Nursing Lung Assessment

Patient: Kevin Klein

Date: 09/09/2027

Time: 9:45 am

Objective Assessment

General Observation:

Patient appears comfortable at rest.
Skin color is normal, no cyanosis noted.
Respiratory rate is 18 breaths per minute.
Patient is able to speak in full sentences without difficulty.

Inspection:

Chest symmetry is maintained.
No use of accessory muscles noted.
No visible pulsations or retractions.

Palpation:

Chest expansion is symmetrical bilaterally.
No tenderness or crepitus noted upon palpation.

Percussion:

Resonance noted throughout lung fields.
No dullness or hyperresonance detected.

Auscultation

Breath sounds:

Vesicular breath sounds heard bilaterally, louder in the lower lobes.
No adventitious sounds such as wheezes, crackles, or rhonchi heard.
Bronchial breath sounds absent over lung fields.

Vocal resonance:

Whispered pectoriloquy negative.
Egophony negative.
Bronchophony negative.

Assessment

Based on the nursing lung assessment, John Doe appears to have normal lung findings.
His shortness of breath may be related to other factors such as fatigue or deconditioning.
Further evaluation may be needed to determine the cause of his symptoms.

Plan

Monitor patient's respiratory status closely.
Encourage deep breathing exercises and activity as tolerated.
Notify physician if symptoms worsen or new symptoms develop.