

Student Name: Caroline Dikes

Date:

12/17/20

PHYSICAL ASSESSMENT NARRATIVE BY SYSTEMS:

Complete using assessment check list and reminders below.

GENERAL INFORMATION (Time of assessment, admit diagnosis, general appearance)

12/15/2020. 0946. Pleasant 80 year old man admitted with respiratory failure, COPD, and NSTEMI. Pt. has a history of COPD, HTN, bladder cancer, hypothyroidism, detached retina, sleep apnea, cardiac catheterization and stent. Pt. appears alert and orientated.

Neurological/Sensory (LOC, sensation, strength, coordination, speech, pupil assessment)

Alert and orientated x3. Moves all extremities on command. HGTW strong and equal bilaterally. Pushes bilateral lower extremities against resistance with strength and coordination. Speaks in clear english and has an understanding of medical diagnosis and interventions.

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

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

Wife is present at bedside. Calm affect, appropriate and friendly interaction with staff and wife. Responds to questions readily. Responsive facial expressions.

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

Sclera clear and white with no drainage noted. Pt. denies sore throat. No nasal drainage noted. Hears spoken words with no difficulty. Swallowed PO medications without difficulty.

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

Pt. receiving 3L Nasal Cannula. Pt. does not use oxygen at home. Pt. Sleeps with CPAP. Respirations 20 per minute, even and unlabored. O2 saturation 96%. Chest symmetrical. Breath sounds clear to auscultation bilaterally. Pt. Denies shortness of breath and cough.

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

S1&S2 audible. Pt. rhythm in sinus. Pt. on telemetry. Pulse rate 60 bpm. Bilateral pedal and radial pulses 2+ with equal rate and rhythm. Apical rate not obtained. No edema noted. BP readings consistently low over 24 hours. Orthostatic blood pressure results are as follows. While

seated BP: 80/44. While standing BP: 87/52. While supine BP: 89/53. Denies chest pain or discomfort.

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

Abdomen soft. No tenderness on palpation. Bowel sounds active X4. Pt. Appetite good. No tenderness on palpation. Last bowel movement 12/14/20. Stool not observed.

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

Pt. denies pain or symptoms of dysuria. Pt. ambulates to the bathroom. Urine not observed.

__NA__ Urine output (last 24 hours) not obtained LMP (if applicable) __NA__

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

Pt gait unsteady. Ambulates x1 assist for balance due to low BP. No deformities noted. Pt. moves extremities on command with strength and coordination. Able to ambulate to the bathroom and makes frequent changes in position from the chair to the bed.

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

Skin warm, dry, and intact. Color normal for pt. Turgor elastic. Braden scale 19. Bruises noted bilateral lower abdominal quadrants, bruises noted on L. brachium and wrist.

Wounds/Dressings

Peripheral venous access site: L. arm. Started 12/14/2020. No redness or swelling at site, dressing intact.

L. groin incision from angiogram. Dressing removed 12/14/20. No redness or swelling noted. Incision open to air

Other