**APPENDIX F**

 **HISTORY TAKING and PHYSICAL EXAMINATION**

| Name  | Date   |
| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |
|  |  |
| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-1**Performing a General Survey** |
| **Goal:** The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patient is formulated, the findings are documented, and the appropriate referral is made to other healthcare professionals, as needed for further evaluation. | **Comments** |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close curtains around the bed and the door to the room, if possible. Explain the purpose of the health examination and what she is going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Assess the patient’s physical appearance. Observe if the patient appears to be his or her stated age. Note the patient’s mental status. Is the person alert and oriented, responsive to questions and responding appropriately? Are the facial features symmetric? Note any signs of acute distress, such as shortness of breath, pain, or anxiousness. |  |
| ☐ | ☐ | ☐ | 5. Assess the patient’s body structure. Does the person’s height appear within normal range for stated age and genetic heritage? Does the person’s weight appear within normal range for height and body build? Note if body fat is evenly distributed. Do body parts appear equal bilaterally and relatively proportionate? Is the patient’s posture erect and appropriate for age? |  |
| ☐ | ☐ | ☐ | 6. Assess the patient’s mobility. Is the patient’s gait smooth, even, well-balanced, and coordinated? Is joint mobility smooth and coordinated with a general full range of motion (ROM)? Are involuntary movements evident? |  |
| ☐ | ☐ | ☐ | 7. Assess the patient’s behavior. Are facial expressions appropriate for the situation? Does the patient maintain eye contact, based on cultural norms? Does the person appear comfortable and relaxed with she? Is the patient’s speech clear and understandable? Observe the person’s hygiene and grooming. Is the clothing appropriate for climate, fit well, appear clean, and appropriate for the person’s culture and age group? Does the person appear clean and well groomed, appropriate for age and culture? |  |
| ☐ | ☐ | ☐ | 8. Assess for pain. (Refer to Chapter 10.) |  |
| ☐ | ☐ | ☐ | 9. Have the patient remove shoes and heavy outer clothing. Weigh the patient using a scale. Compare the measurement with previous weight measurements and recommended range for height. |  |
| ☐ | ☐ | ☐ | 10. With shoes off, and standing erect, measure the patient’s height using a wall-mounted measuring device or measuring pole. |  |
|   |  |  |  |  |
| ☐ | ☐ | ☐ | 11. Use the patient’s weight and height measurements to calculate the patient’s BMI. |  |
| ☐ | ☐ | ☐ | 12. Using the tape measure, measure the patient’s waist circumference. Place the tape measure snugly around the patient’s waist at the level of the umbilicus. |  |
| ☐ | ☐ | ☐ | 13. Measure the patient’s temperature, pulse, respirations, blood pressure, and oxygen saturation. (Refer to Chapter 2, and Chapter 14, for specific techniques.) |  |
| ☐ | ☐ | ☐ | 14. Remove PPE, if used. Clean equipment, based on facility policy. Perform hand hygiene. Continue with assessments of specific body systems as appropriate or indicated. Initiate appropriate referral to other health care practitioners for further evaluation as indicated. |  |

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| Name  | Date   |
| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-2**Assessing the Skin, Hair, and Nails** |
| --- | --- | --- | --- |
| **Goal:** The assessment is completed without the patient experiencing anxiety or discomfort, the findings are documented, and the appropriate referral is made to the other healthcare professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close curtains around the bed and the door to room, if possible. Explain the purpose of the integumentary examination and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Ask the patient to remove all clothing and put on an examination gown (if appropriate). The patient remains in the sitting position for most of the examination, but will need to stand or lie on the side when the posterior part of the body is examined, exposing only the body part being examined. |  |
| ☐ | ☐ | ☐ | 5. Use the bath blanket or drape to cover any exposed area other than the one being assessed. Inspect the overall skin coloration. |  |
| ☐ | ☐ | ☐ | 6. Inspect skin for vascularity, bleeding, or bruising. |  |
| ☐ | ☐ | ☐ | 7. Inspect the skin for lesions. Note bruises, scratches, cuts, insect bites, and wounds. (Refer to Wound Assessment [Fundamentals Review 8-3] in Chapter 8.) If present, note size, shape, color, exudates, and distribution/pattern, and presence of drainage or odor. Assess the location and condition of body piercings and/or tattoos. |  |
| ☐ | ☐ | ☐ | 8. Palpate skin using the backs of your hands to assess temperature. Wear gloves when palpating any potentially open area of the skin. |  |
| ☐ | ☐ | ☐ | 9. Palpate for texture and moisture. |  |
| ☐ | ☐ | ☐ | 10. Assess for skin turgor by gently pinching the skin under the clavicle. |  |
| ☐ | ☐ | ☐ | 11. Palpate for edema, which is characterized by swelling, with taut and shiny skin over the edematous area. |  |
| ☐ | ☐ | ☐ | 12. If lesions are present, put on gloves and palpate the lesion. |  |
| ☐ | ☐ | ☐ | 13. Inspect the nail condition, including the shape, texture, and color as well as the nail angle; note if any clubbing is present. |  |
| ☐ | ☐ | ☐ | 14. Palpate nails for texture and capillary refill. |  |
| ☐ | ☐ | ☐ | 15. Inspect the hair and scalp for color, texture, and distribution. Wear gloves for palpation if lesions or infestation is suspected or if hygiene is poor. |  |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 16. Remove gloves and any additional PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |

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| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-3**Assessing the Head and Neck** |
| --- | --- | --- | --- |
| **Goal:** The assessment is completed without the patient experiencing anxiety or discomfort, the findings are documented, and the appropriate referral is made to the other healthcare professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close the curtains around the bed and close the door to the room, if possible. Explain the purpose of the head and neck examination and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Inspect the head for size and shape. Inspect the face for color, symmetry, lesions, and distribution of facial hair. Note facial expression. Palpate the skull. |  |
| ☐ | ☐ | ☐ | 5. Inspect the external eye structures (eyelids, eyelashes, eyeball, and eyebrows), cornea, conjunctiva, and sclera. Note color, edema, symmetry, and alignment. |  |
| ☐ | ☐ | ☐ | 6. Examine the pupils for equality of size and shape. Examine the pupillary reaction to light: |  |
| ☐ | ☐ | ☐ | a. Darken the room. |  |
| ☐ | ☐ | ☐ | b. Ask the patient to look straight ahead. |  |
| ☐ | ☐ | ☐ | c. Bring the penlight from the side of the patient’s face and briefly shine the light on the pupil. |  |
| ☐ | ☐ | ☐ | d. Observe the pupil’s reaction; it normally constricts rapidly (direct response). Note pupil size. |  |
| ☐ | ☐ | ☐ | e. Repeat the procedure and observe the other eye; it too normally will constrict (consensual reflex). |  |
| ☐ | ☐ | ☐ | f. Repeat the procedure with the other eye. |  |
| ☐ | ☐ | ☐ | 7. Test for pupillary accommodation: |  |
| ☐ | ☐ | ☐ | a. Hold the forefinger, a pencil, or other straight object about 10 to 15 cm (4″ to 6″) from the bridge of the patient’s nose. |  |
| ☐ | ☐ | ☐ | b. Ask the patient to first look at the object, then at a distant object, then back to the object being held. The pupil normally constricts when looking at a near object and dilates when looking at a distant object. |  |
|   |  |  |  |  |
| ☐ | ☐ | ☐ | 8. Assess extraocular movements. |  |
| ☐ | ☐ | ☐ | a. Ask the patient to hold the head still and follow the movement of your forefinger or a penlight with the eyes as you move the patient’s eyes through the six cardinal positions of gaze. |  |
| ☐ | ☐ | ☐ | b. Keeping your finger or penlight about 1 foot from the patient’s face, move it slowly through the cardinal positions: up and down, right and left, diagonally up and down to the left, diagonally up and down to the right. |  |
| ☐ | ☐ | ☐ | 9. Test convergence: |  |
| ☐ | ☐ | ☐ | a. Hold your finger about 6″ to 8″ from the bridge of the patient’s nose. |  |
| ☐ | ☐ | ☐ | b. Move your finger toward the patient’s nose. The patient’s eyes should normally converge (assume a cross-eyed appearance). |  |
| ☐ | ☐ | ☐ | 10. Test the patient’s visual acuity with a Snellen chart. Have the patient stand 20 feet from the chart and ask the patient to read the smallest line of letters possible, first with both eyes and then with one eye at a time (with the opposite eye covered). Note whether the patient’s vision is being tested with or without corrective lenses. |  |
| ☐ | ☐ | ☐ | 11. Inspect the external ear bilaterally for shape, size, and lesions. Palpate the ear and mastoid process. Inspect the visible portion of the ear canal. Note cerumen (wax), edema, discharge, or foreign bodies. |  |
| ☐ | ☐ | ☐ | 12. Use a whispered voice to test hearing. Stand about 1 to 2 feet away from the patient out of the patient’s line of vision. Ask the patient to cover the ear not being tested. Determine whether the patient can hear a whispered sentence or group of numbers from a distance of 1 to 2 feet. Perform a test on each ear. |  |
| ☐ | ☐ | ☐ | 13. Put on gloves. Inspect and palpate the external nose. |  |
| ☐ | ☐ | ☐ | 14. Palpate over the frontal and maxillary sinuses. |  |
| ☐ | ☐ | ☐ | 15. Occlude one nostril externally with a finger while the patient breathes through the other; repeat for the other side. |  |

