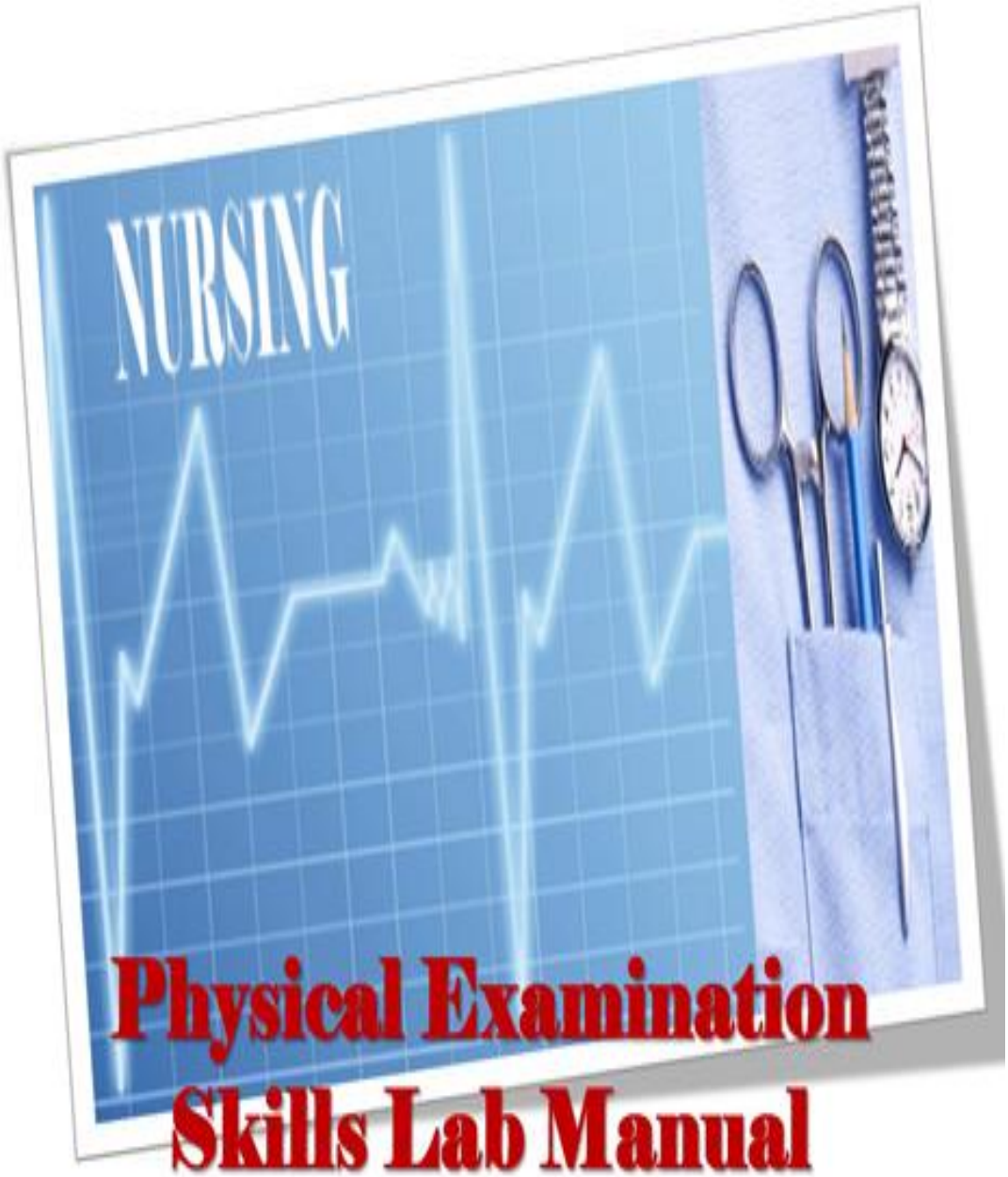


(NRS 242)

Physical Examination Skills Lab Manual (NRS 242)

INDEX

Unit 1

History Collection

PROCEDURE 1: History Collection (Subjective & Objective Data)

Purpose:

1. To collect subjective and objective data.
2. To determine client's overall level of functioning in order to make professional clinical judgement.

A. Preparation of the patient:

a) Greet the patient by name: "Good morning".
b) Introduce yourself and explain that you are a nurse or medical student.
c) Shake the patient's hand, or if they are unwell rest your hand on theirs
d) Ensure that the patient is comfortable.

B. Procedure:

1. **Collect the Identification Data of the patient** including Name , Address , Date of birth (age) , nationality , Occupation , Education , Marital status.

2. Collect history of present complaints in the following question form:

✓ Tell me what seems to be the problem?
✓ How long have you been unwell?
✓ When did the symptoms start?
✓ What are the characteristics of the problem in terms of-

- Site - where exactly is this pain?
- Onset - when did the pain start, did it start suddenly or gradually?
- Character - describe the pain - sharp? knife-like? gripping? burning? crushing?
- Radiation - does the pain spread anywhere? To the arm, jaw, groin ?
- Associations - is the pain accompanied by any other features?

- Timing - does the pain vary in intensity during the day?
- Exacerbating and relieving factors - does anything make the pain better or worse?
- Severity - does the pain interfere with daily activities or with sleep?

3. Collect the following history of past illness /complaints:

- **Previous medical history**
  - ✓ Ask about childhood illness and immunization
  - ✓ Have you had TB or whooping cough?
  - ✓ Have you ever been found to have high blood pressure or sugar?
  - ✓ Have you had rheumatic fever?
  - ✓ Have you ever suffered from epileptic seizures?
  - ✓ Do you get asthma (episodic breathlessness, usually with wheeze)?
  - ✓ Have you suffered from anxiety or depression?

- **Previous surgical history**
  - ✓ Have you had any operations in the past?
  - ✓ If yes, name it and no. of years for operation done.

- **Family history**
  - ✓ Any one in your family has medical diseases like diabetes, hypertension, etc.? If yes, name the disease.
  - ✓ Any one in your family underwent surgical procedure? If yes, name and no. of years?

- **Personal history**
  - ✓ Do you smoke? - If so, how many cigarettes per day/week?
  - ✓ Do you drink alcohol? - If so, how many units per day/week?
  - ✓ Do you take drugs? Which one? How many per day?

- **Menstrual history**
  - ✓ When your periods did started (Menarche)?
  - ✓ Are your periods irregular?

- ✓ How often do your periods occur and for how long do they last?
- ✓ Do you have heavy bleeding (menorrhagia) or do you pass clots during your period?
- ✓ Do you have pain during menses?
- ✓ When did your periods stop (menopause)?
- ✓ Have you had any bleeding since your periods stopped?

- **Obstetrical history (From married client only)**
  - ✓ How many years you are married for?
  - ✓ Have you had any pregnancies?
  - ✓ Were they normal?
  - ✓ Were there any complications such as hypertension and toxaemia, diabetes, Caesarian section?
  - ✓ Do you have history of abortion?
  - ✓ What type of delivery you had--- normal or instrumental or caesarean section?
  - ✓ Any child born with congenital birth defect or stillborn or died later in life?

- **Nutritional history**
  - ✓ What is the type of your diet?
  - ✓ Is your food healthy?
  - ✓ How many meal you take per day?
  - ✓ What is the time between the meals?

- **Developmental history**
  - ✓ When did you started walking as a child?
  - ✓ When did started saying mama....baba….dada…?
  - ✓ What age did you started you schooling?

4. Check vital signs of the patient:

- Temperature
- Pulse
- Respiratory rate
- Blood pressure

C. Procedure Termination:

- ✓ Document all the findings of the procedure in Nurse's Record.

Unit 2

Integumentary System

PROCEDURE 1: Examination of Skin
PROCEDURE 2: Examination of Hair
PROCEDURE 3: Examination of Nail

PROCEDURE 1: Examination of Skin

Purpose

a) Collect an accurate health history for the skin problem.
b) Perform the physical examination techniques to evaluate the skin.
c) Document the physical examination results.

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (gloves, exam light, penlight, magnifying glass, centimeter ruler.)

b) Provide comfortable environment with good light

c) Explain procedure to client.

d) Provide privacy

e) Wash hands

C Procedure

Skin

* Note any distinctive odor

I. Inspection

1. Color

a) Inspect all the skin for increased pigmentation or decreased pigmentation.
b) Inspect for redness or pallor in the fingernails, the lips, and the mucus membranes (mouth and palpebral conjunctiva).
c) Inspect for central cyanosis in the lips, oral mucosa and tongue.
d) Look for the yellow color of jaundice in the sclera, palpebral conjunctiva, lips, hard palate, under surface of the tongue, and skin.

2. Moisture

a) Look for dry areas of the skin
b) Look for acne especially at the face and shoulders.

3. Skin Intactness: Look for lesions noting the following:

a) anatomic location and distribution

b) arrangement
c) Types (macules, papules ...etc.)
d) Color

II. Palpation

1. Palpate for **temperature** (cool, warm, hot), using the dorsal side of hand. Note the temperature of any red areas.
2. **Texture** of skin (rough, smooth), using palmar surface of three middle fingers
3. **Moisture** of skin (dry, sweaty, oily)
4. Lift a fold of skin to note **Mobility and turgor**
   - the ease with which it lifts up (Mobility)
   - the speed with which it returns into place (Turgor)
5. Palpate **lesions** for tenderness

D. Procedure Termination:

✓ Document all the findings of the procedure in Nurse's Record.

PROCEDURE 2: Examination of Hair

Purpose

a) Collect an accurate health history for the Hair problem.
b) Perform the physical examination techniques to evaluate the hair.
c) Document the physical examination results.

A History Taking :

a) Current Symptoms
b) Past History
c) Family History
d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (gloves, exam light, penlight, magnifying glass, centimeter ruler.)
b) Provide comfortable environment with good light
c) Explain procedure to client.
d) Provide privacy
e) Wash hands

C Procedure

Hair Exam:

I. Inspection

a) Color of the hair
b) Length, amount and distribution of hair.

II. Palpation

a) Palpate for thickness, texture, oiliness, lesions, dandruff and parasites present in hair.

b) Measure lesions by ruler, if found.

c) Palpate lesions for tenderness.

D. Procedure Termination:

✓ Document all the findings of the procedure in Nurse's Record.

PROCEDURE 3: Examination of Nail

Purpose

d) Collect an accurate health history for the Nail problem.
e) Perform the physical examination techniques to evaluate the nail.
f) Document the physical examination results.

A History Taking :

a) Current Symptoms

b) Past History
c) Family History
d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (gloves, exam light, penlight, magnifying glass, centimeter ruler.)
b) Provide comfortable environment with good light
c) Explain procedure to client.
d) Provide privacy
e) Wash hands

C Procedure

Nail Exam:

I. Inspection

a) Inspect fingernail and toenail bed color.
b) Inspect fingernail plate shape to determine its curvature and angle.
c) Inspect tissues surrounding nails for any cuts, inflammation, rashes or lesions.

II. Palpation

a) Palpate the fingernail for texture.
b) Perform blanch test of capillary refill: Press two or more nails between your thumb and index finger, look for blanching and return of pink color to nail bed.
c) Measure the lesion size if present.

D. Procedure Termination:

Document all the findings of the procedure in Nurse's Record.

Unit 3

Head & Neck Assessment

PROCEDURE 1: Examination of Head
PROCEDURE 2: Examination of Eye
PROCEDURE 3: Examination of Ear
PROCEDURE 4: Examination of Nose & Sinuses
PROCEDURE 5: Examination of Mouth
PROCEDURE 6: Examination of Neck

PROCEDURE 1: Examination of Head

Purpose:

1. Perform an accurate health history of the previous head problems.
2. Describe the physical examination techniques performed to evaluate the Head.
3. Perform and document a complete head examination utilizing information from the health history and physical examination

Procedure Steps

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (Clean gloves)

b) Provide comfortable environment

c) Explain procedure to client.

d) Provide privacy

e) Wash hands

C Procedure

Head Exam

I. Inspection

a) Inspect the head for size, shape and symmetry.
b) Inspect the facial features (symmetry of structures, distribution of hair & symmetry of facial movements.
c) Inspect the eyes for edema and hollowness.

II. Palpation

a) Palpate the skull for nodules or masses and depression.

D. Procedure Termination:

PROCEDURE 2: Examination of Eye

Purpose:

a) Perform an accurate health history of the eye
b) Describe the physical examination techniques performed to evaluate the eye
c) Perform and document a complete eye assessment utilizing information from the health history and physical examination

Procedure Steps

A History Taking :

a) Current Symptoms
b) Past History
c) Family History
d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (Diagnostic set (ophthalmoscope), Snellen chart, penlight, opaque card, clean gloves, sterile cotton, cotton applicator.)
b) Provide comfortable environment
c) Explain procedure to client.
d) Provide privacy

C. Procedure

1. Inspect external eye structures

a)Eyebrows for

1. quantity
2. distribution
3. Scaliness of the underlying skin

b) Eyelids and lashes

1. Position of the lids in relation to the eyeballs
2. Width of the palpebral fissures
3. Color of the lids

4. Lesions

5. Condition and directions of the eyelashes

c) Conjunctiva and sclera

1 **Inspect the palpebral conjunctiva of the lower eyelid and the sclera for color, vascular pattern, any nodules or swelling**

1. Ask the patient to look up

2. Place thumbs bilaterally at the level of the lower bony orbital rim

3. Gently pull down the lower lids to expose the palpebral conjunctiva and the sclera.

4. for fuller view of the eye

a. rest the thumb and finger on the bones of the cheek and brow, and spread the lids

b. Ask the patient to look to each side and down.

2 Inspect the conjunctiva under the upper eyelid.

a. Instruct the patient to look down relaxing the eye

b. Raise the upper eyelid slightly so that the eyelashes protrude

c. Grasp the upper eyelashes and pull them gently down and forward.

d. Place a small stick such as applicator at least 1cm above the lid margin

e. Push down on the stick as raising the edge of the lid.

f. Secure the upper lashes against the eyebrow with the thumb and inspect the palpebral conjunctiva

e. After inspection grasp the upper eyelashes and pull them gently forward, ask the patient to look up.

d) Lacrimal Apparatus

1. Inspect the regions of the Lacrimal gland and Lacrimal sac for swelling

2. Put on clean gloves

3. Ask the patient to look up

4. Press on the lower lid close to the medial canthus, just inside the rim of the bony orbit (compressing the Lacrimal sac), look for fluid regurgitated from the puncta into the eye

2. Inspect anterior eyeball structures

a) Cornea

- With oblique lighting inspect the cornea of each side for opacities in the lens that may be visible through the pupil.
- Perform the **corneal sensitivity test** to determine the function of 5th trigeminal cranial nerve by asking the client to keep both eyes open
& look straight ahead. Extend your hand behind the client's field of vision, then bring the gauze toward the outer canthus. Client should
blink when the cornea is touched with corner of the gauze.

b) Inspect the Iris for shape and color

Using light shining from the temporal side look for a crescentic shadow on the medial side of the iris. *Normally there is no shadow*.

c) The pupils

Inspect the Pupils for shape, size, and symmetry

Pupillary reactions to light and accommodation

a) Dim the light of the room

b) Ask the client to stare ahead

c) Move the penlight from the client's side, shine light directly into one eye.

d) Observe the constriction of the illuminated pupil

e) Observe the simultaneous reaction (consensual) of the other eye.

If reaction to light is impaired or questionable test for *near reaction* in normal room light

a) Hold a finger or pencil about 10 cm from the patient's eye.

b) Ask the patient to look alternately at it & into the distance behind it watching for pupillary constriction with near effort.

3.Position and alignment of the eyes

Survey the eyes for position and alignment with each other.

To detect for eye ball protrusion

a) Instruct patient to sit down

b) Stand behind the patient

c) draw the upper lids gently upward and then compare the positions of the eyes and note the relationship of the corneas to the lower lids

4. Extra-ocular movements looking for conjugate movements, nystagmus, or lid lag.

a) Stand about two feet (60cm) in front of the client

b) Ask the client to follow the movement of the penlight or the examiner's finger only with the eyes

c) Starting in the midline

1. Move the penlight to the extreme right
2. Then straight up to the right
3. Then pause looking for nystagmus
4. Then down to the right
5. Position the penlight again in the midline without pausing move it to the extreme left
6. Straight up to the left
7. Then pause looking for nystagmus
8. Then down to the left

Convergence

Ask the client to follow the finger or pencil as moving it in toward the bridge of the nose. *The converging eyes normally follow the object to within 5-8 cm of the nose.*

5.Test visual acuity (Central Vision) using Snellen eye chart

a) Ensure placement of the Snellen chart at an appropriate height for the client .

b) Position the client exactly 20 feet (6 meters) from the chart.

c) Ask the client to close one eye using the opaque card and to read the line at 6/6

d) Repeat the process for the other eye

e) Repeat process with both eyes

f) Record the result

6. Test visual fields by Confrontation

Screening (Wiggling test)

a) Position self 2 feet (60cm) away from the client at eye level.

b) Instruct the patient to look directly into the examiner's eye

c) Place the hands about 2 feet apart, lateral to the patient's ear.

d) Instruct the patient to point to the finger's as soon as they are seen.

e) Slowly move the wiggling fingers of both hands toward the line of gaze until the patient identifies them

f) Repeat in the same pattern in the upper and lower temporal quadrants.

D. Procedure Termination:

- ✓ Document all the findings of the procedure in Nurse's Record.

