

Student Name: Maria Cruz

Date: 09/05/23

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)

Patient is admitted with new onset seizures without head trauma. Upon initial assessment at 0847, patient is seen lying in bed asleep, but arousable.

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

Patient is Alert & Oriented X 2/3 (person/time). Residual expressive aphasia is present, causing patient to not be able to express their self properly (comes and goes). When aphasia is not presenting, speech is clear and audible. Right sided hemiparesis is present in both upper and lower extremity, not allowing the patient to differentiate between sensations. Left side upper and lower extremity are able to differentiate between both sharp and dull sensations. Pupil size is 6mm bilaterally, both eyes are equal and reactive to light. HGTW strong in right sided extremities, weak in left sided extremities. Right side of body is able to make coordinated movements, whereas left side is unable to.

Comfort level: Pain rates at 6 **(0-10 scale) Location:** Hips

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

During assessment patient is relaxed and cooperative, interacting with staff appropriately. Patients wife is at bedside to assist with history when patient is unable to respond.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) No drainage noted in EENT. Presents with poor dentition (cavities/missing teeth). Very slight droop noted to left side of patients face. No palpable nodes present. Cough and gag reflex are intact, no trouble swallowing noted. Oral mucosa is moist/not dry.

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

Pulmonary effort is adequate, no SOB. Patient favors the left side causing a droop in chest configuration, no surgical scars present. Equal breath sounds, no wheezing or crackles heard in lung lobes. Patient is on room air at 95% with 17 breaths per minute.

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

S1 and S2 noted. No murmur heard. Apical rate of 88. Radial and pedal pulse strong on left side. Right radial pulse is weak, doppler used to verify right pedal pulse.. Patient in normal sinus Rythm.

Student Name: _____

Date: _____

Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Patient is incontinent of both bowel and bladder. Reports several liquid bowel movements during the night. Abdomen is soft with no distention.
Bowel sounds are Hypoactive in all four quadrants. Patients reports tenderness to right lower quadrant. Last BM 9/4

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Patient is unable to urinate freely, requires occasional straight cath.
Patient is incontinent. Patients wife reports cloudy/amber like urine with a ammonia smell. No bleeding or discharge found.

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

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities)
Patient is bed bound and unable to ambulate freely. Alignment is symmetrical.
Unable to move right side of body, but able to maintain minimal ADL with left side.
Right hand is contracted. Unable to assess gait.

Skin (skin color, temp, texture, turgor, integrity)
Skin color is appropriate to patient ethnicity. Warm to the touch with swelling in right forearm. Skin is intact. Texture is smooth. No cuts, lesions, or bruising. Elasticity is present.

Wounds/Dressings

Left antecubital peripheral 18G on the left side placed 9/4.

Other