BERGEN COMMUNITY COLLEGE
THE SCHOOL OF HEALTH PROFESSIONS
DEPARTMENT OF NURSING

NUR 181
LEVEL I
PHYSICAL ASSESSMENT
COURSE OUTLINE
1 CREDIT

LECTURE: 2 HOUR PER WEEK

FOR USE DURING THE FALL 2015 and SPRING 2016 SEMESTERS ONLY
ALL POLICIES AND COURSE REQUIREMENTS ARE SUBJECT TO REVISION ON
A SEMESTER BY SEMESTER BASIS. STUDENTS WILL BE NOTIFIED OF ANY
REVISION(S) AT THE BEGINNING OF THE SEMESTER IN WHICH THE POLICY OR
REQUIREMENTS IS/ARE TO BE IMPLEMENTED DURING THE FIRST MEETING OF
THE APPROPRIATE NURSING CLASS.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>PAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Description</td>
<td>4</td>
</tr>
<tr>
<td>Learning Outcomes</td>
<td>4</td>
</tr>
<tr>
<td>Course Requirements</td>
<td>4</td>
</tr>
<tr>
<td>Required Texts</td>
<td>5</td>
</tr>
<tr>
<td>Theoretical Content and Teaching/Learning Activities</td>
<td>7 - 27</td>
</tr>
</tbody>
</table>

## ADDENDUM

<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>PAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Assessment Lab Guide</td>
<td>28</td>
</tr>
<tr>
<td>Physical Assessment Final Return Demonstration</td>
<td>54</td>
</tr>
</tbody>
</table>
NUR-181, Physical Assessment

COURSE DESCRIPTION

NUR 181 Physical Assessment is a first level course in the nursing sequence which focuses on taking a
nursing history including a psychosocial assessment and performing a basic systematic head-to-toe
physical assessment of adults using selected techniques. At the end of this course students will be able to
perform a beginning level physical assessment.
2 lab., 1 credit
PREREQUISITE: Admission to the Department
C0-REQUISITES: NUR180, NUR182, NUR183, BIO109, PSY101.

COURSE LEARNING OUTCOMES

1. Applies Orem’s Self Care Model in relation to assessment of normal variations of USCRs for
   individuals.
2. Approaches individuals according to the identified norms for their growth and developmental
   capabilities.
3. Uses appropriate interview techniques to obtain basic information from individuals and expresses in
   written and oral forms an accurate physical assessment.
4. Modifies care according to biological, psychological, sociological, cultural, spiritual and economic
   factors that influence the health of clients.
5. Transfers assessment skills in the college and clinical laboratory.
6. Complies with ethical and legal practice in the classroom and clinical laboratory.
7. Uses the computer and laboratory technological resources pertinent to learning assessment theory
   and skills.
8. Performs systematic assessments and compares findings with textbook norms.
9. Uses normal numerical measurements when assessing individuals.
10. Assesses individuals for their teaching and learning needs.

COURSE REQUIREMENTS

1. There will be four tests which will equal 100% of the grade.
   a. Make-up exams: Students are expected to take exams on the scheduled dates. Refer to the
      Nursing Student Handbook for the Make-up Exam Policy.
2. The student must receive a satisfactory grade on laboratory physical assessment skills validation.
   (Breast/Thorax and Heart/Vascular). An unsatisfactory grade will result in an "F" grade in the
   course.
3. Satisfactory completion of head to toe assessment.
4. A passing course grade requires a numerical theory grade of 77.5% (C+) or greater and satisfactory
   physical assessment skills validation in laboratory.

   A   = 92.5% to 100%
   B+  = 87.5% to 92.4%
   B   = 82.5% to 87.4%
   C+  = 77.5% to 82.4%
   C   = 72.5% to 77.4%
   D   = 67.5% to 72.4%
   F   = 67.4% and below
REQUIRED TEXTS


**CHOOSE EITHER OF THE FOLLOWING:**

**OR**


Student selection

SUGGESTED LEARNING RESOURCES

2. Text CD
3. On-line sources for heart, lung sounds, and assessment components.
4. Faculty Web CT site.
5. Evolve HESI Physical Assessment Tutorials and Practice Test Questions (see next page)
6. Self-Learning Exercises provided on Moodle for each system or assessment.
General Physical Assessment Case Studies

1. Abdominal assessment
2. Heart and Neck Vessels
3. Integumentary System
4. Musculoskeletal System
5. Neurological Assessment
6. Peripheral Vascular/Lymphatics
7. Respiratory Assessment

Unit I Case Studies

1. Domestic Violence
2. Complete Health History
3. Mental Status Assessment
4. Nutritional Assessment

Unit 2

1. General Survey/Measuring Vital Signs
2. Pain Assessment the 5th vital signs

Unit 3

1. Skin, Hair, Nails
2. Eye, Ears, Nose, Throat
3. Breast/Regional Lymph Nodes
4. Thorax/Lungs
5. Heart/Neck Vessels
6. Peripheral Vascular and Lymphatics
7. Abdominal Assessment
8. Musculoskeletal Assessment
9. Neurological Assessment
10. Male/Female Genitalia Assessment
Theoretical Content

UNIT I – Assessment of the Whole Person

1. Health Assessment
   a. Interview
   b. Health history
   c. Focused interview
   d. Physical assessment
   e. Documentation
   f. Interpretation of findings
   g. Relationship to Nursing Process
   h. Critical thinking

