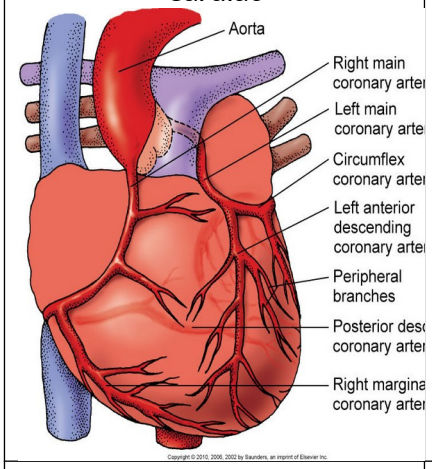
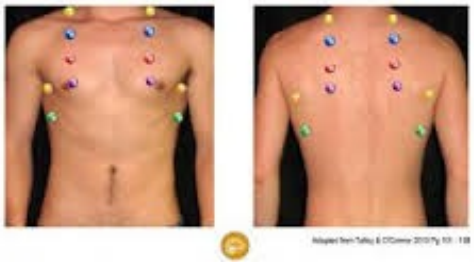
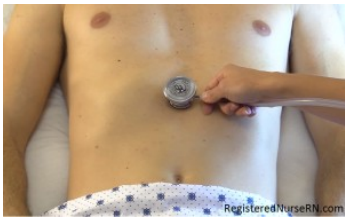
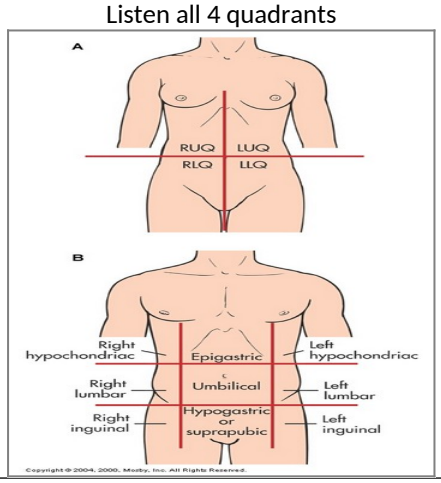
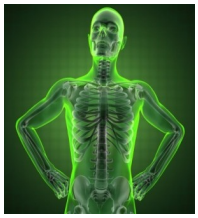
N101- Foundations of Nursing
Health Assessment Clinical Guide Head to Toe Assessment

Assessment	Instructions	Comments
Introduction 	Shake hands as you greet your patient stating your name & role of student nurse noting: • Orientation-person, place, time, & situation • Eye contact/Pupil Size • Speech-clear, rambling, slurred • Facial Symmetry/Expression • Skin (warm & dry) • Capillary refill of fingers <3 seconds • Turgor Anterior Forearm • Check gait if walking • Walking, wheelchair, chair –need assistance? • Pain Assessment (numeric scale 0-10)	**When you are ready to do more in depth assessments you can say to your patient:** ” I need to listen to your heart, lungs, abdomen, and check your circulation. Since I am learning, it will take me longer than the nurse. I may need to have my instructor come in and listen. This does not mean anything is wrong. I am just checking to be sure I am hearing things correctly”.
Neuro 	Pupils equal & round  Recent Memory Remote Memory Coordination Sensation	**Recent** memory-“What did you have for breakfast”? **Remote** memory -“Where were you born”?
Cardiac 	• S1 @ apex 5th ICS • S2 @ base 2nd ICS • Apical rate & rhythm • Skin Turgor • Pulses-carotid, radial, pedal, posterior tibial. • Edema (shin bone) • +1=2mm • +2=2-4mm • +3=5-7mm • +4=8mm • Capillary refill of fingers & toes • Homan’s Sign	**Best position**-supine ***During lab instructor counts radial while student auscultates apical.*** If elderly patient you may use the sternum for **skin turgor** if forearm inelastic Palpate **pulses** bilaterally & simultaneously except for the carotids. **Edema-**pretibial & feet, press 5 seconds each area & document depth:
Pulmonary 	Anterior & Posterior 	**Listen anteriorly** & if easy for patient to sit up then posteriorly. If patient has limited movement wait until last ***but you must perform posterior assessment***. **Best position**-sitting up with arms crossed in lap. (expands chest) Review your notes for adventitious sounds.

Abdomen  	Listen all 4 quadrants  	**Listen** for bowel sounds- (hypo, hyper active or absent). **Listen for 5 minutes** to declare absent. Sounds occur every 5-15 seconds **Sounds like** clicks & gurgles
Musculoskeletal 	Assess muscle strength & gait	**Strength-**Cross fingers before patient squeezes, Perform push/pull hands feet, Assess shoulder resistance **Gait**-steady or unsteady, needs assistance or device
Health Assessment Lab  	***Bring to your assessment practice and to your assessment lab!***	For health assessment lab the student will: Palpate **pulses** & compare bilaterally Palpate for **urinary bladder distention** **Document** per faculty instructions

Bixby/ 2020