

## 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 done at 1000. Pt admitted for infection, location unknown. Pt upright in chair, watching tv.

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

Pt alert and oriented. Responds to touch in all extremities and can move all extremities. Speech is clear. Pupils equal and reactive. Right hand grab, pushes, and pulls are strong and left hand grab, pushes, and pulls are weak. Left leg toe wiggles, pushes and pulls strong. Right lower leg amputated.

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

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

Pt is slow to respond. Interacts pleasantly with staff. No family at bedside. Refused to take meds.

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

Sclera white and yellow without drainage. Ears symmetrical without drainage. Hears without difficulty. Nasal and oral mucosa are pink, moist, and intact. Pt swallows with no difficulty.

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

Chest symmetrical. Trachea midline. Respirations 14 even, unlabored. Breath sounds of the left upper and right upper lobe clear. Breath sounds in the left lower lobe are diminished. Breath sounds in the right lower lobe are crackled on inspiration and diminished on expiration.

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

S1 and S2 audible. Apical rate 89. Radial pulses +1 bilaterally and equal. Left pedal pulses +1. Right lower extremities amputated.

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

Abdomen soft and non-tender. Active bowel sounds x4. Last BM yesterday, 3 on Bristol stool chart. Reports no tenderness to palpation of abdomen.

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

Pt does not make urine.

**Urine Output** (last 24 hrs) \_\_\_\_\_ **LMP** (if applicable) \_\_\_\_\_

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

Pt is on bedrest, can move all extremities on command. Right lower leg amputated around the middle calf area.

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

Skin dry, warm, and intact. Color of skin pale, bruising noted on left upper arm, and abrasions noted on both lower extremities. Turgor within normal limits.

**Wounds/Dressings**

Pt has stage II pressure ulcer on the buttocks, pressure dressing applied yesterday evening.

**Other**

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