Comprehensive Nursing Assessment Template

Patient Information: E.S. **DOB**: 08/15/1950 **Gender**: F

Source of History: Patient and family member

Reason for seeking care (Chief Complaint): "Chest pain and shortness of breath"

History of Present Illness (HPI):

E.S. is a 72-year-old lady who reports to the E.D with a problem of shortness of breath and chest pains. She states that the problem commenced about 3 hours ago while relaxing at home. She experiences the chest pain in the middle of her chest. She explains the shortness of breath and chest pains as a tightening and intermittent. She also reports that she has been feeling shortness of breath after light activities for the last 2 weeks. She reports of having not received any medications for the signs and symptoms. She claims of experiencing HBP, hyperlipidemia and osteoarthritis in the past. She refutes experiencing dizziness, nausea, vomiting or lightheadedness. She used to smoke until 5 years ago when she quit.

Past History:

- Past Medical History: Hypertension, Hyperlipidemia, Osteoarthritis, Former smoker
- Past Surgical History: Appendectomy
- Immunizations: Influenza vaccine, last received in October 2022.

Allergy: No known drug allergies.

Medications:

- Amlodipine 10mg once daily for hypertension
- Atorvastatin 40mg once daily for hyperlipidemia
- Acetaminophen 500mg as needed for pain

Social and Personal History:

- Social: Retired teacher

- ETOH: Occasional glass of wine with dinner
- Illicit drug use: None Smoking:
- Former smoker, quit 5 years ago

Nutritional History:

- Primary Diet:
- Supplements:
- Appetite:
- Number of meals/day:
- Who prepares meals:
- Dentures:
- Religious requirements:
- Eats alone or with others:
- Dysphagia:
- Bowel Frequency:

Family History:

- Father deceased due to heart attack at age 65
- Mother deceased due to stroke at age 80
- Brother with hypertension and hyperlipidemia

Health Patterns:

- Self-concept:
- Value-belief:
- Exercise and diet:
- Sleep-rest:
- Relationship:

- Coping-stress-response:

Functional Assessment:

10-minutes geriatric screener (ADL and IADLs for Elderly) (Chapter 24, Box 24-8)

- Vision:
- Hearing:
- Paralysis:
- Bowel/Bladder incontinence:
- Nutrition:
- Hand – Eye Coordination:
- Dyspnea;
- Memory:
- Depression:
- Amputation:
- Unsteady Gait:

Activities of Daily Living (ADL):

Activity Of Daily	Incapable of Doing	Minimal Assistance	Moderate Assistance	Maximal Assistance	Independent
Bathing					
Toileting					
Dressing					
Transferring					
Feeding					

Instrumental Activities of Daily Living (IADL):

IADL	Incapable Of Doing	Minimal Assistance	Moderate Assistance	Maximal Assistance	Independent
Shopping					
Meal Preparing					
Housekeeping					
Laundry					

Using the telephone					
Ambulation					
Medication reminders					
Medication Administration					
Financial Management					

Review of Systems

General: Reports feeling fatigued over the past week. Head, Eyes, Ears, Throat (HEENT):

- Visual:
- Hearing:
- Neck:
- Breasts:
- Respiratory:
- Cardiovascular:
- Gastrointestinal:
- Urinary:
- Genital:
- Peripheral Vascular:
- Musculoskeletal:
- Psychiatric:
- Neurologic:

Physical Exam

Height: 5’6” Weight: 210 lbs BMI: 34

Vital Signs: Respiratory Rate: 30 breaths per minute Pulse: 90 beats per minute BP: 152/90 mmHg Temperature: 37.6°C (Armpit) Oxygen Saturation: 95% on 2l/min nasal cannula

General Survey: E.S is an aged woman in no acute distress. She appears fatigued and uncomfortable with shortness of breath and chest pains and. She has a nasal cannula providing supplemental oxygen at 2L/min. She is using accessory muscles to breathe. She is well-groomed, with no body odor. She is also oriented to time, place and person and alert.

Head, Eyes, Ears, Throat (HEENT):

- *Head:*
- *Eyes:*
- *Ears:*
- *Throat:*

Neck and lymph nodes:

Thorax and Lungs:

Nose:

- *Congestion:*
- *Epistaxis:*
- *Loss of smell:*
- *Sinus problem:*

Cardiovascular:

- *Cyanosis:*
- *Chest pain:*
- *Claudication:*

- *Varicose veins:*
- *Murmur:*
- *Fatigue:*
- *Palpitations:*
- *Vertigo:*
- *Pulse deficit:*
- *Cardiac pacemaker:*

Breasts:

Abdomen:

Genitalia:

Extremities:

Peripheral Vascular:

Musculoskeletal:

- Fracture:
- Contracture joints:
- Atrophy:
- Decreased ROM:
- Pain: location:

Neurologic/Mental status:

- *Aphasia:*
- *Hemiplegia:*
- *Paraplegia/Quadriplegia:*
- *Numbness:*
- *Seizures:*

- *Unsteady Gait/Ataxia:*
- *Syncope:*
- *Vertigo:*
- *Dizziness:*
- *Agitated:*
- *Anxious:*

Laboratory Data:

- Cardiac enzymes (troponin, CK-MB, myoglobin)
- Lipid panel (cholesterol, triglycerides)
- Complete blood count (CBC)
- Arterial blood gases (ABGs)
- Urinalysis
- Chest X-ray
- D-dimer test

Nursing Assessment Plan:

Problem: Chest pains and shortness of breathe

- Assess cardiovascular status
- Assess respiratory status
- Assess pain level
- Assess activity performance
- Assess patients Nutrition
- Oxygen Therapy
- Educate patient

Interventions:

- Administer oxygen therapy as prescribed to maintain adequate oxygen saturation levels and improve breathing.
- Monitor vital signs to assess for changes in condition and response to treatment. This includes respiratory rate, blood pressure, oxygen saturation and heart rate.
- Position the patient in a comfortable, upright position to improve breathing and relieve chest pain.
- Properly administer drugs as prescribed. This includes Theophylline to improve breathing, Amlodipine for hypertension, Atorvastatin for hyperlipidemia and nitroglycerin to relieve chest pains.
- Perform frequent respiratory assessments, including auscultation of breath sounds, to monitor for changes in lung function and potential complications.
- Assist with activities of daily living as needed, such as feeding, toileting, and mobility, to conserve the patient's energy and prevent exacerbation of symptoms.
- Provide reassurance and emotional support to the patient, as chest pain and shortness of breath can provoke anxiety.

Evaluation:

- Evaluation of the effectiveness of interventions implemented in the nursing care plan
- Assessment of vital signs and symptoms to determine changes in the patient's condition
- Monitoring of laboratory test results to assess the patient's progress
- Assessment of patient response to medication and treatment
- Documentation of any changes in the patient's condition and response to interventions

- Modification of the nursing care plan based on the patient's response to treatment and progress towards desired outcomes.