

PHYSICAL EXAMINATION

Self-study

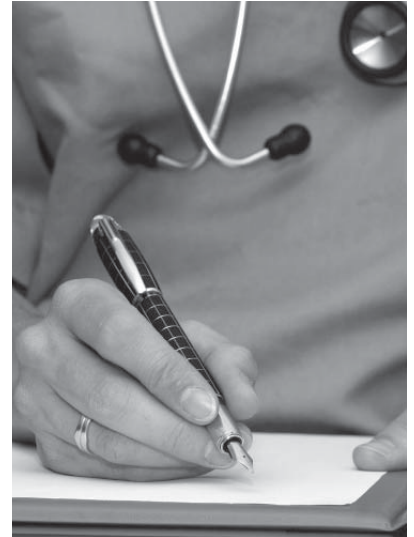


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HEALTH HISTORY AND PHYSICAL EXAMINATION

Obtaining a patient's health history and performing a physical examination are activities completed by the nurse during the assessment phase of the nursing process. The information obtained during this phase contributes to a database that identifies the patient's current and past health state and provides a baseline against which future changes can be evaluated. The purpose of the nursing assessment is to enable the nurse to make a judgment or diagnosis about the patient's health state. Assessment is identified as the first step of the nursing process. However, it is performed continuously throughout the nursing process to validate diagnoses, evaluate the patient's response to nursing interventions, and determine the extent to which patient outcomes and goals have been met.

DATA COLLECTION

Collection of data about the patient is not solely the nurse's responsibility. The database is all the health information about a patient. It includes the nursing history and physical examination, the physician's history and physical examination, results of laboratory and diagnostic tests, and information contributed by other health professionals. Numerous approaches and formats exist for gathering information about the patient in various health care settings. The information's purpose determines the methods of data collection. The nurse and physician both perform a patient history and physical examination, but they use different formats and analyze the data differently because of each discipline's focus.

Medical focus

A medical history is a standard format designed to collect data to be used primarily by the physician to determine risk for disease and diagnose a medical condition. The medical history is usually collected by a member of the medical team or a nurse practitioner. The physician's physical examination and laboratory and diagnostic tests assist in establishing a medical diagnosis and evaluating specific medical therapy. The information collected and reported by the physician is also used by nurses and other health care providers, but within the focus of their care. For example, the abnormal results of a neurological examination by a physician may assist in the diagnosis of a brain lesion, but the nurse may use those same results to identify a nursing diagnosis of risk for falls. The physical therapist may also use the results to plan therapy involving exercise, splints or ambulatory aids.

Nursing focus

The focus of nursing care is the diagnosis and treatment of human responses to actual or potential health problems. The information obtained from the nursing history and physical examination is used to determine what responses the patient is, or potentially could exhibit, as a result of a health problem. The nurse is interested in the functional capabilities of the patient. In the patient with a medical diagnosis of congestive heart failure, the patient's response may be anxiety or a lack of energy to carry out normal daily activities. These are human responses to heart failure that can be diagnosed and treated by the nurse. During the nursing history interview and physical examination, the nurse obtains the necessary data to support the identification of nursing diagnoses.

Interviewing considerations

The purpose of the patient interview is to obtain subjective data about the patient's past and present health state. Collection of data helps the nurse and the patient identify health problems, as well as patient strengths and resources. The nurse can use the data to identify areas where the patient may be unable to meet personal needs and therefore requires nursing assistance. The patient perceives this encounter as an indication of how the health care system will provide assistance.

Effective communication is a key factor in the interview process. Creating a climate of trust and respect is critical to establishing a therapeutic relationship. The nurse must communicate acceptance of the patient as an individual by using an open, responsive, nonjudgmental approach. Individuals communicate not only through language but also in their manner of dress, gestures and body language. Modes of communication are learned through one's culture, influencing not only the words, gestures and posture one uses, but also the nature of information shared with others. In addition to understanding the principles of effective communication, each nurse must develop a personal style of relating to patients. Although no single style fits all people, carefully wording specific questions will increase the probability of eliciting the needed information. Ease in asking questions, particularly those related to sensitive areas such as sexual functioning and economic status, comes with experience.



The amount of time needed to complete a nursing history may vary with the format used and the experience of the nurse. It may be completed in one or several sessions, depending on the setting and the patient. Allowing time for the patient to volunteer information about particular areas of concern enables the nurse to work with the patient to identify existing and potential health problems. When a patient is unable to provide the necessary data, the nurse should ask the person who has assumed responsibility for the patient's welfare to provide as much information as possible.

Before beginning the nursing history, the nurse should explain to the patient that the purpose of a detailed history is to collect information that will provide a health profile for comprehensive health care, including health promotion. This detailed information is collected during entry into the health care system. Only updates are needed after that time. The nurse should explain that personal and social data are needed to individualize the plan of care. This explanation is necessary because the patient may not be accustomed to sharing personal information and may need to know the purpose of such questioning. The nurse should assure the patient that all information will be kept confidential.

