

Student Name: Ashlee GUZMAN

Date: 3/7<sup>th</sup>/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)

Assessment done MARCH 3<sup>rd</sup>, 2021 at 10:00 am.  
Patient's admitted diagnosis is Acute Renal failure  
and hematuria. Patient is awake and alert at  
all times. Family members are by the bedside.

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

Patient is alert, oriented to person, place, & date. She  
moved all extremities on command. She spoke english and  
was responsive to all my questions. Pupils round, 3 mm  
equal, reactive to light. HGTW equal and strong  
bilaterally. Pain level at a 8 from a scale of 1-10.

**Comfort level:** Pain rates at 8 (0-10 scale) Location: headache

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

Patient is interactive with family & staff. She is  
calm/relaxed, friendly, and responsive throughout  
the room visits.

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

No drainage was seen at all. Sclera clear &  
white. Oral mucous membrane is pink & moist. Numerous  
teeth missing on bottom gums. Tracheostomy on right side  
of neck with dressing on but was bothering her. Ears symmetrical.

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

Respirations 16, Breath sounds are clear to auscultation,  
bilaterally, Breathing room air, Chest symmetrical, no  
cough, no distress, normal lung sounds clear to  
auscultation

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

Radial pulse 2+ bilaterally, Pedal pulse 2+, B/p 138/68,  
Denied chest pain, Capillary refill < 2-3 seconds, nailbeds  
pink, S1 and S2 audible had a regular rate & rhythm,  
Apical rate 65, no edema, no heart murmur

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### IM1 Patient Physical Assessment Narrative

**Gastrointestinal** (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Abdomen firm, Active bowel sounds X4 Quadrants, Appetite was fair, no tenderness, BM brown, soft stool, (not observed) bowel incontinence

Last BM feb 28<sup>th</sup>, 2021

**Genitourinary-Reproductive** (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) foley catheter attached feb 23<sup>rd</sup>, 2021 urine is clear, urine output 350 mL and was emptied before discharge, no sediments or hematuria

350 Urine output (last 24 hrs) \_\_\_\_\_ LMP (if applicable) \_\_\_\_\_

**Musculoskeletal** (alignment, posture, mobility, gait, movement in extremities, deformities) moves all extremities, patient weak can not ambulate, not steady, lying in supine position, discharged in her wheel chair, fall risk

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

Skin warm, dry, intact, skin turgor WNL, color appropriate to race, blister on a right foot on her toe, turgor elastic

**Wounds/Dressings**

trialsysis dressing on right side of neck, drainage color surrounding was blood, patient complained of itchy ness on that site, Dressing's last change was March 2<sup>nd</sup>, 2021

**Other**