**Comprehensive Nursing Assessment Template**

**Patient Information**: C.C **DOB**: 10/20/64 **Gender:** M

**Source of History:** Patient who is somewhat reliable and patient's medical record

**Reason for seeking care (Chief Complaints):** ulcers and scar tissue

**History of Present Illness (HPI):**
A 59-year-old male with a history of opioid abuse, alcohol use, HIV, depression, and Methicillin-Sensitive Staphylococcus. Patient was admitted for shooting heroin, in the posterior part of his neck. Which caused an infection of cervical osteomyelitis. Patient was disoriented and confused x3. Narcan was administered. Prior to overdose, the patient was fully aware of risk factors for narcotics and alcohol use. Patient showed symptoms of pain, fatigue, and chills. Patient was administered a methadone tablet 60mg. Blood culture was taken to run for risk of infection. Therapists came in briefly to discuss and assess signs and symptoms of depression and substance induced mood disorder. Surgical history of transoral biopsy. Infection of Osteomyelitis came back positive and the patient was put on intravenous antibiotic long term. Cefazolin of 2000 mg was given. Patient had an open sore on the right side of the arm above the elbow, in which a blood culture was taken.

**Past History:**

Past medical history: HIV, depression, opioid abuse, alcohol use, smoker
Past surgical history: transoral biopsy/single/multiple
Immunizations: COVID vaccines Pfizer x2, no influenza this season

**Allergy:** n/a

**Medications**: Cefazolin 2,000 mg
Sodium chloride infusion 1,000 ml
Methadone (dolophine) tablet 60 mg
Lorazepam tablet 2mg
Injection 15mg

**Social and Personal History**

Drug addict
Social: subacute rehab
ETOH: smoker, drinker
Illicit drug use: cocaine, heroin
Smoking: current smoker

**Family History:** n/a

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

Self-concept: Patient wants to “get better, and get a job”
Value-belief: catholic
Exercise and diet: Patient likes to go on walks, heart healthy diet
Sleep-rest: Patient naps a lot

Relationship: single, no family involved
Coping-stress-response: smoking and drug use to destress

**Functional Assessment (Optional)**

**10-minutes geriatric screener (ADL and IADLs for Elderly) (Chapter 24, Box 24-8)**
Vision 20/30
Hearing: does not use aids, and does not have trouble
Leg mobility:
Urinary incontinence: content
Nutrition: heart healthy diet
Memory: AAO x2
Depression: known
Physical disability: n/a
**Activities of Daily Living (ADL)**: patient is independent
**Instrumental Activities of Daily Living (IADL):** using the telephone, walking around neighborhood, transportation, taking medicine, managing hygiene independently

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

*General: smoker, confused to time and situation*
*Head, Eyes, Ears, Throat (HEENT): denies headaches, and difficulty swallowing or speaking, vision/hearing changes.*
*Neck: has tenderness, difficulty maneuvering,*
*Breasts: denies new masses/lumps*
*Respiratory: denies difficulty breathing in daily activities*
*Cardiovascular: denies of chest pain*
*Gastrointestinal: denies abdominal pain, constipation/diarrhea*
*Urinary: continent*
*Genital: HIV positive*
*Peripheral Vascular: denies pain with ambulation or rest, denies*
*Musculoskeletal: denies pain or difficulty walking, doing ADLs*
*Psychiatric: has known depression, and anxiety*
*Neurologic: AAO x2*
*Hematologic: HIV, cervical osteomyelitis*
*Endocrine: Denies any history, denies heat/cold intolerance, skin changes, or irritability*

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

Height: 5’7 Weight: 140 BMI: 21.93
Vital Signs BP: 101/61 Heart rate: 85 Respiration rate: 18 Temperature: 97.5

*General Survey:* C.C Is a 59 y/o male who appears to be an alert & oriented x3. Patient is well groomed without any body odor. Speech is intact and the thought process is logical. Shows no signs of neglect or abuse. Gate is normal without any assistive devices.
*Head, Eyes, Ears, Throat (HEENT): no deformities, vision and hearing are intact, Patient is attentive. Neck and lymph nodes: tenderness/fixation lymph nodes nonpalpable*
*Thorax and Lungs: lung sounds clear bilaterally, no dyspnea*
*Cardiovascular: s1/s2 present, no murmurs, no signs of PVD/PAD*
*Breasts: no masses or signs of breast cancer*
*Abdomen: bowel sounds present x4, no distention or deformities*
*Genitalia: no presence of abnormalities*
*Extremities: warm and smooth skin, no abnormalities.*
*Peripheral Vascular: no signs of PAD/PVD cap refill 2 seconds*
*Musculoskeletal: muscle grade +5*
*Neurologic: PERRLA*
*Mental Status. AAOx2, needs to be reoriented to time and situation*
*Cranial Nerves: intact*
*Cerebellar: shuffling gait*
*Sensory: intact*
*Reflexes: intact +2*

**Laboratory Data:**
ECG normal

**Nursing Assessment/Plan**
Problem: fall risk, risk for opioid relapse, risk of smoking, risk of skin integrity, risk of deposition of IV, risk of further infection.

Interventions: patient education on medications and situation, administer all medications to reduce risk for further complication of relapse and further infection, assist on cleaning and dressing open wound, possible subacute rehab when discharged

Evaluation: Patient is alert and oriented x3. Patient is aware of the diagnosis, and has no trouble taking medications daily. Patient conveys knowledge for needs of medication and assistance with wanting to shower, walk and use the hospital telephone. Patient is free of falls and can ambulate on his own. Patient hasn't smoked since admitted. Patient hasn't had opioid use since administration. Patient talks about subacute rehab when discharged. Patient talks about getting better and quitting drugs.