كلية العلوم الطبية التطبيقية
College of Applied Medical Sciences

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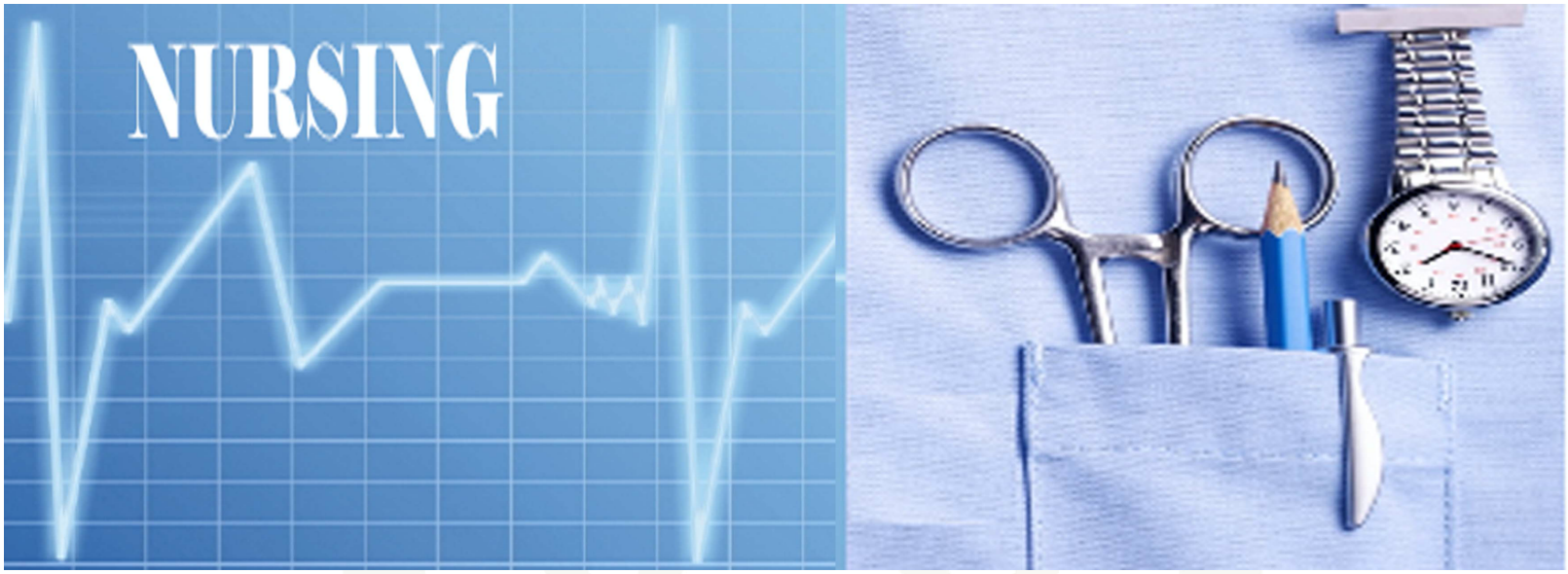

Skills Laboratory Manual in
HEALTH ASSESSMENT
(NRS 242)

Document Revision Control History

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Dr. Sherifa Alasiry Dr. Amira Yahia Mrs. Hadeel Alolah Mr. Bander Albulaytih	2	Update of contents	Dr. Evelyn Feliciano	Department Council	01 March 2020

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Unit 1

History Collection

PROCEDURE 1: History Collection (Subjective & Objective Data)

Purpose:

1. To collect subjective and objective data.
2. To determine client's overall level of functioning in order to make professional clinical judgement.

A. Preparation of the patient:

a) Greet the patient by name: "Good morning".

b) Introduce yourself and explain that you are a nurse or medical student.

c) Shake the patient's hand, or if they are unwell rest your hand on theirs

d) Ensure that the patient is comfortable.

B. Procedure:

1. **Collect the Identification Data of the patient** including Name , Address , Date of birth (age) , nationality , Occupation , Education , Marital status.

2. Collect history of present complaints in the following question form:

✓ Tell me what seems to be the problem?

✓ How long have you been unwell?

✓ When did the symptoms start?

