

**BERGEN COMMUNITY COLLEGE**  
**DIVISION 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 2010 and  
SPRING 2011 SEMESTERS ONLY**

## TABLE OF CONTENTS

<u>DOCUMENT</u>	<u>PAGES</u>
Course Description.....	4
Learning Outcomes.....	4
Course Requirements.....	4
Required Texts.....	5
Theoretical Content and Teaching/Learning Activities.....	7 - 27
 <u>ADDENDUM</u>	
Physical Assessment Lab Guide .....	28
Physical Assessment Final Return Demonstration.....	54

**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.**

### **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 clients.
2. Approaches clients according to the identified norms for their growth and developmental capabilities.
3. Uses appropriate interview techniques to obtain basic information from clients 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 clients.
10. Assesses clients 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 2009, 5<sup>th</sup> edition,  
ISBN: 978-1-1-4160-3243-4

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

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. Health Assessment Across the Life Span (Focus on older adult)
  
3. Cultural Considerations
  
4. 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

Jarvis, Chapters 1, 4, 5  
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, 30

Jarvis, Chapter 3

Jarvis, Chapter 6  
Submit Clinical Lab Guide: Supplemental mental status exam to clinical instructor.

## Theoretical Content

## Teaching/Learning Activities

### UNIT II – Introduction to Physical Assessment

1. 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
  - g. Functional assessment
  
3. Nutrition Assessment / USCR = Food
  - a. Nutritional screening and assessment tools
    - 1) Diet recall, food frequency, questionnaire, food record
    - 2) Food Guide Pyramid (HHS-2005)
  - b. Gathering data
    - 1) Eating patterns
    - 2) Usual weight
    - 3) Changes in appetite, taste, chewing, swallowing
    - 4) Recent surgery, trauma, burns, infection
    - 5) Chronic illnesses
    - 6) Vomiting, diarrhea, Constipation
    - 7) Food allergies or Intolerances
    - 8) Medications and/or nutritional supplements
    - 9) Self care behaviors
    - 10) Alcohol or illegal drug use
    - 11) Tobacco use
    - 12) Exercise and activity Patterns
    - 13) Family history

Jarvis, Chapter 8  
View textbook CD

Jarvis, Chapter 9

Jarvis, Chapter 11  
Submit Clinical Lab Guide: Nutritional Assessment to clinical instructor.  
View textbook CD ROM

### **Theoretical Content**

5. The Aging Adult
6. Laboratory Studies
  - a. Hemoglobin
  - b. Hematocrit
  - c. Cholesterol (HDL & LDL)
  - d. Triglycerides
  - e. Serum albumin
  - f. Blood glucose
7. Abnormal Findings/PCNS
  - a. Obesity overnutrition
  - b. Undernutrition
  - c. Failure to thrive

### **Teaching/Learning Activities**

Refer to Lab/Diagnostic Tests Handbook

## Theoretical Content

## Teaching/Learning Activities

### UNIT III – Physical Assessment

1. Skin, Hair, and Nails (USCR=Prevention of Hazards)
  - a. Gathering the Data
    - 1) Describe the skin
    - 2) Recent illness
    - 3) Body odor
    - 4) Excessive sweating
    - 5) Previous history of skin disease/ infections in self or family
    - 6) Change in pigmentation
    - 7) change in mole/birth mark
    - 8) Excessive dryness or Moisture
    - 9) Pruritus
    - 10) Excessive bruising
    - 11) Rash or lesion
    - 12) Sores or ulcers
    - 13) Medications
    - 14) Hair loss
    - 15) Hair treated with chemicals
    - 16) Change in nails/hair
    - 17) Artificial nails
    - 18) Environmental or occupational hazards
    - 19) Sunbathe/work outdoors
    - 20) Tattoos
    - 21) Piercings of body
    - 22) Self care behaviors
  - b. Physical Assessment
    - 1) Skin
      - a) Color
      - b) Temperature/body odor
      - c) Moisture
      - d) Texture
      - e) Thickness
      - f) Edema
      - g) Mobility or turgor
      - h) Vascularity or bruising
      - i) Lesions
    - 2) Hair
      - a) Color
      - b) Texture
      - c) Distribution
      - d) Cleanliness

