

Comprehensive Health and Assessment

Comprehensive Health History and Physical Assessment

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## Comprehensive Health and Assessment Kim2

**Patient Information:** M.J     **DOB:** 04/31/197\*     **Gender:** F

**Source of History:** Patient who is a reliable historian and medical record

**Reason for seeking care (Chief Complaints):** “I have too much pain”

### **History of Present Illness (HPI):**

A 60 y woman in acute pain with a CAD, diabetes, and lymphoma for 4 years awoke from pain around 9 am this morning of nausea and vomiting. She came to the oncology unit b/c she was having acute pain and abdominal swelling due to lymphoma. She had a similar reaction before and she did not have chest pain and itching. She has skin rashes. She says that she has too much pain everywhere. In the oncology unit, she was given acetaminophen PO, atorvastatin 40 mg, oral, nightly, enoxaparin, 40mg, SQ, daily, Insulin 6 units, SQ, TID with meals, Lisinopril, 5mg, oral, Daily. This has helped the pain some. Cold wet application was able to relieve the pain and nothing made it worse though she has not tried to drink any fluids/foods because of pain. She denies any recent travel, recent exposure to unusual plants or animals or other allergens. She has not started any new medications, has not used any new lotions or perfumes and has not eaten any unusual foods.

### **Past History:**

Past medical history : HTN, Diabetes, CAD, Cancer

Past Surgical history: None

Immunizations : MMR, varicella, TB, COVID vaccines pfizer x 2, flu shot 2/20/23

**Allergies :** None

**Medication :** atorvastatin 40 mg, oral, nightly, enoxaparin, 40mg, subcu, daily, Insulin 6 units, subcu, TID with meals, Lisinopril, 5mg, oral, Daily, acetaminophen, bisacodyl, dextrose, glucagon.

### **Social and Personal History**

Social : Florist

ETOH : non drinker

Illicit drug use : none

Smoking : none

**Family History** : Father deceased with HTN, obesity, and blood disorders.  
Mother had breast cancer.

### **Review of each system**

General : gained no lbs in the last 6months

Neurological assessment/mental status : Patient's mental status and mood is normal. She dresses appropriately. Patient remembered 3 words that I gave her but it was slow. She knows her name, year and why she is here. Glasgow coma scale is 35( eye movement, verbal, and body movement). Verbal and non verbal is normal(she can tell appropriately). Patients take acetaminophen if needed.

- Psychiatric : patient does feel depressed
- Hematologic :patient has anemia and her family does not have anemia also.”
- Skin, Hair and nails : patient does not have facial hirsutum, and anemic”. Capillary refill is in 3 seconds. Patient hair is growing well, and she does not have any abnormality of nails.
- Eyes , ears, mouth, throat, nose and sinuses : The patient wears glasses at home, and can smell everything. Patient does not have hearing loss. The patient does not have breathing problems, and she goes to dental clinics once a year. The patient has no sinus issues, no swallowing problems.

- Thorax and Lungs : Patient states “I do not smoke, I can breathe well when I exercise. I never had pain before”. “My breathing pattern is normal”.
  
- Breast and Lymphatic system : Patient states “ I do not have breast cancer and my family has breast cancer. I do not feel anything in my breast”.
  
- Heart and Neck vessels : Patient states “ I do not have chest pain, my family has no chest pain history, my heart beat is normal, I do not have pain in my hand and feet”.
  
- Peripheral vascular system: The patient has a carotid pulse and there were no bruises. For the abdomen, there is no tenderness and scars, no pulsation. For the legs, there is no skin discoloration, no dry, and distal pulses are normal. Patient states “ No pain on my neck”.
  
- Abdomen: The patient eats once a day, her last bowel movement was 2 days ago. Patient have constipation. The patient urinates every day.
  
- Genital : patient states “I don't have an infection and I don't feel pain”. And there is no pain when I urinate”.
  
- Musculoskeletal system: The patient had no surgery, and he can not work out. The patient said she can move left side arm, and leg joints well, no bone fracture before.

### **Physical Examination**

Height : 5'3 Weight : 130 lbs BMI: 22.6

Vital signs- BP-131/60 Pulse-76 HR-78 Temp-98.3F Oxygen 98%

General survey: M.J is a 60y woman who appears to be tired, and wears clothes appropriately. She states she has too much pain. Speech is intact, and the thought process is logical. Patient can not walk because of pain.

