Student Name: Analicia Robles **Date:** 11/02/2021

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): 0900 patient admitted due to status epilepticus. Patient is sitting up on the side of the bed. Patient appears to be clean with good hygiene.

Neurological–sensory (LOC, sensation, strength, coordination, speech, pupil assessment): Patient is alert and oriented x4, patient has strong push and pulls bilaterally. Patient speaks english. Patient was able to tell soft and sharp sensation bilaterally. Patient's pupils are 3mm equal round and reactive to light. Patient could move all extremities voluntarily.

Comfort level: Pain rates at: 0 **(0-10 scale) Location: N/A**

Psychological/Social (affect, interaction with family, friends, staff)
Patient is friendly and interacts with staff in an appropriately manner. Patient states he is feeling a lot better and would like to go home soon.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing): EENT symmetrical and free of drainage. Dentation appears terminal, multiple teeth missing, lacking oral hygiene. Oral mucosa pink and moist. No redness or pus pockets present in throat. Nodes are not palpable upon palpation. Patient is able to swallow without difficulty. Patient reports of a sore throat.

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)
Chest appears symmetrical w/ equal expansion during inhalation and expiration. Breath sounds are clear upon auscultation both anteriorly and posteriorly. Rhythm is even, depth is deep and pattern is unlabored.. RR is 16 and patient is on room air with a 02 sat of 97%.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern): S1 and S2 can be heard in all 4 locations during auscultation. No murmurs or extra sounds can be heard during auscultation. Apical pulse 88. Both radial and pedal pulses are 2+ bilaterally. Radial pulse is 86.. Capillary refill is <3 seconds in upper and lower extremities. Rhythm and pattern is even, BP is 162/84 blood pressure medication was administered.

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation): Patient states the last bowel movement was 11/1/2021 due to to patient having diarrhea patient was given Imodium 11/1/2021. Abdomen appears symmetrical, soft, flat with no distinction. Bowel sounds are hyperactive x4 quadrants with no tenderness. Patient states appetite has been good.

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge)
Urine output: X3 (last 24 hrs): N/A **LMP (if applicable**
Patient has BRP. Patients urine is clear and yellow. Patient reports no urgency, odor, bleeding, discharge or incontinence at this time.

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities):
Alignment is symmetrical. Posture is upright. Patient gait is steady. Patient is able to move extremities x4. Patient has no deformities.

Skin (skin color, temp, texture, turgor, integrity): Skin is not intact patient has bruises on forearms, integrity compromised, color is appropriate for ethnicity. Skin is warm, texture is smooth with no cracks. Skin turgor is elastic with no tenting..

Wounds/Dressings: None

Other: Patients temperature was 98.7