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

- b. Physical Assessment  
(continued)
  - 3) Nails
    - a) Shape and Contour
    - b) Color
    - c) Hygiene
    - d) Attachment
- c. The Aging Adult
- d. Abnormal Findings/SENS
  - 1) Skin
    - a) Detecting color changes in light and dark skin
    - b) Common shapes and configurations of lesions- ABCDE
    - c) Primary skin lesions – nodule, wheal, urticaria
    - d) Vascular lesions - ecchymosis, hematoma
    - e) Secondary skin lesions– ulcer, decubitus, scar, excoriation, candidiasis
    - f) Color changes
      - i) pallor
      - ii) erythema
      - iii) cyanosis
      - iv) jaundice
    - g) Common skin lesions – psoriasis, dermatitis
  - 2) Hair
    - a) Lice
    - b) Abnormal distribution
    - c) Hirsutism
  - 3) Nails
    - a) Clubbing
    - b) Spoon nails
    - c) Onycholysis

## Theoretical Content

## Teaching/Learning Activities

### UNIT III - continued

2. Head and Neck and Related Lymphatics-  
USCR Prevention of Hazards
  - a. Gathering the 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. Physical assessment
    - 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

Jarvis, Chapter 13  
Submit Physical Assessment Lab Guide:  
Head & Neck to clinical instructor.  
View textbook CD

## Theoretical Content

## Teaching/Learning Activities

### UNIT III - continued

3. Eyes
  - a. Gathering the 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. Physical assessment
    - 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 III - continued

4. Ears
  - a. Gathering 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. Physical Assessment
    - 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
5. Nose, Throat, Mouth USCR = Prevention  
of Hazards
  - a. Gathering 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 III** – continued

5. 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. Physical Assessment
    - 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 III – continued

6. Respiratory System - Thorax and Lungs  
USCR = Air
  - a. Gathering Data
    - 1) Cough
    - 2) Shortness of breath
    - 3) Chest pain with breathing
    - 4) History of lung disease
    - 5) Smoking
    - 6) Environment/ occupational Hazards
    - 7) Medications
    - 8) Describe your breathing Today
    - 9) Sleep with pillow?
    - 10) Cough up mucus or Phlegm
    - 11) Wheezing
    - 12) Immunizations for respiratory illness
  - b. Physical Assessment
    - 1) Inspect posterior chest
    - 2) Palpate posterior chest for symmetrical chest expansion
    - 3) Palpate posterior chest for tactile fremitus
    - 4) Percuss posterior chest for Resonance
    - 5) Auscultate posterior chest
    - 6) Normal breath sounds
      - a) bronchial
      - b) vesicular
      - c) bronchovesicular
  - c. The Aging Adult
  - d. Diagnostics
    - 1) Chest x-ray
    - 2) Arterial blood gas
    - 3) Sputum culture
    - 4) ventilation-perfusion scan
    - 5) Pulmonary function tests
    - 6) 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. 169**

## Theoretical Content

### UNIT III – continued

#### 6. Respiratory System - Thorax and Lungs USCR = Air (continued)

- e. Abnormal findings/PCNS
  - 1) Configurations of the thorax
  - 2) Respiratory patterns
  - 3) Adventitious lung sounds
  - 4) Crepitus

#### 7. Breasts and Axillae

- a. Gathering Data
  - 1) Breast
    - a) Pain
    - b) Lump
    - c) Discharge
    - d) Rash
    - e) Trauma
    - f) History of breast disease (medical & surgical) History of cancer in any other region of the body
    - g) Changes in breast characteristics
    - h) Self-care behaviors-perform breast self exam
    - i) Last mammogram
    - j) Menopause
  - 2) Axilla
    - a) Tenderness
    - b) Lump or swelling profile
  - 3) Risk factors for breast cancer

## Teaching/Learning Activities

Jarvis, Chapter 17

\* Satisfactorily demonstrate a breast exam during skills validation in clinical conference.

View textbook CD

## Theoretical Content

### **UNIT III** – continued

7. Breasts and Axillae (continued)
  - b. Physical Assessment
    - 1) Inspection for retraction; color, size, symmetry and nipple discharge
    - 2) Palpation of breast, nipple & axilla
  - c. The Aging Female
  - d. Abnormal findings-PCNS/SENS
    - 1) Signs of retraction and inflammation in the breast
    - 2) Breast lump
    - 3) Nipple discharge
    - 4) Axillae lump
  
8. Heart & Neck Vessels  
USCR = Water or Air
  - a. Gathering the Data
    - 1) Chest pain
    - 2) Dyspnea
    - 3) Orthopnea
    - 4) Cough
    - 5) Fatigue
    - 6) Past cardiac history
    - 7) Family history of cardiac Disease
    - 8) Cyanosis
    - 9) Pallor
    - 10) Edema/weight
    - 11) Nocturia
    - 12) Syncope
    - 13) Medications
    - 14) Modifiable risk factors
    - 15) 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 III - continued

