Student Name: Serina Duran **Date: 12/16/2020**

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)

1045, rectal bleed, blood in stools x10 days. Patient alert, oriented, and responds readily to inquiry. Interacts appropriately with staff, cheerful affect. Patient follows simple commands.

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

Alert, oriented X3. Pupils 3 mm equal, round, reactive to light. Moves all extremities on command. Hand grasp toe wiggle equal and strong bilaterally. Movements purposeful and coordinated. Speaks English clearly. Patient denies any present pain or discomfort, pain level 0 on 1-10 pain scale.

Comfort level: Rates pain at 0 (0-10 scale) Location: none

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

Cheerful affect, interacts appropriately with staff and son. Interactions with friends not assessed at this time.

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 without difficulty. Nasal septum midline, mucosa pink, oral mucous membranes pink, moist, and intact. Neck supple, with no palpable lymph nodes.

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

Chest symmetrical, trachea midline. Respirations 22, even and unlabored. Breath sounds clear to auscultation bilaterally and in all lobes both during inspiration and expiration. Breathing room air. O2 sat 97%. Cough present and productive with yellow-clear thick secretions. Patient reports secretions to be minimal in amount. Patient also complains of shortness of breath.

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

S1 and S2 audible with regular rate and rhythm. Apical rate 62, radial pulses 2+ bilaterally with rate of 60. Pedal pulses 1+ bilaterally, edema noted with absence of pitting. B/P 117/69. Denies internal chest pain or discomfort. Nailbeds pink, capillary refill <3 seconds.

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

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Abdomen flat, soft, and nontender. Active bowel sounds X4 quadrants. Patient displays incontinence, stool bright red/ amber in color and displays loose watery consistency. Patient states appetite is fair.

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

Voids clear, yellow urine, adequate amount. Denies odor, discharge or pain. Post-menopausal.

Urine Output (last 24 hrs) __N/A_____**LMP** (if applicable) _____

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

Walks ad lib without assistance, gait slow yet steady. Braden scale score assessed to be 21. Spinal alignment without noticeable deformity. Posture alert and relaxed. Mobility displays full ROM. Patient stated she felt her knees and calves bilaterally swollen compared to her perception of their normal baseline. Ted hose applied to both lower extremities.

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

Skin cool in extremities, warm in knees, dry and intact. Color appropriate to race. Turgor elastic. Temperature 98.0 degrees Fahrenheit. Dark purple-yellow bruise noted on anterior right wrist.

Wounds/Dressings

N/A

Other

PICC inserted in right extremity noted with no visible redness or swelling.