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| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-3**Assessing the Head and Neck** *(Continued)* |
| --- | --- | --- | --- |
|  | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 16. Inspect each anterior nares and turbinates by tipping the patient’s head back slightly and shining a light into the nares. Examine the mucous membranes for color and the presence of lesions, exudate, or growths. Also, inspect the nasal septum for intactness and deviation. |  |
| ☐ | ☐ | ☐ | 17. Inspect the lips, oral mucosa, hard and soft palates, gingivae, teeth, and salivary gland openings. Ask the patient to open the mouth wide and use a tongue blade and penlight to visualize structures. |  |
| ☐ | ☐ | ☐ | 18. Inspect the tongue. Ask the patient to stick out the tongue. Place a tongue blade at the side of the tongue while patient pushes it to the left and right with the tongue. Inspect the uvula by asking the patient to say “ahh” while sticking out the tongue. Palpate the tongue for muscle tone and tenderness. Remove gloves. |  |
| ☐ | ☐ | ☐ | 19. Inspect and palpate the lymph nodes for enlargement, tenderness, and mobility, using the finger pads in a slow, circular motion. |  |
| ☐ | ☐ | ☐ | 20. Inspect and palpate the left and then the right carotid arteries. ***Only palpate one carotid artery at a time.*** Note the strength of the pulse and grade it as with peripheral pulses. Use the bell of the stethoscope to auscultate the arteries. |  |
| ☐ | ☐ | ☐ | 21. Inspect and palpate the trachea. |  |
| ☐ | ☐ | ☐ | 22. Assess the thyroid gland with the patient’s neck slightly hyperextended. Observe the lower portion of the neck overlying the thyroid gland. Assess for symmetry and visible masses. Ask the patient to swallow. Observe the area while the patient swallows. Offer a glass of water, if necessary, to make it easier for the patient to swallow. |  |
| ☐ | ☐ | ☐ | 23. Inspect the ability of the patient to move the neck. Ask the patient to touch chin to chest and to each shoulder, each ear to the corresponding shoulder, and then tip the head back as far as possible. |  |
| ☐ | ☐ | ☐ | 24. Remove any additional PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |

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| Name  | Date   |
| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-4**Assessing the Thorax, Lungs, and Breasts** |
| --- | --- | --- | --- |
| **Goal:** The assessment is completed without causing the patient to experience anxiety or discomfort, the findings are documented, and the appropriate referral is made to other healthcare professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close the curtains around the bed and close the door to the room, if possible. Explain the purpose of the thorax, lung, breast, and axillae examination and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Help the patient undress, if needed, and provide a patient gown. Assist the patient to a sitting position and expose the posterior thorax. |  |
| ☐ | ☐ | ☐ | 5. Use the bath blanket to cover any exposed area other than the one being assessed. |  |
| ☐ | ☐ | ☐ | 6. Inspect the posterior thorax. Examine the skin, bones, and muscles of the spine, shoulder blades, and back as well as symmetry of expansion and accessory muscle use during respirations. |  |
| ☐ | ☐ | ☐ | 7. Assess the anteroposterior (AP) and lateral diameters of the thorax. |  |
| ☐ | ☐ | ☐ | 8. Palpate over the spine and posterior thorax. Use the dorsal surface of the hand to palpate for temperature. Use the palmar surface of the hand to palpate for tenderness, muscle development, and masses. |  |
| ☐ | ☐ | ☐ | 9. Assess thoracic expansion by standing behind the patient and placing both thumbs on either side of the patient’s spine at the level of T9 or T10. Ask the patient to take a deep breath and note movement of your hands. |  |
| ☐ | ☐ | ☐ | 10. Auscultate the lungs across and down the posterior thorax to the bases of lungs as the patient breathes slowly and deeply through the mouth, comparing sides. |  |
| ☐ | ☐ | ☐ | 11. Inspect the anterior thorax. With the patient sitting, rearrange the gown so the anterior chest is exposed. Inspect the skin, bones, and muscles, as well as symmetry of lung expansion and accessory muscle use. |  |
| ☐ | ☐ | ☐ | 12. Palpate the anterior thorax using the proper sequence. Use the palmar surface of the hand to palpate for temperature, tenderness, muscle development, and masses. |  |

