Examples of Normal/Abnormal Physical Assessment Findings

REV: 11/15/25

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

Normal: Alert, oriented X3. Pupils 3 mm equal, round, reactive, to light and accommodation (PERRLA). Moves all extremities on command, responds appropriately to sharp & dull sensations. Hand grasp and toe 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. Sluggish pupillary reaction to light. Decreased sensation to extremities x 4. Right hand grasp weak, left strong, toe wiggle absent bilaterally. Speech slurred, incoherent. Reports pain of "8" on 1-10 pain scale.

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

Normal: Responsive 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 Agitated, uncooperative, withdrawn.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 (if not documented in neuro). No signs of hearing deficit. 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, etc.). Swelling of tonsils. Nodes are palpable (note location, i.e., unilaterally, bilaterally).

RESPIRATORY (chest configuration, rate, rhythm, depth, breath sounds, oxygen saturation and device)

Normal: Chest symmetrical, trachea midline. Respirations 18, even and non-labored. Breath sounds clear to auscultation (CTA) bilaterally. O2 98% on room air (RA).

Abnormal: Chest barrel shaped, trachea shifted to right. Respirations 34 and shallow. Breath sounds diminished on the left with expiratory wheezes heard to right lung. Course crackles to right lower lung, respirations labored. O2 88% on 3L NC.

CARDIOVASCULAR (heart sounds, rhythm, apical rate, radial rate, radial and pedal pulse strength, edema, capillary refill)

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

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Abnormal: Heart sounds audible with murmur noted. Irregular rate and rhythm. Apical rate 132, radial rate 120, radial pulse 1+ bilaterally. Right pedal pulse 2+, left pedal pulse absent, audible with doppler only. 3+ pitting edema bilaterally to ankles & feet. Nailbeds pale and gray. Capillary refill >3 seconds.

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

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

Abnormal: Abdomen distended, firm. Bowel sounds absent to RUQ and RLQ. Reports tenderness of 8/10 to RLQ during palpation. Incontinent of bowel, black tarry stools noted.

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

Normal: Voids clear, yellow urine. Denies frequency, urgency, odor, discharge, or pain. Post-menopausal. Noted 350 ml void at 1000.

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

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

Normal: Skin warm, smooth, dry, and intact. Color appropriate to race. 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 left side. Does not ambulate. Inability for active ROM to bilateral lower extremities. Stage III decubitus ulcer on coccyx 10cm X 6cm covered with transparent dressing. Dull pain to left knee.

WOUNDS/DRESSINGS

ALL tubes, drains, wounds & dressings (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. Examples below:

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.