KING SAUD UNIVERSITY
COLLEGE OF NURSING
MEDICAL SURGICAL DEPARTMENT

NURS 221 HEALTH ASSESSMENT (PRACTICAL) PROCEDURE GUIDE AND PERFORMANCE CHECKLIST

MODULE 10
Complete Head-to –Toes Assessment Sequence

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1. The Health History

- Complete the interactive interview with client to obtain health history.
- Include all areas and address present illness (Chief complain), Past and family history which may influence the client's health status.
- The data are subjective; document in the patient's own words.

2. Appearance and Mental Status:

- Assess level of consciousness GCS.
- Compare stated age with appearance. Lifestyle, and health.
- Observe facial expression, posture, and position and observe mobility.
- Observe overall hygiene and grooming. Note body odour and breath odour.
- Note signs of health or illness (skin color, signs of pain).
- Assess attitude, affect, mood, and appropriateness of responses.
- Listen for quantity, quality, relevance, and organization of speech.

At the completion of the interview, have the patient change into an examination gown.
Provide privacy to the patient.
Have the patient empty the bladder; if required, provide a container and instructions for collecting a urine specimen.

3. Measurements Measure height. Measure weigh.

Calculate the body mass index (BMI) = Weight in Kilogram/Height in Meter square.

4. Vital Signs

- Assess the radial & peripheral pulses.
- Count respirations.
- Take the temperature.
- Measure the blood pressure bilaterally.
- Assess for pain.

5. Skin, Hair, and Nails

- Inspect the skin on the face, neck, and upper and lower extremities.
- Inspect for color and uniformity of color.
- Inspect and palpate skin.
- Palpate for skin temperature, moisture, turgor, and edema.
- Inspect, palpate, measure, and describe lesions.
- Inspect the hair on the scalp and body.
- Palpate scalp hair for texture.
- Inspect the fingernails for curvature, angle, and color.
- Palpate the nails for texture and capillary refill.
- Do The Schamroth's Window Test

6. Head, Neck, and Related Lymphatics

- Inspect the skull for size, shape, and symmetry.
- Observe facial expressions and symmetry of facial features and movements (cranial nerves V

and VII).

- Palpate the skull and lymph nodes ofthe head and neck.
- Palpate the muscles of the face (cranial nerve V).
- Assess facial response to sensory stimulation (cranial nerve V).
- Inspect the neck for symmetry, pulsations, swelling, or masses.
- Assess range of motion and strength of muscles against resistance.
- Observe as the patient moves the head forward and back and side to side and shrugs the shoulders (cranial nerve XI).
- Palpate the trachea.
- Palpate the thyroid for symmetry and masses.
- Palpate and auscultate the carotid arteries, one at a time.

7. Eyes

- Inspect the external eye. Inspect the pupils for color, size, shape, and equality (PERRLA).
- Assess vision with the Snellen Chart and Jaeger Card (cranial nerve II).
- Test the visual fields (cranial nerve II).
- Test extraocular movements (cranial nerves III, IV, VI).
- Test pupillary reaction to light and accommodation (cranial nerve III).
- Darken the room and use the ophthalmoscope to assess reflex, optic disc, retinal vessels, retinal background.

8. Ears, Nose, Mouth, and Throat

- Ears: Inspect the external ears.
- Use an otoscope to inspect each external ear canal and the tympanic membrane. Test hearing using the whisper tests (cranial nerve VIII).
- Palpate the auricle and tragus of each ear.
- Nose: Assess patency of the nares.
- Test sense of smell (cranial nerve I). inspect the internal nose.
- Palpate the nose and sinuses.
- Palpate the temporal artery.
- Mouth: Palpate the temporomandibular joint (TMJ) as the patient opens and closes the mouth.
- Inspect the lips.
- Use a penlight to inspect the tongue, palates, buccal mucosa, gums, teeth, the opening to the salivary glands, tonsils, and oropharynx.
- Test the sense of taste (cranial nerve VII).
- palpate the tongue, gums, and floor of the mouth.
- Observe the uvula for position and mobility as the patient says “ah,” and test the gag reflex (cranial nerves IX, X).
- Observe as the patient protrudes the tongue (cranial nerveXII).

9. The Respiratory System, Breasts, and Axillae.

- Inspect the posterior chest for symmetry, musculoskeletal development, and thoracic configuration.
- Observe respiratory excursion.

- Auscultate posterior lung sounds.
- Palpate and percuss the costovertebral angle for tenderness.
- Palpate for thoracic expansion and tactile fremitus.
- Inspect and palpate the scapula and spine.
- Percuss the posterior thorax and for diaphragmatic excursion.
- Inspect the anterior chest for symmetry and musculoskeletal development.
- Assess range of motion and movement against resistance of the upper extremities.
- Inspect the breasts for symmetry, mobility, masses, dimpling, and nipple retraction. Ask the post-pubescent female to lift arms over her head, press her hands on her hips, and lea forward as you inspect and Palpate the breasts and nipples.
- Auscultate anterior lung sounds.
- Palpate the axillary, supraclavicular, and infraclavicular lymph nodes.
- Palpate & Percuss the anterior chest.

10. The Cardiovascular System:

- Inspect the neck for jugular pulsations or distension.
- Inspect and palpate the chest for pulsations, lifts, or heaves.
- Use the bell and diaphragm of the stethoscope to auscultate for heart sounds.
- At each area of auscultation distinguish the rate, rhythm, and location of S1 and S2 sounds.
- Palpate the apical pulse and note the intensity and location (PMI).

11. The Abdomen:

- Inspect the skin of the abdomen.
- Inspect the abdomen for symmetry, contour, and movement or pulsation.
- Auscultate the abdomen for bowel sounds.
- Auscultate the abdomen for vascularsounds.
- Palpate the liver, spleen, and kidneys.
- Palpate to determine if tenderness, masses, or distension are present.
- Palpate the inguinal region for pulses, lymph nodes, and presence of hernias.
- Percuss the abdomen in all quadrants and determine liver and spleen size.
- Observe and test stool for occult blood.

12. The Musculoskeletal System:

- Test range of motion and strength in the hips, knees, ankles, and feet.
- Perform the Romberg test.
- Assist the patient to a standing position.
- Observe as the patient walks in a natural gait. Observe the patient walking heel to toe.
- Observe the patient stand on the right foot, then the left foot with eyes closed.
- Test range of motion of the spine. Stand behind the patient and observe the spine as the patient touches the toes.

1. The Neurologic System: (GCS**)**

- Assess sensory function. Include light touch, pain, temperature.
- Test cerebellar function with finger-to-nose test and with heel-shin test.
- Test stereognosis and graphesthesia. Test tendon reflexes bilaterally and compare.

- **Document findings from comprehensive health assessment according to agency policy.**
- **Include all concepts of patient safety, professional standards in the documentation of assessment data.**
- **Documentation is important; the data documented from the complete assessment establish a baseline for ongoing patient interaction and care.**