

NURSING PHYSICAL HEALTH ASSESSMENT

INSPECT
PALPATE
PERCUSS
AUSCULTATE



INTRODUCTION

- Hand hygiene
- Provide privacy
- Introduce yourself
- Explain procedure to patient
- Verify patient ID & DOB

A & O

- What is your name?
- What is your DOB?
- Where are you?
- Who is the U.S. President?
- Do you know the date?
- What are you doing here?

OBSERVING THE PATIENT

- Emotional status
- Speech
- Behavior / follows instruction
- Skin color appropriate for race
- Looks stated age
- Hygiene maintained
- Responds appropriately
- Outward abnormalities: abnormal smells, lesions, erythema, cyanosis, masses

EARS

INSPECT

- Abnormalities, redness, drainage, tophi (gout patients)

PALPATE

- Palpate ear for tenderness, abnormal masses & lesions

Test cranial nerve VIII

(Vestibulocochlear) with whisper test:

- Have patient occlude one ear & whisper two words behind other & have patient repeat words

NOSE

INSPECT

- Abnormalities, drainage, symmetry, size & shape, inspect septum
- Inspect inside nose for polyps, drainage, redness

Test patency of nares: have patient occlude one nostril & breathe in & out to observe airflow

Test cranial nerve I (Olfactory): have patient close eyes & smell something

MOUTH

INSPECT

- Lips for chapped, sores, & color
- Inside mouth: pink & moist, tongue is moist & pink, look for lesions, sores, broken teeth, soft & hard palate, uvula placement

Test cranial nerve IX (glossopharyngeal): have patient say "ah" & watch uvula move

Test cranial nerve XII (hypoglossal): stick out tongue & move side to side

Test cranial nerve V (vagus) with ability to swallow

Test gag reflex

VITALS

- Heart Rate: 60 - 100 bpm
- Blood Pressure: 90/60 - 120/80 mmHg
- O₂ Saturation: 94-99%
- Respirations: 12-18 bpm
- Temperature: 97.8 - 99.1 F
- Pain: Numeric Scale 1-20

HEAD

INSPECT

- Skin color, appropriate size for frame, looking for any abnormal facial movements / twitching, ensuring face is symmetrical & no signs of facial drooping, examination if eyes & ears are level, hairline

PALPATE

- Palpate cranium for lesions, masses, indentations, infestations, skin breakdown, or any abrupt bald spots, check facial hair
- Palpate temporal mandibular joint for stiffness & clicking
- Palpate sinus cavities: maxillary & frontal

EYES

INSPECT

- Eyelids, iris, pupil, sclera, conjunctiva
- Strabismus: normal inward/outward turning of eye(s)
Anisocoria: one pupil larger/smaller than other
Nystagmus: involuntary shaking of eyes
Pupils should be 3-5mm & equal in size

Test cranial nerves:

III (Oculomotor), IV (Trochlear), VI (Abducens)

Examine how the pupils react to light

- Patient should look at object far away to dilate eyes
- Light shine into on eye- both pupils should dilate

Accommodation

- Have patient stare off at distant object, look at penlight and direct to tip of nose
- Patient's pupils should constrict & accommodate

PERLA

- PUPILS are EQUAL, ROUND & REACTIVE to LIGHT & ACCOMMODATION

The Physical Assessment A Programed Unit Of Study For Nurses

Clemens Wendtner



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