral mucous membranes pink, moist, and intact. Neck supple with palpable lymph nodes. Gag reflux was present when patient tried to drink a sip of water.

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

Barrell chest present. Respirations 30. Breath sounds were rub in the upper lobes and diminished in the lower lobes. Patient was experiencing shortness of breath (SOB) and tachypnea. Nasal cannula 3 L per minute.

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

No abnormal heart sounds present. No murmur. Radial pulses 2+ bilaterally with rate of 94. Pedal pulses 1+ bilaterally. No edema noted. B/P 141/53. Capillary refill <3 seconds.

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

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Abdomen soft. Patient stated she had a bowel movement 2 days ago on 12/12/20. Bowel sounds hypo X 4 quadrants. No tenderness noted.

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

Patient used a bedpan. Stated urine was clear and yellow. No vaginal bleeding or discharge noted.

Urine Output (last 24 hrs) Not observed. **LMP** (if applicable) N/A

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

Patient had a barrel chest. Patient was able to move all extremities however was very weak and extremely shaky. Gait not observed.

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

Patient was a grey color and had bruises on extremities. Patient had a Braden scale score of 20. Skin turgor within normal limits.

Wounds/Dressings

No wounds or dressings present.

Other

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