To obtain factual, easily categorized information, a direct interview technique can be used. Closed questions such as "Have you had surgery before?" that require brief, specific responses are used. When asking sensitive personal and social questions, the nurse can preface questions with phrases such as "most people" or "frequently" to communicate that the behaviors are acceptable and normal. For example, stating, "Most people have sexual concerns; do you have any you would like to discuss?" shows the patient that a particular situation may not be unique to that patient. Another method of putting the patient at ease is to word the question so that an affirmative answer appears expected. An example of this technique is to ask, "What do you like to drink at a party?" instead of "Do you drink?" "How often do you drink alcohol?" is another way of obtaining information related to alcohol intake. These questions are open-ended, encouraging the patient to discuss the issue in the patient's own words and at his or her own pace.

It is important that the nurse determine the patient's most important concerns and expectations during this encounter. For example, the priority for the nurse might be to get a consent form signed, whereas the patient is interested only in getting relief from pain. There is often a lack of congruency between the patient's and the nurse's priorities. Until the patient's priority need is met, the nurse will probably be unsuccessful in meeting the priority goal.

The amount of information that should be collected on initial contact with the patient is a nursing judgment based on the patient, the problem and the setting. Interviews with older adult patients, patients with long-term chronic diseases, and emergency department admissions are examples of situations in which the nurse might use this judgment. The nurse may choose to ask only those questions pertinent to a specific problem and to defer the complete history interview until a more appropriate time.

Symptom investigation

At any time during assessment the patient may relate a symptom such as pain, fatigue or weakness. Because the patient directly experiences symptoms that are not observable to the nurse, the symptoms must be investigated. Appendix A lists eight areas that should be investigated if a symptom is present. The information that is obtained may help determine the cause of the symptoms.



NURSING HISTORY: SUBJECTIVE DATA

A format that could be used for obtaining a nursing history includes an initial collection of important health information followed by assessment of the patient's functional health patterns. Appendix B shows a format designed to promote systematic data collection to determine the presence of problems amenable to nursing diagnosis and treatment. Analysis of the data collected with assessment of each functional health pattern facilitates the nursing diagnosis process.

Important health information

Important health information provides an overview of past and present medical conditions and treatments. Past health history, medications and surgery or other treatments are included in this part of the history.

- **Past health history:** The past health history provides information about the patient's prior state of health. The patient is specifically asked about major childhood and adult illness, injuries and hospitalizations, operations, therapeutic regimens, travel habits, and the use of supportive devices. Specific questioning is more effective than simply asking if the patient has had any illness or health problems in the past.
- **Medications:** Specific details related to past or present medications are obtained. This includes the use of prescription drugs, over-the-counter drugs, vitamins, herbal products and dietary supplements. Patients frequently do not consider herbal products and dietary supplements as drugs. Because they can interact adversely with existing medications, it is important to specifically ask about their use. Examples of specific prescription and over-the-counter medications to ask about include corticosteroids, birth control pills, antibiotics, diuretics, aspirin, antacids and laxatives. Older adult patients, in particular, should be questioned about medication routines. Changes in absorption, metabolism, reaction to drugs, elimination of drugs, surgery and concurrent disease make drug-related concerns a serious potential problem for older adults.

Surgery or other treatments: All injuries, hospitalizations and surgeries are recorded along with the date of the event, the treatment and the outcome (whether the problem was completely resolved). Any blood transfusions are also noted.

Functional health problems

The nurse assesses the patient's functional health pattern to identify patient strengths in function and to determine if dysfunctional health patterns and/or potential dysfunctional patterns exist. Dysfunctional health patterns result in nursing diagnoses, and potential dysfunctional patterns identify risk conditions for assessment that assist the nurse in differentiating between areas for independent nursing intervention and areas requiring collaboration or referral.

- **Health perception/health management pattern:** Assessment of the health perception-health management functional health pattern focuses on the patient's perceived level of health and well-being and on personal practices for maintaining health. These include preventive screening activities, such as breast and testicular examinations; colorectal cancer, hypertension and cardiac risk factor screening; Pap test; and immunizations such as tetanus, pneumonia and flu vaccine. The nurse should ask about the type of health care provider that the patient uses. Culture may play a role in who is the patient's primary health care provider. For example, if the patient is Native American, a medicine man may be considered as the primary health care provider. If the patient is of Hispanic origin, a curandero (Hispanic healer who uses folk medicine, herbal products and/or magic to treat patients) may be the primary health care provider.

The questions for this pattern also seek to identify risk factors by obtaining a family history, history of health habits (smoking, alcohol, drug use), and exposure to environmental hazards.

There are several ways to identify the patient's perceived level of health and well-being. First, when questioning the patient, the nurse determines the patient's feelings of effectiveness at staying healthy by asking what helps and what hinders.

Next, the patient is asked to describe personal health and any concerns about it. This information should be recorded in the patient's own words. It is useful to determine whether the patient considers his or her health to be excellent, good, fair or poor.



In addition, the patient is asked about a family history of major problems, such as cardiovascular disease, hypertension, cancer, diabetes, psychiatric illness and genetic disorders. Information about sexual abuse, violence and drug and alcohol use/abuse should also be obtained. One of the objectives in this pattern is to identify any preventive measures the patient uses to promote personal health.