✓ What are the characteristics of the problem in terms of-

- Site - where exactly is this pain?
- Onset - when did the pain start, did it start suddenly or gradually?
- Character - describe the pain - sharp? knife-like? gripping? burning? crushing?
- Radiation - does the pain spread anywhere? To the arm, jaw, groin ?
- Associations - is the pain accompanied by any other features?
- Timing - does the pain vary in intensity during the day?
- Exacerbating and relieving factors - does anything make the pain better or worse?

- Severity - does the pain interfere with daily activities or with sleep?

3. Collect the following history of past illness /complaints:

- **Previous medical history**
  - ✓ Ask about childhood illness and immunization
  - ✓ Have you had TB or whooping cough?
  - ✓ Have you ever been found to have high blood pressure or sugar?
  - ✓ Have you had rheumatic fever?
  - ✓ Have you ever suffered from epileptic seizures?
  - ✓ Do you get asthma (episodic breathlessness, usually with wheeze)?
  - ✓ Have you suffered from anxiety or depression?
- **Previous surgical history**
  - ✓ Have you had any operations in the past?
  - ✓ If yes, name it and no. of years for operation done.
- **Family history**
  - ✓ Any one in your family has medical diseases like diabetes, hypertension, etc.? If yes, name the disease.
  - ✓ Any one in your family underwent surgical procedure? If yes, name and no. of years?
- **Personal history**
  - ✓ Do you smoke? - If so, how many cigarettes per day/week?
  - ✓ Do you drink alcohol? - If so, how many units per day/week?
  - ✓ Do you take drugs? Which one? How many per day?
- **Menstrual history**
  - ✓ When your periods did started (Menarche)?
  - ✓ Are your periods irregular?
  - ✓ How often do your periods occur and for how long do they last?
  - ✓ Do you have heavy bleeding (menorrhagia) or do you pass clots during your period?
  - ✓ Do you have pain during menses?

- ✓ When did your periods stop (menopause)?
- ✓ Have you had any bleeding since your periods stopped?

- **Obstetrical history (From married client only)**
  - ✓ How many years you are married for?
  - ✓ Have you had any pregnancies?
  - ✓ Were they normal?
  - ✓ Were there any complications such as hypertension and toxaemia, diabetes, Caesarian section?
  - ✓ Do you have history of abortion?
  - ✓ What type of delivery you had--- normal or instrumental or caesarean section?
  - ✓ Any child born with congenital birth defect or stillborn or died later in life?
- **Nutritional history**
  - ✓ What is the type of your diet?
  - ✓ Is your food healthy?
  - ✓ How many meal you take per day?
  - ✓ What is the time between the meals?
- **Developmental history**
  - ✓ When did you started walking as a child?
  - ✓ When did started saying mama....baba….dada…?
  - ✓ What age did you started you schooling?

4. Check vital signs of the patient:

- Temperature
- Pulse
- Respiratory rate
- Blood pressure

C. Procedure Termination:

✓ Document all the findings of the procedure in Nurse's Record.

CHECKLIST: Assessing SKIN, HAIR & NAIL

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (gloves, exam light, penlight, magnifying glass, centimeter ruler.)			S5.1
	b) Provide comfortable environment with good light			S5.1
	c) Explain procedure to client.			S1.1
	d) Provide privacy			S5.1
	e) Wash hands			S5.1
C	**Procedure**			
	Skin			
	* Note any distinctive odor			5.1.2
	Inspection			

	Color a) Inspect all the skin for increased pigmentation or decreased pigmentation. b) Inspect for redness or pallor in the fingernails, the lips, the mucus membranes (mouth and palpebral conjunctiva). c) Inspect for central cyanosis in the lips, oral mucosa and toungue. d) Look for the yellow color of jaundice in the sclera, palpebral conjunctiva, lips, hard palate, under surface of the tongue, and skin.			S5.1
	Moisture a) Look for dry areas of the skin b) Look for acne especially at the face and shoulders.			S5.1
	Skin Intactness Look for lesions noting their: a) anatomic location and distribution b) arrangement c) types (macules, papules ..etc.) d) color			S5.1
	Palpation			
	a) Palpate **lesions** for tenderness			S5.1
	b)**Texture** of skin (rough, smooth), using palmar surface of three middle fingers			S5.1
	c) Palpate for **temperature** (cool, warm, hot), using the dorsal side of hand.note the temperature of any red areas.			S5.1
	d) **Mobility and turgor** Lift a fold of skin note 1. the ease with which it lifts up (Mobility) 2. the speed with which it returns into place (Turgor)			S5.1
	e) **Moisture** of skin (dry, sweaty, oily)			S5.1

