Student Name: _____Meredith Edwards_____ **Date:** __5/17/2022____

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)

Pt. is 60 y/o male admitted 04/25/22 presenting with symptoms of uncontrolled diabetes mellitus. Pt. was diagnosed with Hyperosmolar Hyperglycemia Syndrome. Since Pt. admission he has also been diagnosed with Pancreatic Cancer with metastasis to the liver. Pt. was drowsy and relaxed during assessment completed at 07:20 on 05/17/22. Family was not at bedside.

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

Pt. was alerted and oriented X4. Pupils were equal and reactive to light. Sensations present to dull and sharp X6. Moves all extremities on command and no pain reported. HGTW were equal and strong bilaterally. Hand pushes were strong bilaterally. Observed movements were coordinated. Speech was clear and without difficulty in response, even though pt. was drowsy.

Comfort level: Pain rates at _4_ **(0-10 scale) Location:** Right and Middle Abdominal Pain

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

Pt. affect and facial expression were flat. Pt. was quiet and interacted appropriately with staff. Pt. was responsive to all questions asked, acknowledged staff, and understood assessment.

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

Pt. Sclera clear and white without drainage. Ears symmetrical, and canals are free of drainage. Pt. hearing was clear and could respond to all questions asked without clarification or repetition. Nasal sputum were midline and oral mucous were pink and moist. Trachea was midline. Dentition had cavities noted and missing teeth. No noted or reported difficulties with swallowing. Nodes were not palpable to the touch.

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

Chest was symmetrical and lung sounds were clear bilaterally on inhale and exhale. Respirations were 20. Pt. on RA with an O2 sat of 96%. Breathing rhythm and pattern was equal bilaterally and depth was maintained. Slight nonproductive cough noted without mucus.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern) S1 and S2 audible with no noted murmur. Apical and Radial pulse 74. Radial Pulse 2+ bilaterally. Pedal Pulses bilaterally 2+. Post. Tib pulses bilaterally 1+. Capillary refill at 2 seconds. Heartrate pattern and rhythm were regular.

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation)

Pt. last BM 05/15/22. Last BM was brown and "1" in consistency on the Bristol stool scale. Pt. experiencing constipation. Abdomen was soft and no tenderness was reported with palpitated. Inspection of the abdomen no noted distention. Bowel sounds were active X4. Appetite is fair.

Last BM 5/15/22

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge)

Voids clear and yellow with adequate amount. Odor, discharge, and pain were denied during assessment. Pt. voids in a urinal without the need for urinary catheter. Pt. denied urgency, incontinence, or irregular frequency with voids.

Urine output (last 24 hrs.) x4 in 24 hours **LMP (if applicable)** N/A

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities)

Movement of all extremities without pain or tenderness. No noted deformities in extremities. Able to ambulate and gait is steady. Alignment was symmetrical. Mobility was independent. Posture was upright Semi fowlers while lying on the bed.

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

Skin in normal for race. Skin was pink, warm, and smooth to touch. Turgor elastic. Skin integrity intact; no noted abrasions or bruising on extremities. Pt. is tattooed over the majority of his chest but inspected chest area did not indicate bruises or abrasions. Braden Scale score of 20.

Wounds/Dressings

No drains and dressings. IV site was clean, dry, without redness and/or swelling. IV placed on 05/13/22.

Other

No other noted assessments.