2. Cultural Considerations

3. Psychosocial and Mental Status Assessment – USCR = Normalcy
   a. Mental, emotional, social and spiritual dimensions
   b. Mind – body – spirit connection
   c. Self concept
   d. Roles / relationships
   e. Mental status assessment
   f. Abnormal findings/Partially Compensatory Nursing System (PCNS)
      1) Abnormalities of mood and affect
      2) Delirium, dementia
      3) Aphasia

4. Techniques of Physical Assessment
   a. Equipment needed
   b. Use of personal protective equipment
   c. Inspection, palpation, percussion, auscultation, and positioning

2. The General Survey
   a. Physical appearance
   b. Mental status
   c. Mobility
   d. Behavior
   e. Height and weight
   f. Vital signs

Teaching/Learning Activities

Jarvis, Chapters 1, 3, 4
Lab/Diagnostic Tests Handbook
For all other units refer to Lab/Diagnostic Tests
Audiovisuals: LIBRARY MEDIA/TEXTBOOK CD

Jarvis, Chapter 2

Jarvis, Chapter 5
Submit Clinical Lab Guide: Supplemental mental status exam to clinical instructor.

Jarvis, Chapter 8
Complete the learning exercises provided on Moodle for assessment techniques, describing symptoms, and subjective/objective data.

Jarvis, Chapter 9
UNIT II – NUTRITION ASSESSMENT/ USCR

1. Nutrition Assessment / USCR = Food
   a. Nutritional screening and assessment tools
      1) Diet recall, food frequency, questionnaire, food record
      2) Food Guide Pyramid (HHS-2005)

2. Subjective Data
   a. Eating patterns
   b. Usual weight
   c. Changes in appetite, taste, chewing, swallowing
   d. Recent surgery, trauma, burns, infection
   e. Chronic illnesses
   f. Vomiting, diarrhea, constipation
   g. Food allergies or intolerances
   h. Medications and/or nutritional supplements
   i. Self care behaviors
   j. Alcohol or illegal drug use
   k. Tobacco use
   l. Exercise and activity patterns
   m. Family history
   n. Minimal dietary assessment vs. comprehensive screening

3. The Aging Adult

4. Objective Data
   a. General appearance
   b. Skin
   c. Hair
   d. Eyes
   e. Lips
   f. Tongue
   g. Gums
   h. Nails
   i. Musculoskeletal – posture, muscle tone, mobility

Teaching/Learning Activities

Jarvis, Chapter 11
Submit Clinical Lab Guide: Nutritional Assessment to clinical instructor.
View textbook CD ROM
Complete the Self-Learning exercise provided on Moodle for the Nutritional Assessment.
Theoretical Content

UNIT II – continued

j. Anthropometric measures
   1) Height
   2) Weight
   3) Body weight as a percentage of ideal body weight.
   4) Frame size (estimate)

5. Laboratory Studies
   a. Hemoglobin
   b. Hematocrit
   c. Cholesterol (HDL & LDL)
   d. Triglycerides
   e. Serum albumin
   f. Blood glucose

   Refer to Lab/Diagnostic Tests Handbook

6. Abnormal Findings/PCNS
   a. Obesity overnutrition
   b. Undernutrition
   c. Failure to thrive
# Theoretical Content

**UNIT III – SKIN, HAIR AND NAILS**  
USCR=Prevention of Hazards

## 1. Subjective Data

- a. Describe the skin
- b. Recent illness
- c. Body odor
- d. Excessive sweating
- e. Previous history of skin disease/ infections in self or family
- f. Change in pigmentation
- g. change in mole/birth mark
- h. Excessive dryness or Moisture
- i. Pruritus
- j. Excessive bruising
- k. Rash or lesion
- l. Sores or ulcers
- m. Medications
- n. Hair loss
- o. Hair treated with chemicals
- p. Change in nails/hair
- q. Artificial nails
- r. Environmental or occupational hazards
- s. Sunbathe/work outdoors
- t. Tattoos
- u. Piercings of body
- v. Self care behaviors

## 2. Objective Data

- a. Skin
  - 1) Color
  - 2) Temperature/body odor
  - 3) Moisture
  - 4) Texture
  - 5) Thickness
  - 6) Edema
  - 7) Mobility or turgor
  - 8) Vascularity or bruising
  - 9) Lesions

- b. Hair
  - 1) Color
  - 2) Texture
  - 3) Distribution
  - 4) Cleanliness

---

# Teaching/Learning Activities

<table>
<thead>
<tr>
<th>Jarvis, Chapter 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit Physical Assessment Lab Guide: Skin, Hair, Nails to clinical instructor.</td>
</tr>
<tr>
<td>View textbook CD</td>
</tr>
<tr>
<td>Complete the Self-Learning exercise provided on Moodle for Skin, Hair and Nails Assessment</td>
</tr>
</tbody>
</table>
UNIT III – continued

2. Objective Data (continued)
   a. Nails
      1) Shape and Contour
      2) Color
      3) Hygiene
      4) Attachment

3. The Aging Adult

4. Abnormal Findings/SENS
   a. Skin
      1) Detecting color changes in light and dark skin
      2) Common shapes and configurations of lesions- ABCDE
      3) Primary skin lesions – nodule, wheal, uticaria
      4) Vascular lesions - ecchymosis, hematoma
      5) Secondary skin lesions– ulcer, decubitus, scar, excoriation, candidiasis
      6) Color changes
         a) pallor
         b) erythema
         c) cyanosis
         d) jaundice
      7) Common skin lesions – psoriasis, dermatitis
   b. Hair
      1) Lice
      2) Abnormal distribution
      3) Hirsutism
   c. Nails
      1) Clubbing
      2) Spoon nails
UNIT IV – HEAD AND NECK, LYMPHATICS, EYES, EARS, NOSE, MOUTH, THROAT