PROCEDURE 3: Examination of Ear

Purpose:

1. Perform an accurate health history of the ear, nose, mouth, and throat.
2. Describe the physical examination techniques performed to evaluate the ear, nose, mouth, and throat.
3. Demonstrate how to use the otoscope.
4. Perform and document a complete ear assessment utilizing information from the health history and the physical examination

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (Watch with the seconds' hand, Tuning fork, Otoscope, alcohol swab)

b) Provide comfortable environment

c) Explain procedure to client.

d) Provide privacy

e) Wash hands

C Procedure

1. The auricle

a. Inspect the auricles, tragus and lobule for symmetry, color, lumps and integrity

b. Confirm that the external auditory meatus is patent, with no discharge.

c. If pain or discharge is present move the auricle up and down, press the tragus and press firmly just behind the ear on the mastoid process.

2. Auditory canal inspection using Otoscope

a. Ask the client to tilt the head away toward the opposite shoulder.

b. Hold the Otoscope handle between the thumb and fingers of one hand, brace the hand against the patient's face, the handle may be positioned upward or downward.

c. Use the other hand to stabilize the head and straighten the canal by pulling the pinna upward, backward, and slightly away from the head.

d. With the light insert the speculum gently into the ear canal directing it down and forward.

e. Inspect the ear canal noting any discharge, foreign bodies, redness of the skin, or swelling

f. Inspect the ear drum noting its color, contour, the cone of light , the handle of the malleus, pars flaccida and pars tensa looking for perforation.

3. Auditory Acuity

A: whisper test (Gross hearing)

a. Stand 1-2 feet (30-60 cm) behind the client

b. Ask the client to occlude the ear canal by placing one finger on the tragus of the left ear and move it back, or by the examiner's finger moving it rapidly but gently.

c. Exhale fully, and whisper softly toward the unoccluded ear, choosing words of two equally accented syllables

d. Ask the client to repeat the word back.

e. Repeat the test for the right ear.

If the client has difficulty hearing the normal voice, proceed with the following tests:-

B: Perform the Watch Tick test

a. Have the client occlude one ear. Out of the client's sight, place a ticking watch 2 to 3 cm from the unoccluded ear.

b. Ask what the client can hear. Repeat with the other ear.

C: Perform Weber's test (Lateralization)

a. Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly between the index finger and the thumb or by taping it on knuckles.

b. Place the base of the vibrating fork firmly on top of the patient's head or on the mid-forehead.

c. Ask whether the client hears the sound better in one ear or the same in both ears.

D: Perform Rinne test

a. Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly between the index finger and the thumb or by taping it on knuckles

b. Place the base of the lightly vibrating fork on the client's mastoid process behind the ear and level with the canal.

c. Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.

d. Quickly place the fork close to the ear canal with the (**U**) of the fork facing forward.

e. Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

PROCEDURE 4: Examination of Nose & Sinuses

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (clean gloves, Otoscope with special nasal attachments or nasal speculum/ penlight)

b) Provide comfortable environment

c) Explain procedure to client.

d) Provide privacy

e) Wash hands

C Procedure

1 Inspect the anterior and inferior surfaces of the nose and test for nasal obstruction

.

a) Widen the nostrils by applying gentle pressure on the tip of the thumb to get partial view of the nasal vestibule with the aid of a penlight or Otoscope light noting for asymmetry or deformity.

b) Check the patency of the nostrils' air flow by occluding one nostril at a time and asking the client to sniff.

2 Inspect the internal nose

.

a) Use the Otoscope with the special attachment or the nasal speculum with penlight to inspect the nose

b) Use the non dominant hand to stabilize and gently tilt the client's head back.

c) Insert the speculum into the nostril with out touching the nasal septum.

d) Hold the Otoscope handle to one side to avoid the patient's chin

e) Direct the Otoscope back and up in small steps to see the inferior & middle turbinates, the nasal septum and the nasal passage between them

f) Inspect the nasal mucosa for color and any swelling, bleeding, or exudate.

g) Inspect the nasal septum for deviation, inflammation or perforation of the septum.

h) Inspect for any abnormality such as ulcers or polyps.

3. **Palpate the frontal sinuses by using thumbs to press up on the eye brow on each side of the nose**

4. **Percuss the sinuses by tapping lightly over the frontal and maxillary sinuses for tenderness**

D. Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

PROCEDURE 5: Examination of Mouth

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (clean gloves, 4×4 gauze pad, penlight, tongue depressor).

b) Provide comfortable environment

c) Explain procedure to client.

d) Provide privacy

e) Wash hands

C Procedure

1. The Lips

a) Observe for color and moisture

b) Observe for any lumps, cracking or scaliness.

2. The Oral Mucosa

a) Ask the patient to open mouth widely

b) Look into the patient's mouth with good light and the help of a tongue blade for color, ulcers, white patches, and nodules.

3. The Gums and Teeth

a) Ask the client to open mouth and note the color of gums.

b) Retract the lips and cheeks to check the gums for color and consistency

c) Inspect the gum margins and the inter-dental papillae for swelling or ulceration.

d) Inspect the teeth for number, color, shape, alignment of the teeth.

e) Observe for dental hygiene.

f) Check for looseness of the teeth with gloved thumb and index finger.

4. The roof of the mouth

Inspect the hard palate for

1. color
2. architecture

5. The Tongue and the Floor of the Mouth

a) Ask the patient to put out his tongue

b) Note the color and texture of the dorsum of the tongue .

c) Ask the patient to touch the hard palate with the tip of the tongue

d) Put on gloves and ask the client to protrude his tongue, grasp the tip of the tongue with a square of guaze and gently pull it to the sides noting for white or reddened areas, nodules, or ulcerations

e) Palpate the tongue feeling for any induration (hardness) for both sides.

6. The Pharynx

a) Ask client to open the mouth wide without protruding the tongue, use the penlight to look at the roof.

b) Apply a tongue depressor to the tongue and shine the penlight, note the characteristics and position of the uvula.

c) Inspect the soft palate, anterior and posterior pillars, uvula, tonsils and pharynx for

1. Color
2. Symmetry
3. Presence of exudate.
4. Swelling
5. Ulceration
6. Tonsil enlargement

d) Observe elevation of the soft palate and uvula by asking patient to say "ah"

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

PROCEDURE 6: Examination of Neck

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (clean gloves, Cup of water, light)

b) Provide comfortable environment

c) Explain procedure to client.

d) Provide privacy

e) Wash hands

C Procedure

1. Neck Inspection

a) Note symmetry, any masses or scars

b) Look for enlargement of the parotid or submandibular glands

c) Note any visible lymph nodes

2. Lymph Node Palpation

a) Use the pads of the index and middle fingers moving the skin over the underlying tissues in each area, rolling the node in two directions up and down and side to side.

b) Facing the patient using both hands palpate for the **Preauricular nodes** in front of the ears**.**

c) Move posterior to the ear and feel for the **Posterior auricular nodes** superficial to the mastoid process.

d) Palpate posteriorly at the base of the skull for the **occipital nodes.**

e) Move to the midway between the angle and the tip of the mandible for the palpation of the **submandibular nodes**

f) Bracing the head with one hand, use the other hand to feel for the **Submental node** in the midline a few cm behind the tip of the mandible.

g) Ask the patient to turn his/her head slightly to the right (the side of examination) and palpate for the **Superficial cervical nodes**, superficial to the sternomastoid,

h) With the patient on the same position palpate along the anterior edge of the trapezius for the **Posterior cervical chain.**

i) Hooking the thumb and fingers around either side of the sternomastoid muscle to find the **Deep cervical chain**

j) Ask the patient to turn head to the left to palpate the previous nodes on the other side.

k) Deep in the angle formed by the clavicle and the sternomastoid palpate for the **Supraclavicular nodes**

3. The Trachea

a) Inspect the trachea for any deviation from its midline position

b) Feel for any deviation Palpate sternal notch to make sure trachea is midline by palpating the tracheal ring (sternal notch midway between clavicular heads)

c) place one finger along one side of the trachea and note the space between it and the sternomastoid and compare it with the other side

4. A. The Thyroid Gland (Anterior)

a) ask the patient to extend the neck slightly

b) Using tangential lighting directed downward from the tip of the patient's chin, inspecting the region below the cricoid cartilage for the gland.

c) Ask the patient to sip some water and to extend the neck again and swallow. Watch for upward movement of the thyroid gland noting its contour, and symmetry.

B. Palpate the Thyroid Gland from behind

a) Stand behind the client

b) Place the fingers of both hands on the patient's neck so that the index fingers are just below the cricoid.

c) Adjust the patient's neck extension to avoid tightened neck muscles.

d) Ask the patient to sip and swallow water and feel for any glandular tissue rising under the finger pads.

e) Ask the client to set up right, lower the chin and turn the head slightly to the right.

f) Use the fingers of the left hand to push the trachea to the right.

g) With the fingers of the right hand palpate the area between the trachea and the sternomastoid muscle.

h)Palpate with and without swallowing

i) Reverse the technique to palpate the left lobe of the thyroid.

j) If the thyroid gland is enlarged listen over the lateral lobes with a stethoscope to detect a bruit)

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Wash hands.

Unit 4

Respiratory System

PROCEDURE 1: Examination of Thorax & Lungs (Anterior & Posterior View)

PROCEDURE 1: Examination of Thorax & Lungs (Anterior & Posterior View)

Purpose

1. Identify the locations of each lung lobe using landmarks on the thorax.
2. Identify the percussion and auscultation sites for assessment of the lungs.
3. Obtain an accurate history of the respiratory system.
4. Appropriately prepare and position the client for the respiratory examination.
5. Describe the equipment necessary to perform a respiratory examination.
6. Correctly inspect, palpate, percuss, and auscultate the anterior and posterior thorax.
7. Perform and document a complete finding

Procedure Steps

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (stethoscope, measurement tape, pen)

b) Provide comfortable environment

c) Explain procedure to client.

d) Wash Hands

e) Provide privacy

C Procedure

1 Survey of the Thorax and respiration

a. observe the rate, rhythm, depth and effort of breathing.

b. Check the patient's color for cyanosis and the shape of the fingertips for clubbing and color.

c. Inspect the neck for supraclavicular retraction and for contraction of the sternomastoid or other accessory muscles during inspiration. And position of the trachea

d. Listen to the patient's breathing.

e. observe the shape of the chest.

Transverse – Anterior-Posterior

2 Examination of the posterior chest

a. Inspection

a) Ask the patient to sit down with the arms folded across the chest with the hands resting on the opposite shoulders.

b) From a midline position behind the patient note the shape of the chest and the way in which it moves including :

a. deformities or asymmetry.
b. Abnormal retractions of the interspaces during inspiration (lower interspaces, supraclavicular retractions.)
c. Impairment in respiratory movement on one or both sides (Unilateral lag)

b. Palpation

1 a) Identify **tender areas** by palpating any area where pain has been reported or where

b. lesions are evident.

c) Assess any observed abnormality such as masses

2 Test **Respiratory Expansion** by:

1. placing the thumbs about the level of and parallel to the 10^{th} ribs and the hands Grasping the lateral rib cage, sliding them medially a bit in order to raise loose skin folds between thumbs and the spine

2. ask the patient to inhale deeply and watch for the

divergence of the thumbs during inspiration, feeling for the range & symmetry of the respiratory movements.

3 Feel for **tactile fremitus** (palpable vibrations)

. 1. using either the ball of the or the ulnar surface of the hand.

2. Use both hands to compare sides

3. Ask the patient to repeat the words "ninety-nine" or " one, one, one." If fremitus is faint ask the patient to speak more loudly.

4. Palpate and compare symmetrical areas of the lungs.

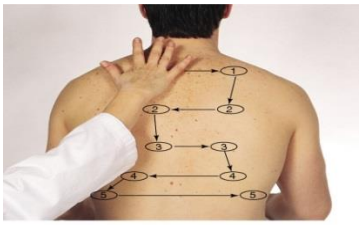
c. Percussion

a) Percuss the posterior chest while the patient keeps both arms crossed in front of the chest.

b) press the distal interphalangeal joint of the middle finger (pleximeter) firmly on the surfaces to be percussed avoiding surface contact by any other part of the hand.

c) with the middle finger of the other hand slightly flexed and relaxed strike over the pleximeter with a quick sharp but relaxed writ motion, using the tip of the flexor finger not the finger pad.

d) Percuss the thorax in symmetrical locations from the apices to the lung bases. twice in each location, compare two areas



d. when percussing the lower posterior chest, stand somewhat to the side rather than directly behind the patient.

Identify the **level of diaphragmatic dullness** (during quiet respiration)

a. with the pleximeter finger held above and parallel to the expected level of the dullness, Percuss in progressive steps downward until dullness clearly replaces resonance.

b. Check the level of this change near the middle of the hemithorax and also more laterally putting a point by a pen on each level.

Diaphragmatic excursion

a. Ask the client to exhale fully then hold .

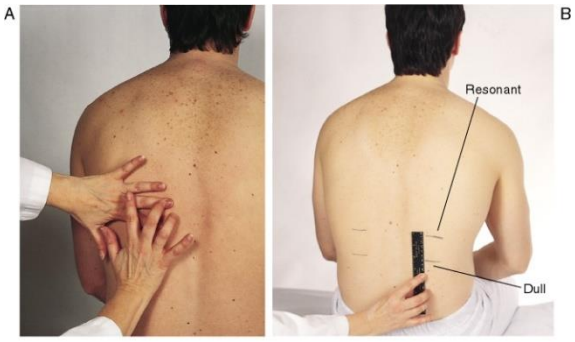
b. Percuss for diaphragmatic dullness as above and put a point.

c. Ask the client to take a deep breath and hold

d. Again percuss for diaphragmatic dullness and put a point

e. measure the distance between the two points

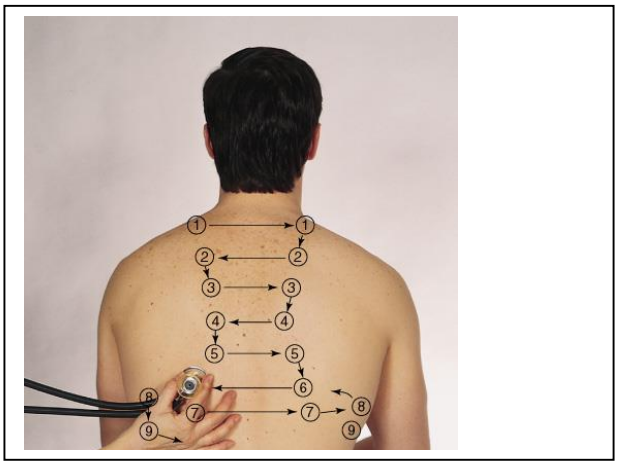
(5-6cm)



d. Auscultation

a. Listen to **the breath sound** with the diaphragm of the stethoscope after instructing the patient to breathe deeply through an open mouth.

1. Bronchial: trachea.
2. Bronchovesicular: Primary Bronchi
3. Vesicular: Lungs.



1. Listen for **Bronchovesicular** sounds between Scapulae
2. Listen for the **Vesicular** sounds over the lungs
3. Listen for any added sounds

b. If breath sounds heard located abnormally assess for **transmitted voice sounds**

1. Ask the patient to say " ninety-nine" normally transmitted sound are muffled and indistinct .
2. Ask the patient to say "ee" normally a muffled long E sound is heard.
3. Ask the patient to whisper "ninety-nine" or "one, two, three" . it will be heard faintly and indistinctly if heard at all.

3 Examination of the Anterior chest

a. Inspection

Ask the patient to lie down into a supine position with the arms abducted. If the patient has difficulty in breathing, he/she should be examined in the sitting position or with the head of the bed elevated at comfortable level.

Note the shape of the chest and the way in which it moves including :

a. Deformities or asymmetry.
b. Abnormal retractions of the lower interspaces during inspiration
c. Impairment in respiratory movement on one or both sides (Unilateral lag)

b Palpation

1 Identify **tender areas** by palpating any area where pain has been reported or where lesions are evident.

Assess any **observed abnormality** such as masses

2 Test **Respiratory Expansion** by:

1. placing the thumbs along each costal margins with the hands along the lateral rib cage. As positioning the hands slide them medially a bit in order to raise loose skin folds between thumbs.

2. ask the patient to inhale deeply and watch for the divergence of the thumbs during inspiration, feeling for the range & symmetry of the respiratory movements.

3 Feel for **tactile fremitus** (palpable vibrations)

1. using either the ball or the ulnar surface of the hand. Fremitus is decreased or absent over the pericardium.

2. Use both hands to compare sides

3. Ask the patient to repeat the words “ninety-nine” or “ one, one, one.” If fremitus is faint ask the patient to speak more loudly.

4. palpate and compare symmetrical areas of the lungs.

c Percussion

a) Percuss the anterior and lateral chest while the patient keeps both arms abducted. press the distal interphalangeal joint of the middle finger (pleximeter) firmly on the surfaces to be percussed avoiding

surface contact by any other part of the hand

b. with the middle finger of the other hand slightly flexed and relaxed strike over the pleximeter with a quick sharp but relaxed wrist motion, using the tip of the flexor finger not the finger pad.

c. Percuss the thorax in symmetrical locations from the apices to the lung bases. twice in each location, compare two areas. In a woman to enhance percussion gently displace the breast with the left hand while percussing with the right

d. when percussing the left chest, dullness will be heard at the level of the heart 3rd to 5th ICS, percussion of the left lung will be lateral to it.

