

NR601 Week 2 Discussion

a.

- Client Information and Assessment Data
 - Assigned Primary Diagnosis: Hyperlipidemia
 - Client Name: Kevin Smith
 - Date of Birth: 9/1/1972
 - Chief Complaint: Client was told their cholesterol was flagged as “high” during a free cholesterol screening when they donated blood at a community blood drive
 - History of Present Illness: Obesity (BMI 34), hypertension, asthma, kidney stones
 - Physical Exam
 - Height: 5’10
 - Weight: 240lbs
 - BMI: 34.4
 - Blood pressure: 132/78
 - Heart rate: 78
 - Respiratory rate: 15
 - Oxygen saturation: 98%
 - Temperature: 98.6
 - Past Medical History (PMH) (Include at least three significant pieces of the client’s past medical history)
 - Obesity
 - Hypertension
 - Lack of regular exercise and unhealthy diet
 - Allergies (Include any drug allergies and the client’s typical reaction)
 - NKDA
 - Medications (Based on the client’s PMH, list at least three current medications, including dose, route, and frequency)
 - Albuterol 90mcg inhalation PRN Q6hrs for shortness of breath
 - Hydrochlorothiazide 25mg PO once every morning
 - Amlodipine 5mg PO once every morning
 - Social History (MUST include status of tobacco, ETOH, and drug use [e.g., usage, type, quantity, using or non-using] AND include at least two other significant social history elements, e.g., marital status, living conditions, social support, etc.)
 - Non-smoker, social drinker about 1-2x/week, no drug use
 - Married with 2 kids
 - Lives in a single-family home and has great family support
 - Completes ADLs independently