HEAD TO TOE ASSESSMENT

Before the Exam

- · Ensure privacy and keep the room at a comportable temperature
- · Sit/ Stand at eye level + make good eve contact
- · Use open-ended questions to gather unbiased information

General & Health History

SUBJECTIVE -

- 1. Health history
- 2. Family history 3 Cheif complaint

OBJECTIVE

- Behavior + mood
- 2. Appears stated age Hygiene + nourishment level
- Posture and mobility
- 5. Level of conciousness L. Alert ? Oriented?

Integument

Inspect Skin. I. Color

- 2. Moisture 3. Texture
- 4. Turgor
- 5 Lesions









E

T Z

PPOO

Account posts I may be about the

WED HIER

bee impassive

- 1. Inspect + parpase hair. scalp + face 2. Test CN VIII - have pt. smile, Frown Show teeth, frown - pure cheeks
- 3. Inspect Science, iris conjunctive for any discoloration /abnormalines 4 Test vision - Snellen Chart
- 5 Check Dupits are equal, round and reactive to light - accommodation

Neurological + Mental Status

- Assess speech patiern
- 2. Orientation to person, place, time and situation
- 3. Assess recent and remote memory
- 4. Screen for depression + anxiety
- 5. Ensure the client's thought process is logical and concrent
- 6. Assess mond + facial expression

Inspection Look I SWEET



Palpation Feel technic consigning with palms



Percussion

two to assers the awanters / sym

Auscultation cismo for sounds



I. Test hearing

2. Inspect pinha and inner ear

Nose



- I. Assess patercy
- 2. Ensure Sense of Sinnelli
- 3 Inspect septum+ turibly actes

Mouth



I Inspect lips/murosa

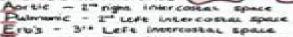
2. Assess teets + gums 3. Check hard + Soft polime

Through

- I inspece uvula-
- 2. Test CN IX
- "Say annhh" 5. Test CN XI move tongue

Cardiovascular

- Inspect anterior aun di posterior Chest
- Percuss lung fields
- 3. Paipate Aprai puve
- 4 Auscultate lung sounds 5 Auscultate heart sounds



ricuspid - 4" Left intercostal space Mibral - 5th intercestal space as misseuricular



Abdomen - GI & GU

- I Inspect Contour, symmetry 2. Auscultate for bowel sounds
- 3. Percuss all 4 quadrants
- 4. Palpate all 4 quadrants
- 5. Assess bladder + voiding habits

Extremities-Musculoskeletal

- I. Assess ROM + muscle Strength
- 2. Check for a grade any edema 3. Inspect posture + quit
- 4. Test deep tendon reflexes /



Nursing Assessment Study Guide

JoAnn Zerwekh

Nursing Assessment Study Guide:

Nursing Assessment (Speedy Study Guides) Speedy Publishing,2014-07-03 A Nursing Assessment Guide is a comprehensive work to outline the procedures nurses use to properly assess patients to determine a patient s needs and apparent state of health It provides a clear blueprint of procedures to follow and outlines the most practical order to follow them Proper technique is described in detail and it has illustrations and diagrams for doing things the correct way for the comfort of the patient and good assessment of possible problems It is a helpful reference for clear and concise charting

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