# **Head To Toe Assessment C**

Wash Hands ( ) Completed - Standard Precautions Introduction ( ) Completed - Introduce self & purpose of assessment to relieve anxiety and role function identification. Vital Signs Pulse\_\_\_\_\_ Rate, Strength, Regularity Oral, Rectal, Tympanic Temperature B/P Respiration Orientation (Oriented x 4) What year is this? Tell me your name? Tell me where you are? Tell me why you are here? Pupil Check ( PERRLA ) Pupils, Equal, Round, React to light, Accommodate Sluggish ( ) No Change ( ) Brisk ( ) Normal ( ) Accommodation Yes () No () Neck Veins Patient at 45o angle () Neck Veins Flat ( ) Distended ( ) **Heart Tones** Apical Pulse with Stethoscope Rate ?\_\_\_\_\_ Rhythm ?\_\_\_ Clarity of Sounds ? \_\_\_\_ Abnormal? ( ) Explain! Bilateral Checks (Radial Pulses) - Rate, Strength, Regularity Left ( Hand Strength ) - 2 fingers only Right Stronger ( ) Left Stronger ( ) Equal ( ) ( Pedal Pulses ) - Top of Foot

Right Foot \_\_\_\_\_ Left Foot ( Capillary Refill ) -On fingers or toes 3 seconds Let the patient know you are finishor less Right Fingers ( ) sec. Left Fingers ( ) sec. Right Toes ( ) sec. Left Toes ( ) sec. Delay or abnormal refill return ? Yes ( ) ie., \_\_\_ Skin Skin Turgor - 1 to 3 second return, on Sternum Return was ( ) sec. Abnormal ( ) sec. Skin Color - Check on inside of Lip or Conjunctiva Lip ( ) Conjunctiva ( ) Pink ( ) Pale ( ) Jaundice ( ) Cyanotic ( )

Skin Temperature - Use back of hand to check

Hot () Warm () Cool ()

Breath Sounds Assess anterior and posterior and take deep breaths, do not move ste patients part. Clear Bilaterally ( ) Left only ( ) Rig Both poor bilaterally ( ) ie., Good air flow ( ) Poor air flow ( ) **Bowel Sounds** Assess all 4 quadrants, do not touc disrupt normal sounds. If irregular, Umbilicus is midpoint. (Stomach) - Check for condition Soft ( ) Hard ( ) Distended ( ) Other RUQ Active ( ) Absent ( ) Hyperact RLQ Active ( ) Absent ( ) Hyperacti LUQ Active ( ) Absent ( ) Hyperacti LLQ Active ( ) Absent ( ) Hyperacting Peripheral Edema Edema is found in dependent area finger by pressing down. Observe t Feet Yes () No () Pitting () R () L Hands Yes () No () Pitting () R () Sacrum Yes () No () Pitting () Ind Assessing For Pain Where is the pain? How long has it lasted? Does the pain travel anywhere? What makes it feel better? What makes pain worse? Descrip. of pain ? Sharp ( ) Stabbir On a scale of 1 - 10, 10 being the v Skin Breakdown Check Check entire body for redness or s Normal ( ) Abnormal ( ) Explain cor effected Homan's Sign Ask patient to dorsiflex both feet. Pain in right calf Yes () No () Pain in both calfs Yes () No () Closure Bedrails up ( )Bed in low position (

# SAMPLE CHARTING ENTRY

# **Sample Nursing Documentation Head Toe Assessment**

**Lorene Payne** 

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