#### DOCUMENTATION

The following is sample documentation from health assessment of the respiratory system of a healthy adult.

## Nurses Notes:

#### Subjective Data:

No problems with breathing. Has had no change in breathing in last 6 months or 2 years. Com-plete all activities without change in breathing. Sleeps with one pillow. No history of problems that affect breathing. No family history of respiratory disease. Has had occasional cold or throat infection. A columnst every year treated with OTC medication and subsides. Sore throat in high school, treated with antibiotics, no ongoing problems. No cough, no wheezing, no chest pain. No history of allergies. Has never smoked. Works and lives in smoke-free environments. No anxiety.

Uses OTG medication for headache, rarely. No change in weight for 5 years. No exposure to furnes or irritants.

#### Objective Data:

Height 5'8", weight 154 lb. Skin of face pink. No nasal flaring, nares patent. Lips pink, moist. Alert and oriented. BP 118/66—P 76—RR 16. Respirations regular, deep, no use of accessory muscles. Chest movement and excursion symmetrical. Transverse to AP diameter 2:1. Scapulae or plane perpendicular to vertebral line. Mus-cle mass firm. Chest color pink, warm. No masses, lesions, pain, or crepitus. Spine vertically aligned, ribs intact.

Symmetrical respiratory expansion. Tactile fremitus strong over trachea, weakening over bronchi, and absent over alveoli. Resonance throughout lung fields to percussion. Diaphragmatic excursion 5 cm bilaterally and parallel. Anterior and posterior breath sounds vesticular over periphery, bronchovesicular between scapulae and lateral to stemum, bronchial sounds next to trachea, tracheal sounds over the trachea. No adventitious sounds.

# **Sample Nursing Documentation To Patient**

**Robyn Rice** 

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