Percuss for **liver dullness** with the pleximeter finger above and parallel to the expected upper border of the liver dullness, in progressive steps from resonance downward to the dullness in the right midclavicular line .

d. Auscultation

a. Listen to the **breath sound** with the diaphragm of the stethoscope after instructing the patient to breathe deeply through an open mouth.

Listen for **tracheal** sounds at the suprasternal notch

Listen for **bronchial** sounds over the manubrium

Listen for **bronchovesicular** sounds at the 1st and 2nd interspaces. For primary bronchi

Listen for the **Vesicular** sounds over the lungs

Listen for any **added sounds**.

b. If breath sounds heard located abnormally assess for transmitted voice sounds

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

e) Document findings

Unit 5

Cardiovascular System

PROCEDURE 1: Examination of Heart & Central Vessels
PROCEDURE 2: Examination of Peripheral Vascular System

PROCEDURE 1: Examination of Heart & Central Vessels

Purpose

1. Identify the landmarks and key auscultation sites of the precordium.
2. Obtain an accurate history of the cardiovascular system
3. Appropriately prepare and position the client for the cardiovascular examination
4. Describe the equipment necessary to perform a cardiovascular examination.
5. Inspect, palpate, and auscultate the jugular veins and carotid arteries of the neck.
6. Inspect, palpate, and auscultate the precordium to evaluate cardiovascular status
7. Perform and document a complete finding

Procedure Steps

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (stethoscope, ruler)

b) Provide comfortable environment

c) Explain procedure to client.

d) Wash hands

e) provide privacy

C Procedure steps

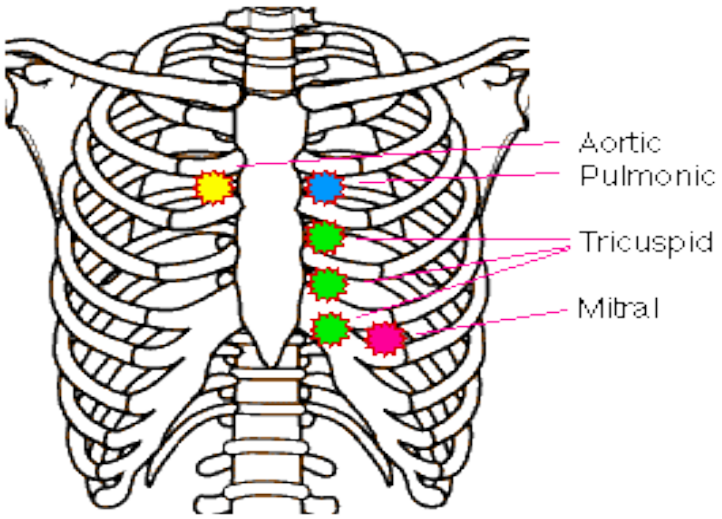
The heart

1. Inspection:

1. While on the client right side,
2. Inspect appropriate points (aortic, pulmonic, 3rd left inter-space, tricuspid and mitral) on the anterior chest for any pulsation.
3. Instruct the patient to move on the left lateral decubitus area to inspect for the apical impulse.

Palpate

same points (aortic, pulmonic, 3rd left inter-space, tricuspid and mitral) using finger pads on the anterior chest for any pulsation, using ball of the hand for the thrills.



2. **Palpation**

a. Palpate for the apical impulse, if unable to detect it ask the client to exhale fully and stop breathing for few seconds. evaluate its location,

diameter, amplitude. Note its location with respect to the mid-sternal line, mid-clavicular line, and anterior axillary line.

b. Palpate the left sternal border (3^{rd},4^{th} and 5^{th} ICS)

1. patient supine at 30°

2. place the tips of fingers in the 3^{rd},4^{th},and 5^{th} ICS trying to feel impulse. If unable to detect it ask the client to exhale fully and stop breathing for few seconds.

c. The epigastric area. press the index finger just under the rib cage and up toward the left shoulder trying to feel right ventricular pulsation.

d. The left and right 2^{nd} Interspaces . (Pulmonary and aortic arteries) During held expiration feel for impulse.

3. **Auscultation**

a. Listen for the first and second heart sounds (S1 and S2) at each auscultatory area (aortic, pulmonic, 3rd L interspace, tricuspid and mitral) using the **diaphragm** of the stethoscope for **S1 & S2** and the **bell for S3 & S4** or any added sounds.

   a. with the patient **supine**
   b. then on the **left decubitus position**
   c. with the patient **sitting up, leaning forward** ask the patient to exhale completely and stop breathing.

- Note the intensity and splitting of S1 and S2.
- Listen for extra heart sounds (e.g., S3 or S4).
- Listen for any systolic and/or diastolic murmurs.

4. Examine The Jugular Venous Pressure(JVP)

a. Position the patient with the head slightly elevated on a pillow and the sternomastoid muscle relaxed, and identify the external jugular vein.

b. Start with the head of the bed elevated about 30°, then adjust the angle so as to maximize visibility of the jugular venous pulsations in the lower half of the neck

c. Turn the patient's head slightly away from the side of inspection.

d. Identify the external jugular vein on each side. Then find pulsation of the internal jugular vein between the attachments of the sternomastoid muscle on the sternum and clavicle (posterior to the sternomastoid)

e. Identify the highest point of pulsation in the internal jugular vein, with a centimeter ruler, measure the vertical distance between this point and the sternal angle.

5. Examine the Carotid pulse.

a. Inspect neck for pulsation medial to the sternomastoid muscle

b. Press inside the medial border of a well relaxed sternomastoid muscle at the level of the cricoid cartilage by the left thumb or the index and middle fingers on the right carotid artery (opposite for the left). For the left carotid artery, use your right fingers or thumb. Never press both carotids at the same time. This may decrease blood flow to the brain and induce syncope.

c. Auscultate the carotid artery for presence of bruit.

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

e) Documents Findings

PROCEDURE 2: Examination of Peripheral Vascular System

Purpose

1. Obtain an accurate history of the peripheral vascular system.
2. Appropriately prepare and position the client for the peripheral vascular examination.
3. Describe the equipment necessary to perform a peripheral vascular examination.
4. Perform and document a complete Peripheral Vascular Assessment

Procedure Steps

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (clean gloves, measurement tape, tourniquet, light)

b) Provide comfortable environment

c) Explain procedure to client.

d) Provide privacy

e) Wash hands

C Procedure

1. The upper limbs

a) Inspect both arms from fingertips to shoulders noting :

1. Their size and symmetry, and any swelling .
2. The venous pattern
3. The color of the skin and nail beds and the texture of the skin

a) Palpate the radial pulse with the pads of fingers, partially flexing the patient's wrist, comparing pulses bilaterally.

b) If arterial insufficiency suspected, feel for brachial pulse by flexing the patient's elbow slightly and palpating the artery just medial to the biceps

tendon at the antecubital crease or higher in the arm groove between the biceps and triceps muscles.

Evaluating the arterial supply to the hand (Allen test)

a) Ask the patient to make a fist with one hand.

b) Compress both radial and ulnar arteries firmly between thumbs and fingers.

c) Ask the patient to open the hand into a relaxed, slightly flexed position when the palm is pale.

d) Release pressure over the ulnar artery , if patent the palm flushes within 3-5 seconds.

e) Patency of the radial artery tested by releasing the radial artery while still compressing the ulnar.

Lymph Nodes

Feel for the epitrochlear nodes with the patient's elbow flexed to 90° and the forearm supported by the examiner's hand reaching around behind the arm and feel in the groove between the biceps and triceps muscles, about 3cm above the medial epicondyle. If present note size, consistency and tenderness.

2. The Lower Limbs

a) The patient should be lying down and draped so that the external genitalia are covered and the legs are fully exposed.

b) Inspect both legs from the groin and buttocks to the feet. Note their:

a. size and symmetry.
b. color and texture of the skin, and the color of the nail beds.
c. venous pattern or edema, and the hair distribution on the lower legs, feet and toes.
d. Note any pigmentation, rashes, scars, and ulcers.

c) Palpate the **superficial inguinal nodes**, including both the **horizonta**l and the **vertical** groups.

d) Palpate **the femoral pulse** by pressing deeply below the inguinal ligament and about midway between the anterior superior iliac spine and the symphysis pubis.

e) To palpate **the popliteal pulse** ask the patient to flex the knee slightly. Place the fingertips of both hands so that they just meet in the midline behind the knee and press them deeply into the popliteal fossa. let the lower leg relax on the examiner's shoulder or upper arm and press by the two thumbs deeply into the popliteal fossa.

f) Feel the dorsum of the foot lateral to the extensor tendon of the great tendon to palpate the **dorsalis pedis pulse**

g) Note the **temperature** of the feet and legs with the backs of fingers. Compare one side with the other.

h) Check for pitting edema by pressing firmly and gently with the thumb for 5 seconds over the dorsum of the foot, behind each medial malleolus and over the shins. if suspected edema, with flexible measurement tape, comparing one side with the other, measure:

1. the forefoot.
2. the smallest possible circumference above the ankle.
3. the largest circumference at the calf
4. the mid-thigh a measured distance above the patella.

i) Ask the patient to stand and inspect the saphenous system for **varicosities** .

o) Palpate the groin just medial to the femoral pulse for tenderness of femoral vein

p) With the patient's leg flexed at the knee and relaxed, palpate the calf with the finger pads compressing the calf muscle against the tibia

Mapping varicose vein :

1. With the patient standing place the palpating fingers gently on the vein with the other hand below it compress the vein sharply.

By Retrograde filling (Trendelenburg) test assess Competency of venous valves:

2. start with the patient supine ,
3. elevate one leg to about 90° to empty it of venous blood.

4. Occlude the great saphenous vein in the upper thigh by manual compression, to occlude this vein not the deep veins.
5. Ask the patient to stand, while keeping the vein occluded, watch for venous filling in the leg within 35sec. After the patient has stood 20 sec, release the compression and look for any sudden additional venous filling.

Postural color changes of chronic arterial insufficiency

If pain or diminished pulses suggest arterial insufficiency look for postural color changes by:

1. raising both legs to about 60° until maximal pallor of the feet develops (within a minute)
2. Then ask the client to sit up with the legs dangling down, comparing both feet noting time required for:

1. Return of pinkness of the skin (10sec or less)
2. filling of the veins of the feet and ankles about (15sec)
3. any unusual rubor to replace pallor of the dependent foot (1minute)

HOMAN'S sign: Firmly dorsiflex the client's foot while supporting the entire leg in extension. Pain in calf muscles with forceful dorsiflexion of the foot indicates **positive Homan's sign**.

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

e) Document findings

Unit 6

Breast and Axilla

PROCEDURE 1: Examination of Breast & Axilla

PROCEDURE 1: Examination of Breast & Axilla

Purpose:

1. Perform an accurate health history of the breasts and axillae.
2. Describe the physical examination techniques performed to evaluate the breasts and axillae.
3. Demonstrate how to perform a clinical breast examination.
4. Document a complete breast and axilla assessment utilizing information from the health history and the physical examination

History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

Preparation

a) Provide comfortable environment

b) Explain procedure to client.

Procedure

Examination of the breasts:

Inspection

1. Ask the patient to sit disrobed to the waist
2. inspect the breasts, with the arms at the sides, for
    a. skin changes
    b. symmetry
    c. contour (masses, dimpling, flattening)
    d. retractions

3. inspect the breasts, with the arms over the head, for

    a. contour

    b. retractions

4. inspect the breasts, with the arms pressed against the hips, for

    a. contour

    b. retractions

5. inspect the breasts, with the arms pressed against the hips

    a. contour

    b. retractions

6. Inspect the nipple for:

    a. size

    b. shape (inversion)

    c. direction (usually outward, downward)

    d. rashes or ulceration

    e. discharge

Palpation of the breasts

1. Ask the patient to lie down with a small pillow under the shoulder on the side of examination.
2. And ask her to rest her arm over the head.(except if the breasts are small)
3. With the fingers flat on the breast compress the tissues gently in a rotary motion against the chest wall
4. Proceed systematically examining the entire breast from clavicle to inframammary fold, from midsternal line to posterior axillary line to the Axillae for the tail of the breast. Palpation for

    a. The consistency of the tissue

    b. Tenderness

    c. Nodules

Palpate the nipples for elasticity, discharge

Examination of Axilla

Inspection

Inspect the skin of each axilla noting :

a. Rashes
b. Infection
c. Unusual pigmentation

Palpation

1. To palpate left Axillae, ask the patient to relax with the arm down. Supporting the left wrist or hand with his/ her hand.

2. Cup together the fingers of the right hand and reach as high as possible toward the apex of the axilla with the fingers lying directly behind the pectoral musclepointing toward the midclavicle. Warn the patient it will be uncomfortable. Press the fingers in toward the chest wall and slide them downward to feel **central nodes**.

3. Grasp the anterior axillary fold between the thumb and fingers inside the border of the pectoral muscle for the **Pectoral Nodes.**

4. From high in the axilla feel along the upper humerous for the **lateral nodes.**

Step behind the patient and with the fingers feel inside the muscle of the posterior axillary fold.

Procedure Termination

a) Put client in comfortable position according to health status
b) Provide patient with reassurance
c) Return back equipments
d) Wash hands

Unit 7

Gastrointestinal System

PROCEDURE 1: Examination of Abdomen

PROCEDURE 1: Examination of Abdomen

Purpose:

1. Identify the landmarks of the abdominal wall and pelvis.
2. Identify the four quadrants and the organs in each quadrant
3. Perform an accurate health history of the gastrointestinal and renal systems
4. Describe the physical examination techniques and the order performed to evaluate the gastrointestinal and renal systems.
5. Perform and document a complete gastrointestinal and renal system assessment utilizing information from the health history and the physical examination.

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Gather equipment (stetheoscope)

b) Provide comfortable environment

c) Explain procedure to client.

d) Wash Hands

e) Provide privacy

C. Procedure

I. Inspection of the abdomen

1. Stand on the right side of the patient

a) Inspect the **skin** for scars, striae, dilated veins, rashes and lesions.

b) The **umbilicus** for contour, location any signs of inflammation or hernia.

c) The **contour of the abdomen**; flat, protuberant or scaphoid. Symmetry, bulging flanks, visible organs or masses.

d) **Peristalsis** : may be visible normally in very thin people

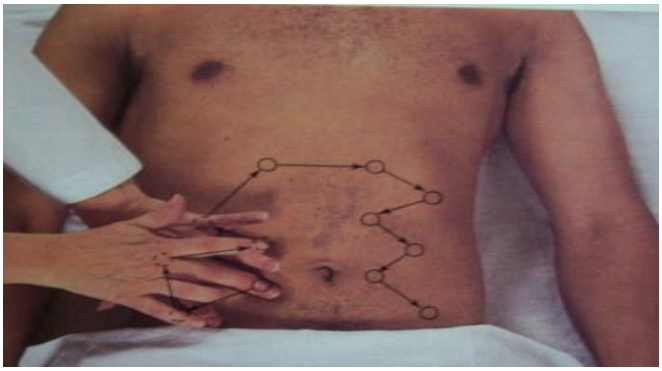
e**) Pulsations**: The normal aortic pulsation is frequently visible in the epigastrium.

II. Auscultation of the abdomen

Auscultate for bowel sounds using the diaphragm of the stethoscope, begin in the RLQ and proceed to all other quadrants of abdomen. Listen for up to 5 minutes to confirm presence of bowel sounds in each quadrant.

III. Percussion of the abdomen

Lightly percuss all the quadrants of the abdomen either using clockwise or up and down sequences to elicit amount of dullness, tympany, resonance or hyperresonance.



Liver Percussion

1 **Measuring the vertical span of the liver in the right midclavicular line.**

a) Start at a level below the umbilicus at area of tympany.

b) Lightly percuss upward toward the liver.

c) Ascertain the lower border of liver dullness in the midclavicular line.

d) Identify the upper border of liver dullness by lightly percusing from lung resonance down toward liver dullness.

e) Measure in centimeters the distance between the two points. (6-12cm).

2 **Measuring the vertical span in the midsternal line**

a) Start percussing at an area of tympany

b) Lightly Percuss upward toward the liver

c) Identify the upper border of the liver dullness by percussing from the xyphoid flatness down toward liver dullness.

d) measure in centimeters the distance between the two points .(4-8cm)

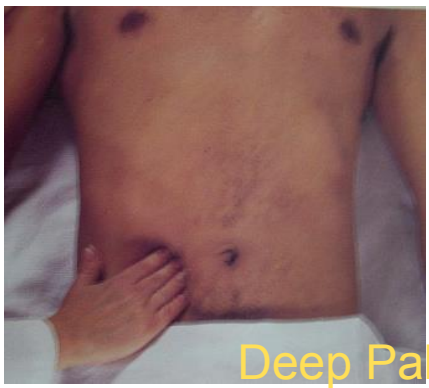
IV. Palpation of the abdomen

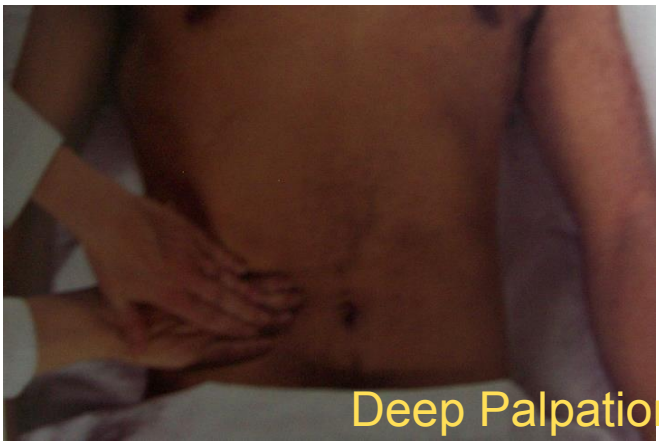
Abdomen can be palpated by

a. Light palpation
b. Deep palpation

a. Light palpation: abdomen is palpated lightly first to assess any tenderness by using **pads of fingertips** in light dipping motions and avoid short jabs.

b. Deep palpation: After surveying the abdomen lightly. Try to identify **abdominal masses** or areas of **deep tenderness**. If masses are felt, note: location, size, shape, consistency, tenderness, pulsations, mobility with respiration or with hand. If patient is obese or rigid, use 2 hands to palpate, place one on top of other and feel with lower hand.





