Student Name: Ty Skiles Date: 2/13/24

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. assessed at 0745. Pt. admitted with sepsis, HTN, & SOB. Pt. appears angry yet responsive towards staff.

Neurological–sensory (LOC, sensation, strength, coordination, speech, pupil assessment)
Pt. alert & oriented x4. Sharp sensation x0, dull sensation x6. Strong grips, pulls, & pushes. Pt. is coordinated. Speech is comprehensible & meaningful. Pupils x2mm.

Comfort level: Pain rates at 0 **(0-10 scale) Location:** N/A

Psychological/Social (affect, interaction with family, friends, staff)
Pt. is angry towards staff. Pt. is responsive to staff. No friends or family present in Pt. room.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) EENTM symmetrical without drainage. No abnormalities in dentition noted. No significant findings upon palpation of lymph nodes. Pt. swallows without difficulty.

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)
Chest Symmetrical. Breath sounds clear bilat. Breathing is labored. 14 respirations per minute. Equal rhythm. Shallow respirations. Pt. on 2L NC.

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)
S1 & S2 audible upon auscultation. Apical 62 & radial 58. Equal rhythm. Radial 2+ Pedal 2+. Cap refill 3 seconds.