BERGEN COMMUNITY COLLEGE
THE SCHOOL OF HEALTH PROFESSIONS
DEPARTMENT OF NURSING

NUR 181
LEVEL I
PHYSICAL ASSESSMENT
COURSE OUTLINE
1 CREDIT

LABORATORY: 3 HOUR PER WEEK

Revised May 2018
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.
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## ADDENDUM

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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.

3 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 90% of the grade.
   There will be 4 quizzes which will equal 10% 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 ("P") 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 77.45% (C+) or greater and satisfactory physical assessment skills validation in laboratory.

**CLASSROOM POLICIES**

With the exception of Test #4, test grades and test review will be provided no sooner than the next week of class after the test and no later than 2 weeks after the test. Grades will not be posted.

All cell phones and other electronic devices must be turned off and put away during ALL class time.
Please refer to Student Handbook for current Nursing Department policies on:
- Student Remediation (Student Success)
- Use of Social Media
- Exam Make-ups

**Office of Special Services (OSS)**

The Office of Specialized Services (OSS) seeks to provide students the opportunity to participate fully in the College’s educational programs and benefit from all aspects of campus life through the use of reasonable and appropriate accommodations and auxiliary services. **Annual documentation of certification of need must be provided on the first day of class to the lead faculty.**

**GRADING SCALE**

- **A** = 89.45 – 100
- **B+** = 85.45 – 89.44
- **B** = 81.45 – 85.44
- **C+** = 77.45 – 81.44
- **C** = 73.45 – 77.44
- **D** = 69.45 – 73.44
- **F +** = 69.44 and below

**REQUIRED TEXTS**


**CHOOSE EITHER OF THE FOLLOWING:**


**OR**


**SUGGESTED LEARNING RESOURCES**

2. Text online resources.
3. On-line sources for heart, lung sounds, and assessment components.
4. Self-Learning Exercises provided on Moodle for each system or assessment.
5. **ATI Tutorials**: *Skills Modules 2.0 – Physical Assessment of an Adult: Accepted Practice and Step-by-Step Viewing*

   - Equipment
   - LOC, General Survey and Vital Signs
   - Integument
   - Head, Neck and Face Examination
   - Eye examination
   - Ear, Nose, and Throat Examination
   - Respiratory
   - Cardiac
Abdominal
Musculoskeletal
Neurological

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
View textbook online resources.
Complete the learning exercises provided on Moodle for assessment techniques, describing symptoms, and subjective/objective data.

Jarvis, Chapter 9
Theoretical Content

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/birthmark
   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

Jarvis, Chapter 12
Submit Physical Assessment Lab Guide: Skin, Hair, Nails to clinical instructor.
View textbook online resources.
Review ATI Skills Module Tutorial for Integument.
Complete the Self-Learning exercise provided on Moodle for Skin, Hair and Nails Assessment.
### Theoretical Content

#### 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, urticaria
     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
Theoretical Content

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 online resources.


Complete the Self-Learning exercise provided on Moodle for Head and Neck, and Eyes, Ears, Nose and Throat assessment.
UNIT IV - continued

2. Eyes

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

b. Objective Data
   1) Test visual acuity
      a) Snellen Chart
      b) Jaeger card
   2) Inspect external ocular
   3) Inspect anterior eyeball structures

c. The Aging Adult

d. Abnormal Findings/PCNS
   1) Ptosis
   2) Conjunctivitis
   3) Strabismus
   4) Cataract
   5) Hordeolum

Theoretical Content

Teaching/Learning Activities

Jarvis, Chapter 14
Submit Physical Assessment Clinical Lab Guide: Eyes to clinical instructor
View textbook online resources.

Review ATI Skill Modules Tutorial for Eye Exam, and Ear, Nose, and Throat Exam.
### UNIT IV - continued

#### 3. Ears

**a. 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

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

**c. The Aging Adult**

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

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#### 4. Nose, Throat, Mouth

**USCR = Prevention of Hazards**

**a. 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

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**Teaching/Learning Activities**

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

Jarvis, Chapter 16
Submit Physical Assessment Clinical Lab Guide: Nose, Mouth & Throat to clinical instructor.
View textbook online resources.
UNIT I – 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
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.

Review ATI Skills Module Tutorial for Respiratory Assessment

View textbook online resources.

Refer to Lab/Diagnostic Tests Handbook

Jarvis, pg. 151
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
### 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 online resources.
Review ATI Skills Module Tutorial for Cardiac Assessment.

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

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### Teaching/Learning Activities

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

A/V – (LIBRARY MEDIA)
- RC683C35 1992: Cardiac System
- RC683P49 1985: Physical Assessment: The Heart

Springhouse: Cardiac System

View textbook online video and listen to heart sounds

Refer to Davis’ Lab/Diagnostic Tests Handbook

#### 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

Jarvis, Chapter 20
Submit Physical Assessment Lab Guide: Peripheral Vascular to clinical instructor

Complete the Self-Learning exercise provided on Moodle for the Peripheral Vascular assessment.
### Theoretical Content

#### UNIT VIII - Peripheral Vascular (continued)

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

### Teaching/Learning Activities

- A/V (LIBRARY MEDIA)
- View textbook online resources.

- Refer to Davis’ Lab/Diagnostic Tests Handbook
## 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 aneurism
   - 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

- **AV – (LIBRARY MEDIA)**
  - RC803.G39 1993: Gastrointestinal System
  - View textbook online resources.

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

- Review ATI Skills Module Tutorial for Abdominal Assessment.

- Refer to Davis’ Lab/Diagnostic Tests Handbook
### 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)**

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<td><strong>d. Diagnostics</strong></td>
<td><strong>Teaching/Learning Activities</strong></td>
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<tr>
<td>1) Cystoscopy</td>
<td>Refer to Davis’ Lab/Diagnostic Tests Handbook</td>
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<tr>
<td>2) Urinalysis - C&amp;S</td>
<td>View textbook online resources.</td>
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<td>3) VDRL</td>
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<td>4) PSA</td>
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<td>5) Digital rectal exam</td>
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<td><strong>e. Abnormal findings – PCNS/SENS</strong></td>
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<tr>
<td>1) Phimosis</td>
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<td>2) Scrotal edema</td>
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<td>3) Urethral discharge</td>
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<td>4) Dysuria</td>
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<td>5) Urinary retention</td>
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### 2. Female

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<tbody>
<tr>
<td><strong>a. Subjective Data</strong></td>
<td>Jarvis, Chapter 26</td>
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<tr>
<td>1) Menstrual history/ LMP</td>
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<td>2) Obstetric history</td>
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<td>3) Menopause</td>
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<td>10) Sexually transmitted diseases / sexual health</td>
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<tbody>
<tr>
<td><strong>b. Objective Data</strong></td>
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<tr>
<td>1) Bladder: inspect, palpate, percuss</td>
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<tr>
<td>2) Inspect external genitalia</td>
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</tbody>
</table>
Theoretical Content

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 online resources.

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.

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

View textbook online resources.

Review ATI Skills Module Tutorial for Musculoskeletal Assessment.
## Theoretical Content

### 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

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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.

A/V – (LIBRARY MEDIA)

View textbook online resources.

Review ATI Skills Module Tutorial for Neurologic Assessment.
### 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
PHYSICAL ASSESSMENT

NUR 181

LAB GUIDE
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:
Physical Assessment
Head and Neck
USCR: Normalcy

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