8. Cardiovascular System (continued)
  - b. Physical Assessment
    - 1) Inspect carotid artery
    - 2) Palpate carotid artery
    - 3) Auscultate carotid artery
    - 4) Inspect jugular vein
    - 5) Locate apical impulse
    - 6) Auscultate apical pulse
    - 7) Auscultate S1 and S2
  - c. The Aging Adult
  - d. Diagnostics
    - 1) CPK-MB – Troponins
    - 2) PT/PTT
    - 3) EKG
    - 4) Echocardiogram
    - 5) Cardiac catheterization
    - 6) Stress test
  - e. Abnormal findings /PCNS
    - 1) Friction rub
    - 2) Murmurs
    - 3) Signs and symptoms of fluid volume excess
9. Peripheral Vascular: USCR = Water or Air
  - a. Gathering the Data
    - 1) Leg pain or cramps
    - 2) Skin changes on arms or Legs
    - 3) Swelling/edema/temperature changes
    - 4) Lymph node enlargement
    - 5) Medications
    - 6) Past peripheral vascular medical/surgical history
    - 7) Smoke
    - 8) 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 III - continued

#### 9. Peripheral Vascular (continued)

- b. Physical Assessment
  - 1) Inspection of upper extremities for capillary return, edema, B/P
  - 2) Palpation of pulses: radial and brachial
  - 3) Allen test
  - 4) Inspection of lower extremities for pallor, edema, ulcers/ temperature
  - 5) Measure calf circumference
  - 6) Palpate for temperature
  - 7) Palpation of pulses: pedal, posterior tibial, popliteal, femoral
  - 8) Auscultate pulses with doppler
- c. The Aging Adult
- d. Diagnostics
  - 1) Doppler ultrasound
  - 2) Angiography
- e. Abnormal findings - PCNS/SENS
  - 1) Variation in pulse
  - 2) Peripheral vascular disease: occlusive, aneurysm
  - 3) Lower extremity ulcers – arterial/venous diabetic
  - 4) 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

10. Abdomen – USCR = Food or Elimination
- a. Gathering the Data
    - 1) Appetite
    - 2) Dysphagia
    - 3) Food tolerance/indigestion
    - 4) Abdominal pain/bloating/  
Gas
    - 5) Nausea/vomiting
    - 6) Bowel habit
    - 7) Past abdominal history
    - 8) Medications
    - 9) Nutritional assessment
  - b. Physical Assessment
    - 1) Inspect abdomen for:
      - a) contour
      - b) symmetry
      - c) umbilicus
      - d) skin changes
      - e) pulsations
    - 2) Auscultate abdomen for  
bowel sounds
    - 3) Percuss abdomen for  
Tympany
    - 4) Light abdominal palpation
  - c. The Aging Adult
  - d. Diagnostics
    - 1) Amylase
    - 2) Liver function test
    - 3) Stool guaiac
    - 4) Abdominal x-ray
    - 5) Upper GI
    - 6) Lower GI
    - 7) Endoscopy
  - 8) Liver biopsy
  - e. Abnormal findings – PCNS
    - 1) Pain
    - 2) Distention
    - 3) Ascites
    - 4) Hyper/hypoactive bowel  
Sounds
    - 5) Aortic aneurysm
    - 6) 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

## Teaching/Learning Activities

### UNIT III – continued

11. Urinary System  
USCR = Elimination
- a. Male
- 1) Gathering the Data
    - a) Frequency, urgency, nocturia
    - b) Dysuria
    - c) Hesitancy/straining
    - d) Urine color
    - e) Past medical/ surgical history
    - f) Penis: pain, lesions
    - g) Testicular self exam
    - h) Contraception
    - i) Sexually transmitted diseases/ sexual health
    - j) Incontinence
    - k) Hx of mumps
  - 2) Physical Assessment
    - a) Bladder: inspect, palpate, percuss
    - b) Penis: inspect and palpate
    - c) Scrotum: inspect and palpate
    - d) Hernia: inspect and palpate
    - e) Palpate inguinal lymph nodes
  - 3) The Aging Adult

Jarvis, Chapter 24

## Theoretical Content

### UNIT III - continued

#### 11. Urinary System (continued)

- 4) Diagnostics
  - a) Cystoscopy
  - b) Urinalysis - C&S
  - c) VDRL
  - d) PSA
  - e) Digital rectal exam
  
- 5) Abnormal findings – PCNS/SENS
  - a) Phimosis
  - b) Scrotal edema
  - c) Urethral discharge
  - d) Dysuria
  - e) Urinary retention