V. Some special tests:

Palpating the Liver (Hooking Technique)

a) Stand to the right of the patient's chest.

b) Place both hands side by side on the right abdomen below the border of the liver dullness.

c) Press in with fingers and up toward the costal margin.

d) Ask the patient to take a deep breath.

Assessing Kidney Tenderness

a) Palpate by the fingertips in each costovertebral angel.

b) If no tenderness in (a), place the ball of one hand in the costovertebral angle and strike it with the ulnar surface of the fist.

Ascites

1 Mapping for ascites

a) With the patient supine

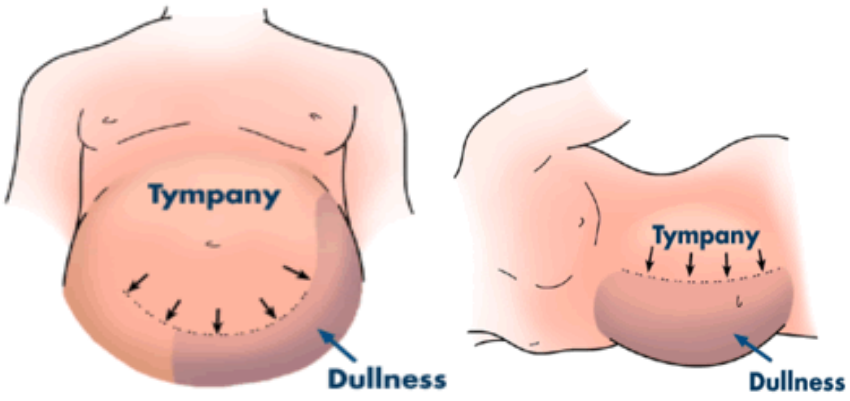
b) Percuss outward in several directions from the central area of tympany

c) map the border between tympany and dullness

2 Test for shifting dullness (after mapping)

a) ask the patient to turn onto one side

b) Percuss and mark the borders of tympany and dullness again



3 Test for a fluid wave

a) Ask the patient or an assistant to press the edges of both hands firmly down the midline of the abdomen

b) Tap sharply on the flank with the fingertips, feel on the opposite flank for an impulse transmitted through the fluid.

Assess for Possible Appendicitis

1 Rebound tenderness

a) Press deeply and evenly in the right lower quadrant

b) Quickly withdraw the fingers

c) Ask the patient when pain is felt more.

2 Rovsing's sign and referred rebound tenderness

a) Press deeply and evenly in the left lower quadrant

b) quickly withdraw the fingers

3 Psoas Sign

a) Place hand just above the patient's right knee

b) Ask the patient to raise that thigh against hand

c) Ask the patient to turn onto the left side

d) extend the patient's right leg at the hip

4 Obturator Sign

a) Flex the patient's right thigh at the hip, with the knee bent.

b) Rotate the leg internally at the hip by stabilizing the thigh with one hand and grasping the ankle with the other and swing the lower leg laterally.

Assess possible acute cholecystitis (Murphy's Sign)

a) Hook the left thumb or the fingers of the right hand under the costal margin at the point where the lateral border of the rectus muscle intersects with the costal margin.

b) Ask the patient to take a deep breath.

c) Watch the patient's breathing and note the degree of tenderness.

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

Unit 8

Female and Male Genitalia

PROCEDURE 1: Examination of Female Genitalia
PROCEDURE 2: Examination of Male Genitalia

PROCEDURE 1: Examination of Female Genitalia

Purpose:

1. Perform an accurate health history of the Female genitalia.
2. Describe the physical examination techniques performed to evaluate the female genitalia.
3. Demonstrate technique to examine female external & internal structures correctly.
4. Document a complete female genitalia assessment utilizing information from the health history and the physical examination

A History Taking :

1. a) Current Symptoms
2. b) Past History
3. c) Family History
4. d) Lifestyle and Health Practices

B Preparation

6. a) Provide comfortable environment
7. b) Explain procedure to client. Respect client's privacy.
   c) Assemble all the equipments for the procedure (vaginal speculum, light source, sitting stool, lubricant jelly, culture tube (if needed), sterile gloves, pH paper, towel, sterile cotton and gauze)

C. Procedure

A. EXTERNAL GENITALIA

I. **Inspection:** Inspect the mons pubis for distribution of hair, worm infestation. Inspect the labia majora, perineum, labia minora, clitoris, urethral opening and vaginal opening for lesions, rashes, swelling, excoriation, discharge.

II. **Palpation:** Palpate the Bartholin's glands for swelling, tenderness and discharge by placing the index finger on vaginal opening & thumb on labia majora, with a gentle pinching motion, palpate from inferior portion of posterior labia majora to anterior portion. Repeat on the opposite side.

B. INTERNAL GENITALIA

I. Inspection:

Inspect the size of vaginal opening, vaginal musculature, vaginal color, surface, consistency and any discharge.

Inspect the cervix using vaginal speculum to observe cervical color, size, position and any discharge.

II. Palpation:

1. Palpate vaginal wall for texture and tenderness.
2. Palpate the cervix for contour, mobility, consistency and tenderness.
3. Palpate the uterus bimanually to note uterine size, position, shape and consistency.Any culture swab can be collected if needed (PAP smear).

Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

PROCEDURE 2: Examination of Male Genitalia

1. Patient seated on exam table. Examiner stands at patient's side.

Kidneys and Bladder

2. Bilaterally palpates costovertebral angle with deep pressure of fingertips.
3. Patient supine with arms folded across chest or at one side. Examiner stands to patient's right
4. Legs and genitalia draped, abdomen undraped.
5. Inspects abdomen noting movement during normal respiration, rigidity, and pain.
6. Uses bimanual technique (pads of fingers of one hand on area to be examined, and other hand underneath the flank) to examine kidneys.
7. Palpates each kidney for pain, displacement, swelling and tenderness.
8. Uses pads of first three fingers of one hand to examine lymph nodes.
9. Palpates inguinal and femoral lymph nodes for size, tenderness, matting, position and fixation.
10. Palpates femoral pulses for turbulence, intensity and equality. Listen for bruits.

Genitalia

11. Patient supine with arms folded across chest or at side, groin area undraped.

Penis

12. Inspects skin.
13. Asks patient to retract foreskin (okay for the M.D. to retract foreskin also) if present for urethral discharge, chancres, carcinomas and shaft lesions. Patient reduces foreskin.
14. Inspects glans for scars, lesions, inflammation, discharges and masses.
15. Palpates penis using thumb and first finger of both hands.
16. Assesses shape, size, tenderness and induration.

Scrotum

17. Inspects skin and contour of scrotum.

18. Lifts scrotum and inspects posterior surface. Palpates perineum for masses and tenderness.
19. Palpates each testis gently.
20. Palpates each epididymis for size, shape, tenderness, consistency/weight and nodules.
21. Locates spermatic cord and vas deferens.
22. Palpates from epididymis to superficial inguinal ring.
23. If appropriate (presence of scrotal mass):
24. **Transilluminates** scrotal swelling in dark room with strong light source placed behind scrotum or mass.
25. Assesses red glow.
26. Patient standing. Examiner seated facing patient.
27. Examiner instructs patient to hold gown up around waist.
28. Inspects groin for bulging during normal respiration.
29. Inspects groin for bulging during Valsalva's maneuver.
30. Palpates testicles, scrotum, inguinal and femoral regions for changes or abnormality during normal respiration.
31. Palpates testicles, scrotum, inguinal and femoral regions for changes or abnormality during Valsalva's maneuver. Assess for varicocele.

Examining for inguinal hernia

32. Palpates inguinal canal by invaginating scrotal skin with
    a. the index finger to the external inguinal ring and instructing
    b. patient to cough or strain.
33. Palpates scrotum while patient bears down to detect hernia.

Rectum/Prostate

34. Patient bending over examination table or chair, facing away from examiner.
35. Examiner inspects external anus for hemorrhoids, tissue tags, injury signs, fissures, and inflammation.
36. Inserts gloved, well-lubricated index finger gently through anus into rectum.
37. Palpates prostate (apex, base and lateral portions) noting texture, masses, and consistency.
38. Using a gentle, firm, slow motion, palpates rectum walls noting texture, masses, and consistency.

Unit 9

Musculoskeletal System

Examination of Musculoskeletal System

Examination of Musculoskeletal System

Purpose:

1. Identify the key landmarks of each joint.
2. Obtain an accurate history of the musculoskeletal system.
3. Appropriately prepare and position the client for the musculoskeletal examination.
4. Inspect and palpate the joints, bones, and muscles.
5. Describe the range of motion of the major joints.
6. Assess muscle strength using the muscle strength grading scale.
7. Correctly document the findings of the musculoskeletal assessment.

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Wash hands

c) Provide comfortable environment

d) Explain procedure to client.

e) Provide privacy

C. Procedure

I. Observe gait and posture of the client.

II. Inspect joints, muscles and extremities for size, symmetry and color.

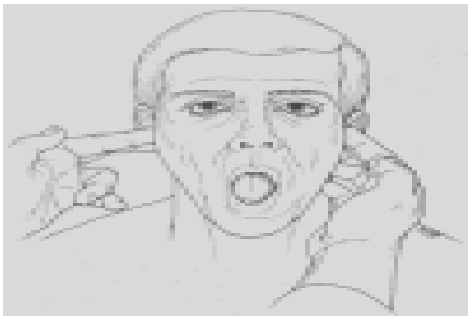
III. Palpate joints, muscles and extremities for tenderness, edema, heat, nodules and creptitus.

IV. Test Range of Motion of the following joints:

Range of Motion at Temporomandibular Joint:

a. The mouth opens easily to 3-6 cm between the upper and lower incisors.

b. The jaw moves laterally from 1 – 2 cm without deviation or dislocation.



Range of Motion at Spine:

a. Of the cervical spine:

i. Flexion.
ii. Hyperextension.
iii. Lateral bending or flexion.
iv. Rotation.




b. Of the thoracic and lumbar spine:

i. Right and lateral flexion 35 degree.
ii. Bend forward and touch the toes; confirm that the lumbar concavity disappears with this movement, and the back assumes a single C-shaped convexity.
iii. Hyperextension 30 degree.
iv. Rotation 30 degree.

Range of Motion at the Shoulder

i. Raise (abduct) the arms to shoulder level (90°), with palms facing down
ii. Raise the arms to a vertical position above the head with the palms facing each other (External Rotation)
iii. Place both hands behind the neck, with the elbows out to the side (external rotation and abduction).
iv. Place both hands behind the small of the back (internal rotation and adduction)

Range of Motion at Elbow

i. The elbow should flex to 160 degree.
ii. The elbow should extend to 0 degree.
iii. The elbow should supinate and pronate to 90 degree.

Range of Motion at the Wrist

i. Flexion: With the patient's forearm stabilized and supinated on a table, placing finger tips in the patient's palm, ask the patient to flex the wrist against gravity.

ii. Extension : With the patient's forearm pronated, placing a hand on the patient's dorsal metacarpals, ask the patient to extend the wrist against gravity

iii. Radial and ulnar deviation: with the palms down ask the patient to move the wrists laterally and medially.

iv. Hyperextension

Assess for the Carpal Tunnel Syndrome

a) Phalen's Test

1. Hold the patient's wrists in acute flexion for 60 seconds.
2. Or ask the patient to press the backs of both hands together to form right angle

b). Tinel's Test

With the finger; percuss lightly over the course of the median nerve in the carpal tunnel.

Range of motion at hands & fingers joint

i. Thumb flexion.
ii. Fingers extension.
iii. Fingers should flex to 90 degree and hyperextend to 30 degree.
iv. Fingers should abduct to 20 degree, and adduct fully.

Range of Motion at the Hip

a) Flexion: with the patient supine,

place a hand under the patient's lumbar spine,

ask the patient to bend each knee in turn up to the chest and pull it firmly against the abdomen

(1. Knee flexed, 2. Knee extended)

b) Extension: with the patient face down, extend the thigh backward (or upward) + hyperextension)

c) Abduction:

1. Stabilize the pelvis by pressing down the opposite
anterior superior iliac spine with one hand
2. With the other hand, grasp the ankle and abduct
the extended leg until feeling the iliac spine move
3. If there's limited movement, stand at the foot of the table, grasp both ankles, and spread them maximally, abducting both extended legs at the hips for comparison.

d) Adduction: With the patient supine stabilize the pelvis, hold one ankle, and move the leg medially across the body and over the opposite extremity.

e) Rotation:

1. Flex the leg to (90°) at hip and knee, stabilize the thigh with one hand, grasp the ankle with the other, and swing the lower leg medially for external rotation at the hip.
2. Flex the leg to (90°) at hip and knee, stabilize the thigh with one hand, grasp the ankle with the other, and swing the lower leg laterally for internal rotation.

Assessing for Low back pain with radiation to the leg

1. With the patient supine, raise the patient's relaxed and straightened leg until pain occurs.
2. Then dorsiflex the foot.

Range of Motion at Knee joint

i. Flexion 120 – 130 degrees (bend each knee up toward buttocks or back)
ii. Extension 0 degree / hyperextension 15 degree (straighten knee)

Assessing The Knee

a) The Bulge sign (minor fluids)

1. With the knee extended, place the left hand above the knee and apply pressure on the supra-patellar pouch, displacing or milking the fluid downward
2. Stroke downward on the medial aspect of the knee and apply pressure to force fluid into the lateral area.
3. Tap the knee just behind the lateral margin of the patella with the right hand.

b) The Balloon sign

1. Place the thumb and index of the right hand on each side of the patella
2. With the left hand, compress the supra-patellar pouch against the femur.
3. Feel for fluid entering into the spaces next to the patella under the right thumb and index.

c) Balloting the patella (major effusions)

1. compress the supra-patellar pouch
2. " ballotte" or push the patella
3. watch for fluid returning to the supra-patellar pouch.

Range of Motion at the Ankle & Foot

i. Dorsiflexion 20 degree (point toes upward).
ii. Plantar flexion 45 degree (point toes downward).
iii. Evert the ankle 20 degree and invert the ankle 30 degree.
iv. Curl the toes downward and upward. (flexion, extension, hyperextension).
v. Spread the toes as far as possible (abduction), then bring the toes together (adduction).

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

Unit 10

Nervous System

Neurological Examination

Procedure: Neurological Examination

Purpose:

1. Obtain an accurate history of the neurologic system.
2. Perform a screening neurologic examination.
3. Document the findings of the nervous system examination.

A History Taking :

a) Current Symptoms

b) Past History

c) Family History

d) Lifestyle and Health Practices

B Preparation

a) Wash hands

b) Gather equipment (Tuning fork (128-256Hz), safety pin, cotton, tongue blade, reflex hammer)

c) Provide comfortable environment

d) Explain procedure to client.

e) provide privacy

C Procedure

1. Assess mental status by

a. **Language**: Whether client has difficulty speaking.
b. **Orientation:** Whether client is oriented to person, place and time.
c. **Memory:** Listen for lapses in memory in terms of immediate, recent and remote memory.
d. **Attention span and calculation**: Check this by asking the client to recite alphabet or to count backward from 100. Test the calculating ability of client in terms of simple addition, subtraction, division and multiplication.

e. **Level of consciousness**: Apply Glasgow Coma Scale in clients with altered consciousness.

2. Examining the Cranial Nerves

I - Olfactory:

a) Make sure that each nasal passage is open by compressing one side of the nose and asking the patient to sniff through the other.

b) Ask the patient to close both eyes

c) Occlude one nostril and test smell in the other.

d) repeat on the opposite side.

II - Optic:

Test visual acuity.

a) Ensure placement of the Snellen chart at an appropriate height for the client .
b) Position the client exactly 20 feet (6 meters) from the chart.
c) Ask the client to close one eye using the opaque card and to read the line at 6/6
d) Repeat the process for the other eye
e) Repeat process with both eyes

Visual Fields by Confrontation

a) Ask the patient to look with both eyes into the examiner's eyes
b) The examiner places hands 2 feet apart lateral to the patient's ears.
c) Instruct the patient to point to fingers as soon as they are seen.
d) Then slowly move the wiggling fingers of both hand toward the line of gaze until the patient identifies them.
e) Repeat the pattern in the upper and lower temporal quadrants.
f) If a defect is found :

*Ask the client to cover the left eye while the examiner covers the right eye.

*Look directly at each other with uncovered eye

*The examiner extends the left arm at the midline & slowly moves an object upward from below until the client sees the object then test the remaining three visual fields of the clients right eye (superior, temporal, and nasal.)

*Repeat the test for the opposite eye.

III – Oculomotor, IV –Trochlear, VI –Abducens..