|   |  |  |  |  |
| --- | --- | --- | --- | --- |
| ☐ | ☐ | ☐ | 13. Auscultate the lungs through the anterior thorax as the patient breathes slowly and deeply through the mouth. |  |
| ☐ | ☐ | ☐ | 14. Inspect the breasts. Ask the patient to rest hands on both sides of the body, then on the hips and finally above the head. With the patient holding each position, inspect the breasts for size, shape, symmetry, color, texture, and skin lesions. Inspect the areola and nipples for size and shape and the nipples for discharge, crusting, and inversion. |  |
| ☐ | ☐ | ☐ | 15. Palpate the axillae with the patient’s arms resting against the side of the body. If any nodes are palpable, assess their location, size, shape, consistency, tenderness, and mobility. |  |
| ☐ | ☐ | ☐ | 16. Assist the patient into a supine position. Place a small pillow or towel under the patient’s back and ask the patient to place a hand on the side being examined under the head, if possible. |  |
| ☐ | ☐ | ☐ | 17. Wear gloves if there is any discharge from the nipples or if a lesion is present. Palpate each quadrant of each breast in a systematic method, using either the circular, wedge, or vertical strip technique. Palpate the nipple and areola and gently compress the nipple between the thumb and forefinger to assess for discharge. |  |
| ☐ | ☐ | ☐ | 18. Assist the patient into a comfortable position and in replacing the gown. Remove gloves and any additional PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |

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| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-5**Assessing the Cardiovascular System** |
| --- | --- | --- | --- |
| **Goal:** The assessment is completed without causing the patient to experience anxiety or discomfort, the findings are documented, and the appropriate referral is made to other healthcare professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close the curtains around the bed and close the door to the room, if possible. Explain the purpose of the cardiovascular examination and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Help the patient undress, if needed, and provide a patient gown. Assist the patient to a supine position with the head elevated about 30 to 45 degrees, if possible, and expose the anterior chest. Use the bath blanket to cover any exposed area other than the one being assessed. |  |
| ☐ | ☐ | ☐ | 5. If not performed previously with the assessment of the head and neck, inspect and palpate the left and then the right carotid arteries. ***Palpate only one carotid artery at a time.*** Note the strength of the pulse and grade it as with peripheral pulses. Use the bell of the stethoscope to auscultate the arteries. Refer to Step 20, Skill 3-4. |  |
| ☐ | ☐ | ☐ | 6. Inspect the neck for distention of the jugular veins. |  |
| ☐ | ☐ | ☐ | 7. Inspect the precordium (the portion of the body over the heart and lower thorax, encompassing the aortic, pulmonic, tricuspid, and mitral (apical) areas, and Erb’s point) for contour, pulsations, and heaves. Observe for the apical impulse at the fourth to fifth intercostal space (ICS) at the left midclavicular line. |  |
| ☐ | ☐ | ☐ | 8. Using the palmar surface with the four fingers held together, gently palpate the precordium for pulsations. Remember that hands should be warm. Palpation proceeds in a systematic manner, with assessment of specific cardiac landmarks—the aortic, pulmonic, tricuspid, and mitral areas and Erb’s point. Palpate the apical impulse in the mitral area. Note size, duration, force, and location in relationship to the midclavicular line. |  |
| ☐ | ☐ | ☐ | 9. Auscultate heart sounds. Ask the patient to breathe normally. Use the diaphragm of the stethoscope first to listen to high-pitched sounds. Then use the bell to listen to low-pitched sounds. Focus on the overall rate and rhythm of the heart and the normal heart sounds. Begin at the aortic area, move to the pulmonic area, then to Erb’s point, then the tricuspid area, and finally listen at the mitral area. |  |
|  ☐ | ☐ | ☐ | 10. Assist the patient in replacing the gown. Remove PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems as appropriate or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |

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| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-6**Assessing the Abdomen** |
| --- | --- | --- | --- |
| **Goal:** The assessments are completed without causing the patient to experience anxiety or discomfort, the findings are documented, and the appropriate referral is made to other healthcare professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close the curtains around bed and close the door to the room, if possible. Explain the purpose of the abdominal examination and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Help the patient undress, if needed, and provide a patient gown. Assist the patient to a supine position, if possible, and expose the abdomen. Use the bath blanket to cover any exposed area other than the one being assessed. |  |
| ☐ | ☐ | ☐ | 5. Inspect the abdomen for skin color, contour, pulsations, the umbilicus, and other surface characteristics (rashes, lesions, masses, scars). |  |
| ☐ | ☐ | ☐ | 6. Auscultate all four quadrants of the abdomen for bowel sounds. Warm the stethoscope and, using light pressure, place the flat diaphragm on the right lower quadrant of the abdomen, then move to the right upper quadrant, left upper quadrant, and finally left lower quadrant. Listen carefully for bowel sounds (gurgles and clicks), and note their frequency and character. |  |
| ☐ | ☐ | ☐ | 7. Auscultate the abdomen for vascular sounds. Using the bell of the stethoscope, auscultate over the abdominal aorta, femoral arteries, and iliac arteries for bruits. |  |
| ☐ | ☐ | ☐ | 8. Palpate the abdomen lightly in all four quadrants. The pads of the fingers are used to palpate with a light, gentle, dipping motion approximately 1 to 2 cm (Jensen, 2011). Watch the patient’s face for nonverbal signs of pain during palpation. Palpate each quadrant in a systematic manner, noting muscular resistance, tenderness, enlargement of the organs, or masses. ***If the patient complains of pain or discomfort in a particular area of the abdomen, palpate that area last.*** |  |
| ☐ | ☐ | ☐ | 9. Palpate and then auscultate the femoral pulses in the groin. Note the strength of the pulse and grade it as with peripheral pulses (see Skill 3-10). Use the bell of the stethoscope to auscultate the arteries. |  |
| ☐ | ☐ | ☐ | 10. Assist the patient into a comfortable position and in replacing the gown. Remove PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate, or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |

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| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-7**Assessing the Female Genitalia** |
| --- | --- | --- | --- |
| **Goal:** The assessments are completed without causing the patient to experience anxiety or discomfort, the findings are documented, and the appropriate referral is made to other health care professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close the curtains around bed and close the door to the room, if possible. Explain the purpose of the examination of genitalia and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Help the patient undress, if needed, and provide a patient gown. Assist the patient to a supine position, or lying on her side, if possible. Use the bath blanket to cover any exposed area other than the one being assessed. |  |
| ☐ | ☐ | ☐ | 5. Inspect the external genitalia for color, size of the labia majora and vaginal opening, lesions, and discharge. |  |
| ☐ | ☐ | ☐ | 6. Palpate the labia for masses. |  |
| ☐ | ☐ | ☐ | 7. Assist the patient to a comfortable position. |  |
| ☐ | ☐ | ☐ | 8. Remove PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate, or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |

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| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-8**Assessing Male Genitalia** |
| --- | --- | --- | --- |
| **Goal:** Assessments are completed without causing the patient to experience anxiety or discomfort, the findings are documented, and the appropriate referral is made to other health care professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close the curtains around the bed and close the door to the room, if possible. Explain the purpose of the examination of genitalia and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Help the patient undress, if needed, and provide a patient gown. Assist the patient to a supine or sitting position, if possible. Use a bath blanket to cover any exposed area other than the one being assessed. |  |
| ☐ | ☐ | ☐ | 5. Put on gloves. Inspect the external genitalia for size, placement, contour, appearance of the skin, redness, edema, and discharge. If the patient is uncircumcised, retract the foreskin for inspection of the glans penis. Assess the location of the urinary meatus. Inspect the scrotum for symmetry. |  |
| ☐ | ☐ | ☐ | 6. Palpate the scrotum for consistency, nodules, masses, and tenderness. |  |
| ☐ | ☐ | ☐ | 7. Inspect the inguinal area. Ask the patient to bear down and look for bulging of the area. |  |
| ☐ | ☐ | ☐ | 8. Assist the patient to a comfortable position. |  |
| ☐ | ☐ | ☐ | 9. Remove PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate, or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |

*Skill Checklists for Taylor's Clinical Nursing Skills:*

*A Nursing Process Approach, 4th edition*

| Name  | Date   |
| --- | --- |
| Unit  | Position  |
| Instructor/Evaluator:  | Position   |

| **Excellent** | **Satisfactory** | **Needs Practice** | SKILL 3-9**Assessing the Neurologic, Musculoskeletal, andPeripheral Vascular Systems** |
| --- | --- | --- | --- |
| **Goal:** The assessments are completed without causing the patient to experience anxiety or discomfort, the findings are documented, and the appropriate referral is made to other healthcare professionals, as needed, for further evaluation. | **Comments** |
|  |  |  |  |  |
| ☐ | ☐ | ☐ | 1. Perform hand hygiene and put on PPE, if indicated. |  |
| ☐ | ☐ | ☐ | 2. Identify the patient. |  |
| ☐ | ☐ | ☐ | 3. Close the curtains around the bed and close the door to the room, if possible. Explain the purpose of the neurologic, musculoskeletal, and peripheral vascular examinations and what you are going to do. Answer any questions. |  |
| ☐ | ☐ | ☐ | 4. Help the patient undress, if needed, and provide a patient gown. Assist the patient to a supine position, if possible. Use the bath blanket to cover any exposed area other than the one being assessed. |  |
| ☐ | ☐ | ☐ | 5. Begin with a survey of the patient’s overall hygiene and physical appearance. |  |
| ☐ | ☐ | ☐ | 6. Assess the patient’s mental status. |  |
| ☐ | ☐ | ☐ | a. Evaluate the patient’s orientation to person, place, and time. |  |
| ☐ | ☐ | ☐ | b. Evaluate level of consciousness. Refer to Chapter 17 for standardized assessment tools to assess level of consciousness. |  |
| ☐ | ☐ | ☐ | c. Assess memory (immediate recall and past memory). |  |
| ☐ | ☐ | ☐ | d. Assess abstract reasoning by asking the patient to explain a proverb, such as “The early bird catches the worm.” |  |
| ☐ | ☐ | ☐ | e. Evaluate the patient’s ability to understand spoken and written word. |  |
| ☐ | ☐ | ☐ | 7. Test cranial nerve (CN) function. |  |
| ☐ | ☐ | ☐ | a. Ask the patient to close the eyes, occlude one nostril, and then identify the smell of different substances, such as coffee, chocolate, or alcohol. Repeat with other nostril. |  |
| ☐ | ☐ | ☐ | b. Test visual acuity and pupillary constriction. Refer to previous discussion in the assessment of the head and neck. |  |
| ☐ | ☐ | ☐ | c. Move the patient’s eyes through the six cardinal positions of gaze. Refer to previous discussion in the assessment of the head and neck. |  |
| ☐ | ☐ | ☐ | d. Ask the patient to smile, frown, wrinkle the forehead, and puff out cheeks. |  |
|   |  |  |  |  |
| ☐ | ☐ | ☐ | e. Ask the patient to protrude tongue and push against the cheek with the tongue. |  |
| ☐ | ☐ | ☐ | f. Palpate the jaw muscles. Ask the patient to open and clench jaws. Stroke the patient’s face with a cotton ball. |  |
| ☐ | ☐ | ☐ | g. Test hearing with the whispered voice test. Refer to previous discussion in the assessment of the head and neck. |  |
| ☐ | ☐ | ☐ | h. Put on gloves. Ask patient to open mouth. While observing soft palate, ask patient to say “ah”; observe upward movement of the soft palate. Test the gag reflex by touching the posterior pharynx with the tongue depressor. Explain to patient that this may be uncomfortable. Ask the patient to swallow. Remove gloves. |  |
| ☐ | ☐ | ☐ | i. Place your hands on the patient’s shoulders while he or she shrugs against resistance. Then place your hand on the patient’s left cheek, then the right cheek, and have the patient push against it. |  |
| ☐ | ☐ | ☐ | 8. Check the patient’s ability to move his or her neck. Ask the patient to touch his or her chin to the chest and to each shoulder, then move each ear to the corresponding shoulder, and then tip the head back as far as possible. |  |
| ☐ | ☐ | ☐ | 9. Inspect the upper extremities. Observe for skin color, presence of lesions, rashes, and muscle mass. Palpate for skin temperature, texture, and presence of masses. |  |