#### b. Female

- 1) Gathering the Data
  - a) Menstrual history/ LMP
  - b) Obstetric history
  - c) Menopause
  - d) Last PAP
  - e) Urinary symptoms/ incontinence
  - f) Vaginal discharge/ protrusions/ bleeding
  - g) Past medical/surgical history
  - h) Sexual activity
  - i) Contraception
  - j) Sexually transmitted diseases / sexual health
  - k) Infection
  
- 2) Physical Assessment
  - a) Bladder: inspect, palpate, percuss
  - b) Inspect external genitalia

## Teaching/Learning Activities

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

Jarvis, Chapter 26

## Theoretical Content

### UNIT III – continued

11. Urinary System (continued)
  - 3) The Aging Adult
  - 4) Diagnostics
    - a) PAP
    - b) Urinalysis
    - c) VDRL
    - d) C&S
  - 5) Abnormal findings – PCNS/SENS
    - a) Lice
    - b) Contact dermatitis
    - c) Candidiasis
    - d) Dysuria
    - e) Vaginal discharge
    - f) Urinary retention
    - g) HPV warts
  
12. Musculoskeletal  
USCR = Prevention of Hazards
  - a. Gathering the Data
    - 1) Joint
      - a) Pain
      - b) Stiffness
      - c) Swelling
      - d) Heat redness
      - e) Limitation of movement
      - f) Infection
    - 2) Muscle
      - a) Pain
      - b) Cramps
    - 3) Bone
      - a) Pain
      - b) Deformity
      - c) Trauma
    - 4) Activity of daily living Assessment
    - 5) 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 III – continued

#### 12. Musculoskeletal (continued)

- b. Physical Assessment
  - 1) Inspect joints for:
    - a) size
    - b) contour
    - c) Swelling
    - d) Color
  - 2) Palpate joints for:
    - a) Heat
    - b) Tenderness
    - c) Swelling
    - d) Masses
  - 3) Test muscle strength
    - a) deltoid
    - b) biceps
    - c) triceps
    - d) wrist/finger
    - e) grip
    - f) hip muscles
    - g) hamstrings
    - h) quadriceps
    - i) ankles/feet
  - 4) Spine
    - a) Inspect
    - b) Palpate
    - c) ROM
- c. The Aging Adult
- d. Diagnostics
  - 1) X-ray
  - 2) EMG
- e. Abnormal findings - PCNS/SENS
  - 1) Rheumatoid arthritis
  - 2) Osteoarthritis
  - 3) Contractures
  - 4) Fractures
  - 5) Back injury
  - 6) Scoliosis
  - 7) Kyphosis

Refer to Davis' Lab/Diagnostic Tests Handbook

## Theoretical Content

### UNIT III - continued

13. Neurologic  
USCR = Prevention of Hazards
  - a. Gathering the Data
    - 1) Headache
    - 2) Head injury
    - 3) Dizziness/vertigo
    - 4) Seizures
    - 5) Past neurologic history
    - 6) Difficulty speaking
    - 7) Environmental/occupational Hazards
    - 8) Tremors
    - 9) Weakness
    - 10) Incoordination
    - 11) Numbness or tingling
    - 12) Difficulty swallowing
    - 13) Medication
    - 14) ADL's
    - 15) Chronic diseases
  - b. Physical Assessment
    - 1) Test cranial nerves 1-12
    - 2) Cerebellar function
      - a) gait
      - b) Romberg
    - 3) Co-ordination and skilled Movements
      - a) finger to finger
      - b) finger to nose
      - c) dexterity
    - 4) Sensory
      - a) pain
      - b) light touch
    - 5) Tactile discrimination
      - a) Stereognosis
      - b) Graphesthesia
    - 6) Reflexes
      - a) biceps
      - b) patellar
      - c) Babinski
  - c. 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

### UNIT III – continued

#### 13. Neurologic (continued)

- d. Diagnostics
  - 1) CT scan/MRI
  - 2) Glasgow Coma Scale
  - 3) Lumbar Puncture
  - 4) EEG
  
- e. Abnormal findings - PCNS/WCNS
  - 1) Paralysis/hemiparesis
  - 2) Tremor
  - 3) Parkinsonian gait
  - 4) Aphasia
  - 5) Brain attack

## Teaching/Learning Activities

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

**PHYSICAL ASSESSMENT**

**NUR 181**

**LAB GUIDE**

**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:

**Physical Assessment**  
**Mental Status**  
**USCR: Normalcy**

**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:

## **Physical Assessment**

### **Nutrition USCR: Food**

#### **Gathering the 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:

#### **Physical Assessment**

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**

**Gathering the 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:

**Physical Assessment**

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**

**Gathering the 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:

**Physical Assessment**

**Inspection**

Skull:

Facial expression:

Neck:

Pulsations:

Trachea:

**Palpation**

Skull:

Lymph nodes:

Trachea:

Thyroid:

Temporomandibular joint:

**Physical Assessment**  
**Eyes**  
**USCR: Prevention of Hazards**

**Gathering the 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:

**Physical Assessment**

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**

**Gathering the Data**

Earache or pain:

Describe hearing:

Ear infections:

Discharge:

Hearing loss:

Environmental noise:

Tinnitus:

Vertigo:

Self care:

**Physical Assessment**

Inspection

Size and shape:

Skin condition:

External auditory meatus:

Palpation

Tenderness:

Test hearing acuity

Voice test L\_\_\_\_\_ R\_\_\_\_\_

**Physical Assessment**  
**Nose, Mouth, and Throat**  
**USCR: Prevention of Hazards**

**Gathering the 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

### **Physical Assessment**

#### 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**

**Gathering the 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::

**Physical Assessment**

**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**

**Gathering the 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:

**Physical Assessment**

Inspection

Inspect for retraction:

Inspect for nipple discharge:

Palpation

Palpation of breast:

Palpation of nipple:

Palpation of axilla:

## **Physical Assessment**

### **Abdomen**

#### **USCR: Elimination**

#### **Gathering the 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:

#### **Physical Assessment:**

##### **Inspection**

Inspect abdominal contour:

Inspect for symmetry:

Skin color and condition:

Pulsation or movement:

Umbilicus:

Hair distribution:

Hydration and nutrition:

##### **Auscultation**

Bowel sounds:

Bruits:

## 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**

**Gathering the 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:

Hx of smoking:

**Physical Assessment**

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:

### **Diagnostics**

Angiogram:

Hemoglobin:

Hematocrit:

Oxygen saturation with pulse oximeter:

Platelets:

PT:

PTT:

Glucose:

**Physical Assessment**  
**Heart (Cardiovascular System)**  
**USCR: Water or Air**

**Gathering the 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:

**Physical Assessment**

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:

**Physical Assessment**  
**Musculoskeletal**  
**USCR: Prevention of Hazards**

**Gathering the 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:

**Physical Assessment**

**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**

**Gathering the 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

Stereognosis:

Graphesthesia:

### Reflexes

Biceps:

Patellar:

Babinski:

### Diagnostics

Scans:

EEG:

Lumbar puncture:

**Physical Assessment**  
**Genitourinary**  
**USCR: Elimination**

**Gathering the Data** (male and female)

Frequency:

Dysuria:

Urine color:

Incontinence:

Past GU history:

Sexual activity/contraception:

Sexually transmitted diseases:

**Gathering the Data** (males)

Hesitancy/straining:

Penis:

Self care behaviors:

**Gathering the Data** (females)

Menstrual history:

Obstetric history:

Menopause:

Vaginal discharge:

Self care behaviors:

**Physical Assessment** (male and female)

**Inspection**

Bladder:

**Palpation**

Bladder:

**Percussion**

Bladder:

## Genitourinary continued

### **Physical Assessment** (males)

#### Inspect

Penis:

Scrotum:

Hernia:

Perineum:

#### Palpate

Penis:

Scrotum:

Lymph nodes:

### **Physical Assessment** (females)

#### Inspection

Labia majora:

Labia minora:

Perineum:

### **Diagnostics**

Cystoscopy:

Urinalysis:

Urine culture and sensitivity

VDRL:

PSA:

PAP smear:

**NUR 181**  
**PHYSICAL ASSESSMENT FINAL RETURN DEMONSTRATION**

	<b>SATISFACTORY</b>	<b>UNSATISFACTORY</b>
<b>NEUROMUSCULAR</b>	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
Hand grasp		
Foot push		
Smile symmetry		
Tongue protrusion		
PERL		
<b>CARDIOVASCULAR</b>	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
Palpate carotid pulse		
Inspect jugular vein		
Auscultate apical pulse (rate)		
Palpate pedal pulse		
<b>RESPIRATORY</b>	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
Auscultate lungs		
Capillary refill		
<b>SKIN</b>	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
Inspect conjunctiva		
Inspect for integrity		
Wounds/dressings		
<b>GASTROINTESTINAL</b>	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
Inspect abdomen		
Auscultate abdomen		
Percuss abdomen		
Gentle palpation		
<b>GENITOURINARY</b>	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
Urine color		
Urine clarity		
Urine amount		