

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

Student Name: Jessica Kavajecz

Date: 4/24/2020

Client Name: John Smith

DOB: 3/14/1957

CC: Abdominal
pain

Vital Signs/Vision Testing/Client Demographics:

B/P: 161/94	Pulse: 116	Temp: 99.8	Gender: Male
Pain: 8/10	RR: 28	Weight: 224	Marital Status: Married
Visual Acuity: Glasses	O2 sat: 94%	Height: 5'11"	Occupation: Electrician
Assistive Devices: No use of assistive devices	Primary Language: English and Spanish Race: Hispanic	Religion: Catholic	Code Status: Circle FULL CODE or DNR or OTHER <i>specify if other selected- Pt is FULL CODE.</i>

Allergies and Type of reaction: Sulfa-Rash and hives; bee stings- difficulty breathing, swelling of throat.

History of present illness (OLD CART):

O: Pain began at 1am. The client awakened out of sleep experiencing extreme pain.
L: Over all quadrants of the stomach.
D: Constant.
C: Sharp pain.
A: Nausea and emesis X2.
R: Attempted moving and walking but no relief.
T: First experience with these symptoms so client has not sought previous treatment.

PMH: Diabetes, hypertension, MI with stent replacement in 2013.

PSH (Provide dates): MI stent replacement in 2013, right femur fracture repair at age 42 after motor vehicle accident.

MEDICATIONS:

Name: Glucophage	Dose: 1000mg	route: orally	Frequency: 2X daily	Last dose: Last PM at dinner.
Metoprolol	25mg	orally	2X daily	This AM
Aspirin	325mg	orally	1X daily	this AM

FAMILY HISTORY (Maternal and Paternal Side- Mother, Father, Grandparents-Clarify maternal or paternal side, and Siblings):

Father- Congestive heart failure, hyperlipidemia. Mother- Atrial fibrillation, diabetes type 2. Paternal grandma- congestive heart failure, asthma, atrial fibrillation. Paternal grandfather-hyperlipidemia, diabetes type 2, prostate cancer. Maternal grandmother-hypothyroidism. Maternal grandfather- deceased at age 37 due to a heart attack.

SOCIAL HISTORY:

Living Arrangements: Lives with spouse, 3 dogs, and 2 birds.

Tobacco Use: smokes ½ PPP for 40 years.

Alcohol Use: drinks beer 1-2 three times/week.

Recreational Drug Use: 0 drug use.

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

General	Fatigue, weight changes, fevers, chills, night sweats. None
Skin	Dryness, rashes, lesions, non-healing sores, hair changes, puritis. None
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, None
Cardiac	Chest pain, palpitations, diaphoresis, dyspnea, PND , Orthopnea, claudication. Pt is experiencing dyspnea- pt often wakes up at night feeling winded and cannot catch breath without sitting up on side of bed.
Respiratory	Wheezing, cough, difficulty breathing , increase in sputum production- Difficulty breathing at night. Wakes up and has to sit up on the side of the bed.
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: <u> Vomited 2X.</u> _____ Passing Gas: YES/NO _____ Last bowel movement: <u> 6 days ago</u> _____
Genitourinary	Hesitancy, frequency, urgency, burning, hematuria, incontinence, flank pain, male urine flow changes , female LMP: <u> NA</u> _____, Last urination: <u>Last PM before bed</u> _____ Sexually Active: YES/NO _____ Chance of pregnancy: YES/NO _____ Pt's stream of urine is weak and often wakes up at night to urinate.
Musculoskeletal	Swelling, stiffness or soreness in joints, back or neck pain None
Neurological	Weakness, numbness, LOC, syncope, dizziness , headache, coordination changes, recent falls Pt is experiencing dizziness with intense pain.

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

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

<p>General: Alert and orient, distress, overall appearance</p> <p>Skin: Inspect for rashes, lesions, color, hair, nails, temperature, turgor, palpate for capillary refill fingers and toes</p>	<p>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</p>
<p>Head and Neck: Inspect symmetry of head/neck, palpate tracheal deviation, palpate thyroid, palpate carotids, palpate lymph nodes and narrate names as you go- <i>Preauricular, posterior auricular, occipital, tonsillar, submaxillary, submental, anterior or deep cervical chain, supraclavicular</i></p> <p>Eyes: Inspect appearance of lids, sclera and conjunctiva, do PERRLA, do EOM's</p> <p>Ears: Inspect external ear, pretend inspection TM bilaterally</p> <p>Nose: Palpate for deviated septum, Pretend inspection of turbinates, polyps, palpate sinuses</p> <p>Throat: Inspect appearance of tonsils, any redness, lesions, exudate, uvula midline, moisture of mouth, dentition</p>	<p>Thorax: Mention symmetry and respiratory effort, auscultate 6 posterior, 4 anterior, auscultate RML</p>
<p>Abdominal: Inspect abdomen, auscultate for bowel sounds, light palpation, deep palpation, blunt percussion for CVA tenderness</p>	
<p>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</p> <p>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)</p> <p>Student demo on self how to perform Rhombergs</p>	

Lab Test Out #3 Documentation:

General: _Pt appears alert and oriented. Overall appearance is good and is in some distress due to abdominal pain he is experiencing.

Skin: Skin is pink and warm.

Head and Neck: Head and neck are symmetrical, no tracheal deviation-midline, thyroid is not palpable, no noted nodules, carotid pulses are palpable and strong, Lymph nodes are all non-palpable.

Eyes: Sclera is white, cornea is clear, conjunctiva is pink, no visible drainage. Eyelids are moist and pink. Pupils are equal, reactive, and respond to light and accommodate. Red light reflex is present, Rosenberg is 20/20 with glasses, and EOM'S intact.

Ears: Ears are pink and moist, ear canal is clear and TM is pearly grey on both sides.

Nose: No nasal deviation, sinuses are non-tender, no polyps, turbinate's are moist and pink.

Throat: Throat/mouth is moist and pink without exudate. Uvula is midline and soft palate rises and falls symmetrical. Teeth are in good condition as well as the general mucosa is pink and moist.

Cardiac: S1 and S2 present. No sign of murmur. PMI at 5th intercostal space at MCL. HR is elevated.

Thorax/Lungs: Respirations are slightly fast (28), non-labored, symmetrical, lung sounds are clear throughout and no sign of crackles or wheezes.

Abdomen: Soft, tender, no rashes or lesions noted, having pain in all four quadrants, guarding stomach, no CVA tenderness. Bowel sounds are hypoactive (pt.'s last BM was 6 days ago).

Extremities: Pink, warm, dry, symmetrical and had full strength and ROM. Pulses are 2+ throughout no edema, homans signs is negative.

Musculoskeletal: Pt has full ROM. Does not use assistive devices and is active.

Neurological: Pt moves all extremities well. Pt responded to the deep tendon reflexes and passed the rhombergs test.

Total points: out of 100 points

PASS or FAIL: _____

Instructor comments if applicable:
