

Student Name: Thalia Cole

Date: 1-31-23

### 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: 1010

Admit diagnosis: Closed left femur fracture

General appearance: Calm/relaxed, friendly to staff and family members upon entering the room.

**Neurological-sensory** (LOC, sensation, strength, coordination, speech, pupil assessment)  
LOC: X4 time, place, person, situation. Sensation: X4 touch, pressure, pain, temp.  
Coordination: follows simple commands Strength: strong with grips & pushes.  
Speech: speaks clear Pupil assessment: 3mm equal, round, reactive to light.

Comfort level: Pain rates at 3 (0-10 scale) Location: left hip region

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

Affect: responsive

Interaction: Readily, friendly, calm/relaxed to staff & family

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

EENT: Sclera white & clear, without drainage, hard of hearing, Oral mucosa pink, moist & intact  
Pt can swallow without difficulty. No nodes swollen.

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

Chest Configuration: Symmetrical Breath sounds: crackles R lower lobe.  
Trachea: midline Rate: 20 BPM Rhythm: equal depth: post-surgical  
Pattern: equal, Pt is on 3LNC

**Cardiovascular** (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)

Heart sounds: normal, S1 & S2 audible with regular rate & rhythm.

Apical & radial rate upon auscultation & palpation, 88 BPM

Rhythm: normal within range

radial & pedal pulse: 2+ bilaterally radial & pedal pulse, capillary < 3 seconds

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**Gastrointestinal** (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Bowel habits: firm (Pt stated) Abdomen: is soft, nondistended  
Bowel sounds: hyper active None tenderness to palpation

Last BM Pt stated 4 days ago.

**Genitourinary-Reproductive** (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Frequency: Normal Urgency: Pt stated she can hold till she reaches the restroom. Continence: Pt is wearing briefs  
Urine appeared yellow in brief, no odor noted. No bleeding or discharge noted. Vagina area is bruised, red in skin tone.

3 times Urine output (last 24 hrs) LMP (if applicable) Post menapausal

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

Alignment: even

Posture: Slouched

Mobility: needs assistance, uses a walker

Gait: unstable, slow

Movement: moves all extremities, No deformities noted

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

Skin: normal for pt

Temp: warm

Texture: dry

Turgor: tenting noted, stays up

Integrity: not intact, laceration on scalp.

**Wounds/Dressings**

• Incision L hip - Rod femoral surgery

• Scalp laceration, 35 staples

• IV 20 gage, intact, CDI, without redness

**Other**