	Scalp and Hair			
	Inspection			
	a) Color.			S5.1
	b) Amount and distribution.			S5.1
	c) Thickness, texture, and lesions.			S5.1
	d) Cleanliness (oiliness, and parasites)			S5.1
	Palpation			
	Palpate for thickness, texture, oiliness, lesions, and parasites.			S5.1
	Measure lesions by ruler			S5.1
	Palpate lesions for tenderness			S5.1
	Nails			
	Inspection			
	a) Inspect for grooming and cleanliness.			S5.1
	b) Inspect for color and markings			S5.1
	c) Inspect shape.			S5.1
	Palpation			
	a) Palpate texture and consistency			S5.1
	b) Test for capillary refill. + Clubbing of fingers			S5.1
	Procedure Termination			
	a) Put client in comfortable position according to health status			S5.1
	b) Provide patient with reassurance			S5.1
	c) Return back equipment			S5.1
	d) Wash hands			S5.1
	e) Document findings			S3.1

Result:

CLO	Student Performance			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Head and Neck Assessment (Eye)

Student's Name: _____ **ID # :** _____

		Performed		CLO
No	**Procedure Steps**	**Yes**	**No**	
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (Diagnostic set (ophthalmoscope), Snellen chart, Near vision screener, penlight, opaque card, clean gloves, sterile cotton, and cotton applicator.)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Provide privacy			S5.1
	e) Wash hands			S5.1
C	**Procedure**			
	Test visual acuity (Central Vision) using Snellen eye chart			
	a) Ensure placement of the Snellen chart at an appropriate height for the client.			S5.1
	b) Position the client exactly 20 feet (6 meters) from the chart.			S5.1
	c) Ask the client to close one eye using the opaque card and to read the line at 6/6			S5.1
	d) Repeat the process for the other eye			S5.1
	e) Repeat process with both eyes			S5.1
	f) Record the result			S3.1
	Inspect external eye structures			

	Eyebrows for 1. quantity 2. distribution 3. Scaliness of the underlying skin			S5.1
	Eyelids and lashes			
	1. Position of the lids in relation to the eyeballs			S5.1
	2. Width of the palpebral fissures			S5.1
	3. Color of the lids			S5.1
	4. Lesions			S5.1
	5. Condition and directions of the eyelashes			S5.1
	6. Adequacy with which the eyelids close.			S5.1
	d) Conjunctiva and sclera			S5.1
	Inspect the palpebral conjunctiva of the lower eyelid and the sclera for color, vascular pattern, any nodules or swelling			
	1. Ask the patient to look up			S5.1
	2. Place thumbs bilaterally at the level of the lower bony orbital rim			S5.1
	3. Gently pull down the lower lids to expose the palpebral conjunctiva and the sclera.			S5.1
	4. for fuller view of the eye a. rest the thumb and finger on the bones of the cheek and brow, and spread the lids b. Ask the patient to look to each side and down.			S5.1
	Lacrimal Apparatus			
	1. Inspect the regions of the Lacrimal gland and Lacrimal sac for swelling			S5.1
	2. Put on clean gloves			S5.1
	3. Ask the patient to look up			S5.1
	4. Press on the lower lid close to the medial canthus, just inside the rim of the bony orbit (compressing the Lacrimal sac), look for fluid regurgitated from the puncta into the eye			S5.1

	The pupils			
	Inspect the Pupils for shape, size, and symmetry			S5.1
	Pupillary reactions to light and accommodation			
	a) Dim the light of the room			S5.1
	b) Ask the client to stare ahead			S5.1
	c) Move the penlight from the client's side, shine light directly into one eye.			S5.1
	d) Observe the constriction of the illuminated pupil			S5.1
	e) Observe the simultaneous reaction (consensual) of the other eye.			S5.1
D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			S5.1
	b) Provide patient with reassurance			S5.1
	c) Return back equipments			S5.1
	d) Wash hands			S5.1
	e) Document findings			S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Head and Neck Assessment (Ear)

