Tina jones comprehensive

Advanced Health Assessment (Walden University)

Comprehensive Assessment Results | Turned In

Health Assessment for the BSN - Muskegon - Spring 2019, NUR 2250

Return to Assignment

Your Results

Lab Pass

Documentation / Electronic Health Record

Documentation

Vitals

Student Documentation	Model Documentation
Vitals BP: 142/82; HR: 68; RR: 16; O2: 98%; Temperature: 37.9 C	• Height: 170 cm • Weight: 84 kg • BMI: 29.0 • Blood Glucose: 100 • RR: 15 • HR: 78 • BP:128 / 82 • Pulse Ox: 99% • Temperature: 99.0 F

Health History

Student Documentation	Model Documentation
Identifying Data & Reliability Patient is in no apparent distress. Alert and oriented x4. Patient is seated upright on the examination table, she is well nourished, and dressed appropriately for the weather with good hygiene.	Ms. Jones is a pleasant, 28-year-old African American single woman who presents for a pre-employment physical. She is the primary source of the history. Ms. Jones offers information freely and without contradiction. Speech is clear and coherent. She maintains eye contact throughout the interview.

Student Documentation	Model Documentation
General Survey	
Tina Jones is a pleasant 28 year old African American woman who presents for pre-employment physical. She offers information freely and without contradiction. Beach is clear and coherent and maintains eye contact throughout the interview. Patient denies any current pain.	Ms. Jones is alert and oriented, seated upright on the examination table, and is in no apparent distress. She is well-nourished, well-developed, and dressed appropriately with good hygiene.
Reason for Visit	
"I came in because I'm required to have a recent physical examination for the health insurance at my new job"	"I came in because I'm required to have a recent physical exam for the health insurance at my new job."
History of Present Illness	Ms. Jones reports that she recently obtained employment at Smith, Stevens, Stewart, Silver & Company. She needs to obtain a pre-employment physical prior to initiating employment. Today she denies any acute concerns. Her last healthcare visit was 4 months ago, when she received her annual gynecological exam at Shadow Health General Clinic. Ms. Jones states that the gynecologist diagnosed her with polycystic ovarian syndrome and prescribed oral contraceptives at that visit, which she is tolerating well. She has type 2 diabetes, which she is controlling with diet, exercise, and metformin, which she just started 5 months ago. She has no medication side effects at this time. She states that she feels healthy, is taking better care of herself than in the past, and is looking forward to beginning the new job.
Denies any pain or present illness.	
Medications	• Metformin, 850 mg PO BID (last use: this morning) • Drospirenone and ethinyl estradiol PO QD (last use: this morning) • Albuterol 90 mcg/spray MDI 1-3 puffs Q4H prn (last use: yesterday) • Acetaminophen 500-1000 mg PO prn (headaches) • Ibuprofen 600 mg PO TID prn (menstrual cramps: last taken 6 weeks ago)
Metformin QD, Yaz QD, Inhaler PRN, "never more than twice a week, sometimes not at all"	
Allergies	• Penicillin: rash • Denies food and latex allergies • Allergic to cats and dust. When she is exposed to allergens she states that she has runny nose, itchy and swollen eyes, and increased asthma symptoms.
Penicillin; rash/ hives.	

Student Documentation	Model Documentation
Medical History Patient diagnosed with diabetes age 24; takes metformin QD and checks blood sugar daily. Reports exercising, walking 30-40 minutes per day, and swims at the Y once a week. Started taking metformin about 5 months ago. Patient reports allergies to cats, and dust. Diagnosed with asthma at 2.5. Last asthma exacerbation was yesterday from running up the stairs, relieved with inhaler. She was hospitalized for asthma as a young child.	Asthma diagnosed at age 2 1/2. She uses her albuterol inhaler when she experiences exacerbations, such as around dust or cats. Her last asthma exacerbation was yesterday, which she resolved with her inhaler. She was last hospitalized for asthma in high school. Never intubated. Type 2 diabetes, diagnosed at age 24. She began metformin 5 months ago and initially had some gastrointestinal side effects which have since dissipated. She monitors her blood sugar once daily in the morning with average readings being around 90. She has a history of hypertension which normalized when she initiated diet and exercise. No surgeries. OB/GYN: Menarche, age 11. First sexual encounter at age 18, sex with men, identifies as heterosexual. Never pregnant. Last menstrual period 2 weeks ago. Diagnosed with PCOS four months ago. For the past four months (after initiating Yaz) cycles regular (every 4 weeks) with moderate bleeding lasting 5 days. Has new male relationship, sexual contact not initiated. She plans to use condoms with sexual activity. Tested negative for HIV/AIDS and STIs four months ago.
Health Maintenance Patient reports diabetes is under control. Daily exercise and eats 3 meals a day. Patient reports that she "feels exhausted at the end of the day".	Last Pap smear 4 months ago. Last eye exam three months ago. Last dental exam five months ago. PPD (negative) ~2 years ago. Immunizations: Tetanus booster was received within the past year, influenza is not current, and human papillomavirus has been received. She reports that she believes she is up to date on childhood vaccines and received the meningococcal vaccine for college. Safety: Has smoke detectors in the home, wears seatbelt in car, and does not ride a bike. Uses sunscreen. Guns, having belonged to her dad, are in the home, locked in parent's room.
Family History History of diabetes in father and paternal uncle. History of hypertension and mother grandmother, and father.	• Mother: age 50, hypertension, elevated cholesterol • Father: deceased in car accident one year ago at age 58, hypertension, high cholesterol, and type 2 diabetes • Brother (Michael, 25): overweight • Sister (Britney, 14): asthma • Maternal grandmother: died at age 73 of a stroke, history of hypertension, high cholesterol • Maternal grandfather: died at age 78 of a stroke, history of hypertension, high cholesterol • Paternal grandmother: still living, age 82, hypertension • Paternal grandfather: died at age 65 of colon cancer, history of type 2 diabetes • Paternal uncle: alcoholism • Negative for mental illness, other cancers, sudden death, kidney disease, sickle cell anemia, thyroid problems