Psychological development: Adulthood

Mental status and psychological development:

- Observed patient appears to be healthy and well dressed.
- Asked questions of consciousness. (name, president, and DOB).
- Glasgow coma scale is 35.
- Tested immediate, recent, and remote memory.
- Observed verbal and behavior. It is a sad mood and behavior.
- Observed the patient's voice quality. It is normal. There is no articulation.

Peripheral vascular system:

- Assessed arteries and veins. Arm size is not normal and color is normal. Arm is asymmetrical, because of paralysis, temperature is normal, no edema, radial and brachial pulse is 60, inspected peripheral cyanosis ( normal).
- Legs - normal size, leg is asymmetry, skin color and temperature is normal, femoral pulse is normal, no bruit, popliteal pulse is normal. No ulcers/lesions. There is no peripheral artery disease.
- Abdomen-Patient has swollen abdomen and no pulsations.

Eyes and ears:

- Eye Inspection- sclera is white and the conjunctiva is pink. No drainage from the eyes.

The patient can state behavioral cues indicating effective vision. Eyes appear appropriately placed in orbits. Pupils are equal, round, reactive to light and accommodation. vision exam 20/30(snellen eye chart).

- Ears - No drainage from the ears and no cerumen impaction. The patient states a hearing sound. Conversation includes behavioral cues of effective hearing. During the whispered voice test, the patient reports more than 3 numbers. Patient states no balance and a no coordinated gait. There are no misunderstandings of my questions.

Head and neck, mouth , nose, throat, and sinuses :

- Head : Inspected the skull, face, skin, scalp. Palpation of skull : no tenderness and trauma. Facial Sensation and motor function is normal. Trigeminal Nerve function : touched forehead of patient on both side and cheek with finger. Patient felt the same on both sides of the face. Facial nerve function : patient can move forehead, close eyes, and show teeth and inflate cheeks.

- Neck : inspected and palpated. Inspected for deformities, symmetry and tracheal deviation. All normal. Papated of the lymph nodes of the neck, parotid gland. Assessed the range of motion of the cervical spine. Patient can flex her neck. Asked for spinal accessory nerve function. Patient can move her head to the left and right, and lift shoulders. I could see cranial nerve palsies are normal. JVD is normal.

Thyroid - It was located below the thyroid cartilage and is normally not visible. Not palpable. It slides beneath the fingers. Size is normal. No enlargement.

- Nose : Examined external nose and tested breathing with nostril. Examined normally the

nasal mucosa, and septum normally. Palpation - no tenderness frontal sinuses. Lip, oral mucosa, and gum are normal. No redness and ulceration.

- Throat : inspected patient's tonsils, soft palate, posterior pharynx and tongue. Tongue movement is normal.

- Mouth : Inspection - lip color is pink, moisture and no lesions. No scars in the mouth, on tongue, no voice change. Patients can taste. Teeth and gums are normal. Normal tongue color, and moisture. For inspecting posterior oropharynx, ask the patient "Ah". There is no tonsillar enlargement. Buccal Mucosa For Color, moisture, and nodules are normal.

Sinuses : Inspection -symmetry and deformity. Palpation :normal nasal patency, frontal and maxillary sinuses (no tenderness).

Thorax and lungs : Inspection - breathing is normal, appearance is fine. Shape of the chest is normal. Posterior/anterior thorax shape is normal and symmetry. Inspected spinal alignment for deformities. Breathing patterns are normal.

Palpation - respiratory excursion is equal bilaterally. No crepitus, no retraction. No vocal tactile fremitus. (say "99")

Percuss- diaphragmatic excursion is equal bilaterally. Tone is low pitched and normal back and front.

Auscultation- using a stethoscope, auscultate the chest the flat disc diaphragm. Auscultate normal trachea. There are no adventitious sounds. Checked bronchophony(say 99) and egophony(say eee). 99 is not clear, so it is normal. Eee sound is clear, so it is normal, not any

sound.

Breast and lymphatic system : inspection - breasts size is normal, and symmetrical. Skin has rash. Palpation : axillary, subclavicular, supraclavicular lymph nodes. Palpation of breast for masses, tenderness present and no discharges.

Cardiovascular : Put patient with supine positions. Inspection - the patient's chest is symmetrical, no edema, no pulsation and no color changed. Auscultated PMI /apical pulse for 1 minute. auscultated heart 5 location -aortic, pulmonic,ERB, tricuspid and mitral) S1 is louder at apex(aortic and pulmonic), S2 is louder at base( tricuspid and mitral). Auscultated apical and radial pulse for 1 min . ( PMI 1min, and radial 1min). No pulse deficit. They match both 70/70. There are no foot edema, good hair growth, and no pigmentation of nail and toes.