1. Head, Face and Neck and Regional Lymphatics - USCR Prevention of Hazards

   a. Subjective Data
   1) Headache
   2) Head injury
   3) Dizziness
   4) Neck pain
   5) Lumps or swelling
   6) History of head or neck surgery or illness/radiation
   7) Any loss of consciousness, seizures, blurred vision
   8) Problems with thyroid gland
   9) Recent infection or cold
  10) Now use or ever use alcohol, recreational drugs, tobacco or caffeine?

   b. Objective Data
   1) Inspect and palpate skull
   2) Inspect face
   3) Palpate temporal artery
   4) Inspect and palpate the Neck
   5) Pulsations
   6) Palpate trachea and thyroid
   7) Temporomandibular joint
   8) Palpate lymph nodes of head/neck

   c. The Aging Adult

   d. Abnormal Findings – PCNS
   1) Head
      a) Classic migraine
      b) Bell’s Palsy
      c) Parkinsons disease
      d) Brain attack
   2) Neck
      a) Hyperthyroidism
      b) Hypothyroidism
      c) Torticollis

Teaching/Learning Activities

Jarvis, Chapter 13
Submit Physical Assessment Lab Guide: Head & Neck to clinical instructor.
View textbook CD
Complete the Self-Learning exercise provided on Moodle for Head and Neck, and Eyes, Ears, Nose and Throat assessment.
### Theoretical Content

#### UNIT IV - continued

2. **Eyes**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong></td>
<td><strong>Objective Data</strong></td>
</tr>
<tr>
<td>1)</td>
<td>State of vision today</td>
</tr>
<tr>
<td>2)</td>
<td>Vision difficulty</td>
</tr>
<tr>
<td>3)</td>
<td>Pain</td>
</tr>
<tr>
<td>4)</td>
<td>Strabismus, diplopia</td>
</tr>
<tr>
<td>5)</td>
<td>Redness, swelling</td>
</tr>
<tr>
<td>6)</td>
<td>Watering, discharge</td>
</tr>
<tr>
<td>7)</td>
<td>Injury</td>
</tr>
<tr>
<td>8)</td>
<td>Surgery/disease of eye</td>
</tr>
<tr>
<td>9)</td>
<td>Glaucoma/cataracts exam</td>
</tr>
<tr>
<td>10)</td>
<td>Use of glasses or contact lenses</td>
</tr>
<tr>
<td>11)</td>
<td>Self care behavior</td>
</tr>
<tr>
<td>12)</td>
<td>Medications</td>
</tr>
<tr>
<td>13)</td>
<td>Exposed to irritants</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>b.</strong></td>
<td><strong>Objective Data</strong></td>
</tr>
<tr>
<td>1)</td>
<td>Test visual acuity</td>
</tr>
<tr>
<td>a)</td>
<td>Snellen Chart</td>
</tr>
<tr>
<td>b)</td>
<td>Jaeger card</td>
</tr>
<tr>
<td>2)</td>
<td>Inspect external ocular</td>
</tr>
<tr>
<td>3)</td>
<td>Inspect anterior eyeball structures</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>c.</strong></td>
<td><strong>The Aging Adult</strong></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>d.</strong></td>
<td><strong>Abnormal Findings/PCNS</strong></td>
</tr>
<tr>
<td>1)</td>
<td>Ptosis</td>
</tr>
<tr>
<td>2)</td>
<td>Conjunctivitis</td>
</tr>
<tr>
<td>3)</td>
<td>Strabismus</td>
</tr>
<tr>
<td>4)</td>
<td>Cataract</td>
</tr>
<tr>
<td>5)</td>
<td>Hordeolum</td>
</tr>
</tbody>
</table>

### Teaching/Learning Activities

- Jarvis, Chapter 14
- Submit Physical Assessment Clinical Lab Guide: Eyes to clinical instructor
- View textbook CD
### Theoretical Content

#### UNIT IV - continued

#### 3. Ears

- **Subjective Data**
  - 1) Earaches
  - 2) Infection/pain
  - 3) Discharge
  - 4) Hearing loss
  - 5) Environmental noise
  - 6) Tinnitus
  - 7) Vertigo
  - 8) Self care behaviors - hearing aid

- **Objective Data**
  - 1) Inspect and palpate the external ear
  - 2) Inspect external auditory meatus
  - 3) Test hearing acuity/Whisper Test

- **The Aging Adult**

- **Abnormal Findings/PCNS**
  - 1) Otitis externa
  - 2) Hearing loss
  - 3) Excessive cerumen
  - 4) Foreign body
  - 5) Tophi

---

#### 4. Nose, Throat, Mouth USCR = Prevention of Hazards

- **Subjective Data**
  - 1) Nose
    - a) Discharge
    - b) Frequent colds
    - c) Sinus pain
    - d) Trauma
    - e) Epistaxis
    - f) Allergies
    - g) Altered smell
    - h) Nose injury/surgery
    - i) Medications
    - j) Recreational drugs

---

### Teaching/Learning Activities

- Jarvis, Chapter 15
  - Submit Physical Assessment Clinical Lab Guide: Ears to clinical instructor.
  - View textbook CD

- Jarvis, Chapter 16
  - Submit Physical Assessment Clinical Lab Guide: Nose, Mouth & Throat to clinical instructor.
  - View textbook CD
### Theoretical Content