Student Documentation	Model Documentation
Social History Patient drinks alcohol about six drinks per month socially with friends. Patient denies drug use.	Never married, no children. Lived independently since age 19, currently lives with mother and sister in a single family home, but will move into own apartment in one month. Will begin her new position in two weeks at Smith, Stevens, Stewart, Silver, & Company. She enjoys spending time with friends, reading, attending Bible study, volunteering in her church, and dancing. Tina is active in her church and describes a strong family and social support system. She states that family and church help her cope with stress. No tobacco. Cannabis use from age 15 to age 21. Reports no use of cocaine, methamphetamines, and heroin. Uses alcohol when “out with friends, 2-3 times per month,” reports drinking no more than 3 drinks per episode. Typical breakfast is frozen fruit smoothie with unsweetened yogurt, lunch is vegetables with brown rice or sandwich on wheat bread or low-fat pita, dinner is roasted vegetables and a protein, snack is carrot sticks or an apple. Denies coffee intake, but does consume 1-2 diet sodas per day. No recent foreign travel. No pets. Participates in mild to moderate exercise four to five times per week consisting of walking, yoga, or swimming.
Mental Health History Patient denies any concerns with mental health. Patient does have slight anxiety, congruent with sleep problems, only lasted for a couple weeks, patient self treated by attending church, and talking with specialist.	Reports decreased stress and improved coping abilities have improved previous sleep difficulties. Denies current feelings of depression, anxiety, or thoughts of suicide. Alert and oriented to person, place, and time. Well-groomed, easily engages in conversation and is cooperative. Mood is pleasant. No tics or facial fasciculation. Speech is fluent, words are clear.
Review of Systems - General Reports 10 pound weight loss in the last 4 months due to exercise. Denies fatigue, fever, chills, or night sweats.	No recent or frequent illness, fatigue, fevers, chills, or night sweats. States recent 10 pound weight loss due to diet change and exercise increase.

HEENT

Student Documentation	Model Documentation

Student Documentation	Model Documentation
Subjective Patient denies any Vision change, good start wearing glasses 3 months ago. Reports no eye pain, itchy eyes redness or dry eyes. Patient denies any changes in hearing your pain or discharge. Patient reports no change in sense of smell sneezing for sinus pressure. Patient reports no General mouth problems or change in taste.	Reports no current headache and no history of head injury or acute visual changes. Reports no eye pain, itchy eyes, redness, or dry eyes. Wears corrective lenses. Last visit to optometrist 3 months ago. Reports no general ear problems, no change in hearing, ear pain, or discharge. Reports no change in sense of smell, sneezing, epistaxis, sinus pain or pressure, or rhinorrhea. Reports no general mouth problems, changes in taste, dry mouth, pain, sores, issues with gum, tongue, or jaw. No current dental concerns, last dental visit was 5 months ago. Reports no difficulty swallowing, sore throat, voice changes, or swollen nodes.
Objective Head is normal cephalic atraumatic. Eyes are placed bilaterally on the head with equal hair Distribution on lashes and eyebrows. No ptosis or edema noted. Conjunctiva pink no lesions white sclera. Eyes are PERRLA. Eyes are intact bilaterally no nystagmus is present. Snellen 20/20 bilaterally. Whispered words heard bilaterally. Frontal and maxillary sinuses nontender to palpation. Nasal mucosa moist and pink septum midline. Oral mucosa moist and without lesions. Tonsils present. No goiter noted.	Head is normocephalic, atraumatic. Bilateral eyes with equal hair distribution on lashes and eyebrows, lids without lesions, no ptosis or edema. Conjunctiva pink, no lesions, white sclera. PERRLA bilaterally. EOMs intact bilaterally, no nystagmus. Mild retinopathic changes on right. Left fundus with sharp disc margins, no hemorrhages. Snellen: 20/20 right eye, 20/20 left eye with corrective lenses. TMs intact and pearly gray bilaterally, positive light reflex. Whispered words heard bilaterally. Frontal and maxillary sinuses nontender to palpation. Nasal mucosa moist and pink, septum midline. Oral mucosa moist without ulcerations or lesions, uvula rises midline on phonation. Gag reflex intact. Dentition without evidence of caries or infection. Tonsils 2+ bilaterally. Thyroid smooth without nodules, no goiter. No lymphadenopathy.