If the patient is hospitalized, expectation of this hospitalization should be determined. A description of the patient's understanding of the current health problem — including a description of its onset, course and treatment — should be obtained. Determining what the patient does when ill is important. These questions elicit information about a patient's knowledge of the health problem, awareness of what should be done, and ability to use appropriate resources to manage the problem.

- **Nutritional/metabolic pattern:** The process of ingestion, digestion, absorption and metabolism are assessed in this pattern. A 24-hour dietary recall should be obtained from the patient. From this information the nurse can evaluate the quantity and quality of foods and fluids consumed. If a problem is identified, the nurse may request that the patient keep a three-day food diary for a more careful analysis of dietary intake. Food frequency questionnaires based on weekly intake are also available to obtain information from the person. Metabolism is evaluated by questioning the patient regarding weight gain, weight loss, energy level, and skin lesions or dryness.

The impact of psychologic factors such as depression, anxiety and self-concept on nutrition is assessed. For example, "How is your appetite affected by your anxiety?" is an appropriate question. Sociocultural factors such as food budget, who prepares the meals and food preferences are also assessed.

Determining how the patient's present condition has interfered with eating and appetite is important. If the patient's present condition has produced symptoms such as nausea, gas or pain, the effect of these symptoms on appetite should be determined. Food allergies and the need for a special or restricted diet should be noted. Additional information about the person's nutritional status can be determined by asking specific questions such as:

- "How many fruits and vegetables do you eat a day?" or
- "Give me an example of your usual intake of meat." or
- "How well do you heal from a wound?"



- **Elimination pattern:** The nurse assesses bowel, bladder and skin function in this pattern. The nurse asks about the frequency of bowel and bladder activity. A description of consistency, amount, color and unusual odor should be elicited. The patient should be asked if loss of control or pain is associated with defecating or urinating. If laxatives or enemas are used, the frequency, type and results should be noted. If any collecting devices are used, such as catheter or colostomy equipment, the nurse asks about their use and care.

The skin is assessed again in the elimination pattern in terms of its excretory function. The patient should be asked about the condition of his or her skin and whether edema, pruritus or excessive perspiration is problematic.

- **Activity/exercise pattern:** The nurse assesses the patient's usual pattern of exercise, activity, active leisure and recreation. The patient should be questioned about his or her ability to perform activities of daily living. If the patient is unable to perform activities of daily living such as toileting, eating and moving independently, the specific problems that limit an activity should be noted. Chest pain, dyspnea, dizziness, intermittent claudication, musculoskeletal pain, fatigue and weakness are problems that commonly result in some degree of self-care deficit.
- **Sleep/rest pattern:** This pattern describes the patient's pattern of sleep, rest and relaxation in a 24-hour period. The individual's perception of the effectiveness of sleep and relaxation is pertinent. This information can be elicited by asking, "Do you feel rested when you wake up?" Most people take sleep for granted unless they have a problem with it. The patient's usual activities should be determined. Particular routines, position, medications and environmental factors used to foster sleep should also be elicited.
- **Cognitive/perceptual pattern:** Assessment of this pattern involves a description of all senses (vision, hearing, taste, touch and smell) and the cognitive functions such as communication, memory and decision making. The patient should be asked about any sensory deficits that affect the ability to perform activities of daily living. Routine eye care,

including the date of the last examination, should be elicited. Ways in which the patient compensates for any sensory-perceptual problems should be discussed and noted. Patients should be asked how they communicate best and about their understanding of their illness and treatment. The nurse uses this information to plan patient teaching.

- **Self-perception/self-concept patterns:** This pattern describes the patient's self-concept, which is critical in determining the way the person interacts with others. Included are attitudes about self, perception of personal abilities, body image and general sense of worth.

The nurse should ask the patient for a self-description and how the health condition affects self-attitude. Nurses should avoid making value judgments about how people perceive themselves. What concerns the patient about a personal situation may differ from what concerns the nurse. For example, the patient may feel cheated by the system when denied disability benefits. The nurse may think the patient was not eligible for the benefit.

- **Role/relationship pattern:** This pattern describes the patient's roles and relationships, including major responsibilities. It also examines the patient's evaluation of his or her performance of the expected behaviors related to these roles.

The patient should be asked to describe family, social and work relationships. The nurse should determine if patterns in these relationships are satisfactory or if strain is evident. The nurse should note the patient's feelings about his or her role in these relationships and the effect the present condition has on his or her role and relationship.

- **Sexuality-reproductive pattern:** This pattern describes satisfaction or dissatisfaction with personal sexuality and describes the reproductive pattern. Assessing this pattern is important because many illnesses, surgical procedures and medications affect sexual function. A patient's sexual and reproductive concerns may be expressed, teaching needs and treatable problems may be identified, and normal growth and development may be monitored through information obtained in this pattern.

The interview should be appropriate to the sex, age and developmental stage of the patient. For example, a 40-year-old widowed female patient might be asked

if she has any problems related to her genital area such as vaginal discharge. She also should be asked whether she is sexually active and, if so, whether she practices safe sex. A 25-year-old male patient might be asked about his knowledge and use of condoms.

