#### 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	Nock Traches: misting mobile, Cringe palpatrir		
Skull: round symmetrical			
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**

Chris E. Stout

# **Sample Of Nursing Documentation:**

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## **Table of Contents Sample Of Nursing Documentation**

- 1. Understanding the eBook Sample Of Nursing Documentation
  - The Rise of Digital Reading Sample Of Nursing Documentation
  - Advantages of eBooks Over Traditional Books
- 2. Identifying Sample Of Nursing Documentation
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Sample Of Nursing Documentation
  - User-Friendly Interface

- 4. Exploring eBook Recommendations from Sample Of Nursing Documentation
  - Personalized Recommendations
  - Sample Of Nursing Documentation User Reviews and Ratings
  - Sample Of Nursing Documentation and Bestseller Lists
- 5. Accessing Sample Of Nursing Documentation Free and Paid eBooks
  - Sample Of Nursing Documentation Public Domain eBooks
  - Sample Of Nursing Documentation eBook Subscription Services
  - Sample Of Nursing Documentation Budget-Friendly Options
- 6. Navigating Sample Of Nursing Documentation eBook Formats
  - o ePub, PDF, MOBI, and More
  - Sample Of Nursing Documentation Compatibility with Devices
  - $\circ$  Sample Of Nursing Documentation Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - o Adjustable Fonts and Text Sizes of Sample Of Nursing Documentation
  - Highlighting and Note-Taking Sample Of Nursing Documentation
  - Interactive Elements Sample Of Nursing Documentation
- 8. Staying Engaged with Sample Of Nursing Documentation
  - o Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Sample Of Nursing Documentation
- 9. Balancing eBooks and Physical Books Sample Of Nursing Documentation
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Sample Of Nursing Documentation
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Sample Of Nursing Documentation
  - Setting Reading Goals Sample Of Nursing Documentation
  - Carving Out Dedicated Reading Time

- 12. Sourcing Reliable Information of Sample Of Nursing Documentation
  - Fact-Checking eBook Content of Sample Of Nursing Documentation
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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