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

Student Name:__Ruva Mutopo_____
Date:_____04/30/2020_____

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 lbs.**	**Marital Status: Married**
Visual Acuity: Glasses	**O2 sat: 94%**	**Height: 5' 11"**	**Occupation: Electrician**
Assistive Devices: no assistive devices	**Primary Language: English and Spanish** **Race: Hispanic**	**Religion: Catholic**	**Code Status: Circle FULL CODE or DNR or OTHER *specify if other selected-***

Allergies and Type of reaction: **Sulfa - client gets a rash and hives; Bee Stings - Cleint's throat swells and has difficulty breathing**

History of present Illness (OLDCART):

O - Client woke up with extreme pain at 1 am
L - points to pain over all quadrants
D - Constant pain
C - Sharp feeling
A - nausea and enesis x@
R - tried to move and walk around and there was no relief
T - Has not sought previous treatment because this is the first time having these symptoms

PMH: Diabetes, hypertension and MI about 7 years ago

PSH (Provide dates): Right femur fracture repair @ age 42 after a motor vehicle accident

MEDICATIONS:
Name: Dose: Route:
Frequency: Last taken:_____
_____Glucophage_____1000_mg_____PO_____2x daily_____lastpm after dinner _____Metoprolol_____25 _mg_____PO_____2x daily_____this am _____Asprin_____325_mg_____PO___ 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, type 2 diabetes, prostate cancer; maternal grandma - hypothyroidism; maternal grandfather - Death due to Heart attack @ age 47

SOCIAL HISTORY:
Living Arrangements: _Lives with spouse, their 3 dogs and 2 birds

Tobacco Use: Smoked ½ a pack a day for 40 years

Alcohol Use: Drinks a beer or two, three times a week

Recreational Drug Use: No drug use

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

General	Fatigue, weight changes, fevers, chills, night sweats
Skin	Dryness, rashes, lesions, non-healing sores, hair changes, puritis
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,
Cardiac	Chest pain, palpitations, diaphoresis, dyspnea, PND, Orthopnea, claudication Client often wakes at night feeling winded and cannot breath without sitting up in bed
Respiratory	Wheezing, cough, difficulty breathing, increase in sputum production
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:__6 days ago_____ 2 episodes of nausea and vomiting - and abdominal pain stated with CC
Genitourinary	Hesitancy, frequency, urgency, burning, hematuria, incontinence, flank pain, male urine flow changes, female LMP: _____, Last urination: _last pm before bed_____ Sexually Active: YES/NO Chance of pregnancy: YES/NO Weak stream of urine and wakes up to urinate
Musculoskeletal	Swelling, stiffness or soreness in joints, back or neck pain
Neurological	Weakness, numbness, LOC, syncope, dizziness, headache, coordination changes, recent falls Client reports intense pain with his dizziness

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: Client appears alert and oriented x3, no signs of acute distress, appears well and stated age.

Skin: No rashes or lesions present, skin is warm to the touch, pink and dry, skin turgor is +2, cap refill is less than 3 seconds, and hair/nails appear healthy.

Head and Neck: Head and neck are symmetric, no tracheal deviation, carotid is +2, strong and bounding bilaterally, lymph nodes are all non palpable bilaterally.

Eyes: No rashes or lesions present on lids, white sclera, pink and moist conjunctiva. Pupils are equal, round and reactive to light and accommodation, EOM positive bilaterally and red light reflex is apparent

Ears: Tympanic membrane is pearly grey bilaterally, ear auricle is absent of bumps and are symmetrical

Nose: Nose is symmetrical, sinuses are not tender, no polyps and turbinates are pink

Throat: Teeth are in good condition, buccal mucosa are pink and moist, soft palate rises and the uvula is midline. Tonsils are a +2 and sublingual is pink and moist

Cardiac: Normal S1 and S2 sounds with no murmurs or gallops

Thorax/Lungs: Normal and clear lung sounds at each APETM, no wheezes or crackles

Abdomen: No abnormalities in shape noted, normal clicks and gurgles heard in all 4 quadrants, no pain or tenderness felt with light and deep palpitations. No pain felt with blunt percussions of the CVA

Extremities: +2 upper extremity pulses bilaterally, no edema palpable bilaterally, +1 lower extremity pulses felt bilaterally, negative homan sign assess bilaterally, cap refill less than 3-5 seconds in upper and lower extremities, and epitrochlear is non palpable bilaterally.

Musculoskeletal: Normal ROM in upper and lower extremities bilaterally, grip and muscle strength are a 4/5 bilaterally

Neurological: Deep tendon reflexes at all points are +2 normal with a negative romberg and babinski test

Total points: ____ out of 100 points

PASS or FAIL: _____

Instructor comments if applicable: