

NUR 245

Complete Physical Examination

Date: 06/20/18

Student: Samuel Kollmorgen

Patient Initials: H.K. **Age:** 25 **Gender:** Male

Occupation: Student

General Survey of Patient

1. **Appears stated age:** Pt seems appropriate for stated age.
2. **Level of consciousness:** Pt is alert and oriented x3
3. **Skin color:** PWD, appropriate appearance for stated age and ethnicity
4. **Nutritional status:** Stated dietary intake is adequate, pt seems well nourished.
5. **Posture and position:** Upright, erect posture. No abnormalities detected.
6. **Obvious physical deformities:** No obvious physical deformities seen.
7. **Mobility:** Normal gait and posture, pt is mobile w/o assistive device.
8. **Facial expression:** No signs of distress, pain, or anxiety. Face symmetrical.
9. **Mood and affect:** Pt is content and displays a normal affect.
10. **Speech:** Pt's speech is appropriate and understandable.
11. **Hearing:** Pt does not state to have any issues hearing.
12. **Personal hygiene:** Pt is well groomed and appropriately dressed.

Measurements and Vital Signs

1. Weight: 178 lbs
2. Height: 70 in.
3. Body mass index: 25.5
4. Vision using Snellen eye chart: 20/20 bilaterally with corrective lenses.
5. Radial pulse, rate, and rhythm: 78, 2+ radial pulses RRR
6. Respirations, rate, depth: 16, Normal work of breathing
7. Blood pressure: 136/72 right arm, sitting.
8. Temperature (if indicated): N/A
9. Pain assessment: 0/10

Skin

1. **Hand and nails:** No clubbing or deformities, cap refill < 2 sec, skin PWD, nail beds pink.

Color and pigmentation: Color tan-pink, even pigmentation, no lesions noted.

Temperature: Warm

Moisture: Dry

Texture: Smooth

Turgor: Good turgor, no signs of tenting.

Any lesions: No notable lesions.

Head and Face

Physical Exam Documentation Example

**Brigitte Niedzwiecki, Julie Pepper, P.
Ann Weaver**



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