

Student Name: JULIE BOREN

Date: 11/19/24

IM2 Patient Physical Assessment Narrative by Systems

(Complete using assessment check list and reminders in parenthesis below)

Age 60 Sex M Diagnosis & Onset PROSTATE CX 11/17/2024

Chief Complaint PAIN WHILE URINATING, URINARY RETENTION

GENERAL INFORMATION (Time of assessment, general appearance)

1030, PT IS RESTING COMFORTABLY IN BED; APPEARS RELAXED, AND IS INTERACTING WITH FAMILY & STAFF.

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

A & O X 4, SENSATION & STRENGTH IN ALL EXTREMITIES, SPEECH IS INTACT, PUPILS PERLA.

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

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

PT. IS FRIENDLY, RESPONSIVE, & RESPONDS TO COMMANDS. PT INTERACTS WITH FAMILY & STAFF.

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

DENTITION, GAB REFLEX, SWALLOW REFLEXES INTACT. NO DRAINAGE OR SWELLING TO EENT. EENT SYMMETRICAL.

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

EQUAL CHEST RISE WITHOUT USE OF ACCESSORY MUSCLES. BREATH SOUNDS CLEAR, 12 BPM, NORMAL RHYTHM & ADEQUATE DEPTH.

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

CLEAR S1 & S2 SOUNDS AT APICAL SITE. 94 BPM AT APICAL & RADIAL SITES. NSR.

Adopted: August 2016

Revised: October 2023

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Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) LAST BM 11/18/2024. STOOL IS SOFT & BROWN.

NO TENDERNESS OF ABDOMEN TO PALPATION. BOWEL SOUNDS ACTIVE IN ALL 4 QUADRANTS.

_____ Last BM 11/18/2024

Genitourinary - Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) URINE OUTPUT OF 3000 ML OVER LAST 24 HRS.

URINE IS CLEAR YELLOW. PT HAS NO Foley PLACED 11/15/24. NO ODOR NOTED. PT IS CONTINENT.

3000ML Urine output (last 24 hrs) _____ LMP (if applicable) N/A

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

PT IS WELL ALIGNED & HAS GOOD POSTURE, STRONG GAIT, AND MOVES ALL EXTREMITIES. NO DEFORMITIES NOTED.

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

SKIN COLOR NORMAL FOR PT, WARM, SMOOTH, & HAS GOOD TURGOR. SKIN IS INTACT.

Wounds/Dressings

186 LAC, DRESSING IS CDI.

Other

#608

PERIPHERAL VASCULAR	NEUROLOGY/PSYCHOSOCIAL	CARDIOVASCULAR
3+-Bounding unable to occlude 2+-Strong able to occlude 1+-Weak palpable 0-Non palpable Extremities: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Ted Hose <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: <u>22</u> Seconds Affected extremity pulse verified with Doppler <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Pulses: Radial R <u>2+</u> L <u>2+</u> Pedal R <u>2+</u> L <u>2+</u> Post. Tib. R <u>2+</u> L <u>2+</u> Comments: _____	Family at bedside <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Drowsy Cough Reflex <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Follows Simple Commands: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Gag <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grips: Rt. <u>S</u> Lt. <u>S</u> Pushes: Rt. <u>S</u> Lt. <u>S</u> Comments: _____ Response to Questions: <input checked="" type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Restless <input type="checkbox"/> Appro. for age <input type="checkbox"/> Hostile/Angry <input type="checkbox"/> Crying <input type="checkbox"/> Anxious <input type="checkbox"/> Concerned Facial expressions: <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment Comments: _____	Edema: <input type="checkbox"/> Generalized <input type="checkbox"/> Dependent Pitting: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ Skin Turgor WNL <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Abnormal Heart Sounds <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Murmur <input type="checkbox"/> Y <input checked="" type="checkbox"/> N PPM Site: <u>NIA</u> Rhythm: <u>NIA</u>
GASTROINTESTINAL	SKELETAL	PACER SETTINGS
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color: <u>BROWN</u> Consistency: <u>SOFT</u> Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Guarding Bowel Sounds: <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent X4 Quadrants Appetite: <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DHT R or L Comments: _____	Moves Extremities: <input checked="" type="checkbox"/> All <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input type="checkbox"/> LL <input checked="" type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness <input type="checkbox"/> Weak <input type="checkbox"/> Deformities <input type="checkbox"/> Contractures <input type="checkbox"/> Spasms <input type="checkbox"/> Paralysis <input type="checkbox"/> Amputation Gait <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady Comments: <u>CELLULITIS, PAIN, SWELLING ON LEFT FOOT</u>	<input type="checkbox"/> None Rate _____ MA: A _____ V Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ Epicardial wires <input type="checkbox"/> Y <input type="checkbox"/> N Permanent Pacemaker Site <input type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular
GENITOURINARY	EYES, EARS, NOSE, THROAT	INCISIONS/WOUNDS/DRAINS
Urine: <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input checked="" type="checkbox"/> Yellow <input type="checkbox"/> Amber <input type="checkbox"/> Bloody <input type="checkbox"/> Voids <input type="checkbox"/> Foley Size <u>NIA</u> Fr Insertion Date <u>NIA</u> <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent Comments: _____	Sclera: <input checked="" type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Red Scleral Edema: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Sore Throat: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Nasal Drainage: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Comments: _____	<input type="checkbox"/> None #1 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #2 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #3 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #4 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____
ARTERIAL AND VENOUS SITES	PULMONARY	CHEST TUBES
A -Without Redness or Swelling B-Redness C-Swelling D-Dressing <input type="checkbox"/> Jugular <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input checked="" type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L <u>ADCDI</u> Start: <u>11/17</u> <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> PA @ _____ cm <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ Hemodialysis Access Location _____ <input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit	Respirations: <input checked="" type="checkbox"/> No Distress <input type="checkbox"/> SOB <input type="checkbox"/> Labored <input type="checkbox"/> Accessory Muscles <input type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea <input checked="" type="checkbox"/> RA O2: <u>94</u> <input type="checkbox"/> NC <input type="checkbox"/> Venti Mask <input type="checkbox"/> Trach Collar <input type="checkbox"/> Non rebreather <input type="checkbox"/> T-Piece <input type="checkbox"/> Ventilator: <input type="checkbox"/> BiPAP/CPAP # _____ ETT @ _____ cm # _____ Shiley Trach BVM at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Obturator at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input checked="" type="checkbox"/> None Secretions: Color _____ Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal Comments: _____	<input type="checkbox"/> None #1 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #2 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #3 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____
SKIN ASSESSMENT	LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub	
<input checked="" type="checkbox"/> Skin Intact Skin assessment codes: 1. Abrasions 2. Decubitis 3. Bruises 4. Incision 5. Redness 6. Edema 7. Rash 8. Lacerations 9. Petechiae 10. Hematoma 11. Blister 12. Stoma 13. Sutures 14. Staples 15. Other: _____ Skin Color normal for patient <input checked="" type="checkbox"/> <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice <input type="checkbox"/> Shiny <input type="checkbox"/> Clammy <input type="checkbox"/> Cool <input type="checkbox"/> Diaphoretic Braden Scale Score <u>20</u> <input checked="" type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol Comments: _____		

Initial Assessment See Narrative for Additional information Signature Julie Boen Date: 11/19/24 Time: 1230
 No Changes to initial assessment See Narrative for Signature _____ Date: _____ Time: _____
 No Changes to previous assessment See Narrative for Signature _____ Date: _____ Time: _____