Due 4/20/17

Comprehensive Write-up Guide

Week 2 Assignment: Comprehensive Patient Assessment

When completing practicum requirements in clinical settings, you and your Preceptor might complete several patient assessments in the course of a day or even just a few hours. This schedule does not always allow for a thorough discussion or reflection on every patient you have seen. As a future advanced practice nurse, it is important that you take the time to reflect on a comprehensive patient assessment that includes everything from patient medical history to evaluations and follow-up care. For this Assignment, you begin to plan and write a comprehensive assessment paper that focuses on *one* female patient from your current practicum setting.

To complete:

Write an 8- to 10-page comprehensive paper that addresses the following:

1. General patient information
   a. Age 26
   b. Race/ethnicity african-American
   c. Partner status married w/ extra marital partner

2. Current health status
   a. Chief concern/complaint and history of present illness (include a complete symptom analysis of chief complaint(s) utilizing OLDCART for a sick/problem focused visit)
   b. Last menstrual period or year of menopause
   c. DES exposure (if born between 1948 and 1971) N/A
   d. Sexual activity status sexually active (2 partners)
   e. Barrier prevention condoms w/ extra marital partner
   f. Sexual preference men
   g. Satisfaction with sometimes dyspareunia

3. Contraception method (if any) mirena

4. Patient history
   a. Past medical history
      - Major medical events (including pediatric events) c-section 9/6/12 tonsillectomy
      - Psychological and mental health
      - Surgeries and/or hospitalizations if pertinent
      - Medications, including prescriptions, over-the-counter medications, home and herbal remedies, calcium, and vitamin supplements
      - Allergies, including drug, food, and environment NKDA

Hx of anxiety & depression in 2013

amitriptyline 10mg PO HS

Pap in 2015 negative
GCC negative 2017

Hep Bs Ag - non-reactive
Syphilis - negative
Trichomonas - negative

HIV - non reactive 2017

- Health maintenance/screenings, including results of patient's last Pap and mammogram as appropriate, as well as previous vaccinations (HPV, MMR, hepatitis B, last dT, and pneumovax/influenza as appropriate)

b. Family medical history

DMI - mom
Hypercholesterolemia - Father
Stroke - Father

G2 P1011

c. Gynecologic history
   - Nullipara vs. multipara
   - History of sexually transmitted infections and sexually transmitted diseases
   - Menarche and menstrual patterns spotting 1 day a wk for Mirena
   - Menopause or peri-menopausal symptoms (if applicable)

d. Obstetric history
   - Gravida and parity status (TPAL)
   - Pregnancy history, including history of preterm or low birth weight, other pregnancy complications, history of sexually transmitted diseases, and any pertinent negatives

e. Personal social history (as appropriate to the current problem)
   - Cultural background
   - Education and economic condition high school - employed
   - Abuse history including assault and forced sex (past and current) N/A
   - Occupational health patterns
   - Environment
   - Current health habits and/or risk factors
   - Substance use (must include for every patient) N/A
   - Tobacco including frequency and longevity N/A
   - Alcohol including results of CAGE unless patient has never used denies usage
   - Recreational drug use (past and current) N/A
   - Exercise and physical activity exercise 1-2 a wk
   - Diet and nutrition low sugar
   - Sleep 6 times a night
   - Caffeine lots of caffeine

Obesity
polydipsia
polyuria

5. Review of systems (ROS)
   a. Must include reproductive system as well as other pertinent systems (systems relevant to HPI should be included under HPI)

6. Physical exam
   a. General exam, including vital signs, height, weight, and BMI on every patient
   b. Physical exam focused on episodic complaint (include numbers of weeks gestation, fundal height, and fetal heart tones for OB patients)

7. Labs, tests, and other diagnostics

a. Pertinent labs, test, and other diagnostics (include routine tests such as triple screen and urine dip for OB patients)

8. Differential diagnoses
   a. Explain why this set of differential diagnoses should be considered and why each diagnosis should be ruled in or ruled out.

9. Management plan
   a. Diagnosis
   b. Treatment
   c. Patient education
   d. Follow-up care

This Assignment is due by **Day 7** of **Week 9**.

Reminder: The School of Nursing requires that all papers submitted include a title page, introduction, summary, and references. The Sample Paper provided at the Walden Writing Center provides an example of those required elements (available at http://writingcenter.waldenu.edu/57.htm*). All papers submitted must use this formatting.*

Please contact the course Instructor with any questions regarding this Assignment.

Chief Complaint

Annual exam

History of Present Illness

26-year-old G2 P1 011 presents for annual exam. She is still sexually active and has 2 partners. She uses condoms with the extramarital partners but not with her husband.

Weight loss: Patient states that she has started going to a weight loss clinic. She is not exercising but states that she walks a lot at work. She has lost 10 pounds since her last visit.

Dyspareunia: Patient was going to pelvic floor therapy and states that she did see improvement with pain with insertion. She states that her pain was with all partners. In that most of the pain is still with insertion. She states that she is currently using lubrication with all of her partner's but still noticing a burning sensation after intercourse. Patient has not use the amitriptyline

Vaginal odor and discharge: Patient states that she has a ammonia-like odor to her vaginal odor sometimes. She states that this comes and goes and started several months ago. She denies any dysuria or hematochezia....

Urinary incontinence. Patient states that she urinates a lot if she drinks a lot of water however she does not actually leak urine anymore.

Polydipsia, polyuria: Patient does complain of having to urinate a lot and also drinking a lot and not filling fully satisfied. This is been occurring for the past several months.