**UNIT IV** – continued

4. Nose, Throat, Mouth USCR = Prevention of Hazards (continued)

2) Mouth and throat
   a) Sores or lesions
   b) Sore throat
   c) Bleeding gums
   d) Toothache
   e) Hoarseness
   f) Dysphagia
   g) Altered taste
   h) Smoking, alcohol consumption
   i) Self care behaviors—dental care pattern, dentures or appliances

b. Objective Data
   1) Inspect and palpate nose
   2) Test patency of nose
   3) Inspect the mouth
   4) Inspect lips, gums & teeth
   5) Inspect the tongue and buccal mucosa
   6) Inspect the throat, including the tonsils, uvula
   7) Palpate sinuses

c. The Aging Adult

d. Abnormal Findings/PCNS-SENS
   1) Acute rhinitis
   2) Sinusitis
   3) Pharyngitis
   4) Dentition-gingivitis
   5) Monilial infection

### Teaching/Learning Activities
### Theoretical Content

**UNIT V – THORAX AND LUNGS: USCR = Air**

1. **Subjective Data**
   - a. Cough
   - b. Shortness of breath
   - c. Chest pain with breathing
   - d. History of lung disease
   - e. Smoking
   - f. Environment/occupational hazards
   - g. Medications
   - h. Self-care behaviors

2. **Objective Data**
   - a. Inspect posterior chest
   - b. Palpate posterior chest for symmetrical chest expansion
   - c. Palpate posterior chest for tactile fremitus
   - d. Percuss posterior chest for resonance
   - e. Auscultate posterior chest
   - f. Normal breath sounds
     1) bronchial
     2) vesicular
     3) bronchovesicular

3. **The Aging Adult**

4. **Diagnostics**
   - a. Chest x-ray
   - b. Arterial blood gas
   - c. Sputum culture
   - d. Ventilation-perfusion scan
   - e. Pulmonary function tests
   - f. Pulse oximeter

### Teaching/Learning Activities

- Jarvis, Chapter 18
- CAI: RALE Lung Sounds Nursing Lab Computers
- Submit Physical Assessment Lab Guide: Thorax & Lungs to clinical instructor.
  - * Satisfactorily demonstrate a thorax and lung assessment during skills validation in clinical conference.

- Complete the Self-Learning Exercise provided on Moodle for the Thorax and Lungs Assessment.
- View textbook CD

**Refer to Lab/Diagnostic Tests Handbook**

- Jarvis, pg. 150
Theoretical Content

UNIT V – Thorax and Lungs
USCR = Air (continued)

5. Abnormal findings/PCNS
   a. Configurations of the thorax
   b. Respiratory patterns
   c. Adventitious lung sounds
   d. Crepitus

UNIT VI - Breasts and Regional Lymphatics

1. Subjective Data
   a. Breast
      1) Pain
      2) Lump
      3) Discharge
      4) Rash
      5) Trauma
      6) History of breast disease (medical & surgical) History of cancer in any other region of the body
      7) Changes in breast characteristics
      8) Self-care behaviors – perform breast self exam
      9) Last mammogram
      10) Menopause
   b. Axilla
      1) Tenderness
      2) Lump or swelling
   c. Risk factors for breast cancer

2. Objective Data
   a. Inspection for retraction; color, size, symmetry and nipple discharge
   b. Palpation of breast, nipple & axilla

3. The Aging Female

Teaching/Learning Activities

Jarvis, Chapter 17
* Satisfactorily demonstrate a breast exam during skills validation in clinical conference.

Complete the Self-Learning exercise provided on Moodle for the Breast Assessment.

View textbook CD
### Theoretical Content

#### UNIT VI – Breasts and Axillae (continued)

4. Abnormal findings-PCNS/SENS
   a. Signs of retraction and inflammation in the breast
   b. Breast lump
   c. Nipple discharge
   d. Axillae lump

#### UNIT VII - Heart & Neck Vessels

**USCR = Water or Air**

1. Subjective Data
   a. Chest pain
   b. Dyspnea
   c. Orthopnea
   d. Cough
   e. Fatigue
   f. Past cardiac history
   g. Family history of cardiac disease
   h. Cyanosis
   i. Pallor
   j. Edema/weight
   k. Nocturia
   l. Syncope
   m. Medications
   n. Modifiable risk factors
   o. Non-modifiable risk factors

### Teaching/Learning Activities

Jarvis, Chapter 19

Submit Physical Assessment Lab Guide: Heart to clinical instructor.

*Satisfactorily demonstrate heart and neck vessel assessment during skills validation in clinical conference.*

View Textbook CD

Complete the Self-Learning exercise provided on Moodle for The Heart Assessment.

Refer to Lab/Diagnostic Tests Handbook
### Theoretical Content

#### UNIT VII - Cardiovascular System (continued)

2. **Objective Data**
   a. Inspect carotid artery
   b. Palpate carotid artery
   c. Auscultate carotid artery
   d. Inspect jugular vein
   e. Locate apical impulse
   f. Auscultate apical pulse
   g. Auscultate S1 and S2

3. **The Aging Adult**

4. **Diagnostics**
   a. CPK-MB – Troponins
   b. PT/PTT
   c. EKG
   d. Echocardiogram
   e. Cardiac catheterization
   f. Stress test

5. **Abnormal findings /PCNS**
   a. Friction rub
   b. Murmurs
   c. Signs and symptoms of fluid volume excess

#### UNIT VIII - Peripheral Vascular: USCR = Water

1. **Subjective Data**
   a. Leg pain or cramps
   b. Skin changes on arms or legs
   c. Swelling/edema/ temperature changes
   d. Lymph node enlargement
   e. Medications
   f. Past peripheral vascular medical/surgical history
   g. Smoke
   h. Exercise regularly

### Teaching/Learning Activities

A/V – (LIBRARY MEDIA)

