

Gecenia Vasquez

## Health Assessment Comprehensive Assignment

**Patient Information:** D. K

**Gender:** Female

**Source of History:** Medical records

**Reason for seeking care (Chief Complaints):** “Abdomen pain and headaches.”

### History of Present Illness

69-years-old female with seizures and HTN presents to the ED in the early morning elevated blood pressure of 180’s at home with concern of RUQ pain on admission and scans showing of acute cholecystitis and admitted to the hospital for further imaging. Patient is able to manage hypertensive urgency. She has no other symptoms. She is AOX2. Arousable and demonstrates basic understanding. The abdomen exam shows a mild distention, no visible evidence of tenderness. She has had breakfast and lunch for the day. Patient has taken all medications for the morning.

### Surgical History:

Knee replacement

### Medical History:

Syncope

Acute cholecystitis

HTN (hypertension)

### Social and personal history:

Patient lives in Bronx by herself. Patient doesn’t need assistance in ADLs and IADLs. Patient doesn’t use and tobacco, alcohol or drugs. Patient’s dad died unknown cause. Both parents had hypertension.

### Allergies:

No unknown allergies

### Medications:

Sodium chloride 0.9% -1000ml IV continuous

metronidazole IVPM- 500 mg IV intermittent

Heparin Injectable-5000 units subcutaneously every 7 hours

Oxycodone IR-5 milligrams oral

### Review of systems:

Eyes - no changes in vision

ENT - No impacted cerebrum, does not wear hearing aids  
Skin – intact and warm  
Cardiovascular - No SOB, chest pain  
Pulmonary - no cough, no SOB  
Endocrine - No changes in appetite  
Gastrointestinal - No constipation. Has not eaten since admission as patient has been put on NPO  
Genitourinary - No increased frequency or pain on urination.  
Musculoskeletal - no changes in strengths, no joint tenderness or swelling  
Neurologic -A&O X2  
Psychology - No changes in mood  
Hematologic – No busing

**Physical Examination:**

**Vitals-**

Temp- 97.9  
Pulse-77  
O2-95% Room Air  
RR-16  
BP-139/79

**General Survey** -Patient has no facial drooping, is lying in bed in nightgown and is well groomed.

Eyes-PERRLA, EOM is not intact  
ENT- Ears, nose and throat are intact, no candidiasis. Tonsils are +1  
Neck- No bumps, edema, bruises  
Lymph Nodes-No tenderness or swelling  
Cardiovascular-No JVD, No bruits,  
Lungs-S1 and S2 sounds clear  
Skin: No rashes, No edema or bruises, warm and dry  
Breast-N/A  
Psychiatry-N/A  
Abdomen-Normal bowel sounds, no rebound tenderness and no pain  
Genitourinary – No redness or sores  
Rectal – Rectal exam not performed  
Extremities - No edema, cyanosis or clubbing  
Musculoskeletal - 3/5 strength, no swollen joints.  
Neurological – Alert and oriented x 2

**Laboratory:**

Na -140  
K -3.7  
Cl -113  
Co2 -23

BUN- 25  
Cr -1.05  
Ca -10.3  
Mg -1.3  
Phos- 4.2  
PTT -25.5  
WBC- 6.05  
Hgb -10.4  
Hct -30.8

**Nursing Assessment/ Plan:**

Risk for fluid overload. Patient has severe RUQ abdominal pain.

Intervention: Continue to monitor the patient. Administer pain medication PRN.

Evaluation: Patient will continue to follow up with primary doctor.