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (Watch with the seconds' hand, Tuning fork, Otoscope, alcohol swab)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Provide privacy			S5.1
	e) Wash hands			S5.1
C	**Procedure**			
	1. The auricle			
	a. Inspect the auricles, tragus and lobule for symmetry, color, lumps and integrity			S5.1
	b. Confirm that the external auditory meatus is patent, with no discharge.			S5.1
	c. If pain or discharge is present move the auricle up and down, press the tragus and press firmly just behind the ear on the mastoid process.			S5.1
	2. Auditory canal inspection using Otoscope			
	a. Ask the client to tilt the head away toward the opposite shoulder.			S5.1
	b. Hold the Otoscope handle between the thumb and fingers of one hand, brace the hand against the patient's face, the handle may be positioned upward or downward.			S5.1

c. Use the other hand to stabilize the head and straighten the canal by pulling the pinna upward, backward, and slightly away from the head.	S5.1
d. With the light insert the speculum gently into the ear canal directing it down and forward.	S5.1
e. Inspect the ear canal noting any discharge, foreign bodies, redness of the skin, or swelling	S5.1
f. Inspect the ear drum noting its color, contour, the cone of light , the handle of the malleus, pars flaccida and pars tensa looking for perfotation	S5.1

3. Auditory Acuity

A: whisper test (Gross hearing)

a. Stand 1-2 feet (30-60 cm) behind the client	S5.1
b. Ask the client to occlude the ear canal by placing one finger on the tragus of the left ear and move it back, or by the examiner's finger moving it rapidly but gently.	S5.1
c. Exhale fully, and whisper softly toward the unoccluded ear, choosing words of two equally accented syllables	S5.1
d. Ask the client to repeat the word back.	S5.1
e. Repeat the test for the right ear.	S5.1

B: Perform Weber's test (Lateralization)

a. Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly between the index finger and the thumb or by taping it on knuckles.	S5.1
b. Place the base of the vibrating fork firmly on top of the patient's head or on the mid-forehead.	S5.1
c. Ask whether the client hears the sound better in one ear or the same in both ears.	S5.1

C: Perform Rinne test

a. Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly between the index finger and the thumb or by taping it on knuckles	S5.1
b. Place the base of the lightly vibrating fork on the client's mastoid process behind the ear and level with the canal.	S5.1
c. Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.	S5.1

	d. Quickly place the fork close to the ear canal with the (**U**) of the fork facing forward.	S5.1
	e. Ask the client to tell when the sound is no longer heard noting the number of seconds since the fork was placed.	S5.1
D	**Procedure Termination**	
	a) Put client in comfortable position according to health status	S5.1
	b) Provide patient with reassurance	S5.1
	c) Return back equipments	S5.1
	d) Wash hands	S5.1
	e) Document findings.	S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: ……

CHECKLIST: Head and Neck Assessment (Mouth & Throat)

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (clean gloves, 4×4 gauze pad, penlight, tongue depressor).			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Provide privacy			S5.1
	e) Wash hands			S5.1
C	**Procedure**			
1.	**The Lips**			
	a) Observe for color and moisture			S5.1
	b) Observe for any lumps, cracking or scaliness.			S5.1
2.	**The Oral Mucosa**			
	a) Ask the patient to open mouth widely			S5.1
	b) look into the patient's mouth with good light and the help of a tongue blade for :			S5.1
	color, ulcers, white patches, and nodules.			
3.	**The Gums and Teeth**			
	a) Ask the client to open mouth and note the color of gums.			S5.1

b) Retract the lips and cheeks to check the gums for color and consistency S5.1

c) Inspect the gum margins and the inter-dental papillae for swelling or ulceration. S5.1

d) Inspect the teeth for number, color, shape, alignment of the teeth. S5.1

e) Observe for dental hygiene. S5.1

f) check for looseness of the teeth with gloved thumb and index finger. S5.1

4. The roof of the mouth

Inspect the hard palate for S5.1

- Color
- Architecture

5. The Tongue and the Floor of the Mouth

a) Ask the patient to put out his tongue S5.1

b) Note the color and texture of the dorsum of the tongue . S5.1

c) Ask the patient to touch the hard palate with the tip of the tongue S5.1

d) Put on gloves and ask the client to protrude his tongue, grasp the tip of the tongue with a square of guaze and gently pull it to the sides noting for white or reddened areas, nodules, or ulcerations S5.1

e) Palpate the tongue feeling for any induration (hardness) for both sides. S5.1

6. The Pharynx

a) Ask client to open the mouth wide without protruding the tongue, use the penlight to look at the roof) S5.1

b) Apply a tongue depressor to the tongue and shine the penlight, note the characteristics and position of the uvula. S5.1

c) Inspect the soft palate, anterior and posterior pillars, uvula, tonsils and pharynx for S5.1

