Name:

**Comprehensive Assessment**

Type your narrative-style documentation for each section of the assignment into the corresponding dialogue boxes below. When you are ready to submit your documentation, ‘Save As’ with this title format: “[LastName\_FirstName] Shadow Health Documentation Template - Comprehensive - NURS 6512”

**Vitals**

BMI 29.0

Blood glucose 91

BP 128/82

HR 78 BPM

RR 15

Temp 99.0 F

PulseOx 99%

**Health History**

Identifying Data

The patient is a 28-year-old African American who reports for a pre-employment medical exam. Throughout the interview, the patient is able to give the required data promptly, clearly and without any contradiction

General Survey

The patient appears to be well oriented throughout the assessment and does not show any sign of distress.

Reason for Visit

The patient has visited Shadow Health clinic for a preemployment physical

History of Present Illness

The patient has diabetes and asthma but denies having any other illness. she was also diagnosed four months ago with PCOS which necessitated her to start using birth control pills.

Medications

Metformin 850mg - started taking it 5 months ago. Dosage is twice a day, last taken this morning

Albuterol inhaler for asthma: takes two puffs

Yaz- birth control pills -takes the pills for PCOS and takes one pill daily

 Advil for cramps, took it six weeks ago

Allergies

Allergic to animals specifically cats and dust - causes asthma flare ups

Allergic to penicillin - causes rashes

The patient used to have seasonal allergies but she has not experienced them for some time

Medical History

The patient reports to have PCOS, diabetes, and asthma. All of these ailments are being managed with medication alongside other lifestyle interventions such as proper diet and exercises. The patient is also allergic to animals, dust and penicillin. she is also short sighted which she has corrected using prescription eye glasses. she currently monitors her blood sugar every morning using a glucometer.

Health Maintenance

Family History

The patient likes to hang out with friends and occasional drinks alcohol sparingly. She however denies taking any other illicit drugs. the patient is of Christian faith and she attends bible studies she currently has a boyfriend but has yet to engage sexually.

Social History

Exercise and healthy diet to manage diabetes, the patient also wears glasses to improve her vision. She also takes medication for her diabetes and asthma. She got tetanus boosters a year ago but all other vaccinations were taken earlier when she was a kid and in college

Mental Health History

The patient denies any psychological issues like depression. she explains that recently she has been feeling pretty good, sleeping well and she has never felt dizzy. he also looks oriented throughout the assessment.

Review of Systems - General

The patient has no recent illnesses and denies having fever, fatigue or any headaches.

Objective

**HEENT**

Head: Normocephalic atraumatic, normal scalp hair distribution, palpable scalp with no masses

Eyes: equal hair distribution on lashes, and eyebrows. lids without lesions. Pink conjunctiva and white sclera. Snellen test 20/20 in both eyes with corrective lenses

Ears: tympanic membrane appears intact pearly gray with positive light reflex. Whispered words heard correctly

Nose: nasal cavity appears moist and pink

Oral mucosa without evidence of ulceration. Gag reflex is intact

Throat and neck thyroid smooth with no nodules No observable masses on axillary and cervical lymph nodes on palpation

**Respiratory**

chest is symmetric, clear to auscultation bilaterally, with no abnormal sounds observed. Resonant to percussion throughout. Spirometry FVC 3.91L, FEV1/FVC ratio 80.56%

**Cardiovascular**

Heart rate is regular, S1, S2, with no murmurs, gallops or rubs observed. Bilateral carotid pulses equal bilaterally. Capillary refill in fingers and toes less than 3 seconds. No peripheral edema

**Abdominal**

Abdomen is symmetric and protuberant, with no scars, lesions or masses. Bowel sounds normoactive in all quadrants. all areas tympanic to percussion. No CVA tenderness. No guarding or tenderness was observed to palpation.

**Musculoskeletal**

all joints have full ROM. Normal strength recorded in movement. No masses or deformities observed.

**Neurological**

Rapid alternating movements. DTRs 2+ and equal bilaterally in both upper and lower extremities. The patient also had decreased sensation to the left plantar surface. The graphesthesia and stereognosis tests returned normal.

**Skin, Hair & Nails**

Nigricans appear on the patient neck. Nails on both the fingers and toes appear normal with no ridges