

Michelle Murray

NUR 204 – Health Assessment

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Comprehensive Nursing Assessment Template

Patient Information: J. M. **DOB:** March 11, 1954. **Gender:** M

Source of History: Patient who is a reliable historian and medical record.

Reason for seeking care (Chief Complaints): “Stroke with the left side weakness.”

History of Present Illness (HPI):

A 69-y o man stroke patient with peg tube, history of hypertension, history of UTI, Aspiration precaution, Assistant to eat, Pressure ulcer is healed on the sacrum area. Patient is alert and oriented x 1, to name. Patient is at risk for fall and Pt is on peg tube on Glucerna 1.2 type feed continuous rate, water is given every 6 hours and received 250 ml and Pt receive PT and OT.

Past History:

Past Medical History: Hypertension, High Cholesterol, Aspiration, Pressure ulcer

Past Surgical History: Peg Tube

Immunizations: Hepatitis B, Measles, mumps, rubella (MMR), varicella, polo

Allergy: No Known Allergies

Medications: Acetaminophen (Tylenol) 325 mg tablet 3 tablets as needed
Carvedilol – 12.5 mg tablet; 1 tablet by G Tube route 2 X a day
Ceftriaxone – 2000 mg in sodium chloride 0.9% 50 ml IVPB
Enoxaparin (Lovenox Injection) – 40 mg / 0.4 ml under the skin day
Losarton (Cozaar) – 100 mg tablet (1 tablet) daily by mouth
Melatonin – At Bedtime
Polyethylen glycol (Miralax) – 17 g packet (take 1 packet) by mouth for 3 days.
Sennosides (Senna) – 17.2 mg (1 tablet) by NG tube route nightly

Social and Personal History

Social: a retired masonry

ETOH: occasional drinker

Illicit drug use: none

Smoking: former smoker, quit 10 years ago, ½ pack for 15 years.

Family History: Father deceased with stroke
Mother deceased with breast cancer

Health Patterns (Chapter 4. Table 4-3) Health Patterns (Optional)

Self-concept: Dominican Republic background
Value-belief: Catholic
Exercise and diet: No diet and exercise but regular meal
Sleep-rest: Regular 8 hours sleep
Relationship: Married
Coping-stress-response: Watch Television

Functional Assessment

Vision: Patient has difficulty reading. Vision 20/50
Hearing: Pass whisper test
Leg mobility: No mobility to legs
Urinary incontinence: Lost control of urine and bowel movement
Nutrition: Tube Feed and puree
Memory: Can remember more than 3 items
Depression: Was not appeared depressed or sad
Physical disability: Bed bound.
Activities of Daily Living (ADL): Total assistant for bathing, dressing, toileting, transferring, incontinence, tube feeding and puree.
Instrumental Activities of Daily Living (IADL): Total assistant in using the telephone, shopping, preparing food, housekeeping, doing laundry, transportation, taking medicine, managing money

Review of Systems (Subjective - you should not document from your physical exam findings):

General: Gained 5 lbs. in the last 6 months
Head, Eyes, Ears, Throat (HEENT): Head: Scalp without lesions, Hair: grey and thin. Eyes: 20/50 near vision. Conjunctiva pink; sclera white. PERLLA. Ears: Acuity hears whisper. Weber midline. Soft light brown cerumen partially obscures right TM. Nose: Mucosa pink, septum midline. No sinus tenderness. Mouth: Oral mucosa pink. Dentition intact. Tongue midline
Neck and lymph nodes: Trachea midline

Neck: Normal, No swollen glands
Breasts: No lumps, no discharge
Respiratory: Normal, no wheezing
Cardiovascular: Rate & Rhythm Normal, High blood pressure
Gastrointestinal: Normal Bowel Sound
Urinary: Recent flank pain, large volume
Genital: The smoothness of the testicles and no abnormalities of the penis.
Peripheral Vascular: No varicose vein
Musculoskeletal: Normal

Psychiatric: Treatment for psychiatric disorders

Neurologic: Confused

Hematologic: Except for bleeding gums

Endocrine: Minimal sweating. History of diabetes, temperature intolerance.

Physical Exam (objective: you should not document from your review of systems findings)

Height: 5 ft 3 in Weight: 210lb BMI: 35

Vital Signs: BP: 124/75 Heart rate: 75 Respiration rate: 18

Temperature: 97.4

General Survey: J.M is 69 y/o man is a short Spanish speaking patient with total care.

Head, Eyes, Ears, Throat (HEENT): Head: Scalp without lesions, Hair: grey and thin. Eyes: 20/50 near vision. Conjunctiva pink; sclera white. PERRLA. Ears: Acuity hears whisper. Weber midline. Soft light brown cerumen partially obscures right TM. Nose: Mucosa pink, septum midline. No sinus tenderness. Mouth: Oral mucosa pink. Dentition intact. Tongue midline

Neck and lymph nodes: Trachea midline

Thorax and Lungs: No abnormal

Cardiovascular: S1 and S2 present

Breasts: No dimples, no discharge

Abdomen: Bowel sound active, no tenderness, no mass

Genitalia: Without lesions

Extremities: Warm without edema, calf nontender

Peripheral Vascular: No trace of edema on both ankles

Musculoskeletal: No joint deformities

Neurologic:

Mental Status.: Tense and not alert and not cooperative

Cranial Nerves: II and XII intact

Cerebellar: RAMs point-to-point movement intact.

Sensory: Light touch, position sense, pinprick, vibration intact.

Reflexes: Biceps 2+, Triceps 2+, Brachioradialis 2+, Patellar 2+. Achilles 1+

Laboratory Data:

Full blood count 793

Glucose 739

Cholesterol 347

Electrocardiogram 782

ESR 513

CT scan 632

MRI 77

Carotid Doppler 150

Chest radiograph 739

Nursing Assessment/Plan

Problem: Allergy reaction or Ineffective airway clearance related to presence of thickened secretions. The patient must be monitored for aspiration prevention. Patient has difficulty swallowing and risk for high cholesterol. High blood pressure and at risk for another stroke

Interventions:

Frequently monitor and assess the neurological status. The nurse must constantly monitor the patient's vital signs. The patient fluid intake and output will provide evidence of homeostatic fluid and electrolyte balance. The patient should receive a brain CT scan to show if there is bleeding in the brain or if there is any damage to the brain cells from the stroke. Then the patient should receive an MRI. The result from the CT scan to diagnose a stroke. MRI uses magnets and radio waves to create a picture of the brain and the type of stroke. Assist patient to eat, assist patient with ADL and bed is in the lowest level to prevent fall and call bell is in reach.

Evaluation: The nurse should continue to monitor the patient. Patient did not fall during shift. Patient was able to verbalize that he needed to be changed. The patient was given a peg and tube feed will start. The head of the bed is in semi-Fowler position to prevent aspiration.