1. Color

2. Symmetry

3. Presence of exudate.

4. Swelling

5. Ulceration

6. Tonsillar enlargement

d) Observe elevation of the soft palate and uvula by asking patient to say "ah" S5.1

D Procedure Termination

a) Put client in comfortable position according to health status S5.1

b) Provide patient with reassurance S5.1

c) Return back equipments S5.1

d) Wash hands S5.1

e) Document findings S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: ……

CHECKLIST: Head and Neck Assessment (Nose & Sinuses)

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (clean gloves, Otoscope with special nasal attachments or nasal speculum/ penlight)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Provide privacy			S5.1
	e) Wash hands			S5.1
C	**Procedure**			
1.	**Inspect the anterior and inferior surfaces of the nose and test for nasal obstruction**			
	a) Widen the nostrils by applying gentle pressure on the tip of the thumb to get partial view of the nasal vestibule with the aid of a penlight or Otoscope light noting for asymmetry or deformity.			S5.1
	b) Check the patency of the nostrils' air flow by occluding one nostril at a time and asking the client to sniff.			S5.1
2.	**Inspect the internal nose**			
	a) Use the Otoscope with the special attachment or the nasal speculum with penlight to inspect the nose			S5.1

	b) Use the non dominant hand to stabilize and gently tilt the client's head back.	S5.1
	c) Insert the speculum into the nostril with out touching the nasal septum.	S5.1
	d) Hold the Otoscope handle to one side to avoid the patient's chin	S5.1
	e) Direct the Otoscope back and up in small steps to see the inferior & middle turbinates, the nasal septum and the nasal passage between them	S5.1
	f) Inspect the nasal mucosa for color and any swelling, bleeding, or exudate.	S5.1
	g) Inspect the nasal septum for deviation, inflammation or perforation of the septum.	S5.1
	h) Inspect for any abnormality such as ulcers or polyps.	S5.1
3.	**Palpate** the frontal sinuses by using thumbs to press up on the eye brow on each side of the nose.	S5.1
4.	**Percuss** the sinuses by tapping lightly over the frontal and maxillary sinuses for tenderness.	S5.1
D	**Procedure Termination**	
	a) Put client in comfortable position according to health status	S5.1
	b) Provide patient with reassurance	S5.1
	c) Return back equipments	S5.1
	d) Wash hands	S5.1
	e) Document findings	S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Head and Neck Assessment (The Neck and Thyroid Gland)

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (clean gloves, Cup of water, light)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Provide privacy			S5.1
	e) Wash hands			S5.1
C	**Procedure**			
1.	**Neck Inspection**			
	a) Note symmetry, any masses or scars			S5.1
	b) Look for enlargement of the parotid or submandibular glands			S5.1
	c) Note any visible lymph nodes			S5.1
2.	**Lymph Node Palpation**			
	Use the pads of the index and middle fingers moving the skin over the underlying tissues in each area, rolling the node in two directions up and down and side to side (front of ears, mastoid process, occipital nodes, submandibular nodes, cervical nodes and supraclavicular nodes).			S5.1
3.	**The Trachea**			
	a) Inspect the trachea for any deviation from its midline position			S5.1

	b) Feel for any deviation Palpate sternal notch to make sure trachea is midline by palpating the tracheal ring (sternal notch midway between clavicular heads)	S5.1
	c) place one finger along one side of the trachea and note the space between it and the sternomastoid and compare it with the other side	S5.1
4.	**A. The Thyroid Gland (Anterior)**	
	a) ask the patient to extend the neck slightly	S5.1
	b) Using tangential lighting directed downward from the tip of the patient's chin, inspecting the region below the cricoid cartilage for the gland.	S5.1
	c) Ask the patient to sip some water and to extend the neck again and swallow. Watch for upward movement of the thyroid gland noting its contour, and symmetry.	S5.1
	B. Palpate the Thyroid Gland from behind	
	a) Stand behind the client	S5.1
	b) Place the fingers of both hands on the patient's neck so that the index fingers are just below the cricoid.	S5.1
	c) Adjust the patient's neck extension to avoid tightened neck muscles.	S5.1
	d) Ask the patient to sip and swallow water and feel for any glandular tissue rising under the finger pads.	S5.1
	e) Ask the client to set up right, lower the chin and turn the head slightly to the right.	S5.1
	f) Use the fingers of the left hand to push the trachea to the right.	S5.1
	g) With the fingers of the right hand palpate the area between the trachea and the sternomastoid muscle.	S5.1
	h)Palpate with and without swallowing	S5.1
	i) Reverse the technique to palpate the left lobe of the thyroid.	S5.1
	j) If the thyroid gland is enlarged listen over the lateral lobes with a stethoscope to detect a bruit)	S5.1
D	**Procedure Termination**	
	a) Put client in comfortable position according to health status	S5.1

