

## Comprehensive Nursing Assessment Template

**Patient Information:** V.S      **DOB:** 04/30/1966      **Gender:** F

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

**Reason for seeking care (Chief Complaints):** SOB, right shoulder, and back pain

**History of Present Illness (HPI):** The patient Ms. S is a 62-year-old female with stage 4 metastatic breast cancer who presents to the emergency department with shortness of breath, right shoulder, and back pain. She reports a history of pleural effusion and has been taking medications for hypertension, diabetes, and deep vein thrombosis. She reports a recent weight gain of 5 pounds in the last 6 months.

### Past History:

Past Medical History: Stage IV Metastatic Breast Cancer, Hypertension, Type 2 Diabetes, Deep Vein Thrombosis (HCC), Pleural Effusion

Past Surgical History:

Tonsillectomy: Age 15

Cesarean Section: Age 31

Breast Biopsy:(RT Breast) - Age 39

Immunizations: COVID 19 Vaccines: Pfizer x2 , Johnson & Johnson x1

Influenza: 06/2023

**Allergy:** No known drug allergies

### Medications:

- Volaren 50 mg, orally, twice daily
- Lovenox 40 mg, subcutaneously, once daily
- Insulin Lantus 20 units, subcutaneously, once daily
- Humalog 10 units, subcutaneously, before meals
- Neurontin 300 mg, orally, three times daily
- Toradol 10 mg, orally, every 6 hours as needed for pain
- Tylenol 650 mg, orally, every 4 hours as needed for pain
- Oxycodone 5 mg, orally, every 4 hours as needed for pain
- Senokot 2 tablets, orally, once daily
- Miralax 17 g, orally, once daily

### Social and Personal History :

Social: Lives alone, retired - one child (male) Age 31

ETOH: None

Illicit drug use: None

Smoking: Former smoker, quit 10 years ago

**Family History:** Father deceased from heart disease  
Mother deceased from breast cancer

**Activities of Daily Living (ADL):** The patient is able to perform all ADLs independently including bathing, dressing, toileting, transferring, continence, feeding

**Instrumental Activities of Daily Living (IADL):** 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, decreased appetite, denies fever, denies insomnia, denies chills, denies irritability

Head, Eyes, Ears, Throat (HEENT) Denies headache, denies dizziness, denies visual disturbances, denies ear pain or tinnitus, denies sore throat, denies difficulty swallowing, denies vertigo, denies nose bleeds

Neck: Denies stiffness or pain

Breasts: Reports right shoulder pain, patient complaints of pain in the upper outer quadrant in the RT breast, RT breast serous discharge

Respiratory: Denies cough, reports shortness of breath, denies wheezing, denies snoring, denies bloody sputum

Cardiovascular: Denies chest pain, palpitation and edema in the legs, denies syncope,

Gastrointestinal: Reports nausea from chemotherapy, denies vomiting, occasional bloating and abdominal distention, denies blood in stool, denies reflux, denies changes in bowel habits

Urinary: Denies painful urination, denies change in frequency and urgency, denies back pain, denies flank pain, denies blood in urine (hematuria), denies cloudy urine, denies excessive urination (polyuria) denies groin pain

Genital: Denies genital discharge, denies lesions. Denies pain and discomfort during sexual activity, denies

Peripheral Vascular: Denies leg cramping, denies swelling in extremities, denies pain, denies leg ulcer

Musculoskeletal: Reports bone and joint pain in back/shoulder area, denies weakness in upper and lower extremities

Psychiatric: Reports feeling sad throughout the day, denies suicidal thoughts, denies hallucinations

Neurologic: Denies tremors, denies seizures, denies headaches and dizziness, denies lightheadedness, denies memory loss

Hematologic: Denies excessive bleeding, denies easy bruising,

Endocrine: Reports hunger but low appetite, denies excessive thirst, denies frequent urination, denies excessive perspiration

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

Height: 5'7                      Weight: 212                      BMI: 33.1  
Vital Signs BP:140/90    Heart rate: 100 bpm                      Respiration rate: 22    Temperature: 98.6

General Survey: Ms. S is a 62 year old female appears uncomfortable and is in moderate distress due to shortness of breath and pain. Patient reports pain in the right shoulder and upper area of her back and rates pain a 7 out of 10. Patient is well groomed without body odor. Speech is clear and cohesive. Pt is alert and oriented x3. Patients face is symmetrical. Patient presents with a normal gait.

