

Complete Comprehensive Health/ History Examination

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Patient Information O.A. **DOB:** 04/ 23/ **Gender:** F

Source Of History: Patient Medical Record (EPIC CHART).

Reason for Seeking Care (Chief Complaints: “Patient complains of chest pain, shortness of breath.

History of Present Illness: Moderate Persistent Asthma

A 53-year-old woman in respiratory distress with bronchospasm, inflammation, and mucus production was admitted to the hospital on April 9, 2023. She has trouble breathing not resolved with an inhaler, wheezing, shortness of breath, and chest tightness. She can speak but frequently pauses to breathe, is very anxious, and states that Asthma has never felt this awful. After presenting in the E.D., O.A. is triaged quickly for moderate persistent Asthma. She receives the dose of albuterol via nebulizer, is started on 2L of oxygen via nasal cannula with continuous pulse oximetry and is moved to an E.D. bed for further management. After entering the room and introduction, the Patient is sitting upright and appears to be in respiratory distress; she states she woke up this morning with increasing shortness of breath, coughing, and tightness in the chest. After using the inhaler three times with no relief, she asked her family member to drop her off at the E.R. She was given ipratropium-albuterol (douneb) 05-2.5gm/3ml nebulizer solution 3l every 4 hrs dextromethorphan-guaifenesin (Robitussin-DM) 10-100mg/5ml solution 10ml orally ever 4-hour PRN, and this will help her reduce coughing. The Patient takes her medication today. Azithromycin 500mg in sodium chloride 0.9% 250 ml IVPB (VTB) for pneumonia. Ceftriaxone (Rocephin) 1000 mg in dextrose 50 ML IVPB (premix) 1000mg, IV infusion at 100ml/hr. Pneumonia. The Patient refused to take Famotidine (Pepcid) 20 mg orally every 12 hours.

Past History: COPD, Anxiety, the varicose vein on the leg, and Asthma

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Past Surgery: None

Allergy: NDKA

Medication:

Albuterol Proventil 2.5 mg Every 4 hours via nebulizer

Ceftriaxone 1000mg in dextrose 5% 50ml - 100mg, IV infusion at 100ml/hr for pneumonia

Guaifenesin 200/20mg per 10ml oral every 4 hours PRN cough congestion

Azithromycin: 500mg in sodium chloride 0.9% 250 mL IVPB- 500mg, IV infusions at 200ml for pneumonia.

Fluticasone propionate: (Flonase) 50mcg/act nasal – 2 spray each nostril daily.

Enoxaparin (Lovenox) injection 40mg, subcutaneous every 12 hours

Loratadine (Claritin) tablet 10mg -10mg oral daily

Montelukast (singular) tablet 10mg oral nightly

Famotidine (Pepcid) tablet 20mg oral every 12 hours.

Social and Personal History

Social: Register Assistant

Smoking: Smoker for three years, two packs

Family History: Father

a heavy smoker for 12 years, four packs a day

Mother has Acute renal failure

Activities of Daily ADL) independent and ambulating, bathing, dressing, toileting, and continence and feeding.

Instrumental Activities of Daily Living (IADL): Cooking, shopping, paying bills, laundry, and taking medication.

General: losing weight

Review of System

The Patient is alert and oriented and was very happy and talking with one of her family members on the phone. She is lying on the bed with no discomfort and in a good mood.

Eyes: The PERRLA EOM intact.

ENNT- Nares are patent, the nose is symmetrical, no drainage, the lips are pink no teeth loss gum is pink, and the tongue is moist. The tongue is obscured the view of posterior oropharynx.

Neck: there are no masses, no noticeable jugular vein distention, no bruit, and pulsation is 2+ bilateral. No noticeable or palpable swelling, redness, or rash around throat or on face.

Respiratory: 18 breaths per minutes. Patient had dyspnea and wheezing, slow deep breathing to promote relaxation and reduce work breathing.

Lymph Nodes- No lymphadenopathy

Cardiovascular- NO Shortness of Breath, chest pain and heart palpation. Adventitious sound is present when patient has wheezing and crackles.

Skin /Breast- no rashes

Endocrine: no changes in appetite

Gastrointestinal- No distention or constipation. Patient did not eat because she has dysphagia.

Urinary- No increased frequency or pain on urination. Patient has some urge incontinence.

Musculo skeletal- No joint swelling and tenderness, no change in strength

Neurologic- No changes in memory

Physical Examination

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Height: 5' 0

Weight: 147lbs

BMI: 20.50kg/m²

Vitals Signs. Blood Pressure: 132/85mmHg **Heart Rate:** 118/minutes

Respiratory rate: 28mm **Temperature:** 99.1F (37.3C) **oxygen saturation:** 90%

Pain: 0/10

Laboratory Data:

Erythrocytes -50ml/mm³

Hemoglobin – 14g/L

Hematocrit- 44%

Platelets- 390,000 /mm³

ABGs PH - 7.5

PaCO₂- 29mmHg

HCO₃ – 24mEq/L

PaO₂ – 80 mmHg

Leukocytes- 98,000/mm³

PERR- 65%

ADPIE- Assessment Diagnosis Planning Implementation and evaluation

Assessment

Alert and oriented but restless to sit still appear anxious.

Heart rate is regular but tachycardic.

She denies chest pain, but chest feels tight.

Capillary refill < 3 sec

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BP: 132/85mmHg

HR: 118 minutes

Temp: 99:1F (37.3 C)

Respiratory 28mm

O2 Saturation 90%

Pain 0/10

Diagnosis

In effective breathing pattern work of breathing

Ineffective airway clearance airway inflammation

Impaired gas exchange ventilation-perfusion misrefer

Anxiety

Difficulty breathing

Impaired Health Maintenance

Deficient Chronic Disease management

Planning

Goals:

Effective breathing pattern

Breathing normal are and depth.

Absence of Dyspnea

No use of accessory muscles

Maintain clear open airway

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Normal breath sounds

Improvement in PEFR value

Optimal Gas exchanged.

Unlabored respiration at 12-20/min

Pulse oximetry at therapeutic levels

Blood gases closer to normal range

Clearly explaining plan of care

Breathing, relaxation techniques

Understand long-term management of asthma.

Implementation

Collaboration with patient and healthcare team

Receive orders.

Receive plan care.

Collaborate with respiratory therapist.

Administering peak flow meter and monitoring per values

Teaching breathing and airway clearance techniques

Decreasing blood for blood gas analysis

Monitor for signs of deterioration.

Report to attending physician immediately for increase dyspnea, cyanosis, and low consciousness decrease.

Evaluation

Breathing less labored

No longer using accessory muscles.

Oxygen saturation improved at 95% on room air.

Latest Perf shows improvement at 72%

Remained alert oriented and appear less anxious.

Vital Signs

BP = 120/80mmhg

HR = 80bpm

Temp = 98.6 F (37C)

Pain = 0/10

ABG's PH = 7.44

PaCO₂ = 34mmHg

HCO₃ = 24MEq/L

PaO₂ = 90mmHg

Follow-up with family physician in a week.

Monitor response to treatment.

Make adjustments to treatment plan.

