Student Name: Kaegan Lovelady **Date:** 11/11/25

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 of assessment: assessment was performed at 0830.

Admit diagnosis: Pt came in with intentional overdose.

General appearance: Pt is calm and relaxed, but affect is flat. Pt is also clean and well kept.

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

LOC: A&O x 4

Sensation: Pt was able to feel touch when arms and legs were palpated. Sharp and dull sensation intact on the hands and feet. No numbness or tingling reported in extremities.

Strength: HGTW strong bilaterally.

Coordination: Pt's movements and speech are coordinated.

Pupil assessment: pupil size 5 mm, PERRLA

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

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

Affect: Pt was withdrawn and affect was flat. Pt did not report any suicidal ideation today but seemed indifferent towards life itself. When pt was talking with her father, she was tearful.

Interaction with family/staff: appropriate with staff and family

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

EENT: symmetrical with no drainage

Dentition: Intact with no signs of inflammation, good oral hygiene

Nodes: not palpable or swollen

Swallowing: pt able to swallow without difficulty

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

Configuration: Symmetrical

Breath: clear breath sounds in all lobes, equal bilaterally, with regular pattern and rhythm, respiratory rate at 14

Depth: regular depth, not deep or shallow

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

Heart sounds: S1 and S2 auscultated, with no murmur present

Apical and radial rate: Regular rate, rhythm, and pattern, rate at 68 bpm per monitor

Radial and pedal pulse: radial, tibial, and pedal pulses 2+ bilaterally, strong upon palpation

Student Name: _____ Date: _____

Patient Physical Assessment Narrative

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

Bowel habits: Last BM was last night, stool brown and soft with no unusual smell

Appearance of abdomen: no lesions, or bruising observed

Bowel sounds: active x 4 quadrants

Palpation: abdomen soft upon palpation with no tenderness

Last BM 11/10/25

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

Frequency: Pt voids multiple times a day ambulating to the bathroom

Urine appearance: clear and yellow, no foul odor observed

Urgency: Urgency present

Continence: pt is continent, no discharge observed

Urine output (last 24 hrs) pt voiding regularly, but exact amount observed and recorded by sitter **LMP** (if applicable) **N/A**

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

Alignment: symmetrical

Posture: upright with no slouching

Mobility: able to move all extremities without pain or stiffness

Gait: steady, pt can ambulate on their own

Movement: voluntary

Deformities: no deformities observed

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

Color: normal for race

Temp: warm

Texture: smooth

Turgor: no tenting present

Integrity: skin intact

Wounds/Dressings

Peripheral IV: Rt arm, placed on 11/10/25, dressing dry and intact, dried blood observed on site, patent today, but difficult to flush

Other

N/A