- RC683C35 1992: Cardiac System
- RC683P49 1985: Physical Assessment: The Heart

Springhouse: Cardiac System

- View textbook CD ROM and listen to heart sounds

Refer to Davis’ Lab/Diagnostic Tests Handbook

- Submit Physical Assessment Lab Guide: Peripheral Vascular to clinical instructor
- Submit documentation of a peripheral vascular Assessment on a lab partner
- Complete the Self-Learning exercise provided on Moodle for the Peripheral Vascular assessment.
### UNIT VIII - Peripheral Vascular (continued)

<table>
<thead>
<tr>
<th>Theoretical Content</th>
<th>Teaching/Learning Activities</th>
</tr>
</thead>
</table>

2. **Objective data**  
   a. Inspection of upper extremities for capillary return, edema, B/P  
   b. Palpation of pulses: radial and brachial  
   c. Allen test  
   d. Inspection of lower extremities for pallor, edema, ulcers, temperature  
   e. Measure calf circumference  
   f. Palpate for temperature  
   g. Palpation of pulses: pedal, posterior tibial, popliteal, femoral  
   h. Auscultate pulses with doppler

3. **The Aging Adult**

4. **Diagnostics**  
   a. Doppler ultrasound  
   b. Angiography

5. **Abnormal findings - PCNS/SENS**  
   a. Variation in pulse  
   b. Peripheral vascular disease: occlusive, aneurysm  
   c. Lower extremity ulcers – arterial/venous diabetic  
   d. Deep vein thrombosis
### Theoretical Content

**UNIT IX** – ABDOMEN – USCR = Food and Elimination

1. **Subjective Data**
   a. Appetite
   b. Dysphagia
   c. Food tolerance/indigestion
   d. Abdominal pain/bloating/gas
   e. Nausea/vomiting
   f. Bowel habit
   g. Past abdominal history
   h. Medications
   i. Nutritional assessment

2. **Objective Data**
   a. Inspect abdomen for:
      1) contour
      2) symmetry
      3) umbilicus
      4) skin changes
      5) pulsations
   b. Auscultate abdomen for bowel sounds
   c. Percuss abdomen for tympany
   d. Light abdominal palpation

3. **The Aging Adult**

4. **Diagnostics**
   a. Amylase
   b. Liver function test
   c. Stool guaiac
   d. Abdominal x-ray
   e. Upper GI
   f. Lower GI
   g. Endoscopy
   h. Liver biopsy

5. **Abnormal findings – PCNS**
   a. Pain
   b. Distention
   c. Ascites
   d. Hyper/hypoactive bowel sounds
   e. Aortic aneurysm
   f. Abdominal hernias

### Teaching/Learning Activities

- Jarvis, Chapter 21
  - Submit Physical Assessment Lab Guide: Abdomen to clinical instructor
  - Submit documentation of an abdominal assessment on a lab partners
  - A/V – (LIBRARY MEDIA)
  - RC803.G39 1993: Gastrointestinal System
  - View textbook CD ROM

- Complete the Self-Learning Exercise provided on Moodle for the Abdominal Assessment.
### Theoretical Content

**UNIT X - GENITOURINARY SYSTEM**  
USCR = Elimination

1. **Male**
   a. **Subjective Data**
      1) Frequency, urgency, nocturia
      2) Dysuria
      3) Hesitancy/straining
      4) Urine color
      5) Past medical/ surgical history
      6) Penis: pain, lesions
      7) Testicular self exam
      8) Contraception
      9) Sexually transmitted diseases/ sexual health
      10) Incontinence
      11) Hx of mumps
   
   b. **Objective Data**
      1) Bladder: inspect, palpate, percuss
      2) Penis: inspect and palpate
      3) Scrotum: inspect and palpate
      4) Hernia: inspect and palpate
      5) Palpate inguinal lymph nodes
   
   c. **The Aging Adult**

### Teaching/Learning Activities

- **Jarvis, Chapter 24,**
- Complete the Self-Learning Exercise provided on Moodle for the Genitourinary Assessment.
### Theoretical Content

#### UNIT X - Genitourinary System (continued)

d. **Diagnoses**
   1) Cystoscopy  
   2) Urinalysis - C&S  
   3) VDRL  
   4) PSA  
   5) Digital rectal exam  

e. **Abnormal findings – PCNS/SENS**
   1) Phimosis  
   2) Scrotal edema  
   3) Urethral discharge  
   4) Dysuria  
   5) Urinary retention

#### Teaching/Learning Activities

- Refer to Davis’ Lab/Diagnostic Tests Handbook  
- View textbook CD ROM  

---

2. **Female**

   a. **Subjective Data**
      1) Menstrual history/ LMP  
      2) Obstetric history  
      3) Menopause  
      4) Last PAP  
      5) Urinary symptoms/ incontinence  
      6) Vaginal discharge/ protrusions/ bleeding  
      7) Past medical/surgical history  
      8) Sexual activity  
      9) Contraception  
     10) Sexually transmitted diseases / sexual health  

   b. **Objective Data**
      1) Bladder: inspect, palpate, percuss  
      2) Inspect external genitalia  

---

**Note:** Jarvis, Chapter 26
UNIT X – Genitourinary System (continued)

c. The Aging Adult

d. Diagnostics
1) PAP
2) Urinalysis
3) VDRL
4) C&S

e. Abnormal findings – PCNS/SENS
1) Lice
2) Contact dermatitis
3) Candidiasis
4) Dysuria
5) Vaginal discharge
6) Urinary retention
7) HPV warts

UNIT XI - Musculoskeletal
USCR = Prevention of Hazards

1. Subjective Data
   a. Joint
      1) Pain
      2) Stiffness
      3) Swelling
      4) Heat redness
      5) Limitation of movement
      6) Infection
   b. Muscle
      1) Pain
      2) Cramps
   c. Bone
      1) Pain
      2) Deformity
      3) Trauma

d. Activity of daily living assessment

e. Self care behaviors

Teaching/Learning Activities

Refer to Davis’ Lab/Diagnostic Tests Handbook
View textbook CD ROM

Jarvis, Chapter 22
Submit Physical Assessment Lab Guide: Muscle Strength to clinical instructor.
Submit documentation of a muscle strength assessment on a lab partner.
Complete the Self-Learning Exercise provided on Moodle for the Musculoskeletal Assessment.

