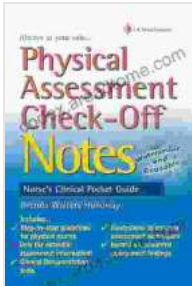


# Physical Assessment Check Off Notes: Nurse Clinical Pocket Guide



## Physical Assessment Check-Off Notes Nurse's Clinical Pocket Guide (Nurse's Clinical Pocket Guides)

by Brenda Walters Holloway

★★★★☆ 4.5 out of 5

Language : English

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Screen Reader : Supported

X-Ray for textbooks : Enabled



Physical assessment is an essential skill for all nurses. It allows nurses to assess a patient's overall health and identify any potential problems. This pocket guide provides quick and easy access to the key steps and findings for each physical assessment skill.

## Contents

- General Survey
- Respiratory Assessment
- Cardiovascular Assessment
- Abdominal Assessment
- Neurological Assessment
- Musculoskeletal Assessment

## **General Survey**

The general survey is a quick and easy way to assess a patient's overall health. It includes the following steps:

- Observe the patient's overall appearance. Note their posture, body habitus, and any obvious deformities.
- Measure the patient's vital signs (temperature, pulse, respirations, and blood pressure).
- Assess the patient's skin for any rashes, lesions, or other abnormalities.
- Palpate the patient's lymph nodes for any enlargement or tenderness.
- Auscultate the patient's heart and lungs for any abnormal sounds.

## **Respiratory Assessment**

Respiratory assessment is important for assessing a patient's ability to breathe. It includes the following steps:

- Observe the patient's respiratory rate and pattern.
- Palpate the patient's chest for any tenderness or crepitus.
- Percuss the patient's chest for any dullness or hyperresonance.
- Auscultate the patient's lungs for any abnormal sounds (e.g., wheezes, rales, or rhonchi).

## **Cardiovascular Assessment**

Cardiovascular assessment is important for assessing a patient's heart and blood vessels. It includes the following steps:

- Take the patient's blood pressure.
- Palpate the patient's pulse for any abnormalities (e.g., rate, rhythm, or volume).
- Auscultate the patient's heart for any abnormal sounds (e.g., murmurs, gallops, or clicks).
- Inspect the patient's peripheral pulses for any abnormalities (e.g., weak or absent pulses).

## **Abdominal Assessment**

Abdominal assessment is important for assessing a patient's gastrointestinal system. It includes the following steps:

- Inspect the patient's abdomen for any distension, scars, or hernias.
- Palpate the patient's abdomen for any masses, tenderness, or organomegaly.
- Percuss the patient's abdomen for any dullness or hyperresonance.
- Auscultate the patient's abdomen for any abnormal sounds (e.g., bowel sounds or bruits).

## **Neurological Assessment**

Neurological assessment is important for assessing a patient's nervous system. It includes the following steps:

- Assess the patient's mental status (e.g., orientation, memory, and concentration).

- Test the patient's cranial nerves (e.g., vision, hearing, smell, taste, and touch).
- Test the patient's motor function (e.g., strength, coordination, and balance).
- Test the patient's sensory function (e.g., pain, temperature, and vibration).

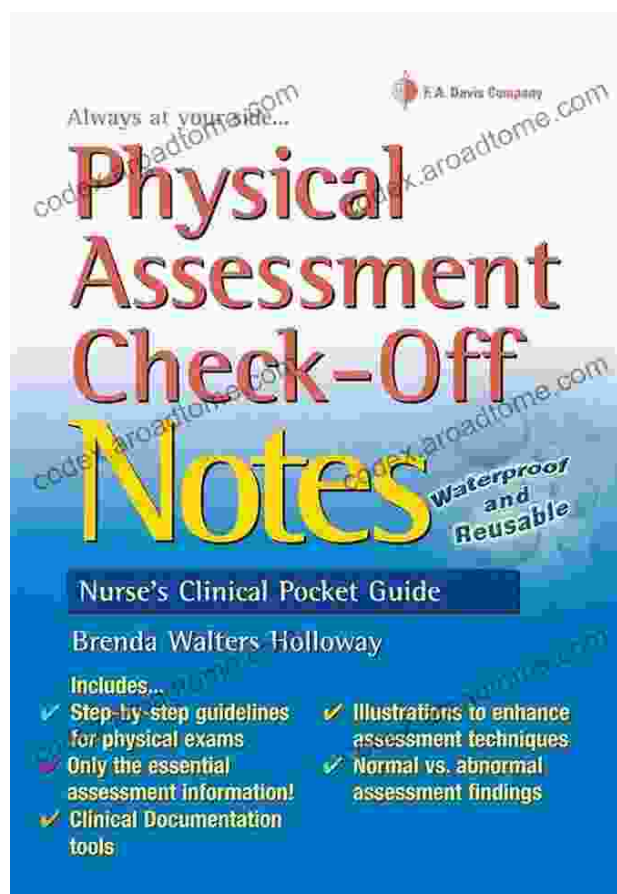
## **Musculoskeletal Assessment**

Musculoskeletal assessment is important for assessing a patient's bones, muscles, and joints. It includes the following steps:

- Inspect the patient's musculoskeletal system for any deformities, swelling, or tenderness.
- Palpate the patient's muscles for any tenderness or masses.
- Test the patient's range of motion.
- Test the patient's strength.

This pocket guide is a valuable resource for all nurses who perform physical assessments. It provides quick and easy access to the key steps and findings for each physical assessment skill.

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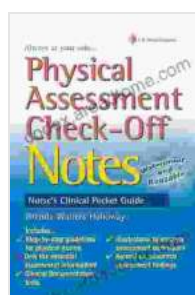
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