Physical Assessment Documentation Sheet
(To be reviewed and initialed by lab faculty and retained in your clinical binder)
Student:_______Instructor______

OBJECTIVE VITAL SIGNS: not needed if signed off on vital signs prior to final Temperature Pulse Blood Pressure / Respirations O2 Saturation	
NEURO	A&OX3 person, place, time. Swallow and cough reflex present. Facial symmetry present no facial drooping noted, able to move tongue freely, PERL4to3 consensual and accommodation present Dorsal and plantar flexion present
NS NS	Moves easily in bed, sits on edge of bed without assistance. Bilateral equal strong hand grasp
S	aortic and pulmonic S2>S1, triscuspid and mitral S1>S2, No JVD present ,Mucus membranes appear pink and moist , radial pulses present bilaterally and equal. Cap refill on upper extremities < 2sec. Cap refill on lower extremities< 3 sec. No edema noted, dorsalis pedis pulses present and equal. Skin temperature noted to be slightly warmer on upper extremities as compared to lower.
RESP	trachea midline, no signs of respiratory distress, no nasal flaring, no use of accessory muscles to breath, speaking full sentences, anterior, posterior, lateral all clear breath sounds. Excursion present and equal with deep breath.
ъ	abdomen contour,umbilicus midline, no bulges, pulsations or masses present, Bowel sounds present on ausculatation, no pain on palpation, belly button piercing present no redness or exudate from piercing site. States has BM every other day, brown soft, denies constipation
3	States urinates 6 times a day, pale yellow, denies odor or pain, nocturia X 1
SKOM	warm, dry, appropriate for ethnicity, hair distribution equal, freckles on upper extremity tattoo present on right lower extremity
Psych/Social	good grooming, appears to be in good mood, makes eye contact, no body odor noted, clothing clean and dry. Speech as normal cadence

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Carolyn Jarvis, PhD Apn Cnp

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