COLLEGE OF THE SISKIYOUS
NURS 0951
HEAD TO TOE ASSESSMENT

Assessment	**Normal expected findings**
GENERAL SURVEY	
• *Introduction: Call patient by name, introduce self, shake hands, walk pt to exam room observing gait and posture	
• Purpose	Pt states reason for visit and time of appointment
• *Mental status	Pt is alert and oriented (A&O) x4 to person, place, time, and event/situation
• Eye contact	Pt makes good eye contact with nurse
• Posture	Posture is erect
• *Gait	Walking gait is steady
• *Appearance	Pt shows no signs of distress/ dressed appropriately for the weather
• Hygiene	Hair, nails, and clothing are clean and well groomed
• *Speech	Speech is clear and appropriate
• Nutritional status	Ask pt whether they follow any special diet, whether they drink water, assess whether weight is appropriate for height
• *Skin	Skin is warm, dry and intact when shaking hands. No observable bruising, concerning moles, or other skin problems. **Skin will be assessed as you move through each area**.
Tell pt that if they experience pain/discomfort at any time during the exam to let you know.	
HEAD AND FACE & EYES AND EARS	
• Inspect hair for texture, distribution, and quantity of hair	Hair should not be excessively oily or dry, even distribution on scalp, and no alopecia
• *Inspect symmetry and external characteristics of eyes and ears	Eyes and ears should be symmetrical with no drainage
• Inspect eyelids, eyelashes and eyebrows	No drooping of lids, full eyelashes & brows
• *Inspect sclerae, conjunctivae	White sclerae, pink conjunctivae
• *Assess visual fields (**CN II – optic nerve**) Use a snellen eye chart for visual acuity or assess peripheral vision from behind pt	Pt will read at 20/20 While looking straight ahead, pt will see your fingers moving in from the side
• *Test pupillary response to light (with lights dimmed) and accommodation • *Test extraocular eye movements “H” *(**CN III – oculomotor** – pupil constriction and EOM) *(**CN IV- trochlear**- EOM) *(**CN VI – abducens** – abducts the eyes with	Pupils constrict with light and dilate when light is removed. They should do so consensually (e.g., when light is on one eye, the other should also constrict) When an item is brought close to the eyes, the pupils constrict. When the item is moved to a distance, the pupils dilate

accomodation) Hint: “3, 4 & 6 make your eyes do tricks”	(accommodation) The crossing of the eyes is called consensual convergence. PERRLA: Pupils are equal, round, reactive to light and to accommodation With head not moving, eyes follow pen to all points of the “H” – EOM intact (extra ocular movements)
• *Ask pt to open jaw and clench teeth as you palpate the masseter muscle. *(**CN V – trigeminal** – muscles for chewing) • *Ask them to squeeze eyes shut tight, raise eyebrows, smile, and puff out cheeks *(**CNVII – facial** – taste in front 2/3 of tongue and facial expression) Hint: Think chewing a burger with Heinz 57 sauce.	Jaw should open fully. You should feel the masseter muscle contract as they clench teeth Able to squeeze eyes shut tight, raise eyebrows, smile, and puff out cheeks
• *Test hearing – have pt cover one ear while you whisper a number in the other. Have them repeat the number *(**CN VIII – vestibulocochlear**/auditory-hearing and balance)	Pt repeats the correct number
MOUTH AND PHARYNX	
• Using a penlight: Inspect lips, buccal mucosa, gums, hard and soft palates, floor of the mouth for color and surface characteristics/dentition, oropharnyx: uvula, tonsils, posterior pharynx, mouth odor	Gums, tongue and oral mucosa are pink, moist and intact Teeth are intact and in good condition Tonsils of normal size and no halitosis
• *Ask pt to swallow and say “ah” *(**CN IX – glossopharyngeal** – taste posterior 1/3 of tongue/tonsil & pharynx/swallowing)	With “ah”, there is symmetrical rise of the soft palate and uvula.
• *Have pt. stick out tongue straight and then move from side to side *(**CN XII - hypoglossal**)	Tongue is midline with no deviation and full tongue mobility
NECK	
• *(**CN X – vagus** – gland innervation/digestion/HR) • *Inspect for symmetry and smoothness of neck and thyroid and palpate thyroid, ask pt. to swallow	Neck should be smooth and symmetrical and no obvious nodules on thyroid as the patient swallows and the thyroid moves up and down. Pt can swallow without difficulty and has intact gag reflex (if tested with a tongue depressor).
• Inspect for right internal jugular venous distention with pt laying at 45 degree angle with head turned to the left	No distention of the right IJV
• *Test strength of head and neck and shoulder shrug with resistance	Pt can push head in all directions against resistance and shrug shoulders against

