

Student Name: Jennifer Griffith

Date: _____

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)

Pt was assessed on Dec. 16, 2020 at 1430. Pt was drowsy but easy to alert. Pt is admitted to floor for osteomyelitis in LT lower extremity (foot).

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

Pt was oriented x2. Pt had strong muscle grips + pushes. Pt answered to questions slowly but appropriate for age, calmly, friendly + with responsive facials. Pupils are equal in size + shape.

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

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

No family at pt bedside. Pt was appropriate with student nurse.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) Pt eyes are symmetrical + free of drainage - no scleral edema present + sclera is white. No drainage in ears or throat with normal symmetry.

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

Pt oxygen saturation is within normal range + shows no signs of distress or shortness of breath. Pt is on RA - no cough present. Clear lung sounds in lower + upper lobes upon inspiration + expiration.

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

Normal heart sounds present. Pt shows no edema or skin turgor. Capillary refill is less than three seconds. Radial pulses are strong + able to occlude bilaterally. One pedal pulse found weak but palpable - ~~other~~ foot wrapped from amputation.

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IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Pt abdomen appears flat, no distention present.
~~Abdomen~~ Active bowel sounds present x 4 quadrants -
hyperactive epigastric region. Abdomen firm r/t
pt constipation. Last BM _____

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Pt voids into urinal/bedpan. No output
upon assessment.

Urine output (last 24 hrs) _____ LMP (if applicable) _____

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities)
Pt has normal alignment + posture for age. Pt was
able to move both upper + lower extremities. Lower
extremities move weakly w/ some pain r/t amputation. Pt
is on bedrest.

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

Skin is intact + pt has warm + pink skin. Pt skin
texture is normal, dry, + clean.

Wounds/Dressings

Pt has two wounds upon assessment. First location
is in LT foot/toes - dressing + ace bandage are clean
+ intact. Second location in RT antecubital space from
IV/blood draw. - covered with cotton ball + medical bandage.

Other

Pt has an peripheral IV site in LT arm without
redness/swelling with a clean dressing that was started
two days prior on December 14.