

**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 2011 and  
SPRING 2012 SEMESTERS ONLY**

### **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.

### **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 individuals.
5. Develops 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.
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 75% or greater and satisfactory physical assessment skills validation in laboratory.

A = 89.5% and above

B+ = 84.5 to 89.4%

B = 79.5% to 84.4%

C+ = 74.5% to 79.4%

F = 74.4% and below

5. Completion of an end of course standardized exam (Evolve HESI)

## **REQUIRED TEXTS**

Jarvis, Carolyn. Physical Examination & Health Assessment, Elsevier 2012, 6<sup>th</sup> edition,  
ISBN: 978-1-4377-0151-7

### **CHOOSE EITHER OF THE FOLLOWING:**

Leeuwen, A. Kranpitz, T., and Smith L., Davis' Comprehensive Handbook of Laboratory and  
Diagnostics Tests with Nursing Implications. Davis, 2009, 3<sup>rd</sup> edition.  
ISBN: 13: 978-0-8036-1826-8

### **OR**

Pagana and Pagana, Mosby's Diagnostic and Laboratory Test Reference. 2009.  
ISBN: 978-0-3230-5345-7  
Student selection

## **SUGGESTED LEARNING RESOURCES**

1. B.C.C. Library [www.Bergen.edu](http://www.Bergen.edu)
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)

## **NUR 181 Evolve Tutorials**

### **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 5<sup>th</sup> 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

## Teaching/Learning Activities

### 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 Health 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

Jarvis, Chapters 1, 3, 4  
Submit Clinical Lab Guide: Health History/Review of Systems to clinical instructor.  
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 CD

Jarvis, Chapter 9

## Theoretical Content

### **UNIT II – NUTRITION ASSESSMENT/ USCR FOOD**

- 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

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

Refer to Lab/Diagnostic Tests Handbook

## 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

Jarvis, Chapter 12

Submit Physical Assessment Lab Guide:

Skin, Hair, Nails to clinical instructor.

View textbook CD

## Theoretical Content

## Teaching/Learning Activities

### 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 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

## Theoretical Content

## Teaching/Learning Activities

### 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

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

## Theoretical Content

## Teaching/Learning Activities

### 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
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

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

## Teaching/Learning Activities

### 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

## 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.

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.

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

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

Jarvis, Chapter 20

Submit Physical Assessment Lab Guide:

Peripheral Vascular to clinical instructor

Submit documentation of a peripheral vascular Assessment on a lab partner

## Theoretical Content

## Teaching/Learning Activities

### **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

A/V (LIBRARY MEDIA)  
RC670.V37 1992: Vascular System  
View textbook CD ROM

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 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

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,

## Theoretical Content

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

- d. Diagnostics
  - 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
  
- 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

## Teaching/Learning Activities

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

Jarvis, Chapter 26

## 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 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.

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

View textbook CD ROM

## Theoretical Content

## Teaching/Learning Activities

### 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.

A/V – (LIBRARY MEDIA)

RC348.N46 1992: Nervous System

RC348.P49 1985: Physical Assessment: The Neurologic System

View textbook CD ROM

## Theoretical Content

## Teaching/Learning Activities

### 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

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