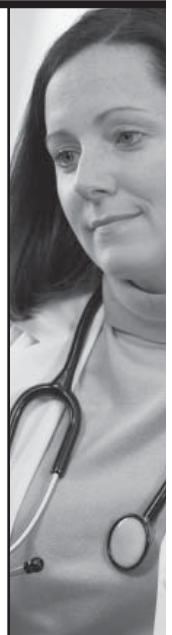
Obtaining information related to sexuality often is difficult for the nurse. However, it is important to take a health history and screen for sexual function and dysfunction. Based on the complexity of the problem, the nurse may be able to provide limited information or refer the patient to a more experienced professional.

Specifically, the nurse should determine if the patient lacks knowledge of sexuality and reproduction. Whether the patient perceives a problem in the area of sexuality should also be determined. The effect of the patient's present condition or treatment on personal sexuality should be noted.

- **Coping/stress tolerance pattern:** This pattern describes the general coping pattern and the effectiveness of the coping mechanisms. Assessment of this pattern involves analyzing the specific stressors or problems that confront the patient, the patient's perception of the stressor and the patient's response to the stressor.

The major losses or changes experienced by the patient in the previous year are important to document. Current major stressors confronting the patient are also important. The strategies used by the patient to deal with stressors and relieve tension should be noted. Individuals and groups who make up the patient's social support networks should be recorded.

- **Value/belief pattern:** This pattern describes the values, goals and beliefs (including spiritual) that guide health-related choices. The patient's ethnic background and the effects of culture and beliefs about health and illness on health practices should be documented. The patient's wishes about continuation of religious practices and the use of religious articles should be noted and honored. The possibility of a conflict in values or beliefs can be determined by asking a question such as, "Does your plan of care cause any conflict in your value or belief system?"



PHYSICAL EXAMINATION: OBJECTIVE DATA

General survey

Following the nursing history, a general survey statement is made. The general survey is a statement of the provider's general impressions of a patient, including behavioral observations. This initial survey is considered a scanning procedure and begins with the provider's first encounter with the patient and continues during the health history interview.

Although the provider may include other data that seem pertinent, the major areas usually included in the general survey statement are body features, state of consciousness and arousal, speech, body movements, obvious physical signs, nutritional status and behavior. Vital signs, height and weight are often included in the general survey statement. Observations of these areas provide the data for the general survey statement. The following is a sample of a general survey statement:

Mrs. H. is a 34-year-old Hispanic woman. BP 130/84, P 88, R 18. No distinguishing body features. Alert but anxious. Speech rapid with trailing thoughts. Wringing hands and shuffling feet during interview. Skin flushed, hands clammy. Overweight relative to height. Sits with eyes downcast and shoulders slumped and avoids eye contact.

Physical examination

The physical examination is the systematic assessment of the physical and mental status of a patient, and findings are considered objective data. Throughout the physical examination, any positive findings are explored using the same criteria as the investigation of a symptom during the nursing history. A positive finding indicates that the patient has or had the particular problem or sign under discussion. For example, if the patient with jaundice has an enlarged liver, it is a positive finding. Relevant information about this problem should then be gathered.

Negative findings may also be significant. A negative finding is the absence of a sign or symptom usually associated with a problem. For example, peripheral edema is common with congestive heart failure. If edema is not present in a patient with congestive heart failure, this should be specifically noted as "no peripheral edema."

Types

There are two types of physical examination: the screening physical examination and the branching (regional) examination. The screening physical examination is performed for screen situations, health surveillance and health maintenance purposes. It is an organized, purposeful check of major body systems to detect any possible problems. If a problem is detected in the course of the screening physical examination, a more detailed branching examination of the involved system should be done.

A branching (regional) examination is a more detailed assessment of a particular body system. The patient's clinical manifestations should alert the nurse to the appropriate branching examination. For example, abdominal pain indicates the need to do a branching examination of the abdomen. Some problems necessitate more than one branching examination. A complaint of headache may indicate the need to do musculoskeletal, neurological and head and neck examinations.

Techniques

Four major techniques are used in performing the physical examination: inspection, palpation, percussion and auscultation.

- **Inspection:** Inspection is the visual examination of a part or region of the body to assess normal conditions or deviations from normal. Inspection is more than just looking. This technique is deliberate, systematic and focused. The nurse needs to compare what is seen with the known, generally visible characteristics of the body part being inspected. For example, most 30-year-old men have hair on their legs. Absence of hair may indicate a vascular problem and signals the need for further investigation, or it may be normal for a patient of a particular ethnicity. For example, Native American men have very little body hair.
- **Palpation:** Palpation is the examination of the body through the use of touch. The use of light and deep palpation can yield information related to masses, pulsations, organ enlargement, tenderness or pain, swelling, muscular spasm or rigidity, elasticity, vibration of voice sounds, crepitus, moisture and differences in texture. The nurse will learn that different



parts of the hand are more sensitive for specific assessments. For example, the tips of the fingers are used to palpate lymph nodes; the dorsa of hands and fingers are used to assess temperatures; and the palmar surface is best suited for feeling vibrations.