Test papillary reactions

a) Darken the room
b) Ask the patient to look into a distance
c) Shine a bright light obliquely into each pupil in turn.
d) Look for direct and consensual reaction.
e) If the reaction to light is impaired test the near reaction in normal room light:
   * Hold a finger or a pencil about 10cm from the patient's eye.
   * Ask the patient to look alternately at it and
   into the distance directly behind it.

Extra-ocular muscle movements

a) Stand about two feet (60cm) in front of the client
b) Ask the client to follow the movement of the penlight only with the eyes.
c) Starting in the midline, move the penlight to the extreme left, then straight up then down. Position the penlight again in the midline, move it to the extreme right, straight up then down.

V –Trigeminal

Motor:

a) Palpate the temporal and masseter muscles
b) Ask the patient clinches the teeth. Note muscle strength.

Sensory:

a) Test the forehead, cheeks and jaw on each side for pain sensation while patient eyes are closed
b) If There is abnormality confirm it by testing temperature sensation
c) Then test for light touch, ask the patient to respond whenever skin is touched
d) **(CN V + VII)**Test the corneal reflex
   *Ask the patient to look up and away. Approaching from the other side, out from the patient's line of vision, and avoiding the eyelashes, touch the cornea with a fine wisp of cotton.

VII -Facial:

a) Have the patient raise the eyebrows
b) Frown.
c) Close the eyes and resist their being opened

d) Have the patient show his/her teeth, smile, and puff out his/her cheeks.

VIII -Acoustic:

Assess hearing (whisper)

a) Stand 1-2 feet (30-60 cm) behind the client
b) Ask the client to place one finger on the tragus of the left ear and move it back
c) Whisper a word with 2 distinct syllables toward the clients right ear.
d) Ask the client to repeat the word back.
e) repeat the test for the left ear.

If Hearing loss is present test for **lateralization (Weber's test)**

a) Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly with the back of the hand and place the vibrating fork in the center of the client's head or forehead.
b) Ask whether the client hears the sound better
in one ear or the same in both ears

Compare for **air and bone conduction (Rinne test)**

a) Strike a tuning fork (use 512Hz or 256Hz tuning fork) and place the base of the fork on the client's mastoid process.
b) Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.
c) Move the tines of still vibrating 1-2 cm in front of the external auditory meatus.
d) Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.

IX – Glossopharyngeal X –Vagus

a) Note any hoarseness of the voice.
b) Ask the patient to say "ah." Note the upward movement of the soft palate and
the inward movement of the posterior pharynx
c) Note the gag reflex

XI - Spinal Accessory

a) Have the patient shrug the shoulders upward against hands. Note strength and contraction of trapezii.
b) Have the patient turn the head against the observer's hand (s). Observe the contraction of the sternomastoid and note the force of movement against hand.

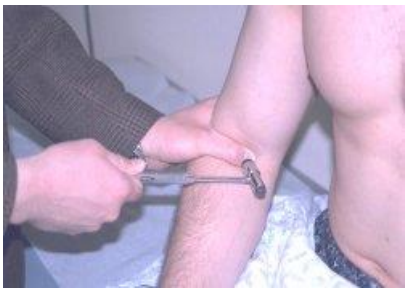
XII –Hypoglossal

Note any fasciculation of the tongue Have the patient stick out the tongue and move it from side to side. Note any asymmetry, deviation, or atrophy

3. Deep Tendon Reflexes

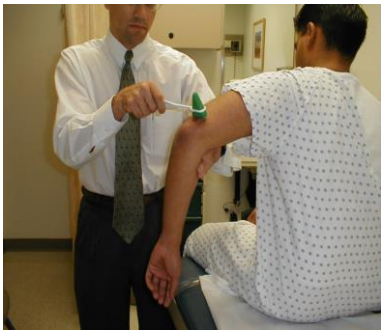
A. The Biceps Reflex

a) Flex the patient's arm at the elbow with the palm down.
b) Place the thumb or finger firmly on the biceps tendon.
c) Strike with the reflex hammer so that the blow is aimed directly through the digit toward the biceps tendon.
d) Observe for flexion at the elbow, and watch for and feel the contraction of the biceps muscle.
e) If unable to elicit a reflex, use the reinforcement.



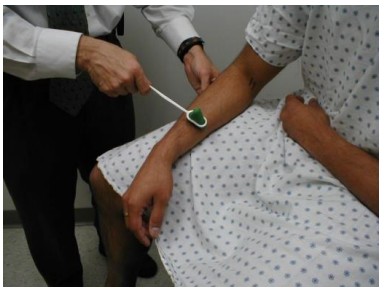
B. The Triceps Reflex

a) Flex the patient's arm at the elbow with the palm toward the body, and pull it slightly across the chest
b) Strike the triceps tendon above the elbow
c) Use a blow directly from behind it
d) Watch for contraction of the triceps muscle and extension at the elbow
e) If unable to elicit a reflex, use the reinforcement.



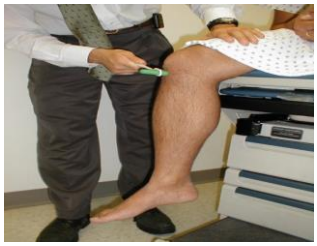
C. The Supinator or Brachioradialis Reflex

a) Let the patient's hand rest on the abdomen or the lap with the forearm partly pronated
b) Strike the radius about (1-2) inches above the wrist
c) Watch for flexion and supination of the forearm
d) If unable to elicit a reflex, use the reinforcement.



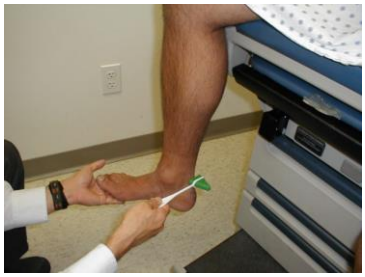
D. The Patellar or Knee reflex

a) With the patient sitting or lying down, and the knee flexed.
b) Briskly tap the patellar tendon just below the patella
c) Note contraction of the quadriceps with extension at the knee.
d) If unable to elicit a reflex, use the reinforcement.



E. **Achilles reflex**, occurs when the Achilles tendon is tapped while the foot is dorsi-flexed. A positive result would be the jerking of the foot towards its plantar surface.

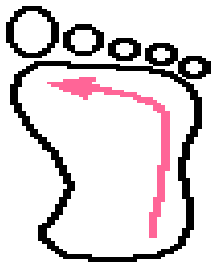
- The Achilles reflex checks if the S_1 and S_2 nerve roots are intact and could be indicative of sciatic nerve pathology
  - Dorsiflex the foot at the ankle.
  - Strike the Achilles tendon.
  - Watch and feel for plantar flexion at the ankle.



F. The Planter Reflex

a) With an object such as a key or the wooden end of an applicator stick, stroke the lateral aspect of the sole from the heel to the ball of the foot, curving medially across the ball.

b) Note movement of the toes, normally flexion.



Meningeal Signs

Neck Mobility

a) Make sure there is no injury to the cervical vertebrae or cervical cord

b) With the patient supine, place the hands behind the patient's head and flex the neck forward, until the chin touches the chest if possible

Brudzinski's Sign

As flexing the neck, watch the hips and knees in reaction to the maneuver, normally should remain relaxed and motionless.

Kernig's Sign

a) Flex the patient's legs at both the hip and the knee

b) Then straighten the knee.

4. MOTOR FUNCTION TEST: (Gross & Fine motor function test)

I. GROSS MOTOR FUNCTION TESTS

a. Assess walking gait of the client.

b. Romberg test

a) Remove sharp and harmful objects from around the area of exam

b) Ask the patient to stand with feet together and eyes open

c) Close both eyes for (20-30) seconds without support while stay near the patient to prevent falling.

c. **Test for Pronator Drift**

a) ask the client to stand I for 20-30 seconds with both arms straight forward, palms up, and with eyes closed

b) Instruct the patient to keep arms up and eyes shut tap the arms briskly downward.

d. Heel to toe walking

e. Toe or heel walking

II. FINE MOTOR FUNCTION TESTS

a. Rapid Alternating Movements

Arms

a) Show the patient how to strike one hand on the thigh, raise the hand, turn it over, and then strike the back of the hand down on the same place. Urge the patient to repeat these alternating movements as rapidly as possible.

b) Show the patient how to tap the distal joint of the thumb with the tip of the index finger again as rapidly as possible.

Legs

Ask the patient to tap the examiner's hands with the ball of each foot in turn as quickly as possible.

b. Point to point movements

Arms

a) Ask the patient to touch the examiners index finger and then his /her nose alternatively several times
b) Move the finger about so that the patient has to alter directions and extend the arm fully to reach it
c) Hold finger in one place so that the patient can touch it with one arm and finger outstretched
d) Ask the patient to raise the arm over the head and lower it again to touch the finger
e) After several repeats, ask the patient to close both eyes and try several more times

Legs

a) Ask the patient to place one heel on the opposite knee, and then run it down the shin to the big toe
b) Repeat with the patients eyes closed
c) Repeat on the other side.

5. The Sensory system

1 **Pain**

a) Instruct the patient to close eyes
b) use a safety pin substituting the blunt end for the point as a stimulus
c) Ask the patient to report whether it is "sharp" or "dull" and to compare sides.

2 **Temperature**

a) Omitted if pain sensation is normal

b) Using a test tube filled with hot and another with cold water or a tuning fork heated or cooled by water, touch the skin and ask the patient identify “hot” or “cold”.

3 **Light touch**

a) With a wisp of cotton, touch the skin lightly, avoiding pressure.
b) Ask the patient to respond whenever a touch is felt
c) Compare one area with another

Vibration

a) Tap a tuning fork (128-256Hz) on the heel of hand
b) Place it over a distal interphalangeal joint of the patient’s finger
c) Then over the interphalangeal joint of the big toe
d) Ask what the patient feels
e) If not sure whether it is pressure or vibration ask the patient to tell when vibration stops, then touch the fork to stop it.
f) If vibration sense is impaired, proceed to more proximal bony prominences.

4. **Position**

a) Grasp the patients big toe, holding it by its sides between thumb and index finger
b) Pull it away from the other toes to avoid friction
c) Demonstrate “up” and “down”
d) With the patient’s eyes closed, ask for a response of “up” or “down” when moving the toe in a small arc.
e) In similar fashion test position in fingers

5. Discriminative Sensation

1. Stereognosis

a) ask the client to close eyes
b) Place a familiar object in the patient’s hand
c) Ask the patient to tell what it is.

2. Number Identification (Graphesthesia)

a) Ask the patient to close eyes

b) With a blunt end of a pen or a pencil, draw a large numbering the patient's palm.

c) ask the patient to tell what it is.

3. Two-point discrimination

a) using the two ends of an opened paper clip, or the sides of two pins touch a finger pad in two places simultaneously

b) Alternate the double stimulus irregularly with a one- point touch.

c) Find the minimal distance at which the patient can discriminate one from two points.

4. Point Localization

a) Ask the patient to close eyes

b) Briefly touch a point on the patient's skin

ask the patient to open both eyes and point to the place touched

5. Extinction

a) Ask the patient to close eyes

b) Simultaneously stimulate corresponding areas on both sides of the body

ask where the patient feels the touch

D Procedure Termination

a) Put client in comfortable position according to health status

b) Provide patient with reassurance

c) Return back equipments

d) Wash hands

e) Document findings

Clinical Physical Assessment
Skin, Hair and Nail Checklist

Student's Name:_____
ID # : _____ **Date :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (gloves, exam light, penlight, magnifying glass, centimeter ruler.)			5.1
	b) Provide comfortable environment with good light			
	c) Explain procedure to client.			5.2
	d) Provide privacy			5.2
	e) Wash hands			5.2
C	**Procedure**			
	Skin			
	* Note any distinctive odor			5.2
	1) Inspection			
	Color e) Inspect all the skin for increased pigmentation or decreased pigmentation. f) Inspect for redness or pallor in the fingernails, the lips, the mucus membranes (mouth and palpebral conjunctiva). g) Inspect for central cyanosis in the lips, oral mucosa and toungue. h) Look for the yellow color of jaundice in the sclera, palpebral conjunctiva, lips, hard palate, under surface of the tongue, and skin.			5.2
	Moisture c) Look for dry areas of the skin d) Look for acne especially at the face and shoulders.			5.2

	Skin Intactness Look for lesions noting their: e) anatomic location and distribution f) arrangement g) types (macules, papules ..etc.) h) color			5.2
	2) Palpation			
	a) Palpate **lesions** for tenderness			5.2
	b)**Texture** of skin (rough, smooth), using palmar surface of three middle fingers			5.2

No	Procedure Steps	Yes	No	Comments
	c) Palpate for **temperature** (cool, warm, hot), using the dorsal side of hand.note the temperature of any red areas.			5.2
	d) **Mobility and turgor** Lift a fold of skin note 1. the ease with which it lifts up (Mobility) 2. the speed with which it returns into place (Turgor)			5.2
	e) **Moisture** of skin (dry, sweaty, oily)			5.2
	Scalp and Hair			
	Inspection			5.2
	a) Color.			5.2
	b) Amount and distribution.			5.2
	c) Thickness, texture, and lesions.			5.2
	d) Cleanliness (oiliness, and parasites)			5.2
	Palpation			5.2
	Palpate for thickness, texture, oiliness, lesions, and parasites.			5.2
	Measure lesions by ruler			5.2
	Palpate lesions for tenderness			5.2
	Nails			5.2
	Inspection			5.2
	a) Inspect for grooming and cleanliness.			5.2
	b) Inspect for color and markings			5.2
	c) Inspect shape.			5.2
	Palpation			5.2
	a) Palpate texture and consistency			5.2
	b) Test for capillary refill. + Clubbing of fingers			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2
	e) Document findings			5.2

Physical Assessment (Clinical)
Head and Neck Assessment (Eye)

Student's Name:_____
ID # : _____ **Date :** _____

		Performed		CLO
No	**Procedure Steps**	**Yes**	**No**	
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (Diagnostic set (ophthalmoscope), Snellen chart, Near vision screener, penlight, opaque card, clean gloves, sterile cotton, and cotton applicator.)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Provide privacy			5.2
	e) Wash hands			5.2
C	**Procedure**			
	1. Test visual acuity (Central Vision) using Snellen eye chart			5.2
	a) Ensure placement of the Snellen chart at an appropriate height for the client.			5.2
	b) Position the client exactly 20 feet (6 meters) from the chart.			5.2
	c) Ask the client to close one eye using the opaque card and to read the line at 6/6			5.2
	d) Repeat the process for the other eye			5.2
	e) Repeat process with both eyes			5.2
	f) Record the result			5.2
	2. Test visual acuity using Pocket vision screener			5.2
	a) Give the client a hand- held vision chart to hold 14 inches (35.5 cm) from the eye.			5.2
	b) Have the client to cover one eye with the opaque card before reading from the largest print to the smallest.			5.2
	c) Repeat the test for the other eye			5.2
	3. Test visual fields by Confrontation			5.2
	Screening (Wiggling test)			

	a) Position self 2 feet (60cm) away from the client at eye level.			5.2
	b) Instruct the patient to look directly into the examiner's eye			5.2
	c) Place the hands about 2 feet apart, lateral to the patient's ears .			5.2
	d) Instruct the patient to point to the finger's as soon as they are seen.			5.2
	e) Slowly move the wiggling fingers of both hands toward the line of gaze until the patient identifies them			5.2
	f) Repeat in the same pattern in the upper and lower temporal quadrants.			5.2
	Further testing			
	a) Position self 2 feet (60cm) away from the client at eye level.			5.2
	b) Ask the client to cover the left eye while the examiner covers the right eye.			5.2
	c) Look directly at each other with uncovered eye.			5.2
	d) The examiner extends the left arm at the midline & slowly moves an object upward from below until the client sees the object then test the remaining three visual fields of the clients right eye (superior, temporal, and nasal.)			5.2
	Repeat the test for the opposite eye.			5.2
	3.Position and alignment of the eyes			5.2
	Survey the eyes for position and alignment with each other .			5.2
	To detect for eye ball protrusion			5.2
	a) Instruct patient to sit down			5.2
	b) Stand behind the patient			5.2
	c) draw the upper lids gently upward and then compare the positions of the eyes and note the relationship of the corneas to the lower lids			5.2
	4. Extra-ocular muscles			
4-1	**Reflections in the corneas**			5.2
	Direct a light onto the patient's eyes from about 2 feet directly in front of the patient . *Reflections should be visible slightly nasal to the center of the pupils.*			5.2
4-2	**Extra-ocular movements looking for conjugate movements, nystagmus, or lid lag.**			5.2
	a) Stand about two feet (60cm) in front of the client			5.2
	b) Ask the client to follow the movement of the penlight or the examiner's finger only with the eyes			5.2
	c) Starting in the midline 1. Move the penlight to the extreme right 2. Then straight up to the right 3. Then pause looking for nystagmus 4. Then down to the right 5. Position the penlight again in the midline without pausing move it to the extreme left 6. Straight up to the left 7. Then pause looking for nystagmus			5.2

