NUR 245 Complete Physical Examination

Date: 06/20/18

Student: Samuel Kollmorgen

Patient Initials: H.K. Age: 25 Gender: Male

Occupation: Student

General Survey of Patient

- Appears stated age: Pt seems appropriate for stated age.
- 2. Level of consciousness: Pt is alert and oriented x3
- Skin color: PWD, appropriate appearance for stated age and ethnicity
- Nutritional status: Stated dietary intake is adequate, pt seems well nourished.
- Posture and position: Upright, erect posture. No abnormalities detected.
- Obvious physical deformities: No obvious physical deformities seen.
- Mobility: Normal gait and posture, pt is mobile w/o assistive device.
- 8. Facial expression: No signs of distress, pain, or anxiety. Face symmetrical.
- Mood and affect: Pt is content and displays a normal affect.
- Speech: Pt's speech is appropriate and understandable.
- Hearing: Pt does not state to have any issues hearing.
- Personal hygiene: Pt is well groomed and appropriately dressed.

Measurements and Vital Signs

- 1. Weight: 178 lbs
- 2. Height: 70 in.
- 3. Body mass index: 25.5
- Vision using Snellen eve chart: 20/20 bilaterally with corrective lenses.
- Radial pulse, rate, and rhythm: 78, 2+ radial pulses RRR.
- 6. Respirations, rate, depth: 16, Normal work of breathing
- 7. Blood pressure: 136/72 right arm, sitting.
- 8. Temperature (if indicated): N/A
- 9. Pain assessment: 0/10

Skim

Hand and nails: No clubbing or deformities, cap refill < 2 sec. skin PWD, nail beds pink.

Color and pigmentation: Color tan-pink, even pigmentation, no lesions noted.

Temperature: Warm

Moisture: Dry Texture: Smooth

Turgor: Good turgor, no signs of tenting.

Any lesions: No notable lesions.

Head and Face

Physical Exam Documentation Example

Carol Berger, Theresa Galakatos, Nina A. Zimmermann **Physical Exam Documentation Example:**

Physical Exam Documentation Example Book Review: Unveiling the Magic of Language

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