| ☐ | ☐ | ☐ | 10. Ask the patient to extend arms forward and then rapidly turn palms up and down. |  |
| ☐ | ☐ | ☐ | 11. Ask the patient to flex upper arm and to resist examiner’s opposing force. |  |
| ☐ | ☐ | ☐ | 12. Inspect and palpate the hands, fingers, wrists, and elbow joints. |  |
| ☐ | ☐ | ☐ | 13. Ask the patient to bend and straighten the elbow, and flex and extend the wrists and hands. |  |
| ☐ | ☐ | ☐ | 14. Palpate the skin and the radial and brachial pulses. Assess the pulse rate, quality or amplitude, and rhythm. Test capillary refill. |  |
| ☐ | ☐ | ☐ | 15. Have the patient squeeze two of your fingers. |  |
| ☐ | ☐ | ☐ | 16. Ask the patient to close his or her eyes. Using your finger or applicator, trace a one-digit number on the patient’s palm and ask him or her to identify the number. Repeat on the other hand with a different number. |  |
|   |  |  |  |  |
| ☐ | ☐ | ☐ | 17. Ask the patient to close his or her eyes. Place a familiar object, such as a key, in the patient’s hand and ask him or her to identify the object. Repeat using another object for the other hand. |  |
| ☐ | ☐ | ☐ | 18. Assist the patient to a supine position. Palpate and then use the bell of the stethoscope to auscultate the femoral pulses in the groin, if not done during assessment of the abdomen. Note the strength of the pulse and grade it as with peripheral pulses. |  |
| ☐ | ☐ | ☐ | 19. Examine the lower extremities. Inspect the legs and feet for color, lesions, varicosities, hair growth, nail growth, edema, and muscle mass. |  |
| ☐ | ☐ | ☐ | 20. Assess for pitting edema in the lower extremities by pressing fingers into the skin at the pretibial area and dorsum of the foot. If an indentation remains in the skin after the fingers have been lifted, pitting edema is present. |  |
| ☐ | ☐ | ☐ | 21. Palpate for pulses and skin temperature at the posterior tibial, dorsalis pedis, and popliteal areas. Assess the pulse rate, quality or amplitude, and rhythm. Test capillary refill. |  |
| ☐ | ☐ | ☐ | 22. Have the patient perform the straight leg test with one leg at a time. |  |
| ☐ | ☐ | ☐ | 23. Ask the patient to move one leg laterally with the knee straight to test abduction and medially to test adduction of the hips. |  |
| ☐ | ☐ | ☐ | 24. Ask the patient to raise the thigh against the resistance of your hand; next have the patient push outward against the resistance of your hand; then have the patient pull backward against the resistance of your hand. Repeat on the opposite side. |  |
| ☐ | ☐ | ☐ | 25. Test plantar reflex. Stroke the sole of the patient’s foot with the end of a hard object, such as the edge of a tongue depressor or a key. Begin at the heel and apply firm but gentle pressure to the lateral aspect of the foot. Continue to the base of the toes. Repeat on the other side. |  |
| ☐ | ☐ | ☐ | 26. Ask patient to dorsiflex and then plantarflex both feet against opposing resistance. |  |
| ☐ | ☐ | ☐ | 27. As needed, assist the patient to a standing position. Observe the patient as he or she walks with a regular gait, on the toes, on the heels, and then heel to toe. |  |

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| ☐ | ☐ | ☐ | 28. Perform the Romberg test; ask the patient to stand straight with feet together, both eyes closed with arms at side. Wait 20 seconds and observe for patient swaying and ability to maintain balance. Be alert to prevent patient fall or injury related to losing balance during this assessment. |  |
| ☐ | ☐ | ☐ | 29. Assist the patient to a comfortable position. |  |
| ☐ | ☐ | ☐ | 30. Remove PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate, or indicated. Initiate appropriate referral to other health care practitioners for further evaluation, as indicated. |  |