Abdomen and genitourinary : I inspected for normal contour, markings and scars. Patient has swelling in the abdomen. Abdomen is round and symmetrical, skin tone is even. I auscultated 4 quadrants for 1 minute starting right lower, right upper, left upper and left lower. I also auscultated aorta, iliac, kidney, femoral artery. No bruit sounds, no pain. Palpated abdomen and patient has no pain. Palpated bladder. There is no urinary retention, no pain. I heard a crackle. Percussion abdomen. Murphy's sign exam is negative. I asked the patient to take a deep breath. And there is no pain. Iliopsoas muscle exam is negative. With supine position, lift the right leg straight. When pushed down the leg, there is no pain. The Blumberg exam is negative. Pushed down my hand at 90 degrees and removed it quickly. I checked the appendix. I asked when was the last bowel movement? Patient said “5 days ago”, Do you have constipation? “ Yes”.

Genitourinary: palpation only. Not examined and rational.

## Musculoskeletal :

- Patients can not posture, gait, and walk. Patient posture is symmetry and no gait exam.
- Inspected and palpated joints for color, symmetry, swelling, pain and visible masses.  
Color was even, joints are symmetrical, no swelling and pain.
- Patient can not follow ROM of joint.
- Inspected Spine for not normal curvature, symmetry of muscle, and uniformity of shoulder height. Patient's spine has no normal curvature, muscles are symmetrical, and shoulders are even.

## Sensory and motor

- Compared Sensory responses between left and right extremities. Patients can do the exam on both side of the arm and leg.
- Applied sensory stimuli in distal to proximal manner. Told the patient to close your eyes and tell me where you feel using cotton swabs. Patient told me the right location. - Tested touch and discrimination to sharp and dull and vibration sensation. Patient could feel vibrations. Used tuning fork at patient finger tips. - Testing Joint position sensation. Patient moved fingers up or down. - Assessed stereognosis and graphognosis. Patient told me what I put in her hand. Patient could tell me what I was drawing in her hands. No sensory and motor function tested for the right side of the body.
- Patient can not assess cerebellar function using the Romberg test. Told the patient to stand while assessing for balance with and without vision. The patient could not extend right arms straight out, turn palms up, turn palms down.

## Deep tendon reflexes

- Assessed patellar reflex by positioning the client seated with legs dangling. And striked tendon. Patient's both leg reflexed.

- Assessed Achilles In seated position. Striked tendon above heel. patient 's left achilles reflexes normally.

#### Neurological:

- Assessed olfactory nerves by asking patient eyes and identifying odor. She could tell the smell of alcohol swabs.
- Assessed optic nerve by testing visual acuity snellen chart. Patient could read. - Assessed oculomotor, abducens, and trochlear nerves by testing extraocular eye movements and pupillary reactions. Used fingers. Pupils were around and reactive to light and accommodation.
- Assessed trigeminal nerve. Palpating temporal and masseter muscles (teeth clenched, touch to forehead, cheek and chin). Patient could show teeth. Corneal reflex is normal. ( used cotton swab)
- Assessed acoustic nerve; hearing acuity with weber and rinne. The patient could feel vibration at both sides of face. Right side of the body was weak.
- Assessed Glossopharyngeal nerve;gag reflex and swallow. Patients can show thorat. It is normal. But for the gag reflex, not examined and rational. (because of covid-19)
- Assessed vagus nerve ; movement of uvula. Patient's quality of speech is clear, I could see her uvula (say Ahh). Movement of uvula is normal.
- Assessed spinal accessory nerve. The patient could shrug shoulders and turn head against resistance. Patient could turn from side to side and up and down. Patient's spinal nerve is normal.
- Assessed hypoglossal nerve. Patient moved tongue toward chin and nose.

Female genitalia: not examined-not included in paper and rational.

**Laboratory Data:** Blood glucose level is 130 mg/dL.

WBC 20,000 cells.

**Nursing Assessment/Plan**

Problem: Abdominal swelling, nausea and vomiting related to the presence of too much pain.

Interventions: Give heat and cold application, position changing, administering ordered PRN medication.

Evaluation: Patient pain scale is 5/10 in one month.