N312 HEALTH ASSESSMENT
LAB TEST OUT #3 FORM
Total 100 points

Student Name: Kristy Geier Date: 4/26/2020
Client Name: Brea Baine
DOB: 3-23-1994
CC: Abdominal Pain

Vital Signs/Vision Testing/Client Demographics:

B/P: 120/78 mmHg	Pulse: 78 BPM	Temp: 98.6°F	Gender: Female
Pain: 0/10	RR: 16	Weight: 215lb.	Marital Status: Single
Visual Acuity:	O2 sat: 96% RA	Height: 5'6"	Occupation: Nurse
Assistive Devices: Eyeglasses	Primary Language: English Race: White	Religion: Christian	Code Status: Circle FULL CODE or DNR or OTHER *specify if other selected-*

Allergies and Type of reaction: Penicillin

History of present Illness (OLDCART):

This is a pleasant, 26 year old white female presenting today for abdominal pain. She has been very healthy prior to today's visit. She works as a Nurse at Carle hospital. She states she ate some pizza yesterday at work and has not felt well since coming home from work yesterday evening. She states she last had a BM yesterday at work. NO pain felt in her abd. area as she reports on a numeric scale, but she states intermittent pain, comes + goes about every 2-3 hr. It is a dull, achy pain. She is healthy otherwise. She states she suffers from asthma & uses an inhaler PRN. She had a hernia repair in 2016. She wears eyeglasses. She states her pain is not really aggravating - more annoying. Nothing relieves it, no treatment tried at home with OTC meds.

PMH: Asthma

PSH (Provide dates): Hernia Repair 2016

MEDICATIONS: Ø

Name:	Dose:	Route:	Frequency:	Last taken:
Albuterol	180mcg (2 Puff)	oral	PRN	Last wk.
pt not taking any otc meds				

FAMILY HISTORY (Maternal and Paternal Side- Mother, Father, Grandparents-Clarify maternal or paternal side, and Siblings):
None - All healthy. Mother, Father, 3 triplet sisters all living + healthy.

SOCIAL HISTORY:
Living Arrangements: Lives with significant other in own home.
Tobacco Use: Ø
Alcohol Use: Social Drinker
Recreational Drug Use: Ø

Review of Systems (Circle if positive and provide detail):

General	Fatigue, weight changes, fevers, chills, night sweats N/A to All
Skin	Dryness, rashes, lesions, non-healing sores, hair changes, puritis N/A to All
HEENT	Headache, head injury, blurry vision, double vision, earache, drainage, change in hearing, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing difficulty, N/A to All
Cardiac	Chest pain, palpitations, diaphoresis, dyspnea, PND, Orthopnea, claudication N/A to All
Respiratory	Wheezing, cough, difficulty breathing, increase in sputum production N/A to All
Gastrointestinal	Nausea, vomiting, diarrhea, constipation, abdominal pain, heartburn, jaundice, Hematochezia, Melena, Last episode of nausea and/or vomiting if connected with history of present illness: _____ Passing Gas: YES/NO Last bowel movement: yesterday N/A to all except Abd. pain.
Genitourinary	Hesitancy, frequency, urgency, burning, hematuria, incontinence, flank pain, male urine flow changes, female LMP: Last week Last urination: today Sexually Active: YES/NO Chance of pregnancy: YES/NO N/A to All
Musculoskeletal	Swelling, stiffness or soreness in joints, back or neck pain N/A to All
Neurological	Weakness, numbness, LOC, syncope, dizziness, headache, coordination changes, recent falls N/A to All

Physical Exam-Objective-10 points per section/TOTAL POINTS=60

****Students must demonstrate items in each section and narrate items that instructor cannot observe****

General: Alert and orient, distress, overall appearance **Skin**: Inspect for rashes, lesions, color, hair, nails, temperature, turgor, palpate for capillary refill fingers and toes	**Cardiac/Peripheral Vascular**: Auscultate for presence of S1 and S2, aortic, pulmonic, Erb's point, tricuspid, mitral Palpate Pulses (bilaterally)- brachial, radial, ulnar, femoral, popliteal, posterior tibial, dorsalis pedis), inspect and palpate for edema bilaterally inspect symmetry of all extremities, test for homan's sign bilaterally
Head and Neck: Inspect symmetry of head/neck, palpate tracheal deviation, palpate thyroid, palpate carotids, palpate lymph nodes and narrate names as you go- *Preauricular, posterior auricular, occipital, tonsillar, submaxillary, submental, anterior or deep cervical chain, supraclavicular* **Eyes**: Inspect appearance of lids, sclera and conjunctiva, do PERRLA, do EOM's **Ears:** Inspect external ear, pretend inspection TM bilaterally **Nose**: Palpate for deviated septum, Pretend inspection of turbinates, polyps, palpate sinuses **Throat:** Inspect appearance of tonsils, any redness, lesions, exudate, uvula midline, moisture of mouth, dentition	**Thorax**: Mention symmetry and respiratory effort, auscultate 6 posterior, 4 anterior, auscultate RML
Abdominal: Inspect abdomen, auscultate for	

bowel sounds, light palpation, deep palpation, blunt percussion for CVA tenderness	
Musculoskeletal: Student demo on self how to perform flexion & extension of upper extremities; flexion & extension of lower extremities; abduction and adduction of upper and lower extremities; supination and pronation of upper extremities; student narrate/explain how to assess grip strength and strength of lower extremities **Neurological:** deep tendon reflexes (triceps, brachioradialis, patellar, Achilles, Babinski) **point to the area where reflex is tested and demo how one could strike with a reflex hammer (use another object to replace reflex hammer)** **Student demo on self how to perform Rhombergs**	

Lab Test Out #3 Documentation:

General: Patient appears AOx3, No signs of distress, well-dressed appearance

Skin: No turgor, capillary refills less than 3, no lesions, rashes, non-healing sores.

Head and Neck: Trachial Deviation at midline, Symmetrical, thyroid appears normal, not swollen, No bruit heard in carotids, bilaterally. All Lymph nodes to head normal.

Eyes: Extra Ocular Eye movement normal on exam, ~~Eyes~~ Pupils appear equal, round, reactive to light & accomodation. Lids appear normal, not swollen. Sclera appear norm not red.

Ears: Tympanic membrane appears pearly grey, small amount of cerumen.

Nose: No sinus surgeries / broken Nose; No turbinates, polyps, lesions, ~~has~~ Septal deviation Sinuses appear normal not swollen.

Throat: Uvla ~~was~~ appears at midline, soft palate rises + falls appropriately, tonsils within normal size, mucosa appears moist, dentition appears excellent.

Cardiac: S1, S2 heard, No S3, S4, No gallops, murmurs, rubs. heard. Checked + said pulses-all heard/normal.

Thorax/Lungs: ~~No wheezes or crackles heard throughout.~~ Lungs appear, symmetrical. Lungs appear/sound clear + equal bilaterally both anterior / posterior

Abdomen: Inspect, Asscultate, percuss, palpated abd. - No pain perpt. light + deep palpation.

Extremities: Performed passive ROM on upper + lower extremities, explained those.

Musculoskeletal: No edema, sores, open wounds, toenails normal appearance, No turgor, less than 3 seconds on capillary refills.

Neruological: Neuro fleves equal on both upper + lower extremities. - Explained Nerves of head + what they controlled.

Total points:_____out of 100 points

PASS or FAIL: _____

Instructor comments if applicable:

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