Student Name: Rafael Alegre 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)
Time: 0939. Patient has been admitted for aspiration pneumonia. Patient is on bedrest with a tracheostomy collar with 9L oxygen in CPAP setting.

Neurological–sensory (LOC, sensation, strength, coordination, speech, pupil assessment)
Patient is non-verbal but alert and awake. When asked, patient will nod yes and no. will also point at specific areas for location. Pt grips and foot push weak. Pt can lift arms a little- above shoulders, can not move legs well. Pupils PERRL.

Comfort level: Pain rates at 0 **(0-10 scale) Location:** Nods head NO when asked if ~~feels any pain.~~

Psychological/Social (affect, interaction with family, friends, staff)
Patient is calm and friendly. Will respond to questions and gesture hands for specific needs (points at lips for dryness). Patient acts appropriately for age and friendly to nursing staff.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) Eyes symmetrical with no drainage. Ears with small amount of cerumen. Oral mucosa pink and moist but lips were dry. Given lip balm and lotion of on face for itchiness. Speech therapist was ordered to assess swallowing. No report yet. Teeth clean and nodes palpable.

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)
Chest expands normally. Crackles are heard on ascultation during inspiration and expiration. O^2 sat of 93 with respirations of 20. Breathing is fast and shallow. Patient has a trach collar with 9L liters on CPAP setting. Pt suctioned every 2 hours.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)
HR is 85 and strong. No murmurs. Radial rate 84, strong 2+ on both arms. Pedal pulses present at 2+. No edema on legs. Regular sinus rythm.

Student Name: Rafael Alegre **Date:** 12/15/2021

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Bowel sounds normoactive on 4 quadrants. Patient is on flexi-seal. Bowels are brown. abdomen soft and not distended.

Last BM N/A

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Patient is on foley catheter, size 14 French. Urine is clear and yellow. No bladder distention, genitalia assessed and no signs of skin breakdown.

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

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) Patient is on bed rest, semi-fowlers position. Right arm and left arms have limited mobility. Legs ~~have~~ are weak and toe wiggle slow. anti-contractures are placed on feet.

Skin (skin color, temp, texture, turgor, integrity) Skin color normal for patient. No skin breakdown present. Temperature is 99 and skin turgor within normal limits. Skin is smooth and moisturized, except for face. Patient pointed at face for itching due to beard length. Back assessed and no signs of breakdown.

Wounds/Dressings

No wounds noted. Dressing on right jugular is intact.

Other

Adopted: August 2016