- **Percussion:** Percussion is an assessment technique involving the production of sound to obtain information about the underlying area. The percussion sound may be produced directly or indirectly. Direct percussion is performed by directly tapping the body with one or two fingers to elicit a sound. Indirect, or mediated, percussion is the more common percussion technique. The middle finger of the nondominant hand is placed firmly against the body surface. The tip of the middle finger of the dominant hand strikes the distal phalanx or the distal interphalangeal joint of the nondominant finger. A relaxed wrist and rapid strike produce the best sounds. The sounds and the vibrations produced are elevated relative to the underlying structures. Deviation from an expected sound may indicate a problem. For example, the usual percussion sound in the right lower quadrant of the abdomen is tympany. Dullness in this area may indicate a problem that should be investigated.
- **Auscultation:** Auscultation is listening to sounds produced by the body to assess normal conditions and deviations from normal. Auscultation is usually indirect, using a stethoscope to clarify sounds by blocking out extraneous sounds. The bell of the stethoscope is more sensitive to low—pitched sounds. The diaphragm of the stethoscope is more sensitive to high—pitched sounds. Auscultation is particularly useful in evaluating sounds from the heart, lungs, abdomen and vascular system.

Not all assessment techniques are appropriate for all body parts and systems. The nurse will learn which techniques to use to elicit the most information. The physical assessment techniques are usually performed in the sequence of inspection, palpation, percussion and auscultation. The only exception to this sequence is for the abdominal examination. In this situation the sequence is inspection, auscultation, percussion and palpation. Palpation and percussion of the abdomen before auscultation can alter bowel sounds and produce false findings.

- **Equipment:** The equipment needed for the physical examination should be easily accessible during the examination. Organizing equipment before the examination saves the patient's and the nurse's time and energy. Lack of organization can discourage the patient and lead to a lack of trust and confidence in the nurse.

- **Developing a system:** The physical examination should be performed systematically and efficiently. Explanations should be given to the patient as the examination proceeds. The factors to be considered are the nurse's efficiency and the patient's comfort, safety and privacy. The examiner is less likely to forget a procedure, a step in the sequence, or a portion of the body if the same sequence is followed every time.

Adaptations of the physical examination often are useful for the older adult patient, who may have age—related problems such as decreased mobility, limited energy and perceptual changes.

- **Recording the screening physical examination:** Only abnormal findings should be recorded during the actual examination. This prevents needless interruption in the examination to write lengthy normal findings. At the conclusion of the examination, the nurse should combine the normal and abnormal findings in a carefully recorded physical examination.



Investigation of a symptom

1. Location:

Ask: Where do you feel it? Where is it located?

Record: Region of the body. Local or radiating, superficial or deep.

2. Quality:

Ask: What does it (feel, look) like?

Record: The patient's analogy ("Like being burned.")

3. Quantity:

Ask: How often do you have this feeling? How bad is it? How much is it?
How big is it?

Record: Frequency (mild, moderate, severe), volume, size, extent, number.

4. Chronology:

Ask: When was the first time it occurred? Any particular time of day, week, month or year?

Record: Time of onset, duration, periodicity and frequency, course of symptoms.

5. **Setting:**

Ask: Where are you when this occurs? What are you doing?

Record: Where patient is when symptoms occur, what patient is doing, if symptom is related to anything.

6. **Aggravating or alleviating factors:**

Ask: What makes it better? Worse? Is there any activity that seems to cause it? What have you done for it? Did it help? Was there some reason you didn't do anything about it?

Record: Influence of physical and emotional activities, patient's attempts to alleviate (or treat) the symptom.

7. **Associated manifestations:**

Ask: What other things do you see or feel when it occurs? Has it affected your appetite? Elimination? Sleeping?

Record: Other symptoms.

8. **Meaning of the symptom to the patient:**

Ask: How has it affected your life? Why have you sought care now? What do you think may be the cause?

Record: Patient's statements about the effect of the symptom and the cause of the symptom

Nursing history: Functional health pattern format

1. Demographic data

- Name
- Address
- Age
- Occupation
- Culture
- Ethnicity

2. Important health information

- Past health history
- Medications
- Surgery or other treatments

3. Functional health patterns**Health perception/health management pattern**

- a. Reason for visit
- b. General state of health
- c. Any colds in past year
- d. Most important things done to keep healthy? Breast self—examination? Testicular self—examination? Other routine screening?
- e. Health compliance problems
- f. Cause of illness, action taken, results

-
- g. Things important to you while here
 - h. Family health history
 - i. Illness and injury risk factors: use of cigarettes, alcohol, drugs
 - j. Allergies, immunizations

Nutritional/metabolic pattern

- a. Typical daily food intake (describe)? Supplements?
- b. Typical daily fluid intake (describe)?
- c. Weight loss or gain (amount, time span)
- d. Desired weight
- e. Appetite
- f. Food or eating: Discomfort? Diet restrictions?
- g. Heal well or poorly?
- h. Skin problems: Lesions? Dryness?
- i. Dental problems
- j. Change in appetite with anxiety
- k. Food preferences
- l. Food allergies

Activity/exercise pattern

- a. Sufficient energy for desired or required activities
- b. Exercise pattern type regularity
- c. Spare time (leisure) activities
- d. Dyspnea? Chest pain? Palpitation? Stiffness? Aching? Weakness?
- e. Perceived ability for (code for level): feeding, bed mobility, toileting, cooking, bathing, shopping, grooming, dressing, general mobility

