Examples of Normal/Abnormal Physical Assessment Findings

REV: 8/15/24

NEUROLOGICAL/SENSORY (LOC, sensation, strength, speech, pupil assessment, pain):

Normal: Alert, oriented X3. Pupils 3 mm equal, round, reactive, to light (PERRL). Moves all extremities on command, responds appropriately to sharp & dull sensations. Hand grasp and tow wiggle (HGTW) equal & strong bilaterally. Movements purposeful & coordinated. Speaks English (native language) clearly. Pain level "0" on 1-10 scale.

Abnormal: Confused to place & time, oriented to person. R pupil 3 mm, L pupil 6 mm. Pupils react sluggishly to light. Does not respond to on 1-10 sharp/dull sensations. Right hand grasp weak, left strong, toe wiggle absent bilaterally. Speech slurred, incoherent. Reports pain of "8" on 1-10 pain scale. Pain is dull ache to left knee.

PSYCHOLOGICAL/SOCIAL (affect, interaction with family, friends, staff):

Normal: Cheerful affect interacts appropriately with family, friends, and staff.

Abnormal: Flat affect. Little interaction with family, friends, or staff. Agitated, uncooperative, withdrawn.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing.)

Normal: Eyes and ears symmetrical. PERRLA. Hearing is intact. No drainage of EENT. Oral mucosa is pink and moist with good dentition. Nodes are non-palpable. Swallowing intact.

Abnormal: Clear drainage of left eye. Hearing impaired with bilateral hearing aids. Oral mucosa is pink and dry with poor dentition (missing teeth, multiple caries, etc.). Swelling of tonsils. Nodes are palpable (unilaterally, bilaterally).

RESPIRATORY (chest configuration, breath sounds, rate, rhythm, depth)

Normal: Chest symmetrical, trachea midline. Respirations 28, even and non-labored. Breath sounds clear to auscultation (CTA) bilaterally. Breathing room air, O2 sat 98%.

Abnormal: Chest barrel shaped, trachea shifted to right. Respirations 34 and shallow. Breath sounds diminished on the left with expiratory wheezes heard throughout. Course crackles bilaterally, respirations labored. O2 3L nasal cannula (N/C) with O2 sat 86-88%.

CARDIOVASCULAR (heart sounds, apical and radial rate, rhythm, radial and pedal pulse)

Normal: S1 & S2 audible with steady, consistent rate and rhythm. Apical rate 72, radial rate 72; radial pulses 2+ bilaterally. Pedal pulses 2+ bilaterally, no edema noted. B/P 110/76. Denies chest pain or discomfort. Nailbeds pink, capillary refill <2-3 seconds.

Examples of Normal/Abnormal Physical Assessment Findings

REV: 8/15/24

Abnormal: Heart sounds audible with murmur noted. Irregular rate and rhythm. Apical rate 132, radial pulse 1+ bilaterally with rate of 102. Right pedal pulse 2+, left pedal pulse 0, audible with doppler only. 3+ pitting edema bilaterally to ankles & feet. Nailbeds pale and gray. Capillary refill >3 seconds.

GASTROINTESTINAL (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpitation):

Normal: Abdomen flat, soft and nontender. Active bowel sounds X 4 quadrants. States usually has BM every AM with soft, formed brown stool. (not observed)

Abnormal: Abdomen distended, firm. Bowel sounds absent X 4 quadrants. Right lower quadrant (RLQ). Reports/States severe tenderness to RLQ during palpation. Incontinent of frequent, black tarry stools.

GENITOURINARY/REPRODUCTIVE (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge):

Normal: Voids clear yellow urine, adequate amount. Denies odor, discharge or pain. Post-menopausal.

Abnormal: Foley to gravity draining cloudy amber colored urine with foul smell and sediment. Urine output 100 mL in past 8 hours.

SKIN/MUSCULOSKELETAL (skin color, temperature, texture, turgor, integrity, mobility, gait):

Normal: Skin warm, dry and intact. Color appropriate to race. Texture supple. Turgor elastic. Walks ad lib without assistance, gait steady.

Abnormal: Skin cool, clammy. Texture dry, scaly. Turgor poor. Bilateral lower extremities (BLE) contracted, lying in fetal position. Does not ambulate. Stage III decubitus ulcer on coccyx 10cm X 6cm covered with transparent dressing.

WOUNDS/DRESSINGS

ALL tubes, drains, wounds & drsgs should be assessed. May document with the pertinent body system assessment. Type of wound/drsg, Location (proximal point – distal point), size of wound if visible, Condition of wound/drsg, condition of skin near drsg/cast of not previously addressed. Tubes/drains: type and size, point of insertion and skin condition, drainage or fluid infusing, to suction or gravity, if drainage present describe color, amount, include amount in your I&O

Splint with gauze drsg and ace wrap to LLE, below knee to toes. clean, dry & intact. No sign of skin irritation or breakdown at edges of drsg. 18 g peripheral IV to R arm clamped. Occlusive dressing dry & intact. No edema, redness or drainage. Pt denies pain when site palpated.

10 cm midline abdominal incision, edges well approximated. sutures intact, reddened with small amount of serous drainage.

Occlusive dressing to right knee abrasion clean, dry and intact. Abrasion is 2 x 7 cm.