A/V – (LIBRARY MEDIA)
RC 76.P558 1985 Physical Assessment: The Musculoskeletal System

View textbook CD ROM
UNIT XI – Musculoskeletal (continued)

2. Objective Data
   a. Inspect joints for:
      1) size
      2) contour
      3) Swelling
      4) Color
   b. Palpate joints for:
      1) Heat
      2) Tenderness
      3) Swelling
      4) Masses
   c. Test muscle strength
      1) deltoid
      2) biceps
      3) triceps
      4) wrist/finger
      5) grip
      6) hip muscles
      7) hamstrings
      8) quadriceps
      9) ankles/feet
   d. Spine
      1) Inspect
      2) Palpate
      3) ROM

3. The Aging Adult

4. Diagnostics
   a. X-ray
   b. EMG

5. Abnormal findings - PCNS/SENS
   a) Rheumatoid arthritis
   b) Osteoarthritis
   c) Contractures
   d) Fractures
   e) Back injury
   f) Scoliosis
   g) Kyphosis

Refer to Davis’ Lab/Diagnostic Tests Handbook
Theoretical Content

UNIT XII - Neurologic
USCR = Prevention of Hazards

1. Subjective Data
   a. Headache
   b. Head injury
   c. Dizziness/vertigo
   d. Seizures
   e. Past neurologic history
   f. Difficulty speaking
   g. Environmental/occupational Hazards
   h. Tremors
   i. Weakness
   j. Incoordination
   k. Numbness or tingling
   l. Difficulty swallowing
   m. Medication
   n. ADL’s
   o. Chronic diseases

2. Objective Data
   a. Test cranial nerves 1-12
   b. Cerebellar function
      1) gait
      2) Romberg
   c. Co-ordination and skilled movements
      1) finger to finger
      2) finger to nose
      3) dexterity
   d. Sensory
      1) pain
      2) light touch
   e. Tactile discrimination
      1) Stereognosis
      2) Graphesthesia
   f. Reflexes
      1) biceps
      2) patellar
      3) Babinski

3. The Aging Adult

Teaching/Learning Activities

Jarvis, Chapter 23
Submit Physical assessment Clinical Lab
Guide:
  Neurologic to clinical instructor.
Submit documentation of a neurologic assessment on a lab partner.

Complete the Self-Learning Exercise provided on Moodle for the Neurologic Assessment.

AV – (LIBRARY MEDIA)

View textbook CD ROM
**Theoretical Content**

**UNIT XII – Neurologic (continued)**

4. **Diagnostics**
   - a. CT scan/MRI
   - b. Glasgow Coma Scale
   - c. Lumbar Puncture
   - d. EEG
   - e. Neuro rechecks

5. **Abnormal findings - PCNS/WCNS**
   - a. Paralysis/hemiparesis
   - b. Tremor
   - c. Parkinsonian gait
   - d. Aphasia
   - e. Brain attack

---

**Teaching/Learning Activities**

Refer to Davis’ Lab/Diagnostic Tests Handbook

View textbook CD ROM
Physical Assessment
Health History

Biographical Data
Name:
Address:
Phone number:
Age: Birthdate: Birthplace: Sex: Marital Status:
Race/ethnic origin: Occupation:
Religion: Health Insurance:
Source of history and reliability:
Reason for seeing care:

Past History
Past medical history:
Past surgical history:
Obstetrical history:
Allergies:
Medications:
Family history:

Review of Systems
Neurologic:
Cardiovascular:
Respiratory:
Gastrointestinal:
Genitourinary:
Skin:
Health History continued

Musculoskeletal:

Exposure to communicable disease:

Home environment:

Leisure activities:

Nutrition:

Support systems:

Smoking:

Alcohol use:
Supplemental Mental Status Exam

Orientation
Date/season (5 points):
State, country, town (5 points):

Registration/memory
3 unrelated objects (0-3 points):

Attention/concentration
Spell world backwards (0-5 points):

Recall
Ask for 3 unrelated objects under registration/memory (0-3 points):

Language
Show 2 objects, ask patient to state what they are (0-2 points):
Repeat a sentence (1 point):
3 stage command (3 points):
Follow command written on a piece of paper (1 point):
Write a sentence with a subject and a verb (1 point):
Draw 2 intersecting pentagons and have patient copy (1 point):

TOTAL:
**Subjective Data**
Eating Patterns:

Usual weight:
Change in appetite, taste, chewing, swallowing:
Recent surgery, trauma, burns, infection:
Chronic illness:
Vomiting, diarrhea, constipation:
Food allergy/intolerance:
Medications:
Self-care behaviors:
Alcohol/drug use:
Tobacco use:
Exercise and activity patterns:
Family history:
Dietary screening tool data:

**Objective Data**
General appearance:
Skin:
Face:
Hair:
Eyes:
Lips:
Nutrition Assessment continued

Tongue:

