Student Name: Hailee Damron **Date:** 12/15/20

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 was done at 1430 on 12/15/20. Pt was admitted with c/o L sided chest pain and a heartburn sensation. He was alert and oriented but seemed drowsy. He was able to follow simple commands however he was slow to respond. He is mostly spanish speaking and understands a little bit of english.

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

He was alert and oriented but drowsy. He has sensation and 2+ strength bilaterally in his arms and RL. His speech was normal but quiet with responses. Coordination was normal. Pupils were 3mm dilated and reactive to light equal and round with cataracts in both eyes

Comfort level: Pain rates at 6/10 **(0-10 scale) Location:** chest

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

He had his daughter present at his bedside. He was able to interact with her well and the daughter was able to help him follow commands He was cooperative with staff and had no issues interacting with others

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) Sclera is white with no drainage. Pupils dilate with light and cataracts are in both eyes. Ears are symmetrical with no drainage. Nose has moist mucous membranes with no drainage and straight septum. Throat is pink and moist with no redness or c/o sore throat All teeth are present and no signs of decay. Nodes are normal and no c/o tenderness. Trachea is midline and straight. He has bilateral hearing aids

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

Chest appeared normal with no abnormalities. Breath sounds are normal and deep. He is on O2 with 3L NC and has no no distress, c/o SOB during ADL's. Lung sounds are clear during inspiration and expiration. Respirations are 18/min. Capillary refill is < 3 sec

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

Heart sounds are even and normal, radial pulse is 105, no abnormal heart sounds or murmurs, radial pulse was strong and 2+ bilaterally

Student Name: _____ **Date:** _____

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) c/o constipation and no BM was noted on shift. Abdomen is soft and bowel sounds are active no abnormal palpitations and appearance of the abd was normal

Last BM N/A

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge**)** Urine output is yellow in color with no abnormal odor. He was able to void in his brief

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

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

Ambulation was no observed. He has an amputated LL below the knee. He was able to move his arms bilaterally and his RL.

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

Skin color was normal for race and warm to the touch. Texture is a little dry with redness on his RL. Turgor is elastic.

Wounds/Dressings

No incisions, wounds, or dressings

Other

Pt has a peripheral IV in his left arm with no redness or swelling and a dressing. Pt c/o being cold and shaking but is sweating. He has a hx of CAD, HF, HTN, DM2. Allergies are ertapenem. He has possible septicemia but the location is unknown

Adopted: August 2016