DOCUMENTATION

The following is a sample narrative documentation from assessment of the head and neck of a healthy adult.

Nurses Notes:

Subjective Data:

Denies problems with the head and neck, reports no current headache, no lesions, and no changes in skin or hair. Recalls no problem with swollen glands or breathing. No personal or family history of headache, allergy, or thyroid disease. Takes 2 Tylenol for occasional headache, that is once a week during busy season at work (1 month) and "maybe one a month." Headache is associated with lack of sleep or stress and relieved with single dose (2 tableto) of Tylenol. Weight has been constant for several years.

Objective Data:

Skull round with symmetrical protuberances. Skull nontender to palpation. Hair even distribution, scalp free of lesions, clean. Eyebrows symmetrical, equal distances of brow to pupil and outer canthus to pinna. Nose is midline with equal nasolablal folds. Lips symmetrical. Facial movement and expression symmetrical. Traches mobile, midline with palpable C rings. TMJ movement smooth and symmetrical. Thyroid nonpalpable, rises with swallow. Lymph nodes of neck nonpalpable.

ieneral Overview	Neck		
Skull: round symmetrical	Trachea: midline mobile, Cringo polpuble		
Protuberances: symmetrical	Thyroid: nonpalpatile, rises with swallow		
Hair: even allostribution	Lymph Nodes		
Scalp: clean, no lesions	PALPABLE	NO	YES
yes	Presuricular:		
Brows: symmetrical	Postauricular:		
Distance Brow to Pupil: equal	Occipital:	*	
Distance Outer Canthus to Pinna: equal	Retropharyngesit	100	-
lose	Submodillary:		
Position: midling	Submentalt		
Deviation: none, straight	Superficial cervical:	190	
Nasolabial Folds: caust	Deep cervical:		_
louth	Supraclavicular:		_

Sample Of Nursing Documentation

Clifford Lane

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