Gums:

Nails:

Musculoskeletal:

Height:

Weight:

Body weight as a percent of ideal body weight:

**Labs**

Hemoglobin:

Hematocrit:

Cholesterol:

Triglycerides:

Albumin:

Glucose:
Physical Assessment
Skin, Hair, Nails
USCR: Prevention of Hazards

**Subjective Data**

History of skin disease or infection:

Change in pigment:

Change in mole:

Excessive dryness or moisture:

Pruritis:

Bruising:

Rash or lesion:

Sores or ulcers:

Medications:

Hair loss:

Hair treated with chemicals:

Nails:

Artificial nails:

Environmental or occupational hazards:

Self care behaviors of skin, hair, and nails:

**Objective Data**

*Inspect skin*

Color:

Vascularity or bruising:

Lesions:
Skin, Hair and Nails continued

Palpate skin
Temperature:

Moisture:
Texture:
Thickness:
Edema:
Mobility or turgor:

Inspect hair
Texture:
Color:
Distribution:
Cleanliness:

Inspect nails
Shape:
Color:
Hygiene:
Attachment:
Subjective Data
Headaches:
Head Injury:
Dizziness:
Neck pain:
Lumps or swelling in head or neck:
Surgery on head or neck:
Loss of consciousness or seizures:
Recent infection:

Objective Data
Inspection
Skull:
Facial expression:
Neck:
Pulsations:
Trachea:

Palpation
Skull:
Lymph nodes:
Trachea:
Thyroid:
Temporomandibular joint:
Physical Assessment
Eyes
USCR: Prevention of Hazards

**Subjective Data**
- Difficulty seeing or blurred vision:
- State of vision today:
- Eye pain:
- Crossed eyes:
- Redness or swelling:
- Watering or tearing:
- Injury to the eye:
- Eye surgery/disease of eye:
- Last glaucoma test:
- Glasses or contacts:
- Last vision exam:
- Medications:

**Objective Data**
- Test visual acuity
  - Snellen Eye Chart
    - L______ R______
  - Jaeger Chart
    - L______ R______
- Inspect external eye structures
  - Eyebrows L______ R______
  - Eyelids and lashes L______ R______
  - Eyeballs L______ R______
  - Conjunctiva L______ R______
  - Sclera L______ R______
- Inspect anterior eye structures
  - Cornea L______ R______
  - Iris L______ R______
Physical Assessment
Ears
USCR: Prevention of Hazards

Subjective Data
Earache or pain:

Describe hearing:

Ear infections:

Discharge:

Hearing loss:

Environmental noise:

Tinnitus:

Vertigo:

Self care:

Objective Data
Inspection
Size and shape:

Skin condition:

External auditory meatus:

Palpation
Tenderness:

Test hearing acuity
Voice test L______ R______
Subjective Data

Nose
Discharge:

Frequent colds:
Sinus pain:
Trauma:
Epistaxis:
Allergies or hay fever:
Altered smell:

Mouth and Throat
Sores or lesions

Sore throat:
Bleeding gums:
Toothache:
Hoarseness:
Dysphagia:
Altered taste:
Smoking:
Self-care behaviors:
Nose, Mouth, and throat continued

Objective Data
Inspect nose
Symmetry:

Test patency of each nostril:

Palpate sinus area
Frontal:

Maxillary:

Inspect the mouth
Lips:

Gums:

Teeth:

Tongue

Buccal mucosa:

Throat:
Physical Assessment
Thorax and Lungs (Respiratory System)
USCR: Air

**Subjective Data**
Cough (productive or non-productive):

Shortness of breath (quantify):

Chest pain with breathing:

Past history of lung diseases (medical and surgical):

Smoke (type, amount, and pack years):

Living or work conditions that affect breathing:

Last TB test, chest x-ray, flu vaccine, Pneumovax:

**Objective Data**

**Inspection**
Thoracic cage:

Respiratory rate and pattern:

Person’s position:

Person’s facial expression:

Level of consciousness:

**Palpation of Posterior Chest**
Symmetrical chest expansion:

Tactile fremitus:

**Percussion of Posterior Chest**
Document percussion note that predominates over lung fields:

**Auscultation of Posterior Chest**
Describe lung sounds:

**Diagnostics**
Chest x-ray:

Arterial blood gas:

Oxygen saturation with pulse oximeter:
Physical Assessment
Breasts
USCR: Prevention of Hazards

**Subjective Data**
- Pain or tenderness in breasts:
- Lump or thickening:
- Discharge from nipples:
- Rash:
- Swelling:
- Trauma or injury:
- Past history of breast disease (medical and surgical):
- Performs breast self-exam:
- Last mammogram:

**Objective Data**

**Inspection**
- Inspect for retraction:
- Inspect for nipple discharge:

**Palpation**
- Palpation of breast:
- Palpation of nipple:
- Palpation of axilla:
**Physical Assessment**  
**Abdomen**  
**USCR: Elimination**

**Subjective Data**  
Change in appetite:

Difficulty swallowing:

Food intolerance:

Abdominal pain:

Nausea or vomiting:

Frequency of bowel movements:

Past GI history (medical and surgical):

Medications:

24 hour food history:

**Objective Data**  
**Inspection**  
Inspect abdominal contour:

Inspect for symmetry:

Skin color and condition:

Pulsation or movement:

Umbilicus:

Hair distribution:

Hydration and nutrition:

**Auscultation**  
Bowel sounds:

Bruit:
Abdomen continued

**Percussion**
Percuss 4 abdominal quadrants

**Palpation**
Lightly palpate 4 abdominal quadrants:

**Diagnostics**
Amylase:

SGOT:

