Physical Assessment

Name: _____ Date: _____

S/U	Physical Assessment	S/U 2nd	S/U 3rd
	Initial Assessment/General Survey ABCs: Airway - Breathing - Circulation Is everything attached patent & working properly? Pain Signs of Distress; behavior; affect State of health (nutrition/hygiene)		
	Vital Signs Blood Pressure___/___ Pulse ___ Respiratory Rate ___ O2 Sat ___ Temperature ___		
	HEENT - Neurological Alert & oriented X3 (person, place, time) All extremities equal strength No parenthesis or numbness Nose/mouth Verbalization clear & understandable Hearing deficits/external ears Vision/PERRLA/eyes		
	Cardiovascular Apical rate & rhythm Auscultate 4 cardiac sites & identify S1 & S2 No calf tenderness Capillary refill < 3 seconds/nailbeds Mucosa membranes pink, moist No peripheral edema No JVD Peripheral pulses (T,C,B,R,F,P,DP,PT)		
	Respiratory Auscultate breath sounds in all lung fields Identify 3 normal sounds: vesicular, bronchial, broncho-vesicular Identify 3 abnormal sounds: crackles, wheezes, rhonchi		
	Gastrointestinal Bowel sounds audible No pain with palpation X 4 quads Continent of stool/last BM If eating: tolerates diet; no N/V/diarrhea		
	Genitourinary Able to empty bladder completely & without pain Assess urine color/odor Continent of urine/last void		
	Musculoskeletal Absence of joint swelling and tenderness Extremities are symmetrical & in alignment Fall risk assessment ROM Ambulate with steady gait		
	Integumentary Skin warm, dry, intact, skin color within patient's norm ; turgor Lesions, rashes, redness, breakdown Surgical Site and/or Dressing IV site: Asymptomatic (No phlebitis, No infiltration)		