

**Physical Assessment
Required Components
Nursing Process**

| | Required Components | |
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| General survey | <ol style="list-style-type: none"> 1. General appearance & behavior 2. Posture 3. Gait 4. Hygiene 5. Speech 6. Mental Status 7. Vital Signs 8. Nutritional Status | |
| Head and Neck | <ol style="list-style-type: none"> 1. Symmetry 2. Head & hair 3. Ears/Hearing 4. PERLL(A) 5. EOM 6. Convergence/Accommodation 7. Color/condition conjunctiva 8. Color/condition of mucus membranes 9. Nose 10. Mouth/teeth 11. ROM of neck 12. Cervical nodes 13. Palpate trachea for symmetry 14. Carotids, auscultate optionally 15. JVD | |
| Upper extremities | <ol style="list-style-type: none"> 1. Skin – condition, 2. Palpate for temperature, sensation, muscle tension/firmness 3. Capillary refill 4. Turgor 5. Pulses 6. Strength 7. ROM | |

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| Thorax/ Respiratory | <ol style="list-style-type: none"> 1. Inspect Thoracic expansion, symmetry 2. Inspect respiratory pattern 3. Palpate for tenderness, symmetry, and fremitus 4. Auscultate normal & abnormal sounds 5. Auscultate breath sounds (identify areas for normal breath sounds A & P) 6. Discuss anatomy | |
| Cardiac | <ol style="list-style-type: none"> 1. Inspect for abnormal pulsations 2. Palpate PMI 3. Auscultate heart sounds, identify sites, normal sounds, terminology 4. Discuss anatomy | |
| Abdomen | <ol style="list-style-type: none"> 1. Inspect for symmetry, pulsations, bladder distention 2. Auscultate for Bowel Sounds X 4 3. Light palpation for surface lumps or nodules 4. Discuss/demonstration assessment for abdominal pain 5. Discuss underlying anatomy | |
| Lower Extremities | <ol style="list-style-type: none"> 1. Inspect Skin – condition, hair distribution. 2. Palpate for temperature, sensation, muscle tension/firmness 3. Capillary refill 4. Pulses 5. Pedal and Ankle Edema 6. Strength, dorsal and plantar flexion 7. ROM 8. Homan's Sign | |