Functional levels code

Level 0: Full self-care

Level 1: Requires use of equipment or device

Level 2: Requires assistance or supervision from another person

Level 3: Is dependent and does not participate

Sleep/rest pattern

- a. Generally rested and ready for daily activities after sleep?
- b. Sleep onset problems? Aids? Dreams (nightmares)? Early awakening?
- c. Usual sleep rituals
- d. Usual sleep patterns

Cognitive/perceptual pattern

- a. Hearing difficulty? Hearing aids?
- b. Vision? Wear glasses? Last checked?
- c. Any changes in taste? Any change in smell?
- d. Any recent change in memory?
- e. Easiest way to learn things?
- f. Any discomfort? Pain? How managed?
- g. Ability to communicate
- h. Understanding of illness
- i. Understanding of treatments

Self-perception/self-concept pattern

- a. Self-description? Self-perception?
- b. Effect of illness on self-image
- c. Relieving factors

Role/relationship pattern

- a. Live alone? Family? Family structure diagram
- b. Difficult family problems
- c. Family problem solving
- d. Family dependence on you for things? How managing?
- e. Family's and others' feelings about illness/hospitalization
- f. Problems with children? Difficulty handling?
- g. Belong to social groups? Have close friends? Feel lonely (frequency)?
- h. Work satisfaction (school)? Income sufficient for needs?
- i. Feel part of or isolated from neighborhood where living

Sexuality/reproductive pattern

- a. Any changes or problems in sexual relations?
- b. Effect of illness
- c. Use of contraceptives? Problems?
- d. When menstruation started? Last menstrual period? Menstrual problems? Gravida? Para?
- e. Effect of present condition or treatment on sexuality
- f. Sexually transmitted diseases

Coping/stress tolerance pattern

- a. Tense a lot of the time? What helps? Use any medicines, drugs, alcohol?
- b. Have someone to confide in? Available to you now?
- c. Recent life changes
- d. Problem—solving techniques? Effective?

Values/belief pattern

- a. Satisfied with life?
- b. Religion important in your life?
- c. Conflict between treatment and beliefs?

Other

- a. Other important issues
- b. Questions



Overview of functional health patterns

Health perception/health management pattern:

- Description of health (usual), description of present illness (onset, course, treatment)
- Relevance of health to activities
- Preventive measures, general health care behavior
- Previous hospitalizations, expectation of this hospitalization
- Potential self—care problems

Nutritional/metabolic pattern:

- Usual food and fluid intake, appetite
- Daily eating times
- Recent weight change and reason
- Food restrictions or preferences, food supplements
- Swallowing, chewing, eating problems, food allergies
- Skin lesions and general ability to heal
- Condition of skin, hair, nails, mucous membranes and teeth
- Temperature, pulse, respiration, height and weight

Elimination pattern:

Bowel

- Usual time, frequency, color, consistency
- Assistive devices (laxatives, suppositories, enemas)
- Constipation, diarrhea

Bladder

- Usual frequency
- Problems with dysuria or polyuria
- Assistive devices

Skin condition

- Color, temperature
- Turgor, lesions, edema, pruritus

Activity/exercise pattern:

- Exercise, activity, leisure and recreational programs
- Limitations in activities of daily living

Sleep/rest pattern:

- Usual sleep routine, sleep pattern
- Perception of quality and quantity of sleep

Cognitive/perceptual pattern:

- Sensory adequacy — hearing, sight, smell, touch, taste
- Prosthetic devices (glasses, hearing aides)
- Pain
- Problems with vertigo
- Heat or cold sensitivity
- Language, understanding, memory abilities

Self-perception/self-concept pattern:

- Self-description
- Effects of illness on self
- Perception, body image, identify, self-esteem
- Posture, eye contact, voice and speech patterns

Role/relationship pattern:

- Life roles and responsibilities
- Satisfaction or dissatisfaction in family, work and social relationships

Sexuality/reproductive pattern:

- Sexuality patterns; satisfaction or dissatisfaction with sexuality patterns
- Adequacy of sexual knowledge
- Reproductive state (female— pre– or post–menopausal)

Coping/stress tolerance pattern:

- General coping strategies
- Stress tolerance, stress reduction behaviors
- Support systems
- Ability to manage situations

Value/belief pattern:

- Values, goals, beliefs that are basis for decisions
- Value or belief conflict
- Spiritual practices

Equipment for screening physical examination

1. Stethoscope with bell and diaphragm
2. Wristwatch (with second hand or digitalized)
3. Blood pressure cuff
4. Ophthalmoscope/otoscope set
5. Eye chart
6. Pocket flashlight
7. Tongue blades
8. Cotton balls
9. Percussion hammer
10. Tuning fork
11. Alcohol swabs
12. Patient gown
13. Paper cup with water
14. Examining table or bed

Outline for screening physical examination

1. General survey**Observe general state of health (patient is seated):**

- Body features
- State of consciousness and arousal
- Speech
- Body movements
- Physical signs
- Nutritional status
- Stature

2. Vital signs**Record vital signs:**

- Blood pressure
- Radial pulse
- Respiration
- Temperature
- Height and weight

3. Integument

Inspect and palpate skin for the following:

- Color
- Lesions
- Scars
- Bruises
- Edema
- Moisture
- Texture
- Temperature
- Turgor
- Vascularity

Inspect and palpate nails for the following:

- Color
- Lesions
- Size
- Flexibility
- Shape
- Angle

4. **Head and neck**

Inspect and palpate head for the following:

- Shape and symmetry of skull
- Masses
- Tenderness
- Hair
- Scalp
- Skin
- Temporal arteries
- Temporomandibular joint
- Sensory (cranial nerve 5, light touch, pain)
- Motor (cranial nerve 7, shows teeth, purses lips, raises eyebrows)
- Looks up, wrinkles forehead (cranial nerve 7)
- Raises shoulders against resistance (cranial nerve 11)

Inspect and palpate (occasionally auscultate) neck for the following:

- Skin (vascularity and visible pulsations)
- Symmetry
- Postural alignment
- Range of motion
- Pulses and bruits (carotid)
- Middle structure (trachea, thyroid gland, cartilage)
- Lymph nodes (preauricular, postauricular, occipital, mandibular, tonsillar, submental, anterior and posterior cervical, infraclavicular, supraclavicular)

Inspect and palpate eyes for the following:

- Visual acuity
- Eyebrows
- Position and movement of eyelids (cranial nerve 7)
- Visual fields
- Extraocular movements (cranial nerves 3, 4, 6)
- Cornea, clear, conjunctiva
- Papillary response (cranial nerve 3)
- Red reflex
- Eyeball tension

Inspect and palpate nose and sinuses for the following:

- External nose-shape blockage
- Internal nose-patency of nasal passages shape, turbinates or polyps, discharge
- Frontal and maxillary sinuses

Inspect and palpate ears for the following:

- Placement
- Pinna
- Auditory acuity (whispered voice, ticking watch) (cranial nerve 8)
- Mastoid process
- Auditory canal
- Tympanic membrane

Inspect and palpate mouth for the following:

- Lips (symmetry, lesions, color)
- Buccal mucosa (Stensen's and Wharton's ducts)
- Teeth (absence, state of repair, color)
- Gums
- Tongue for strength (asymmetry, ability to stick out tongue, side to side, fasciculations) (cranial nerve 12)
- Palates
- Tonsils and pillars
- Uvular elevation (cranial nerve 9)
- Posterior pharynx
- Gag reflex (cranial nerve 9 and 10)
- Jaw strength (cranial nerve 5)
- Moisture
- Color
- Floor of mouth

5. Extremities

Observe size and shape, symmetry and deformity, involuntary movements.

Inspect and palpate arms, fingers, wrists, elbows, shoulders for the following:

- Strength
- Range of motion
- Crepitus
- Joint pain
- Swelling
- Fluid

Test reflexes:

- Biceps
- Triceps
- Brachioradialis
- Patellar
- Achilles
- Plantar

Inspect and palpate legs for the following:

- Strength of hips
- Edema
- Hair distribution
- Pulses (dorsalis pedis, posterior tibialis)

6. *Posterior thorax***Inspect for muscular development, respiratory movement, approximation of AP diameter**

- Palpate for symmetry of respiratory movement, tenderness of CVA (costovertebral angle), spinous processes, tumors or swelling, tactile fremitus
- Percuss for pulmonary resonance
- Auscultate for breath sounds

7. **Anterior thorax**

- Assess breast for configuration, symmetry, dimpling of skin
- Assess nipples for rash, direction, inversion, retraction
- Initiate teaching or review breast self-examination
- Inspect for PMI (point of maximal impulse), other precordial pulsations
- Palpate for thrills, lifts, heaves, tenderness over precordium
- Inspect neck for venous distention, pulsations, waves
- Palpate axillae
- Palpate breasts
- Auscultate for rate and rhythm, character of S1 and S2 in the aortic, pulmonic, Erb's point, tricuspid, mitral areas; bruits at carotid, epigastrium; breath sounds at RML (right middle lobe)

8. **Abdomen**

- Inspect for scars, shape, symmetry, bulging, muscular position and condition of umbilicus, movements (respiratory, pulsations, presence of peristaltic waves)
- Auscultate for peristalsis, bruits
- Percuss border of liver, four abdominal quadrants
- Palpate to confirm positive findings; check liver (size, surface contour, tenderness), spleen, kidney (size, contour, consistency, tenderness), urinary bladder (distention), femoral pulses, inguino-femoral nodes

9. **Completion of examination of extremities**

Observe the following:

- Range of motion of hips, knees, ankles, feet
- Crepitus
- Joint pain
- Swelling;
- Fluid
- Muscle development
- Coordination (heel to shin)
- Homan's sign
- Proprioception (position sense of great toe)

10. **Neurologic**

Motor status observations:

- Gait
- Toe walk
- Heel walk
- Drift

Coordination:

- Finger to nose
- Romberg sign
- Spine (scoliosis)

11. Genitalia

Male external genitalia

- Inspect penis, noting hair distribution, prepuce, glans, urethral meatus, scars, ulcers, eruptions, structural alterations
- Inspect epidermis of perineum, rectum
- Inspect skin of scrotum; palpate for descended testes, masses, pain

Female external genitalia

- Inspect hair distribution, mons pubis, labia (minora and majora), urethral meatus, Bartholin's, urethral, Skene's glands (may also be palpated, if indicated), introitus
- Assess for presence of cystocele, prolapse
- Inspect perineum, rectum

Recording a screening physical examination

Here is an example of how a completed screening would be documented.