	8. Then down to the left			
4-3	**Convergence**			
	Ask the client to follow the finger or pencil as moving it in toward the bridge of the nose. *The converging eyes normally follow the object to within 5-8 cm of the nose.*			5.2
	5. Inspect external eye structures			5.2
	a)Eyebrows for 1. quantity 2. distribution 3. Scaliness of the underlying skin			5.2
	b) Eyelids and lashes			5.2
	1. Position of the lids in relation to the eyeballs			5.2
	2. Width of the palpebral fissures			5.2
	3. Color of the lids			5.2
	4. Lesions			5.2
	5. Condition and directions of the eyelashes			5.2
	6. Adequacy with which the eyelids close.			5.2
	d) Conjunctiva and sclera			
1	**Inspect the palpebral conjunctiva of the lower eyelid and the sclera for color, vascular pattern, any nodules or swelling**			5.2
	1. Ask the patient to look up			5.2
	2. Place thumbs bilaterally at the level of the lower bony orbital rim			5.2
	3. Gently pull down the lower lids to expose the palpebral conjunctiva and the sclera.			5.2
	4. for fuller view of the eye a. rest the thumb and finger on the bones of the cheek and brow, and spread the lids b. Ask the patient to look to each side and down.			5.2
2	**Inspect the conjunctiva under the upper eyelid.**			
	a. Instruct the patient to look down relaxing the eye			5.2
	b. Raise the upper eyelid slightly so that the eyelashes protrude			5.2
	c. Grasp the upper eyelashes and pull them gently down and forward.			5.2
	d. Place a small stick such as applicator at least 1cm above the lid margin			5.2
	e. Push down on the stick as raising the edge of the lid.			5.2
	f. Secure the upper lashes against the eyebrow with the thumb and inspect the palpebral conjunctiva			5.2
	e. After inspection grasp the upper eyelashes and pull them gently forward, ask the patient to look up.			5.2
X	**e) Lacrimal Apparatus**			5.2
	1. Inspect the regions of the Lacrimal gland and Lacrimal sac for swelling			5.2
	2. Put on clean gloves			5.2
	3. Ask the patient to look up			5.2

	4. Press on the lower lid close to the medial canthus, just inside the rim of the bony orbit (compressing the Lacrimal sac), look for fluid regurgitated from the puncta into the eye			5.2
	6. Inspect anterior eyeball structures			5.2
	Cornea			5.2
	With oblique lighting inspect the cornea of each side for opacities in the lens that may be visible through the pupil.			5.2
	Inspect the Iris for shape and color			5.2
	Using light shining from the temporal side look for a crescentic shadow on the medial side of the iris. *Normally there is no shadow*.			5.2

No	Procedure Steps	Yes	No	Comments
	The pupils			
	Inspect the Pupils for shape, size, and symmetry			5.2
√	**Pupillary reactions to light and accomodation**			5.2
	a) Dim the light of the room			5.2
	b) Ask the client to stare ahead			5.2
	c) Move the penlight from the client's side, shine light directly into one eye.			5.2
	d) Observe the constriction of the illuminated pupil			5.2
	e) Observe the simultaneous reaction (consensual) of the other eye.			5.2
	If reaction to light is impaired or questionable test for *near reaction* in normal room light			5.2
	a) Hold a finger or pencil about 10 cm from the patient's eye.			5.2
	b) Ask the patient to look alternately at it & into the distance behind it watching for pupillary constriction with near effort.			5.2
	7. Inspect ocular fundus			5.2
	a) Dim the light in the room			5.2
	b) Ask the client to look at a fixed point straight ahead & not to move.			5.2
	c) For the right eye: hold the ophthalmoscope in the right hand with the index finger on the lens wheel .			5.2
	d) Begin with the lens on 0 diopter.			5.2
	e) Stand at a slight angle lateral to the client line of vision			5.2
	F) Approach the client at about 15 degrees angel toward the nose using the right eye to examine the right eye of the client			5.2
	g) Place the left hand on the client shoulder			5.2
	h) Advance toward the client to assess the red reflex.			5.2
	i) Keep advancing toward the client until the ophthalmoscope touches the eyelashes.			5.2
	j) Rotate the wheel to inspect the fundus			5.2
	k) Look for the optic disk			5.2

	l) Note the major vessels & there color.			5.2
D	**Procedure Termination**			5.2
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2
	e) Document findings			5.2

Physical Assessment (Clinical)
Head and Neck Assessment (Ear)

Student's Name:_____
ID # : _____ Date : _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (Watch with the seconds' hand, Tuning fork, Otoscope, alcohol swab)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Provide privacy			5.2
	e) Wash hands			5.2
C	**Procedure**			
	1. The auricle			
	a. Inspect the auricles, tragus and lobule for symmetry, color, lumps and integrity			5.2
	b. Confirm that the external auditory meatus is patent, with no discharge.			5.2
	c. If pain or discharge is present move the auricle up and down, press the tragus and press firmly just behind the ear on the mastoid process.			5.2
	2. Auditory canal inspection using Otoscope			
	a. Ask the client to tilt the head away toward the opposite shoulder.			5.2
	b. Hold the Otoscope handle between the thumb and fingers of one hand, brace the hand against the patient's face, the handle may be positioned upward or downward.			5.2
	c. Use the other hand to stabilize the head and straighten the canal by pulling the pinna upward, backward, and slightly away from the head.			5.2
	d. With the light insert the speculum gently into the ear canal directing it down and forward.			5.2
	e. Inspect the ear canal noting any discharge, foreign bodies, redness of the skin, or swelling			5.2
	f. Inspect the ear drum noting its color, contour, the cone of light , the handle of the malleus, pars flaccida and pars tensa looking for perfotation			5.2
	3. Auditory Acuity			
	A: whisper test (Gross hearing)			
	a. Stand 1-2 feet (30-60 cm) behind the client			5.2

	b. Ask the client to occlude the ear canal by placing one finger on the tragus of the left ear and move it back, or by the examiner's finger moving it rapidly but gently.			5.2
	c. Exhale fully, and whisper softly toward the unoccluded ear, choosing words of two equally accented syllables			5.2
	d. Ask the client to repeat the word back.			5.2
	e. Repeat the test for the right ear.			5.2
	B: Perform Weber's test (Lateralization)			5.2
	a. Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly between the index finger and the thumb or by taping it on knuckles.			5.2
	b. Place the base of the vibrating fork firmly on top of the patient's head or on the mid-forehead.			5.2
	c. Ask whether the client hears the sound better in one ear or the same in both ears.			5.2
	C: Perform Rinne test			
	a. Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly between the index finger and the thumb or by taping it on knuckles			5.2
	b. Place the base of the lightly vibrating fork on the client's mastoid process behind the ear and level with the canal.			5.2
	c. Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.			5.2
	d. Quickly place the fork close to the ear canal with the (**U**) of the fork facing forward.			5.2
	e. Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2

Physical Assessment (Clinical)
Head and Neck Assessment (Mouth & Throat)

Student's Name:_____
ID # : _____ **Date :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (clean gloves, 4×4 gauze pad, penlight, tongue depressor).			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Provide privacy			5.2
	e) Wash hands			5.2
C	**Procedure**			5.2
1.	**The Lips**			5.2
	a) Observe for color and moisture			5.2
	b) Observe for any lumps, cracking or scaliness.			5.2
2.	**The Oral Mucosa**			
	a) Ask the patient to open mouth widely			5.2
	b) look into the patient's mouth with good light and the help of a tongue blade for : color, ulcers, white patches, and nodules.			5.2
3.	**The Gums and Teeth**			
	a) Ask the client to open mouth and note the color of gums.			5.2
	b) Retract the lips and cheeks to check the gums for color and consistency			5.2
	c) Inspect the gum margins and the inter-dental papillae for swelling or ulceration.			5.2
	d) Inspect the teeth for number, color, shape, alignment of the teeth.			5.2
	e) Observe for dental hygiene.			5.2
	f) check for looseness of the teeth with gloved thumb and index finger.			5.2
4.	**The roof of the mouth**			
	Inspect the hard palate for 3. color 4. architecture			5.2
5.	**The Tongue and the Floor of the Mouth**			
	a) Ask the patient to put out his tongue			5.2
	b) Note the color and texture of the dorsum of the tongue .			5.2
	c) Ask the patient to touch the hard palate with the tip of the tongue			5.2
	d) Put on gloves and ask the client to protrude his tongue, grasp the tip of the tongue with a square of			5.2

	guaze and gently pull it to the sides noting for white or reddened areas, nodules, or ulcerations			
	e) Palpate the tongue feeling for any induration (hardness) for both sides.			5.2
6.	**The Pharynx**			
	a) Ask client to open the mouth wide with out protruding the tongue, use the penlight to look at the roof)			5.2
	b) Apply a tongue depressor to the tongue and shine the penlight, note the characteristics and position of the uvula.			5.2
	c) Inspect the soft palate, anterior and posterior pillars, uvula, tonsils and pharynx for 1. Color 2. Symmetry 3. Presence of exudate. 4. Swelling 5. Ulceration 6. Tonsillar enlargement			5.2
	d) Observe elevation of the soft palate and uvula by asking patient to say "ah"			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2

Physical Assessment (Clinical)
Head and Neck Assessment (Nose & Sinuses)

Student's Name:_____
ID # : _____ **Date :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (clean gloves, Otoscope with special nasal attachments or nasal speculum/ penlight)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Provide privacy			5.2
	e) Wash hands			5.2
C	**Procedure**			
1.	**Inspect the anterior and inferior surfaces of the nose and test for nasal obstruction**			5.2
	a) Widen the nostrils by applying gentle pressure on the tip of the thumb to get partial view of the nasal vestibule with the aid of a penlight or Otoscope light noting for asymmetry or deformity.			5.2
	b) Check the patency of the nostrils' air flow by occluding one nostril at a time and asking the client to sniff.			5.2
2.	**Inspect the internal nose**			
	a) Use the Otoscope with the special attachment or the nasal speculum with penlight to inspect the nose			5.2
	b) Use the non dominant hand to stabilize and gently tilt the client's head back.			5.2
	c) Insert the speculum into the nostril with out touching the nasal septum.			5.2
	d) Hold the Otoscope handle to one side to avoid the patient's chin			5.2
	e) Direct the Otoscope back and up in small steps to see the inferior & middle turbinates, the nasal septum and the nasal passage between them			5.2
	f) Inspect the nasal mucosa for color and any swelling, bleeding, or exudate.			5.2
	g) Inspect the nasal septum for deviation, inflammation or perforation of the septum.			5.2
	h) Inspect for any abnormality such as ulcers or polyps.			5.2
3.	**Palpate the frontal sinuses by using thumbs to press up on the eye brow on each side of the nose**			5.2
4.	**Percuss the sinuses by tapping lightly over the frontal and maxillary sinuses for tenderness**			5.2
5.	**Transilluminate the sinuses**			
	A)Hold a strong narrow light source. To assess the frontal sinuses put it snugly superiorly from superior			5.2

	orbital rim bilaterally, use the other hand to shield the light.			
	b) Compare relative light transmission through frontal sinuses			
	c) From inferior orbital rim direct light inferomedially and while having patient open mouth, see if light shines through to hard palate for maxillary sinuses			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2

Physical Assessment (Clinical)
Head and Neck Assessment (The Neck and Thyroid Gland)

Student's Name:_____

ID # : _____ **Date :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (clean gloves, Cup of water, light)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Provide privacy			5.2
	e) Wash hands			5.2
C	**Procedure**			5.2
1.	**Neck Inspection**			
	a) Note symmetry, any masses or scars			5.2
	b) Look for enlargement of the parotid or submandibular glands			5.2
	c) Note any visible lymph nodes			5.2
2.	**Lymph Node Palpation**			
	a) Use the pads of the index and middle fingers moving the skin over the underlying tissues in each area, rolling the node in two directions up and down and side to side.			5.2
	b) Facing the patient using both hands palpate for the **Preauricular nodes** in front of the ears**.**			5.2
	c) Move posterior to the ear and feel for the **Posterior auricular nodes** superficial to the mastoid process.			5.2
	d) Palpate posteriorly at the base of the skull for the **occipital nodes.**			5.2
	e) Move to the midway between the angle and the tip of the mandible for the palpation of the **submandibular nodes**			5.2
	f) Bracing the head with one hand, use the other hand to feel for the **Submental node** in the midline a few cm behind the tip of the mandible.			5.2
	g) Ask the patient to turn his/her head slightly to the right (the side of examination) and palpate for the **Superficial cervical nodes**, superficial to the sternomastoid,			5.2
	h) With the patient on the same position palpate along the anterior edge of the trapezius for the **Posterior cervical chain.**			5.2
	i) Hooking the thumb and fingers around either side of the sternomastoid muscle to find the **Deep cervical chain**			5.2

	j) Ask the patient to turn head to the left to palpate the previous nodes on the other side.			5.2
	k) Deep in the angle formed by the clavicle and the sternomastoid palpate for the **Supraclavicular nodes**			5.2
3.	**The Trachea**			
	a) Inspect the trachea for any deviation from its midline position			5.2
	b) Feel for any deviation Palpate sternal notch to make sure trachea is midline by palpating the tracheal ring (sternal notch midway between clavicular heads)			5.2
	c) place one finger along one side of the trachea and note the space between it and the sternomastoid and compare it with the other side			5.2
4.	**A. The Thyroid Gland (Anterior)**			
	a) ask the patient to extend the neck slightly			5.2
	b) Using tangential lighting directed downward from the tip of the patient's chin, inspecting the region below the cricoid cartilage for the gland.			5.2
	c) Ask the patient to sip some water and to extend the neck again and swallow. Watch for upward movement of the thyroid gland noting its contour, and symmetry.			5.2
	B. Palpate the Thyroid Gland from behind			5.2
	a) Stand behind the client			5.2
	b) Place the fingers of both hands on the patient's neck so that the index fingers are just below the cricoid.			5.2
	c) Adjust the patient's neck extension to avoid tightened neck muscles.			5.2
	d) Ask the patient to sip and swallow water and feel for any glandular tissue rising under the finger pads.			5.2
	e) Ask the client to set up right, lower the chin and turn the head slightly to the right.			5.2
	f) Use the fingers of the left hand to push the trachea to the right.			5.2
	g) With the fingers of the right hand palpate the area between the trachea and the sternomastoid muscle.			5.2
	h)Palpate with and without swallowing			5.2
	i) Reverse the technique to palpate the left lobe of the thyroid.			5.2
	j) If the thyroid gland is enlarged listen over the lateral lobes with a stethoscope to detect a bruit)			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2

Physical Assessment (Clinical)
Peripheral Vascular Assessment

Student's Name:_____
ID # : _____ **Date :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (clean gloves, measurement tape, tourniquet, light)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Provide privacy			5.2
	e) Wash hands			5.2
C	**Procedure**			5.2
1.	**The upper limbs**			
	a) Inspect both arms from fingertips to shoulders noting : 4. their size and symmetry, and any swelling . 5. The venous pattern 6. The color of the skin and nail beds and the texture of the skin			5.2
	a) Palpate the radial pulse with the pads of fingers, partially flexing the patient's wrist, comparing pulses bilaterally.			5.2
	b) If arterial insufficiency suspected , feel for brachial pulse by flexing the patient's elbow slightly and palpating the artery just medial to the biceps tendon at the antecubital crease or higher in the arm groove between the biceps and triceps muscles.			5.2
	Evaluating the arterial supply to the hand (Allen test)			
	a) Ask the patient to make a fist with one hand.			5.2
	b) Compress both radial and ulnar arteries firmly between thumbs and fingers.			5.2
	c) Ask the patient to open the hand into a relaxed, slightly flexed position when the palm is pale.			5.2
	d) Release pressure over the ulnar artery , if patent the palm flushes within 3-5 seconds.			5.2
	e) Patency of the radial artery tested by releasing the radial artery while still compressing the ulnar.			5.2
	Lymph Nodes			
	Feel for the epitrochlear nodes with the patient's elbow flexed to 90° and the forearm supported by the			5.2

	examiner's hand reaching around behind the arm and feel in the groove between the biceps and triceps muscles, about 3cm above the medial epicondyle. If present note size, consistency and tenderness.			

