

Head-To-Toe Assessment

General Survey



1. Patient position
2. Level of consciousness
3. Level of alertness
4. Eye opening
5. Presence or absence of nasal flaring

Head & Face

1. Size and shape of head
2. position of head
3. proportion of head
4. facial features
5. facial symmetry
6. facial hair
7. facial skin
8. facial features
9. facial features?

Neck



1. Inspect neck for pulsations
2. Inspect neck for symmetry
3. Check trachea for midline
4. palpate thyroid gland (one side at a time)
5. Auscultate carotid arteries with bell for bruits
6. Auscultate carotid artery with diaphragm

Eyes



1. Check external eyes
2. Inspect palpebral fissures
3. Inspect lid margin
4. Inspect conjunctiva (clear or pink?)
5. Inspect sclera (white or yellow?)
6. Palpate lacrimal gland
7. Assess extraocular muscles
8. Snell test
9. Assess eyes range of motion by corneal light reflex
10. Inspect PERLA
11. Inspect red light reflex

Ears



1. Size of ear
2. Shape of external ear
3. Color of ear consistent with face?
4. Inspect for drainage, cerumen, lesions, rashes, skin integrity, and hair
5. Inspect for deformities
6. Inspect for tenderness
7. Perform Weber test
8. Inspect tympanic membrane. Is it clear and translucent? Light reflex is appropriate bilaterally? (5:00 right ear, 7:00 left ear)
9. Perform Romberg test

Mouth & Throat



1. Inspect lips for color, moisture, integrity, and lesions
2. Inspect tongue for cavities, level of oral cavity, and lesions
3. Inspect throat for color and presence of tonsils
4. Inspect uvula using tongue depressor
5. Inspect throat color and presence of tonsils
6. Palpate uvula using tongue depressor

Heart



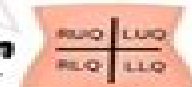
1. Inspect precordium for heaves, lifts
2. Palpate apical pulse
3. Palpate sternum and tricus
4. Auscultate heart and bell APETM (aortic, Erb's point, tricus)

Lungs



1. Inspect ratio to transverse diameter
2. Palpate chest expansions anterior and posterior
3. Percuss anterior and posterior (dull, flat)
4. Auscultate breath sounds
5. Inspect for crackles and wheezes

Abdomen



1. Inspect for contour
2. Inspect for tenderness, pulsations, and umbilicus
3. Auscultate bowel sounds in all 4 quadrants
4. Percuss tympany or dullness
5. Light palpation for deep pain in all 4 quadrants
6. Palpate gallbladder (Murphy's sign)
7. Palpate appendix (RLQ)

Skin

1. Inspect for edema, hair, moles, rashes, scars, and bruising
2. Inspect for discoloration, cyanosis, and pallor
3. Inspect for temperature
4. Inspect for moisture
5. Inspect for texture
6. Inspect for turgor
7. Inspect for any cyanosis?

Peripheral Vessels

1. Inspect fingers for clubbing
2. Check capillary refill
3. Palpate brachial and radial pulse
4. Palpate femoral and popliteal nodes
5. Inspect for varicose veins
6. Palpate pedal pulse
7. Inspect for edema

Guide Sheet For Nursing Assessment

Hussin A.Rothana



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