Student Name: Grace Perreira **Date:** 3/30/22

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- 1000, 3/30/22
admit dx- BPH, TURP post-op
general appearance- clean, well-kept, resting in bed.

Neurological–sensory (LOC, sensation, strength, coordination, speech, pupil assessment)
LOC- alert & oriented x4. sensation- reported accurate sensations (sharp/dull) and reported no numbness/tingling. Strength- grips/pushes strong & equal bilaterally in all extremities. coordination- displayed good coordination w stable ambulation. speech- clear, follows conversation & simple commands. pupils- 3mm equal & reactive to light.
Comfort level: Pain rates at 1 **(0-10 scale) Location:** pelvis
Psychological/Social (affect, interaction with family, friends, staff)
affect- friendly verbal communication interactions- friendly conversation with staff. involved in care. wife present at bedside and very friendly.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) EENT symmetrical w no excessive drainage noted. No dental/oral abnormalities observed. Mucosa moist & clean. Nodes were not palpable or visible. No difficulty swallowing.

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)
chest configuration- symmetrical, slight intercostal retractions noted. No barrel chest. Breath sounds- clear on I&E in upper lobes, slight crackles noted in lower lobes on I&E. Rate- 16. Rhythm- equal. Depth- equal between breaths, not shallow. pattern- equal & WNL for titrating off O2 therapy.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)
Heart sounds- S_1 & S_2 auscultated. Apical & radial rates equal. Radial & pedal pulses were all 2+ w equal rhythm. pattern- 72 bpm.

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Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Bowel habits- usually 2-3 BM's a day. Passing gas regularly. Appearance of abdomen- firm & distended, WNL for post-op. Bowel sounds active x4 & epigastric. No tenderness on palpation. Laxative given.

Last BM 3/28/22 (pre-op)

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Murphey drip in place, so pt. reports no frequency or urgency. Reports both occuring pre-op. Continence- 16 French in place. Color, clarity, odor- blood in urine due to TURP. No discharge noted.

Murphey drip

Urine output (last 24 hrs) 3000 mL/hr **LMP** (if applicable) NA

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) Alignment- No spinal abnormalities observed. Posture- No abnormalities noted. Mobility- independent mobility w full ROM & ambulation. Gait- stable. Movement in extremities- full ROM, self. No deformities noted.

Skin (skin color, temp, texture, turgor, integrity) skin color normal for patient. Warm extremities with slightly dry skin texture. Slight edema noted in extremities, non-pitting. Edema due to large fluid volume. Turgor displayed no tenting. Thick, durable skin. Intact besides IV site and dry patches on extremities.

Wounds/Dressings No wounds. Clean, dry, intact dressing over right forearm 20g IV.

Other