*(**CN XI – spinal accessory nerve** – innervates sternocleidomastoid/trapezius muscles/ controls shoulder and neck movements)	resistance
• *Palpate carotid pulses; only one side at a time!	Pulses are strong and equal bilaterally
• *Auscultate carotid arteries for bruits with bell of stethoscope	No bruits
• Palpate tracheal position	Trachea is midline
UPPER EXTREMITIES	
• Inspect and palpate shoulders, arms, and hands for hair distribution and muscle tone, skin and nail characteristics, temperature, edema	Even hair distribution / no muscles atrophy/ no edema, warm, dry, intact skin/ clean healthy nails
• *Assess capillary refill of one finger on each hand by blanching and releasing	Capillaries refill with blood within 2-3 seconds
• *Palpate brachial and radial pulses	Pulses are strong and equal bilaterally
• *Assess range of motion – wrists (rotation), elbows (flexion/extension), shoulders (circumflexion)	Full range of motion bilateral upper extremities
• *Assess strength of grip and against resistance	Strong grip and able to push against resistance
FEET AND LEGS	
• *Inspect and palpate hips, thighs, calves and feet for hair distribution and muscle tone, skin and nail characteristics, temperature, edema	Even hair distribution / no muscles atrophy/ warm, dry, intact skin/ clean healthy nails/ no edema
• *Assess capillary refill of one toe on each foot by blanching and releasing	Capillaries refill with blood within 2-3 seconds
• *Palpate femoral, popliteal, posterior tibialis and dorsalis pedis pulses	(Gloves when assessing the femoral pulses) Pulses are strong and equal bilaterally
• *Assess range of motion – hips (abduction/adduction/flexion and extension), knees (flexion and extension) ankles (circumduction), and feet (plantar flexion and dorsiflexion)	Full range of motion bilateral lower extremities
• *Assess strength of thighs, lower legs, and feet against resistance	Strong and able to push against resistance
SPINE	
• Ask pt to bend over as though touching their toes, but only as far as is comfortable: Palpate spinal processes and place hands on scapulae and hips	No curvature of the spine or masses and scapulae and hips are level bilaterally – no kyphosis, scoliosis, or lordosis

CHEST AND LUNGS	
• Inspect skin and chest expansion	Skin is intact and even chest expansion
• Inspect respiratory effort/depth, rhythm, and any pulsations	Breathing is nonlabored, even rhythm, no visible pulsations
• *Palpate chest wall	No tenderness, crepitus, or palpable pulsations
• *Auscultate systematically (bronchial, bronchovesicular, vesicular) for breath sounds	Lung sounds are clear in all fields
• Inspect skin of posterior thorax and spine	Skin is intact
• *Palpate thorax	No tenderness or crepitus
• *Auscultate systematically (bronchial, bronchovesicular, vesicular) for breath sounds	Lung sounds are clear in all fields
HEART	
• *Auscultate systematically for heart sounds: aortic valve (2nd intercostal space (ICS) right sternal border), pulmonic valve (2nd ICS left sternal border), ERBS point (3rd ICS left sternal border), tricuspid valve (4th ICS left sternal border), and mitral valve (5th ICS left midclavicular line)	No murmurs Aortic and pulmonic valves S2 is louder than S1, Erbs point S1 and S2 are equal, tricuspid and mitral valves S1 is louder than S2. The mitral valve is the point of maximal impulse where you auscultate an apical heart rate for one full minute.
ABDOMEN	
• *Ask pt when was their last bowel movement and any problems with the stool • *Inspect skin and contour	Pt verbalize recent BM no diarrhea/constipation/blood/change in bowel habits Skin is intact, no distention or visible masses, no herniation or pulsations
• *Auscultate all quadrants for bowel sounds (RLQ, RUQ, LUQ, LLQ) • If no bowels sound are heard, auscultate at least 5 min in each quadrant to confirm the absence of bowel sounds	Positive bowels sounds in all four quadrants (a minimum of 5 gurgles per quadrant within one minute)
• Auscultate the aorta and renal & iliac arteries using the bell of the stethoscope	No bruits
• Percuss all quadrants for tone	Dull over organs and fecal filled bowels, tympanic (air) over stomach and gas filled bowels, and flat over bone
• *Lightly palpate all 4 quadrants 2 cm depth	Nontender
• *Deeply palpate all 4 quadrants 4 cm depth	Soft nontender, nondistended or no masses
• *Identify organs in appropriate quadrants	RLQ appendix & McBurney's Point/ ascending, under the diaphragm is the transverse colon and LLQ descending colon and sigmoid colon RUQ liver/gallbladder LUQ pancreas and spleen
• *Assess urinary function	Clear, yellow, odorless urine/ no pain, frequency, burning, nocturia, or blood.

HEALTH PROMOTION QUESTIONS	
Men: monthly self-chest and self-testicular exams, annual prostate exam after 40, colonoscopy after 50 (every 10 years)	
Women: monthly self-breast exam, annual gynecologic exam, menses assessment, annual mammogram after 40, colonoscopy after 50 (every 10 years)	