2.	**The Lower Limbs**			
	a) The patient should be lying down and draped so that the external genitalia are covered and the legs are fully exposed.			5.2
	b) Inspect both legs from the groin and buttocks to the feet. Note their: e. size and symmetry. f. color and texture of the skin, and the color of the nail beds. g. venous pattern or edema, and the hair distribution on the lower legs, feet and toes. h. Note any pigmentation, rashes, scars, and ulcers.			5.2
	c) Palpate the **superficial inguinal nodes**, including both the **horizonta**l and the **vertical** groups.			5.2
	d) Palpate **the femoral pulse** by pressing deeply below the inguinal ligament and about midway between the anterior superior iliac spine and the symphysis pubis.			5.2
	e) To palpate **the popliteal pulse** ask the patient to flex the knee slightly.			5.2
	f) Place the fingertips of both hands so that they just meet in the midline behind the knee and press them deeply into the popliteal fossa.			5.2
	g) If not palpated, with the patient in prone position flex the patient's knee to about 90˚.			5.2
	h) let the lower leg relax on the examiner's shoulder or upper arm and press by the two thumbs deeply into the popliteal fossa.			5.2
	i) Feel the dorsum of the foot lateral to the extensor tendon of the great tendon to palpate the **dorsalis pedis pulse**			5.2
	j) Curve fingers behind and slightly below the medial malleolus of the ankle to palpate **the posterior tibialis pulse.**			5.2
	k) Note the **temperature** of the feet and legs with the backs of fingers. Compare one side with the other.			5.2
	l) Check for pitting edema by pressing firmly and gently with the thumb for 5 seconds over the dorsum of the foot, behind each medial malleolus and over the shins.			5.2
	m) if suspected edema, with flexible measurement tape, comparing one side with the other, measure: 1. the forefoot. 2. the smallest possible circumference above the ankle. 3. the largest circumference at the calf 4. the mid-thigh a measured distance above the patella.			5.2
	n) Ask the patient to stand and inspect the saphenous system for **varicosities** .			5.2

	o) Palpate the groin just medial to the femoral pulse for tenderness of femoral vein			5.2
	p) With the patient's leg flexed at the knee and relaxed, palpate the calf with the finger pads compressing the calf muscle against the tibia			5.2
	Mapping varicose vein : With the patient standing place the palpating fingers gently on the vein with the other hand below it compress the vein sharply.			5.2
	Retrograde filling (Trendelenburg) test (Competency of venous valves)			5.2
	a. start with the patient supine , elevate one leg to about 90° to empty it of venous blood			5.2
	b. occlude the great saphenous vein in the upper thigh by manual compression, to occlude this vein not the deep veins			5.2
	c. ask the patient to stand, while keeping the vein occluded, watch for venous filling in the leg within 35sec			5.2
	d. after the patient has stood 20 sec, release the compression and look for any sudden additional venous filling.			5.2
	Postural color changes of chronic arterial insufficiency			5.2
	If pain or diminished pulses suggest arterial insufficiency look for postural color changes by: raising both legs to about 60° until maximal pallor of the feet develops (within a minute)			5.2
	Then ask the client to sit up with the legs dangling down, comparing both feet noting time required for: 4. Return of pinkness of the skin (10sec or less) 5. filling of the veins of the feet and ankles about (15sec) 6. any unusual rubor to replace pallor of the dependent foot (1minute)			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2
	e) Document findings			5.2

Physical Assessment (Clinical)
Cardiovascular Assessment

Student's Name:_____
ID # : _____ Date : _____

No	Procedure Steps	Yes	No	Comments
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (stethoscope, ruler)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Wash hands			5.2
	e) provide privacy			5.2
C	**Procedure**			
1.	**Examine The Jugular Venous Pressure(JVP)**			5.2
	a. Position the patient with the head slightly elevated on a pillow and the sternomastoid muscle relaxed, and identify the external jugular vein.			5.2
	b. Start with the head of the bed elevated about 30°, then adjust the angle so as to maximize visibility of the jugular venous pulsations in the lower half of the neck			5.2
	c. Turn the patient's head slightly away from the side of inspection.			5.2
	d. Identify the external jugular vein on each side. Then find pulsation of the internal jugular vein between the attachments of the sternomastoid muscle on the sternum and clavicle (posterior to the sternomastoid)			5.2
	e. Identify the highest point of pulsation in the internal jugular vein, with a centimeter ruler, measure the vertical distance between this point and the sternal angle.			5.2
2.	**Examine the Carotid pulse.**			
	a. Inspect neck for pulsation medial to the sternomastoid muscle			5.2
	b. Press inside the medial border of a well relaxed sternomastoid muscle at the level of the cricoid cartilage by the left thumb or the index and middle fingers on the right carotid artery (opposite for the left)			5.2
3.	**The heart**			
	Inspection:			
	While on the client right side, Inspect appropriate points (aortic, pulmonic, 3rd left inter-space, tricuspid and mitral) on the anterior chest for any pulsation.			5.2
	Instruct the patient to move on the left lateral decubitus area to inspect for the apical impulse.			5.2
	palpate same points (aortic, pulmonic, 3rd left inter-space, tricuspid and mitral) using finger pads on the anterior			5.2

	chest for any pulsation, using ball of the hand for the thrills.			

Physical Assessment (Clinical)
Cardiovascular Assessment

	Palpation			
	a. Palpate for the apical impulse, if unable to detect it ask the client to exhale fully and stop breathing for few seconds. evaluate its location, diameter, amplitude. Note its location with respect to the mid-sternal line, mid-clavicular line, and anterior axillary line.			5.2
	b. Palpate the left sternal border (3^{rd},4^{th} and 5^{th} ICS) 1. patient supine at 30° 2. place the tips of fingers in the 3^{rd},4^{th},and 5^{th} ICS trying to feel impulse. If unable to detect it ask the client to exhale fully and stop breathing for few seconds.			5.2
	c. The epigastric area. press the index finger just under the rib cage and up toward the left shoulder trying to feel right ventricular pulsation.			5.2
	d. The left and right 2^{nd} Interspaces . (Pulmonary and aortic arteries) During held expiration feel for impulse.			5.2
XX	**Percussion**			
	Starting to the left on the chest Percuss from resonance toward cardiac dullness in the 3^{rd}, 4^{th}, 5^{th} and the 6^{th} interspaces.			5.2
	Auscultation			
	Listen for the first and second heart sounds (S_1 and S_2) at each auscultatory area (aortic, pulmonic, 3rd L interspace, tricuspid and mitral) using the **diaphragm** of the stethoscope for **S1 & S2** and the **bell for S3 & S4** or any added sounds. d. with the patient **supine** e. then on the **left decubitus position** f. with the patient **sitting up, leaning forward** ask the patient to exhale completely and stop breathing. Note the intensity and splitting of S_1 and S_2. Listen for extra heart sounds (e.g., S_3 or S_4). Listen for any systolic and/or diastolic murmurs.			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2
	e) Documents Findings			5.2

Physical Assessment (Clinical)
Respiratory System Assessment

Student's Name:_____
ID # : _____ **Date :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (stethoscope, measurement tape, pen)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Wash Hands			5.2
	e) Provide privacy			5.2
C.	**Procedure**			
1.	**Survey of the Thorax and respiration**			5.2
.	a. observe the rate, rhythm, depth and effort of breathing 18 BPM, regular, Normal Depth, LLL 24 BPM, Irregular, Shallow, LLLLLL 8 BPM, Irregular Deep			5.2
	b. Check the patient's color for cyanosis and the shape of the fingertips for clubbing and color.			5.2
	c. Inspect the neck for supraclavicular retraction, and for contraction of the sternomastoid or other accessory muscles during inspiration. And position of the trachea			5.2
	d. Listen to the patient's breathing.			5.2
	e. observe the shape of the chest. Transverse – Anterior-Posterior			5.2
2.	**Examination of the posterior chest**			5.2
	Inspection			5.2
	a) Ask the patient to sit down with the arms folded across the chest with the hands resting on the opposite shoulders.			5.2
	b) From a midline position behind the patient note the shape of the chest and the way in which it moves including : d. deformities or asymmetry. e. Abnormal retractions of the interspaces during inspiration (lower interspaces, supraclavicular retractions.) f. Impairment in respiratory movement on one or both sides (Unilateral lag)			5.2
	Palpation			5.2
1.	a) Identify **tender areas** by palpating any area where pain has been reported or where b. lesions are evident.			5.2
	c) Assess any observed abnormality such as masses			5.2

2.	Test **Respiratory Expansion** by: 1. placing the thumbs about the level of and parallel to the 10th ribs and the hands Grasping the lateral rib cage, sliding them medially a bit in order to raise loose skin folds between thumbs and the spine			5.2
	2. ask the patient to inhale deeply and watch for the			5.2
	divergence of the thumbs during inspiration, feeling for the range & symmetry of the respiratory movements.			
3.	Feel for **tactile fremitus** (palpable vibrations) 1. using either the ball of the or the ulnar surface of the hand.			5.2
	2. Use both hands to compare sides			5.2
	3. Ask the patient to repeat the words “ninety-nine” or “ one, one, one.” If fremitus is faint ask the patient to speak more loudly.			5.2
	4. palpate and compare symmetrical areas of the lungs.			5.2
	Percussion			5.2
	a) Percuss the posterior chest while the patient keeps both arms crossed in front of the chest.			5.2
	b) press the distal interphalangeal joint of the middle finger (pleximeter) firmly on the surfaces to be percussed avoiding surface contact by any other part of the hand.			5.2
	c) with the middle finger of the other hand slightly flexed and relaxed strike over the pleximeter with a quick sharp but relaxed writ motion, using the tip of the flexor finger not the finger pad.			5.2
	d) Percuss the thorax in symmetrical locations from the apices to the lung bases. twice in each location, compare two areas			5.2
	d. when percusing the lower posterior chest, stand somewhat to the side rather than directly behind the patient.			5.2
	Identify the **level of diaphragmatic dullness** (during quiet respiration)			5.2
	a. with the pleximeter finger held above and parallel to the expected level of the dullness, Percuss in progressive steps downward until dullness clearly replaces resonance.			5.2
	b. Check the level of this change near the middle of the hemithorax and also more laterally putting a point by a pen on each level.			5.2
	Diaphragmatic excursion			5.2
	a. Ask the client to exhale fully then hold .			5.2
	b. Percuss for diaphragmatic dullness as above and put a point.			5.2
	c. Ask the client to take a deep breath and hold			5.2
	d. Again percuss for diaphragmatic dullness and put a point			5.2

	e. measure the distance between the two points (5-6cm)			5.2
	Auscultation			5.2
	a. Listen to **the breath sound** with the diaphragm of the stethoscope after instructing the patient to breathe deeply through an open mouth. 1. Bronchial: trachea. 2. Bronchovesicular: Primary Bronchi 3. Vesicular: Lungs.			5.2
	1. Listen for **Bronchovesicular** sounds between Scapulae			5.2
	2. Listen for the **Vesicular** sounds over the lungs			5.2
	3. Listen for any added sounds			5.2
	b. If breath sounds heard located abnormally assess for **transmitted voice sounds**			5.2
	1. Ask the patient to say " ninety-nine" normally transmitted sound are muffled and indistinct .			5.2
	2. Ask the patient to say "ee" normally a muffled long E sound is heard.			5.2
	3. Ask the patient to whisper "ninety-nine" or "one, two, three" . it will be heard faintly and indistinctly if heard at all.			5.2
3.	**Examination of the Anterior chest**			5.2
	Inspection			5.2
	Ask the patient to lie down into a supine position with the arms abducted . if the patient has difficulty in breathing, he/she should be examined in the sitting position or with the head of the bed elevated at comfortable level.			5.2
	Note the shape of the chest and the way in which it moves including : d. deformities or asymmetry. e. Abnormal retractions of the lower interspaces during inspiration f. Impairment in respiratory movement on one or both sides (Unilateral lag)			5.2
b.	**Palpation**			5.2
1	Identify **tender areas** by palpating any area where pain has been reported or where lesions are evident.			5.2
	Assess any **observed abnormality** such as masses			5.2
2	Test **Respiratory Expansion** by: 1. placing the thumbs along each costal margins with the hands along the lateral rib cage. As positioning the hands slide them medially a bit in order to raise loose skin folds between thumbs.			5.2

	2. ask the patient to inhale deeply and watch for the divergence of the thumbs during inspiration, feeling for the range & symmetry of the respiratory movements.			5.2
3	Feel for **tactile fremitus** (palpable vibrations) 1. using either the ball or the ulnar surface of the hand. Fremitus is decreased or absent over the pericardium.			5.2
	2. Use both hands to compare sides			5.2
	3. Ask the patient to repeat the words “ninety-nine” or “ one, one, one.” If fremitus is faint ask the patient to speak more loudly.			5.2
	4. palpate and compare symmetrical areas of the lungs.			5.2
c.	**Percussion**			5.2
X	a) Percuss the anterior and lateral chest while the patient keeps both arms abducted. press the distal interphalangeal joint of the middle finger (plexiimeter) firmly on the surfaces to be percussed avoiding			5.2
	surface contact by any other part of the hand			5.2
	b. with the middle finger of the other hand slightly flexed and relaxed strike over the plexiimeter with a quick sharp but relaxed wrist motion, using the tip of the flexor finger not the finger pad.			5.2
	c. Percuss the thorax in symmetrical locations from the apices to the lung bases. twice in each location, compare two areas. In a woman to enhance percussion gently displace the breast with the left hand while percusing with the right			5.2
	d. when percusing the left chest, dullness will be heard at the level of the heart 3rd to 5th ICS, percussion of the left lung will be lateral to it.			5.2
	Percuss for **liver dullness** with the plexiimeter finger above and parallel to the expected upper border of the liver dullness, in progressive steps from resonance downward to the dullness in the right midclavicular line .			5.2
	Auscultation			5.2
	a. Listen to the **breath sound** with the diaphragm of the stethoscope after instructing the patient to breathe deeply through an open mouth.			5.2
	Listen for **tracheal** sounds at the suprasternal notch			5.2
	Listen for **bronchial** sounds over the manubrium			5.2
	Listen for **bronchovesicular** sounds at the 1st and 2nd interspaces. For primary bronchi			5.2
	Listen for the **Vesicular** sounds over the lungs			5.2
	Listen for any **added sounds**.			5.2
	b. If breath sounds heard located abnormally assess for transmitted voice sounds			5.2
D	**Procedure Termination**			5.2
	a) Put client in comfortable position according to health status			5.2

	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2
	e) Document findings			5.2

Physical Assessment (Clinical)
Breast and Axillae

Student's Name:_____
ID # : _____ Date : _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
1.	a) Current Symptoms			5.2
2.	b) Past History			5.2
3.	c) Family History			5.2
4.	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
6.	a) Provide comfortable environment			5.2
7.	b) Explain procedure to client.			5.2
C.	**Procedure**			
	Examination of the breasts:			
	Inspection			
8.	Ask the patient to sit disrobed to the waist			5.2
9.	inspect the breasts, with the arms at the sides, for e. skin changes f. symmetry g. contour (masses, dimpling, flattening) h. retractions			5.2
10.	inspect the breasts, with the arms over the head, for a. contour b. retractions			5.2
11.	inspect the breasts, with the arms pressed against the hips, for c. contour d. retractions			5.2
12.	inspect the breasts, with the arms pressed against the hips C. contour b. retractions			5.2
13.	Inspect the nipple for: f. size g. shape (inversion) h. direction (usually outward, downward) i. rashes or ulceration j. discharge			5.2
	Palpation of the breasts			
14.	Ask the patient to lie down with a small pillow under the shoulder on the side of examination. And ask her to rest her arm over the head.(except if the breasts are small)			5.2
15.	With the fingers flat on the breast compress the tissues gently in a rotary motion against the chest wall			5.2
16.	Proceed systematically examining the entire breast from clavicle to inframammary fold, from midsternal line to posterior axillary line to the Axillae for the tail of the breast. Palpation for			5.2

	d. The consistency of the tissue e. Tenderness f. Nodules			
17.	Palpate the nipples for elasticity, discharge			5.2
	Examination of Lymph Nodes			5.2
	Inspection			5.2
18.	Inspect the skin of each axilla noting : d. Rashes e. Infection f. Unusual pigmentation			5.2
	Palpation			
19.	To palpate left Axillae, ask the patient to relax with the arm down. Supporting the left wrist or hand with his/ her hand.			5.2
20.	Cup together the fingers of the right hand and reach as high as possible toward the apex of the axilla with the fingers lying directly behind the pectoral musclepointing toward the midclavicle. Warn the patient it will be uncomfortable. Press the fingers in toward the chest wall and slide them downward to feel **central nodes**.			5.2
21.	Grasp the anterior axillary fold between the thumb and fingers inside the border of the pectoral muscle for the **Pectoral Nodes.**			5.2
22.	From high in the axilla feel along the upper humerous for the **lateral nodes.**			5.2
23.	Step behind the patient and with the fingers feel inside the muscle of the posterior axillary fold.			5.2
24.	Feel for the **Infraclavicula**r nodes and reexamine the Supraclavicular node			5.2
D	**Procedure Termination**			
37.	a) Put client in comfortable position according to health status			5.2
38.	b) Provide patient with reassurance			5.2
39.	c) Return back equipments			5.2
40.	d) Wash hands			5.2

