

Student Name: Samantha Reeves

Date: 2/24/21

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)

Patient was admitted for Sepsis with a second admit for pneumonia, time of assessment was at 1030. Patient is a female of 68 years of age, general appearance was clean and well taken care of. Patient allergic to Penicillian, and Amoxicillin.

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

Alert, oriented x3 peoples 3 mm equal, round reactive to light (PERRL). Moves all extremities on command, responds appropriately to sharp and dull sensations. Hand grasp till wiggle (HGTW) equal and strong bilaterally. Movements purpose and coordinated. Speaks English (native language) clearly. Pain level 0 on 0-10 pain scale

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

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

Normal affect, interacts appropriately with staff. Facial expressions responsive and appropriate for age. No family at the bed side.

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 mucosa membranes pink, moist and intact. Neck supple with palpable lymph nodes. Can swallow medication without difficulty.

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

Chest symmetrical, trachea midline. Respirations 20, even and labored. Breath sounds heard with crackles and wheezing to auscultation bilaterally, depth and pattern abnormal. Breathing room air with breathing treatments done twice, RO Neb/MDI non vent BiPAP Assessment 2L/min, O2 sat on room air 98%, lung sounds clear, even and unlabored after breathing treatments.

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 82 radial pulses 2 +bilaterally with rate of 81. Pedal pulses 1 + bilaterally, no edema noted. B/P 141/62. Denies chest pain or discomfort, nail beds 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 X 4 quadrants. Stated had a bowel movement on Sunday (2/21/21) with dark brown hard stool (not observed).

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) N/A

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

Walks to restroom with some assistance, has a walker at home. Gait sturdy, can move all extremities on command, no deformities. Stated no pain, stiffness, swelling, or tenderness in her extremities.

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

Skin color normal for patient, dry and intact. Temperature 97.1 with skin turgor elastic and good integrity.

Wounds/Dressings

Has a left forearm peripheral IV with dressing

Other

Patient has an angiogram scheduled for 2/24/21 at 1pm, cardiology noted that the echo had a mild concentrated left ventricular hypertrophy. Mild to moderately reduced left ventricular relaxation pattern.