Student Name: Grace Perreira **Date:** 12-15-2021

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)
Patient admitted for SOB and chest pain with a history of COPD and CHF. Patient stated that her symptoms started after the recent dust storm. Appears clean, friendly and cooperative with staff. She displayed slight confusion at times, but overall alert and oriented to person.

Neurological–sensory (LOC, sensation, strength, coordination, speech, pupil assessment**)**
Slightly drowsy, but alert and oriented overall. Sensation on extremities was WNL. Strength on hand grasp/toe wiggle was weak bilaterally as well as with flexion/extension.

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

Psychological/Social (affect, interaction with family, friends, staff)
She seemed to improve drastically in mood from day one to day two. Family was never seen at the bedside. Patient was always kind to staff.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) Oral mucosa appeared pink and moist. No cough, no increased mucous production. Patient tolerated PO medications very well and her appetite increased from day one to day two. No signs of drainage noted.

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)
Slight barrel chest deformity present. Breath sounds were diminished on both assessments. Breaths sound had slight wheezing on day one but not on day two. Breaths were shallow and labored with tachypnea present. Accessory muscle breathing also noted.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)
Slightly abnormal heart sounds with a steady rate of 55 bpm. Radial pulses were strong once found, pedal pulses were weaker and took longer to find. Diastolic blood pressure was hanging around 50-55 consistently with a systolic of 90-115.

Student Name: Grace Perreira **Date:** 12-15-2021

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Last bowel movement was 12-13-2021. Appetite has improved and nausea has subsided. Bowel sounds were active in all four quadrants. Abdomen showed no distension or signs of tenderness.

Last BM above

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge**)** 1 person assist to the restroom. Voids with no issues independently. Urine is clear and yellow with no abnormal odor.

Urine output (last 24 hrs) _____ **LMP** (if applicable) _____

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) Unsteady gait, 1 person assist to ambulate. Patient stated she uses a walker at home.

Skin (skin color, temp, texture, turgor, integrity) Skin color was normal for patient and warm. Turgor was WNL. She had some slight bipedal edema and bruising on her arms, lower legs, and abdomen.

Wounds/Dressings No wounds. Dressing over left AC IV site, no signs of infection or irritation. IV flushes and is used for medications.

Other NA

Adopted: August 2016