Physical Assessment (Clinical)
Abdomen Physical Assessment

Student's Name:_____
ID # : _____ **Date :** _____

No	Procedure Steps	Yes	No	Comments
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Gather equipment (stetheoscope)			5.1
	b) Provide comfortable environment			5.2
	c) Explain procedure to client.			5.2
	d) Wash Hands			5.2
	e) Provide privacy			
C.	**Procedure**			
	Inspection of the abdomen			5.2
	1. Stand on the right side of the patient			5.2
1.	a) Inspect the **skin** for scars, striae, dilated veins, rashes and lesions.			5.2
2.	b) The **umbilicus** for contour, location any signs of inflammation or hernia.			5.2
3.	c) The **contour of the abdomen**; flat, protuberant or scaphoid. Symmetry, bulging flanks, visible organs or masses.			5.2
4.	d) **Peristalsis** : may be visible normally in very thin people			5.2
5.	e**) Pulsations**: The normal aortic pulsation is frequently visible in the epigastrium.			5.2
10.	**Liver Percussion**			
1	**Measuring the vertical span of the liver in the right midclavicular line.**			5.2
	a) Start at a level below the umbilicus at area of tympany.			5.2
	b) lightly percuss upward toward the liver.			5.2
	c) Ascertain the lower border of liver dullness in the midclavicular line.			5.2
	d) Identify the upper border of liver dullness by lightly percusing from lung resonance down toward liver dullness.			5.2
	e) Measure in centimeters the distance between the two points. (6-12cm).			5.2
2	**Measuring the vertical span in the midsternal line**			5.2
	a) Start percussing at an area of tympany			5.2
	b) Lightly Percuss upward toward the liver			5.2
	c) Identify the upper border of the liver dullness by percussing from the xyphoid flatness down toward liver dullness.			5.2

	d) measure in centimeters the distance between the two points .(4-8cm)			5.2
11.	**Palpating the Liver (Hooking Technique)**			
	a) Stand to the right of the patient's chest.			5.2
	b) Place both hands side by side on the right abdomen below the border of the liver dullness.			5.2
	c) Press in with fingers and up toward the costal margin.			5.2
	d) Ask the patient to take a deep breath.			5.2
12.	**To assess possible acute cholecystitis (Murphy's Sign)**			
	a) Hook the left thumb or the fingers of the right hand under the costal margin at the point where the lateral border of the rectus muscle intersects with the costal margin.			5.2
	b) Ask the patient to take a deep breath			5.2
	c) Watch the patient's breathing and note the degree of tenderness.			5.2
12.	**Assessing Kidney Tenderness**			
	a) Palpate by the fingertips in each costovertebral angel.			5.2
	b) If no tenderness in (a), place the ball of one hand in the costovertebral angle and strike it with the ulnar surface of the fist.			5.2
13.	**Ascites**			
13.1	**Mapping for ascites**			
	a) With the patient supine			5.2
	b) Percuss outward in several directions from the central area of tympany			5.2
	c) map the border between tympany and dullness			5.2
13.2	**Test for shifting dullness** (after mapping)			5.2
	a) ask the patient to turn onto one side			5.2
	b) Percuss and mark the borders of tympany and dullness again			5.2
13.3	**Test for a fluid wave**			
	a) Ask the patient or an assistant to press the edges of both hands firmly down the midline of the abdomen			5.2
	b) Tap sharply on the flank with the fingertips, feel on the opposite flank for an impulse transmitted through the fluid.			5.2
14.	**Assess for Possible Appendicitis**			
14.1	**Rebound tenderness**			5.2
	a) Press deeply and evenly in the right lower quadrant			5.2
	b) Quickly withdraw the fingers			5.2
	c) Ask the patient when pain is felt more.			5.2
14.2	**Rovsing's sign and referred rebound tenderness**			5.2
	a) Press deeply and evenly in the left lower quadrant			5.2
	b) quickly withdraw the fingers			5.2
14.3	**Psoas Sign**			5.2
	a) Place hand just above the patient's right knee			
	b) Ask the patient to raise that thigh against hand			5.2

	c) Ask the patient to turn onto the left side			5.2
	d) extend the patient's right leg at the hip			5.2
14.4	**Obturator Sign**			
	a) Flex the patient's right thigh at the hip, with the knee bent.			5.2
	b) Rotate the leg internally at the hip by stabilizing the thigh with one hand and grasping the ankle with the other and swing the lower leg laterally.			5.2
14.5	**Cutaneous hyperesthesia**			
	At a series of points down the abdominal wall, gently pick up a fold of skin between thumb and index finger, without pinching it.			5.2
D	**Procedure Termination**			
15.	a) Put client in comfortable position according to health status			5.2
16.	b) Provide patient with reassurance			5.2
17.	c) Return back equipments			5.2
18.	d) Wash hands			5.2

Physical Assessment (Clinical)
Assessment of The Nervous System

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Wash hands			5.2
	b) Gather equipment (Tuning fork (128-256Hz), safety pin, cotton, tongue blade, reflex hammer)			5.1
	c) Provide comfortable environment			5.2
	d) Explain procedure to client.			5.2
	e) provide privacy			5.2
C.	**Procedure**			5.2
1.	**Examining the Cranial Nerves**			5.2
	I - Olfactory: a) Make sure that each nasal passage is open by compressing one side of the nose and asking the patient to sniff through the other.			5.2
	b) Ask the patient to close both eyes			5.2
	c) Occlude one nostril and test smell in the other.			5.2
	d) repeat on the opposite side.			5.2
	II - Optic: **Test visual acuity**. f) Ensure placement of the Snellen chart at an appropriate height for the client . g) Position the client exactly 20 feet (6 meters) from the chart. h) Ask the client to close one eye using the opaque card and to read the line at 6/6 i) Repeat the process for the other eye j) Repeat process with both eyes			5.2
	Visual Fields by Confrontation g) Ask the patient to look with both eyes into the examiner's eyes h) The examiner places hands 2 feet apart lateral to the patient's ears. i) Instruct the patient to point to fingers as soon as they are seen. j) Then slowly move the wiggling fingers of both hand toward the line of gaze until the patient identifies them. k) Repeat the pattern in the upper and lower temporal quadrants. l) If a defect is found : *Ask the client to cover the left eye while the examiner covers the right eye. *Look directly at each other with uncovered eye *The examiner extends the left arm at the midline & slowly moves an object upward from			5.2

	below until the client sees the object then test the remaining three visual fields of the clients			
No	**Procedure Steps**	**Yes**	**No**	5.2
	right eye (superior, temporal, and nasal.) *Repeat the test for the opposite eye.			5.2
	III – Oculomotor, IV –Trochlear, VI –Abducens..			5.2
	Test papillary reactions f) Darken the room g) Ask the patient to look into a distance h) Shine a bright light obliquely into each pupil in turn. i) Look for direct and consensual reaction. j) If the reaction to light is impaired test the near reaction in normal room light: * Hold a finger or a pencil about 10cm from the patient's eye. * Ask the patient to look alternately at it and into the distance directly behind it.			5.2
	Extra-ocular muscle movements d) Stand about two feet (60cm) in front of the client e) Ask the client to follow the movement of the penlight only with the eyes. f) Starting in the midline, move the penlight to the extreme left, then straight up then down. Position the penlight again in the midline, move it to the extreme right, straight up then down.			5.2
	V –Trigeminal **Motor:** a) Palpate the temporal and masseter muscles b) Ask the patient clinches the teeth. Note muscle strength. **Sensory:** e) Test the forehead, cheeks and jaw on each side for pain sensation while patient eyes are closed f) If There is abnormality confirm it by testing temperature sensation g) Then test for light touch, ask the patient to respond whenever skin is touched h) **(CN V + VII)**Test the corneal reflex *Ask the patient to look up and away. Approaching from the other side, out from the patient's line of vision, and avoiding the eyelashes, touch the cornea with a fine wisp of cotton.			5.2
	VII -Facial: e) Have the patient raise the eyebrows f) Frown. g) Close the eyes and resist their being opened h) Have the patient show his/her teeth, smile, and puff out his/her cheeks.			5.2
	VIII -Acoustic: **Assess hearing (whisper)** e) Stand 1-2 feet (30-60 cm) behind the client f) Ask the client to place one finger on the tragus of the left ear and move it back			5.2

	g) Whisper a word with 2 distinct syllables toward the clients right ear. h) Ask the client to repeat the word back.			
	e) repeat the test for the left ear.			5.2
	If Hearing loss is present test for **lateralization (Weber's test)** c) Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly with the back of the hand and place the vibrating fork in the center of the client's head or forehead. d) Ask whether the client hears the sound better in one ear or the same in both ears			5.2
	Compare for **air and bone conduction (Rinne test)** e) Strike a tuning fork (use 512Hz or 256Hz tuning fork) and place the base of the fork on the client's mastoid process. f) Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed. g) Move the tines of still vibrating 1-2 cm in front of the external auditory meatus. h) Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.			5.2
	IX – Glossopharyngeal X –Vagus c) Note any hoarseness of the voice. d) Ask the patient to say "ah." Note the upward movement of the soft palate and the inward movement of the posterior pharynx c) Note the gag reflex			5.2
	XI - Spinal Accessory c) Have the patient shrug the shoulders upward against hands. Note strength and contraction of trapezii. d) Have the patient turn the head against the observer's hand (s). Observe the contraction of the sternomastoid and note the force of movement against hand.			5.2
	XII –Hypoglossal Note any fasciculation of the tongue Have the patient stick out the tongue and move it from side to side. Note any asymmetry, deviation, or atrophy			5.2
	Rapid Alternating Movements			
	Arms c) Show the patient how to strike one hand on the thigh, raise the hand, turn it over, and then strike the back of the hand down on the same place. Urge the patient to repeat these alternating movements as rapidly as possible. d) Show the patient how to tap the distal joint of the thumb with the tip of the index finger again as rapidly as possible.			5.2
	Legs Ask the patient to tap the examiner's hands with the ball of each foot in turn as quickly as possible.			5.2
	Point to point movements			5.2

	Arms f) Ask the patient to touch the examiners index finger and then his /her nose alternatively several times g) Move the finger about so that the patient has to alter directions and extend the arm fully to reach it h) Hold finger in one place so that the patient can touch it with one arm and finger outstretched i) Ask the patient to raise the arm over the head and lower it again to touch the finger j) After several repeats, ask the patient to close both eyes and try several more times			
	Legs d) Ask the patient to place one heel on the opposite knee, and then run it down the shin to the big toe e) Repeat with the patients eyes closed f) Repeat on the other side.			5.2
	Romberg Test d) Remove sharp and harmful objects from around the area of exam e) Ask the patient to stand with feet together and eyes open f) Close both eyes for (20-30) seconds without support while stay near the patient to prevent falling.			5.2
	Test for Pronator Drift c) ask the client to stand I for 20-30 seconds with both arms straight forward, palms up, and with eyes closed d) Instruct the patient to keep arms up and eyes shut e) Tap the arms briskly downward.			5.2
	The Sensory system			
1	**Pain** d) Instruct the patient to close eyes e) use a safety pin substituting the blunt end for the point as a stimulus f) Ask the patient to report whether it is “sharp” or “dull” and to compare sides.			5.2
2	**Temperature** c) Omitted if pain sensation is normal d) Using a test tube filled with hot and another with cold water or a tuning fork heated or cooled by water, touch the skin and ask the patient identify “hot” or “cold”.			5.2
3	**Light touch** d) With a wisp of cotton, touch the skin lightly, avoiding pressure. e) Ask the patient to respond whenever a touch is felt f) Compare one area with another			5.2
	Vibration g) Tap a tuning fork (128-256Hz) on the heel of hand			5.2

	h) Place it over a distal interphalangeal joint of the patient's finger i) Then over the interphalangeal joint of the big toe j) Ask what the patient feels k) If not sure whether it is pressure or vibration ask the patient to tell when vibration stops, then touch the fork to stop it. l) If vibration sense is impaired, proceed to more proximal bony prominences.			
	Position f) Grasp the patients big toe, holding it by its sides between thumb and index finger g) Pull it away from the other toes to avoid friction h) Demonstrate "up" and "down" i) With the patient's eyes closed, ask for a response of "up" or "down" when moving the toe in a small arc. j) In similar fashion test position in fingers			5.2
33	**Discriminative Sensation**			
	1. Stereognosis a) ask the client to close eyes b) Place a familiar object in the patient's hand c) Ask the patient to tell what it is.			5.2
	2. Number Identification (Graphesthesia) a) Ask the patient to close eyes b) With a blunt end of a pen or a pencil, draw a large numbering the patient's palm. c) ask the patient to tell what it is.			5.2
	3. Two-point discrimination a) using the two ends of an opened paper clip, or the sides of two pins touch a finger pad in two places simultaneously b) Alternate the double stimulus irregularly with a one-point touch. c) Find the minimal distance at which the patient can discriminate one from two points.			5.2
	4. Point Localization a) Ask the patient to close eyes b) Briefly touch a point on the patient's skin ask the patient to open both eyes and point to the place touched			5.2
	5. Extinction a) Ask the patient to close eyes b) Simultaneously stimulate corresponding areas on both sides of the body ask where the patient feels the touch			5.2
	Deep Tendon Reflexes			
	The Biceps Reflex			.
	f) Flex the patient's arm at the elbow with the palm down. g) Place the thumb or finger firmly on the biceps tendon. h) Strike with the reflex hammer so that the blow is aimed directly through the digit toward the biceps tendon.			5.2

	i) Observe for flexion at the elbow, and watch for and feel the contraction of the biceps muscle. j) If unable to elicit a reflex, use the reinforcement.			
	The Triceps Reflex			
	f) Flex the patient's arm at the elbow with the palm toward the body, and pull it slightly across the chest g) Strike the triceps tendon above the elbow h) Use a blow directly form behind it i) Watch for contraction of the triceps muscle and extension at the elbow j) If unable to elicit a reflex, use the reinforcement.			5.2
	The Supinator or Brachioradialis Reflex			
	e) Let the patient's hand rest on the abdomen or the lap with the forearm partly pronated f) Strike the radius about (1-2) inches above the wrist g) Watch for flexion and supination of the forearm h) If unable to elicit a reflex, use the reinforcement.			5.2
	The Knee reflex			
	e) With the patient sitting or lying down, and the knee flexed. f) Briskly tap the patellar tendon just below the patella g) Note contraction of the quadriceps with extension at the knee. h) If unable to elicit a reflex, use the reinforcement.			5.2
	The Planter Response			
	c) With an object such as a key or the wooden end of an applicator stick, stroke the lateral aspect of the sole from the heel to the ball of the foot, curving medially across the ball. d) Note movement of the toes, normally flexion.			5.2
	Meningeal Signs			
	Neck Mobility			
	a) Make sure there is no injury to the cervical vertebrae or cervical cord b) With the patient supine, place the hands behind the patient's head and flex the neck forward, until the chin touches the chest if possible			5.2
	Brudzinski's Sign			
	As flexing the neck, watch the hips and knees in reaction to the maneuver, normally should remain relaxed and motionless.			5.2
	Kernig's Sign			

	c) Flex the patient's legs at both the hip and the knee d) Then straighten the knee.			5.2
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			5.2
	b) Provide patient with reassurance			5.2
	c) Return back equipments			5.2
	d) Wash hands			5.2
	e) Document findings			5.2

Physical Assessment (Clinical)
Musculoskeletal Assessment

Student's Name:_____

ID # : _____ Date : _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			5.2
	b) Past History			5.2
	c) Family History			5.2
	d) Lifestyle and Health Practices			5.2
B	**Preparation**			
	a) Wash hands			5.2
	c) Provide comfortable environment			5.2
	d) Explain procedure to client.			5.2
	e) Provide privacy			5.2
C.	**Procedure**			
	Range of Motion at the Shoulder			
	a) Raise (abduct) the arms to shoulder level (90°), with palms facing down			5.2
	b) Raise the arms to a vertical position above the head with the palms facing each other (External Rotation)			5.2
	c) Place both hands behind the neck, with the elbows out to the side (external rotation and abduction).			5.2
	d) Place both hands behind the small of the back (internal rotation and adduction)			5.2
	Range of Motion at the Wrist			
	a) Flexion: With the patient's forearm stabilized and supinated on a table, placing finger tips in the patient's palm, ask the patient to flex the wrist against gravity.			5.2
	b) Extension : With the patient's forearm pronated, placing a hand on the patient's dorsal metacarpals, ask the patient to extend the wrist against gravity			5.2
	c) Radial and ulnar deviation: with the palms down ask the patient to move the wrists laterally and medially.			5.2
	d. Hyperextension			5.2
	Assess for the Carpal Tunnel Syndrome			
	b) Phalen's Test 3. Hold the patient's wrists in acute flexion for 60 seconds. 4. Or ask the patient to press the backs of both hands together to form right angle			5.2
	c) Tinel's Test With the finger; percuss lightly over the course of the median nerve in the carpal tunnel.			5.2
	Range of Motion at the Hip			
	a) Flexion: with the patient supine, place a hand under the patient's lumbar spine, ask the patient to bend each knee in turn up to the chest and pull it firmly against the abdomen (1. Knee flexed, 2. Knee extended)			5.2
	b) Extension: with the patient face down, extend the thigh backward (or upward) + hyperextension)			5.2

	c) Abduction: 1. Stabilize the pelvis by pressing down the opposite			5.2
	anterior superior iliac spine with one hand 2. With the other hand, grasp the ankle and abduct the extended leg until feeling the iliac spine move 3. If there's limited movement, stand at the foot of the table, grasp both ankles, and spread them maximally, abducting both extended legs at the hips for comparison.			5.2
	d) Adduction: With the patient supine stabilize the pelvis, hold one ankle, and move the leg medially across the body and over the opposite extremity.			5.2
	e) Rotation: 1. Flex the leg to (90°) at hip and knee, stabilize the thigh with one hand, grasp the ankle with the other, and swing the lower leg medially for external rotation at the hip. 2. Flex the leg to (90°) at hip and knee, stabilize the thigh with one hand, grasp the ankle with the other, and swing the lower leg laterally for internal rotation.			5.2
12.	**Assessing for Low back pain with radiation to the leg**			
	3. With the patient supine, raise the patient's relaxed and straightened leg until pain occurs. 4. Then dorsiflex the foot.			5.2
13.	**Assessing The Knee**			
	d) The Bulge sign (minor fluids) 4. With the knee extended, place the left hand above the knee and apply pressure on the supra-patellar pouch, displacing or milking the fluid downward 5. Stroke downward on the medial aspect of the knee and apply pressure to force fluid into the lateral area. 6. Tap the knee just behind the lateral margin of the patella with the right hand.			5.2
	e) The Balloon sign 4. Place the thumb and index of the right hand on each side of the patella 5. With the left hand, compress the supra-patellar pouch against the femur. 6. Feel for fluid entering into the spaces next to the patella under the right thumb and index.			5.2
	f) Balloting the patella (major effusions) 4. compress the supra-patellar pouch 5. " ballotte" or push the patella 6. watch for fluid returning to the supra-patellar pouch.			5.2
14.	**Range of Motion at the Ankle**			5.2
	a) Dorsiflex and plantar flex the foot at the ankle. b) Invert and evert the foot at the ankle.			5.2
D	**Procedure Termination**			
15.	a) Put client in comfortable position according to health status			5.2
16.	b) Provide patient with reassurance			5.2
17.	c) Return back equipments			5.2
18.	d) Wash hands			5.2