Respiratory

Student Documentation	Model Documentation
Subjective Patient denies shortness of breath wheezing chest pain dyspnea or cough.	Reports no current breathing problems. Reports occasional shortness of breath, wheezing, and chest tightness.
Objective Chastise symmetric with respiration clear to auscultation bilaterally without cough or wheeze. FVC 3.91 L; FEV1: 3.15L. Tactile fremitus present. Palpating thoracic expansion symmetric.	Chest is symmetric with respiration, clear to auscultation bilaterally without cough or wheeze. Resonant to percussion throughout. In office spirometry: FVC 3.91 L, FEV1/FVC ratio 80.56%.

Cardiovascular

Student Documentation	Model Documentation

Student Documentation	Model Documentation
Subjective	
Patient reports no palpitations tachycardia, easy bruising or edema.	Reports no palpitations, tachycardia, easy bruising, or edema.
Objective	
Heart rate is regular S1 S2 without murmurs. Auscultated carotids equal bilaterally without bruit. No edema noted in extremities. PMI 5th intercostal space. Capillary refill <3 seconds in all extremeties.	Heart rate is regular, S1, S2, without murmurs, gallops, or rubs. Bilateral carotids equal bilaterally without bruit. PMI at the midclavicular line, 5th intercostal space, no heaves or lifts. Bilateral peripheral pulses equal bilaterally, capillary refill less than 3 seconds. No peripheral edema.

Abdominal

Student Documentation	Model Documentation
Subjective	
Patient reports no nausea vomiting pain constipation diarrhea. No food intolerances. Reports no urinary problems such as dysuria nocturia polyuria hematuria. No difficulty urinating.	Gastrointestinal: Reports no nausea, vomiting, pain, constipation, diarrhea, or excessive flatulence. No food intolerances. Genitourinary: Reports no dysuria, nocturia, polyuria, hematuria, flank pain, vaginal discharge or itching.
Objective	
Can a swarm in dry symmetric no visible masses scars lesions coarse hair from pubis to umbilicus. Bowel sounds are normoactive in all four quadrants. No bruit and abdominal aorta. No tenderness to palpation.	Abdomen protuberant, symmetric, no visible masses, scars, or lesions, coarse hair from pubis to umbilicus. Bowel sounds are normoactive in all four quadrants. Tympanic throughout to percussion. No tenderness or guarding to palpation. No organomegaly. No CVA tenderness.

Musculoskeletal

Student Documentation	Model Documentation
Subjective	
Patient denies no muscle pain joint pain muscle weakness or edema.	Reports no muscle pain, joint pain, muscle weakness, or swelling.
Objective	
No obvious injuries or deformities. No edema or lacerations. Patient demonstrated full range of motion and neck shoulders arms wrists ankles hips spine knees with strength 5 + bilaterally. No pain with movement.	Bilateral upper and lower extremities without swelling, masses, or deformity and with full range of motion. No pain with movement.

Neurological

Student Documentation	Model Documentation
Subjective	
Patient denies any dizziness lightheadedness tingling loss of coordination no seizures.	Reports no dizziness, light-headedness, tingling, loss of coordination or sensation, seizures, or sense of disequilibrium.
Objective	
Normal graphesthesia, sterognosis, and able to make rapid movements bilaterally. Decreased sensation to monofilament in bilateral plantar surfaces.	Strength 5/5 bilateral upper and lower extremities. Normal graphesthesia, stereognosis, and rapid alternating movements bilaterally. Tests of cerebellar function normal. DTRs 2+ and equal bilaterally in upper and lower extremities. Decreased sensation to monofilament in bilateral plantar surfaces.

Skin, Hair & Nails

Student Documentation	Model Documentation
Subjective	
Patient reports an improve in acne due to oral contraceptives. Skin on neck has stopped darkening and facial and body hair has improved. She reports I feel moles but no other hair or nail changes.	Reports improved acne due to oral contraceptives. Skin on neck has stopped darkening and facial and body hair has improved. She reports a few moles but no other hair or nail changes.
Objective	
No obvious injuries lacerations rashes dandruff or bruising . Patience hair is well-groomed with even distribution . No nail deformities. Scattered pustules on face and facial hair on upper lip.	Scattered pustules on face and facial hair on upper lip, acanthosis nigricans on posterior neck.

Comments

If your instructor provides individual feedback on this assignment, it will appear here.