

## Comprehensive Nursing Assessment

**Patient Information:** S. S.      **DOB:** 01/25/1963      **Gender:** Male

**Source of History:** Patient who seems reliable.

**Reason for seeking care (Chief Complaints):** “I am feeling dizzy and slurring my speech and it seems my face feels slightly numb.”

### History of Present Illness (HPI):

A 60-year-old man with no acute distress with a h/o CKD, DM2, HTN, A-fib with an irregular pulse. Pt was on the phone with his friend while making some lunch in his living room around 1:45 pm and started not make sense while on the phone. Then had to sit down due to feeling dizzy. Patients friend quickly drove over and saw their friend in distress and immediately drove him to the ED. Pt has not felt this way in a long time since diagnosed with diabetes and high blood pressure. Occasional feelings of tiredness and cramping He states that his legs feel extremely heavy. In the ED he was given aspirin 80 mg. This will help a stroke by breaking up the blood clot. He has not started any new medications. Patient has not taken any of his oral medications today.

### Past History:

Past Medical History: CKD, DM II, A-FIB, HTN  
Immunizations: COVID vaccines pfizer x 4, influenza in Sep, 2022

**Allergy:** NKA

### Medications:

Metformin 1000 mg TID for Diabetes  
Amlodipine 10 mg/day PO for HTN  
Eliquis 5MG PO BID for A-fib

### Social and Personal History:

Social: Works as a plumber  
ETOH: social drinker.  
Illicit drug use: none  
Smoking: former smoker, quit 1 years ago, ½ pack for 20 years.

### Family History:

Patient is adopted. No known family history

## **Review of Systems:**

*General:* Gained 10 lbs in the last 2 years

*Head, Eyes, Ears, Throat (HEENT):* Patient denies history of abnormal urination

*Neck:* Denies lumps, goiter, pain. No swollen glands

*Breasts:* Denies lumps, pain, discharge.

*Respiratory:* Denies cough, wheezing, SOB.

*Cardiovascular:* Hx of high blood pressure, currently on meds. Denies chest pains and or palpitations.

*Gastrointestinal:* Appetite picking up. Denies nausea, vomiting, indigestion. Bowel movement about two times every two days. Denies bleeding, jaundice, gallbladder, or liver problems.

*Urinary:* Nocturia x 1, large volume. Occasionally loses urine when coughs hard.

*Genital:* Denies testicle or pelvic infections.

*Peripheral Vascular:* History of phlebitis and leg swelling.

*Musculoskeletal:* Mild lower back pain; no radiation down the legs. No other joint pain.

*Psychiatric:* Denies history of depression or treatment for psychiatric disorders.

*Neurologic:* Slurred speech, motor, and sensory loss briefly. Denies fainting, seizures. Memory currently intact.

*Hematologic:* Denies easy bleeding.

*Endocrine:* History of diabetes. Denies thyroid trouble, temperature intolerance.

## **Physical Exam**

Height: 6ft, 3in      Weight: 270lbs      BMI: 33.7

Vital Signs BP: 128/93    Heart rate:    Respiration rate: 18    Temperature: 97.7

*General Survey:* S.S is a man who appears to be vibrant and obese in no acute distress. Pt is well groomed without body odor. Speech is intact after given medications in the ED, and the thought process is logical. Gait is normal without any assistive devices.

*Head, Eyes, Ears, Throat (HEENT):* Head: hair coarse, full, brown. Scalp without lesion. Eyes: Distant vision 20/30 in each eye. Visual fields full by confrontation. Conjunctiva pink; sclera white. PERRLA. EOMs intact. Ears: soft, light cerumen partially obscures right TM; left canal clear, TM with cone of light. Acuity hears whispered voice at 1 ft BL. Weber midline. 2AC > BC. Nose: Mucosa pink, septum midline. No sinus tenderness or polyps.

*Neck and lymph nodes:* Neck Lobes not felt; Soft, nontender, mobile.

*Thorax and Lungs:* No wheezes or crackles

*Cardiovascular:* Heart normal size; no thrills, no heaves

*Breasts:* No dimpling, rashes, masses; nipples without discharge.

*Abdomen:* Non-distended, no scars, non-tender to palpation, no masses.

*Genitalia:* External genitalia without lesions

*Extremities:* Edema present, capillary refill more than 3 secs

*Peripheral Vascular:* Pitting edema at both ankles. Stage 2 stasis pigmentation, no ulcers.

*Musculoskeletal:* No joint deformities. FROM in hands, wrists, elbows, shoulders. Hips, knees, ankles negative.

*Neurologic:*

*Mental Status:* Lethargic but cooperative and alert. Alert and oriented x 3

*Cranial Nerves:* II to XII slightly intact

*Cerebellar:* RAM's point-to-point movements positive. Gait unstable

*Sensory:* Light touch, position sense vibration, stereognosis non intact. Romberg positive

*Reflexes:* Strength of biceps, triceps, hand grip, finger spread, hip flexion, knee flexion, and knee extension 2/5 bilaterally.

**Laboratory Data:** None currently.

### **Nursing Assessment/Plan**

**Problem:** Risk for injury, risk for ineffective cerebral tissue perfusion, impaired verbal communication, impaired physical mobility precautions due to acute right side stroke.

**Interventions:** Reposition the patient every 2 hours. Position head slightly elevated in a neutral position. Elevate legs and continue to check for decreasing edema. Assess level of consciousness and monitor vital signs, assess for murmurs.

Melissa Hobson  
Health Assessment Assignment

Prof: Hwang  
04/22/23

Evaluation: Patient has improved level of consciousness, cognition, and motor/sensory function.  
Patient demonstrates stable vital signs.