Head, Eyes, Ears, Throat (HEENT): Head is normocephalic and atraumatic. Pupils are equal, round and reactive to light and accommodation. Ears are clear bilaterally with normal hearing. Fundoscopic exam reveals no papilledema and sharp disc margins. Throat is clear, no exudates or erythema noted.

Neck and lymph nodes: Lymph nodes show no sign of adenopathy and no signs of palpable masses.

Thorax and Lungs: Diminished breath sounds heard in the right lung with crackles and wheezing. The patient is tachypneic

Cardiovascular: Normal S1 and S2, no S3 or S4 heard upon auscultation.

Regular rhythm with tachycardia. No murmurs, rubs, or gallops.

Breasts: Right shoulder pain on palpation, no visible abnormalities or masses noted on inspection.

Abdomen: Soft and non-tender, no masses or organomegaly palpated. Bowel sounds present in all four quadrants.

Genitalia: Normal female genitalia, no erythema, discharge, or lesions

Extremities: The patient reports right shoulder and back pain. No edema or visible abnormalities noted on inspection. No cyanosis, no clubbing, capillary refill less than three seconds, limited ROM in right shoulder, no joint deformities

Peripheral Vascular: No visible edema or abnormalities, no bruits auscultated.

Musculoskeletal: Limited range of motion noted on the right shoulder. No visible abnormalities or deformities noted on inspection. No muscle atrophy. No muscle weakness

Neurologic: The patient is alert and oriented x3. No focal deficits noted on examination.

Mental Status: The patient is cooperative and appears anxious

Cranial Nerves: I-XII Intact.

Cerebellar: No gross motor deficits noted.

Sensory: No sensory deficits noted

Reflexes: 2+ bilaterally in all extremities ( biceps, triceps, brachioradialis, patellar and Achilles)

**Laboratory Data:**

HGB 11.3  
HCT 36.6  
CO2 21  
Glucose 211  
Protein 6.1  
WBC 3.8

## **Nursing Assessment/Plan**

**Assessment:** The patient is a 62-year-old female with a history of stage 4 metastatic breast cancer, hypertension, diabetes, deep vein thrombosis, and pleural effusion presenting to the ED with shortness of breath, right shoulder pain, and back pain. Physical examination reveals diminished breath sounds with crackles and wheezing in the right lung, tachypnea, tachycardia, and limited range of motion on the right shoulder.

### **Problem:**

1. Impaired gas exchange related to decreased lung function secondary to pleural effusion and metastatic breast cancer
2. Acute pain related to right shoulder and back pain

### **Nursing Interventions:**

1. Administer supplemental oxygen to maintain SpO<sub>2</sub> > 92%.
2. Administer Toradol 30 mg IV every 6 hours as needed for pain.
3. Administer Volatren 50 mg PO every 8 hours as needed for pain.
4. Administer Neurontin 300 mg PO every 8 hours as needed for neuropathic pain.
5. Administer Lovenox 80 mg subcutaneously every 12 hours as ordered for deep vein thrombosis prophylaxis.
6. Monitor vital signs, oxygen saturation, and pain level regularly.
7. Educate the patient on deep breathing exercises to improve lung function and alleviate shortness of breath.
8. Consult with the healthcare provider for further management and treatment of the patient's underlying conditions.

### **Evaluation:**

- The patient's oxygen saturation improved to 95% on supplemental oxygen. The patient reports decreased pain level after receiving Toradol and Volatren. The patient was able to perform deep breathing exercises effectively. The healthcare provider was consulted for further management of the patient's pleural effusion and metastatic breast cancer.