Comprehensive Nursing Assessment Template

Patient Information: G. V. **DOB**:08/29/1940 **Gender:** M.

Source of History: Patient who is unable to provide full history and medical record

Reason for seeking care (Chief Complaints): Patient was found with altered mental status in a shelter.

History of Present Illness (HPI):

An 82y Male presented to the Emergency room on 01/28/2023 with altered mental status, elevated glucose levels and blood pressure levels. The patient was living in a shelter and cannot provide a good medical and family history. Pt is refusing the glucose check and states that he isn't diabetic. Patient was transferred to a med-surg unit and is currently out of bed independent, on full code, and currently on a general diet. Patient has concerned for dementia and is currently on a placement for a nursing home. Pt might need a CT scan. Pt needs and anemia work up.

Past History:

Past Medical History: ETOH, BPH, Hypertension, Dementia
Past Surgical History: Laparotomy
Immunizations: COVID vaccines Moderna x 3, influenza- Unknown

Allergy: No Known Allergies

Medications: Amlodipine 5mg 2x daily for HTN
Atorvastatin 20 mg once times a day for high cholesterol
Lovenox 40 mg daily for DVT
Losartan 25mg daily for HTN
Flowmax 0.6 mg once daily for BPH
Famotidine 20 mg daily for heartburn
Thiamine 200 mg daily for muscle loss
Aspirin 81mg daily for heart disease
Clopidogrel 75 mg daily for angina

Social and Personal History

Social: Unknown; Lives in shelter.
ETOH: Heavy drinker.
Illicit drug use: none
Smoking: Never.

Family History: No known family history- Patient wasn't able to provide an accurate family history.

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

Self-concept:Describe himself as s good person
Value-belief:Catholic
Exercise and diet: Non-specific

Sleep-rest: sleeps when he's tired
Relationship: No romantic relationship; patient stated he lives alone.
Coping-stress-response: Patient was not able to answer this question.

Functional Assessment (Optional)

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

Vision
Hearing
Leg mobility
Urinary incontinence
Nutrition
Memory
Depression
Physical disability

Activities of Daily Living (ADL): 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
Head, Eyes, Ears, Throat (HEENT)- **Negative**
Neck- **Negative**
Breasts:
Respiratory: **Negative**
Cardiovascular: **Negative**
Gastrointestinal: **Negative**
Urinary **Negative**
Genital: **Negative**
Peripheral Vascular: **Negative**
Musculoskeletal: **Negative**
Psychiatric: **Negative**
Neurologic: **Negative**
Hematologic: **Negative**
Endocrine: **Negative**

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

Height:5'5 Weight: 105lbs BMI: 17.47
Vital Signs BP:117/62 Heart rate: 68 Respiration rate: 17 Temperature: 97.8 F. Pco2: 98%

General Survey: G. V. Is a 82yr old male who is currently alert and oriented x3 and is shows no signs for acute distress. Pt is well groomed without body odor. Mucous membranes are moist,

patient is Spanish speaking and speech is intact, and the thought process is currently logical. Gait is normal without any assistive devices.

Head, Eyes, Ears, Throat (HEENT):
Neck and lymph nodes: Symmetrical and no swelling
Thorax and Lungs: Lung sound clear.
Cardiovascular: S1 and S2 heard
Breasts:
Abdomen: Flat no distention.
Genitalia:
Extremities: Skin is warm
Peripheral Vascular: pulses +2 , warm skin
Musculoskeletal: Normal ROM
Neurologic: No focal deficit
Mental Status.
Cranial Nerves:
Cerebellar:
Sensory:
Reflexes:

Laboratory Data: *Sodium- 146mmd/L. BUN- 21.0 mg/dl. Hgb: 10.8g/dl. WBC: 4.28 mm^3. EGFR: > 60ml/min. Phosphorus: 2.9mg/dl. Creatinine: 0.75 mg/dl. Glucose: 72 mg/dl. Calcium: 9.6mg. CO2: 26. Magnesium: 0.8 mg/dl*

Nursing Assessment/Plan
Problem: Fall risk, skin integrity, inadequate tissue perfusion, fluid electrolyte imbalance, potential risk for infection due to length of stay.

Interventions: pt was placed on bed alarm, given non-skid socks, intravenous fluids being given after it site was placed and pt was also given IV magnesium.

Evaluation: After evaluating, pt was in a good mood and vitals are still stable, pt shows no signs of distress and was given flomax to aid in the urination process and bed was left in the lowest position, care ongoing.