Patient's name: _____

Age: _____

General status: _____

Well-nourished, well-hydrated, well-developed white (woman) or (man) in NAD; appears stated age; looks pleasant; smiles readily; speech clear and evenly paced; is alert and oriented times 3; cooperative; calm.

Skin: _____

Clear without lesions; warm and dry; trunk warmer than extremities; turgor returns quickly; no increased vascularity; no varicose veins.

Nails: _____

Well-groomed, round 160—degree angle without lesions, nail beds pink, nails flexible.

Hair: _____

Thick, brown, shiny, normal (male, female) distribution.

Head: _____

Normocephalic, sinuses nontender.

Eyes: _____

Visual fields intact on gross confrontation.

Visual acuity (VA): *20/20 in both eyes without glasses.*

Extraocular movements (EOM): *Intact on all gazes without ptosis, nystagmus.*

Fundi: *Red reflex present bilat no opacities, fundi, optic disc has clear margins and appropriate cup size; vessels taper with no indentation or displacement.*

Pupils: *Pupils equal, round, reactive to light and accommodation (PERRLA) negative cover and uncover tests; negative Hirschberg test.*

Ears: _____

Pinna intact, in proper alignment; external canal patent; small amount cerumen present; tympanic membranes intact; pearly gray landmarks, light reflex visible, not bulging; Rinne's test:: AC>BC (air conduction greater than bone conduction); Weber's: does not lateralize, whisper heard at 3 feet.

Nose: _____

Patent bilaterally; turbinates pink; no swelling.

Mouth: _____

Moist and pink; soft and hard palates intact; uvula rises midline on "ahh;" 24 teeth present and in good repair.

Throat: _____

Tonsils surgically removed, no redness.

Tongue: _____

Moist, pink, size appropriate for mouth.

Neck: _____

Supple without masses or bruits; lymph nodes nonpalpable and nontender..

Thyroid: palpable, smooth, not enlarged.

ROM: full, intact strong.

Trachea: midline, nontender.

Breasts: _____

Soft, nonpendulous, without venous pattern, without dimpling, puckering.

Nipples: without inversion, point in same direction, areola dark and symmetric, no discharge, no masses, nontender.

Axilla: _____

Hair present, shaved, no lesions, nontender.

Lungs: _____

No increase in AP diameter; respiratory rate 18; regular rhythm; no increase in tactile fremitus; no tenderness; lungs resonant throughout; diaphragmatic excursion 4 cm bilaterally; lung fields clear throughout.

Heart: _____

Rate 82, regular rate and rhythm; no lifts, heaves.

***PMI:** 5th ICS at midclavicular line (MCL); no palpable thrills, S1, S2 louder, softer in appropriate locations; no S3, S4; no murmurs, rubs, clicks; carotid, femoral, pedal and radial pulses present; equal, 2+ bilaterally.*

Abdomen: _____

No pulsations visible, rounded, active bowel sounds; no bruits or CVA (costovertebral angle) tenderness; no palpable masses.

Liver: _____

Lower border percussed at costal margin; smooth; nontender; approximately 9 cm span.

Spleen: _____

Nonpalpable, nontender.

Neurologic system: _____

Cranial nerves I-XII intact.

Motor (drift, toe stand) intact.

Coord ((FN (finger to nose), Romberg)), Romberg) intact.

Reflexes.

Sensation (touch, vibration, prop) intact.

Musculoskeletal system: _____

Well developed, no muscle wasting; without crepitus, nodules, swelling

ROM: *full, intact, and equal bilaterally; no scoliosis*

Strength: *equal, strong bilaterally*

Gait: *walks erect two foot steps; arms swinging at side without staggering*

Female genitalia:* _____

External genitalia: no swelling, redness, tenderness in BUS (Bartholin's gland, urethral meatus, Skene's duct); normal hair distribution, no cysts.

Vagina: *no lesions, discharge, bulging, pink.*

Cervix: *Os closed, pink, no lesions, erosions, nontender.*

Uterus: *small, firm, nontender.*

Adnexa: *no enlargement; nontender.*

Rectovaginal: *sphincter intact; confirms above findings.*

Male genitalia: _____

Normal male hair distribution, negative inguinal hernia.

Penis: *urethral opening patent; no redness, swelling, discharge; no lesions, structural alterations.*

Scrotum: *tests descended; no redness, masses, tenderness.*

Rectal: *no lesions, redness; sphincter intact; prostate small, nontender.*

Psychologic status: _____

Affect appropriate; eye contact.

Orientation: *oriented times 3.*

Mood: *pleasant, appropriate.*

Thought content: *intelligent, coherent.*

Memory: *remote and recent intact*

Serial sevens: *not done or intact*

Signature: _____

**Some of these data would be obtained from a pelvic examination if the nurse has the appropriate training.*



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