SGPT:

Stool guaiac:

Abdominal x-ray:
Physical Assessment
Peripheral Vascular
USCR: Water or Air

**Subjective Data**
- Leg pain or cramps:
- Skin changes on arms or legs:
- Lesions on arms or legs:
- Swelling or edema in the legs:
- Swollen glands:
- Medications:
- Past peripheral vascular medical/surgical history:
- History of smoking:

**Objective Data**
- Inspection of upper extremities
  - Capillary refill:
  - Edema of upper extremities:
- Palpation of upper extremities
  - Radial pulse:
  - Brachial pulse:
  - Allen test:
- Inspection of lower extremities
  - Color of lower extremities:
  - Edema of lower extremities:
  - Calf circumference:
Peripheral Vascular continued

Palpation of lower extremities
Temperature of lower extremities:

Femoral pulse:
Popliteal pulse:
Posterior tibial pulse:
Dorsalis pedis/pedal pulse:

Auscultation
Doppler: If pulses are not palpable

Diagnostics
Angiogram:

Hemoglobin:
Hematocrit:
Oxygen saturation with pulse oximeter:
Platelets:
PT:
PTT:
Glucose:
**Physical Assessment**  
**Heart (Cardiovascular System)**  
**USCR: Water or Air**

**Subjective Data**  
Chest pain or tightness (quantify):

Shortness of breath:

Orthopnea:

Cough (productive or non-productive):

Fatigue:

Cyanosis:

Edema:

Nocturia:

Past history of heart disease (medical or surgical):

Family history of cardiac disease:

Modifiable risk factors:

Non-modifiable risk factors:

**Objective Data**  
Inspect carotid arteries:

Palpate carotid arteries:

Auscultate carotid artery:

Inspect external jugular vein:

**Auscultate apical pulse**

Document rate and rhythm:

Identify S1 and S2:

Palpate pedal pulse

**Diagnostics**

CPK:

PT:

PTT:

EKG:

Hemoglobin:

Hematocrit:
Subjective Data
Joint pain:

Joint stiffness:

Swelling, heat, redness in joints:

Limitation of movement:

Muscle pain:

Bone or joint deformity:

Accidents or trauma to bone:

Back pain:

Functional assessment:

Self-care behaviors:

Objective Data
Inspection
Joints:

Palpation
Joints:

Muscle strength
Deltoid:

Biceps:

Triceps:

Wrist and fingers:

Hand grip:

Hips:

Hamstrings:

Quadriceps:

Ankles and feet:
Musculoskeletal continued

Spine

Inspect:

Palpate:

ROM:

**Diagnostics**

X-ray:

EMG:

ANA:
Physical Assessment
Neurologic
USCR: Prevention of Hazards

Subjective Data
Headaches:

Head injury:

Dizziness:

Seizures:

Tremors:

Weakness:

Coordination:

Numbness or tingling:

Difficulty swallowing:

Difficulty speaking:

Past neurologic history (medical or surgical):

Environmental/occupational hazards:

Physical Assessment
Cranial nerves
I:

II:

III, IV, VI:

V:

VII:

VIII:

IX, X:

XI:

XII:
Neurologic continued

Motor system
Hand grasp:

Foot push:

Cerebellar function
Gait:

Romberg:

Finger to finger test:

Finger to nose test:

Sensory system
Pain:

Light touch:

Tactile discrimination
Sterognosis:

Graphesthesia:

Reflexes
Biceps:

Patellar:

Babinski:

Diagnostics
Scans:

EEG:

Lumbar puncture:
Physical Assessment
Genitourinary
USCR: Elimination

Subjective Data (male and female)
Frequency:

Dysuria:

Urine color:

Incontinence:

Past GU history:

Sexual activity/contraception:

Sexually transmitted diseases:

Subjective Data (males)
Hesitancy/straining:

Penis:

Self care behaviors:

Subjective Data (females)
Menstrual history:

Obstetric history:

Menopause:

Vaginal discharge:

Self-care behaviors:

Objective Data (male and female)
Inspection
Bladder:

Palpation
Bladder:

Percussion
Bladder:
Genitourinary continued

**Objective Data (males)**

**Inspect**

Penis:

Scrotum:

Hernia:

Perineum:

**Palpate**

Penis:

Scrotum:

Lymph nodes:

**Objective Data (females)**

**Inspection**

Labia majora:

Labia minora:

Perineum:

**Diagnostics**

**Cystoscopy:**

Urinalysis:

Urine culture and sensitivity

**VDRL:**

**PSA:**

**PAP smear:**
<table>
<thead>
<tr>
<th></th>
<th>SATISFACTORY</th>
<th>UNSATISFACTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEUROMUSCULAR</strong></td>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
</tr>
<tr>
<td>Hand grasp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot push</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smile symmetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tongue protrusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PERL</strong></td>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
</tr>
<tr>
<td><strong>CARDIOVASCULAR</strong></td>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
</tr>
<tr>
<td>Palpate carotid pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect jugular vein</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auscultate apical pulse (rate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpate pedal pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RESPIRATORY</strong></td>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
</tr>
<tr>
<td>Auscultate lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capillary refill</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SKIN</strong></td>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
</tr>
<tr>
<td>Inspect conjunctiva</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect for integrity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wounds/dressings</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GASTROINTESTINAL</strong></td>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
</tr>
<tr>
<td>Inspect abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auscultate abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percuss abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentle palpation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GENITOURINARY</strong></td>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
</tr>
<tr>
<td>Urine color</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine clarity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine amount</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>