Review of Systems

Constitutional: Negative.
Respiratory: Negative.
Cardiovascular: Negative.
Breast: Negative.
Gastrointestinal: Negative.
Genitourinary: See history of present illness
Gynecologic: Negative except as documented in history of present illness.
Hematology/Lymphatics: Negative.
Endocrine: Negative.
Immunologic: Negative.
Musculoskeletal: Negative.
Integumentary: Negative.
Neurologic: Negative.
Psychiatric: Negative.

Physical Exam

Gen.: Alert and oriented, not acute distress
Respiratory: Lungs are clear to auscultation, respirations are nonlabored, breath sounds are equal
Cardiovascular: Regular rate and rhythm
Gastrointestinal: Soft, nontender, nondistended
Breast: , no masses, no discharge, no pain to palpation
Abdominal: Nontender nondistended, bowel sounds present,

Vagina: Within normal limits, no discharge, patient does have pain with insertion of the speculum at the introitus, there is no erythema, there is no nodularity or spasms that are felt on the posterior floor of the vagina or anteriorly on the bladder.
Labia: Within normal limits
Cervix: No cervical motion tenderness
Uterus: Within normal limits
Neurologic: Alert and oriented
Psychiatric: Cooperative, appropriate mood and affect Assessment/Plan 1. Encounter for gynecological examination (general) (routine) without abnormal findings Encouraged healthy eating, regular exercise of 150min per week and regular seatbelt use. Patient is currently seeing a weight loss clinic who helps with diet. I did discuss with her that exercise is an important factor for weight loss. Patient encouraged to use condoms consistently with other partners. STD screening today. Pap due in 2018.

GCC- Negative

2. Vaginal odor Affirm collected. Treat per results

3. Dyspareunia in female not due to substance or known physiological condition Patient advised to start with amitriptyline. She has completed her pelvic floor therapy. Amitriptyline does not work discussed with patient referral to pelvic for specialist.

Polydipsia Hemoglobin A1c obtained well a CMP

Polyuria Hemoglobin A1c and CMP obtained

Lab Flowsheet	3/16/2017 12:00 AM	12/17/2015 12:00 AM	12/5/2015 12:00 AM	12/4/2015 12:00 AM
General Chemistry				
Sodium Level	143			142 (c)
Potassium Level	4.3			4.4 (c)
Chloride Level	107			105 (c)
CO2 Level	28			29 (c)
AGAP	8			8 (c)
Glucose Level	76 *			90 * (c)
BUN	12			10 (c)
Creatinine Level	0.7			0.7 (c)
eGFR	116 *			120 *
eGFR African American	134 * (c)			140 * (c)
Calcium Level	9.4			9.3 (c)
Bilirubin Total				0.5 (c)
Alkaline Phosphatase				104 (c)
AST				13 (L) (c)
ALT				26 (c)
Protein Total				7.6 * (c)
Albumin Level				4.0 * (c)
Hgb A1c	5.6 *			5.6 *
Est Average Glucose mg/dL	114			114
Lipids				
Cholesterol				169 *
HDL				42 *
LDL Calc				116 (H)
VLDL Calc				13
Non HDL Cholesterol				127 *
Triglyceride				65 *
Thyroid Studies				
TSH				0.762
Pregnancy Testing				
hCG Ql POC				Negative
CBC				
WBC				7.2
RBC				5.23 * (H)
Hgb				13.6 *
Hct				44.8
MCV				85.7
MCH				26.0
MCHC				30.4 * (L)
RDW CV				14.3
RDW SD				44.4
Platelet				290
MPV				11.9
Differential				
Lymph Auto				24.4
Neutrophil Auto				67.0
Mono Auto				6.8
Eos Auto				1.4
Basophil Auto				0.1

Lab Flowsheet	3/16/2017 12:00 AM	12/17/2015 12:00 AM	12/5/2015 12:00 AM	12/4/2015 12:00 AM
Immature Grans Auto				0.3
Abs Neutrophils				4.82
Abs Lymphocytes				1.76
Abs Monocytes				0.49 (H)
Abs Eosinophils				0.10
Abs Basophils				0.01
NRBCs				0.0
Morphology				
Abs Immature Granulocytes				0.02
UA Dipstick				
Urine Color	Yellow	Yellow		Yellow
Urine Appearance	Clear	Clear		Clear
Glucose	Negative	Negative		Negative
Ketones	Negative	Negative		Negative
Blood	Small	Trace		Trace
pH	7	7		7
Protein	Negative	Negative		Negative
Nitrite	Negative	Negative		Negative
Leukocyte Esterase	Negative	Small		Negative
Immunology General				
Rubella IgG Ab				19.8 *
Chlamydia/N. gonorrhea Testing				
Chlamydia/GC Source	Swab		Thin Prep	
Hepatitis Testing				
Hep Bs Ag				Non-Reactive *
HIV Testing				
HIV Ag/Ab including P24	Non-Reactive *			Non-Reactive *
Syphillis Testing				
RPR/Syphilis				Non-Reactive *
FTA-IGG	<0.10 *			
Bacteriology				
Vag Panel Gardnerella	Negative	Positive		
Vag Panel Limitations	See Comment *	See Comment *		
Vag Panel Method	DNA Probe	DNA Probe		
Chlamydia/GC Organism ID				
Chlamydia PCR	Negative *		Negative *	
GC PCR	Negative *		Negative *	
Mycology				
Vag Panel Candida	Negative	Negative		
Parasitology				
Vag Panel Trichomonas	Negative	Negative		
Gyn Cytology Reports				
Thinprep Report			Thinprep Report	
Pap Smear Report				Pap Smear Rep