b) Provide patient with reassurance S5.1

c) Return back equipment S5.1

d) Wash hands S5.1

e) Document findings S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Peripheral Vascular Assessment

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (clean gloves, measurement tape, tourniquet, light)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Provide privacy			S5.1
	e) Wash hands			S5.1
C	**Procedure**			
1.	**The upper limbs**			
	a) Inspect both arms from fingertips to shoulders noting :			S5.1
	1. their size and symmetry, and any swelling .			
	2. The venous pattern			
	3. The color of the skin and nail beds and the texture of the skin			
	a) Palpate the radial pulse with the pads of fingers, partially flexing the patient's wrist, comparing pulses bilaterally.			S5.1
	b) If arterial insufficiency suspected , feel for brachial pulse by flexing the patient's elbow slightly and palpating the artery just medial to the biceps tendon at the antecubital crease or higher in the arm groove between the biceps and triceps muscles.			S5.1
	Evaluating the arterial supply to the hand (Allen test)			

a) Ask the patient to make a fist with one hand. S5.1

b) Compress both radial and ulnar arteries firmly between thumbs and fingers. S5.1

c) Ask the patient to open the hand into a relaxed, slightly flexed position when the palm is pale. S5.1

d) Release pressure over the ulnar artery , if patent the palm flushes within 3-5 seconds. S5.1

e) Patency of the radial artery tested by releasing the radial artery while still compressing the ulnar. S5.1

2. The Lower Limbs

a) The patient should be lying down and draped so that the external genitalia are covered and the legs are fully exposed. S5.1

b) Inspect both legs from the groin and buttocks to the feet. Note their: S5.1

a. Size and symmetry.
b. Color and texture of the skin, and the color of the nail beds.
c. Venous pattern or edema, and the hair distribution on the lower legs, feet and toes.
d. Note any pigmentation, rashes, scars, and ulcers.

c) Palpate the **superficial inguinal nodes**, including both the **horizonta**l and the **vertical** groups. S5.1

d) Palpate **the femoral pulse** by pressing deeply below the inguinal ligament and about midway between the anterior superior iliac spine and the symphysis pubis. S5.1

e) To palpate **the popliteal pulse** ask the patient to flex the knee slightly. Place the fingertips of both hands so that they just meet in the midline behind the knee and press them deeply into the popliteal fossa. S5.1

f) Feel the dorsum of the foot lateral to the extensor tendon of the great tendon to palpate the **dorsalis pedis pulse** S5.1

g) Curve fingers behind and slightly below the medial malleolus of the ankle to palpate **the posterior tibialis pulse.** S5.1

h) Note the **temperature** of the feet and legs with the backs of fingers. Compare one side with the other. S5.1

	i) Check for pitting edema by pressing firmly and gently with the thumb for 5 seconds over the dorsum of the foot, behind each medial malleolus and over the shins.	S5.1
	j) Ask the patient to stand and inspect the saphenous system for **varicosities** .	S5.1
	k) **HOMAN'S sign:** Firmly dorsiflex the client's foot while supporting the entire leg in extension. Pain in calf muscles with forceful dorsiflexion of the foot indicates **positive Homan's sign**.	S5.1
D	**Procedure Termination**	
	a) Put client in comfortable position according to health status	S5.1
	b) Provide patient with reassurance	S5.1
	c) Return back equipments	S5.1
	d) Wash hands	S5.1
	e) Document findings	S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……/10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Cardiovascular Assessment

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	Comments
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (stethoscope, ruler)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Wash hands			S5.1
	e) provide privacy			S5.1
C	**Procedure**			
1.	**Examine The Jugular Vein**			
	Position the patient with the head slightly elevated on a pillow and the sternomastoid muscle relaxed, and identify the external jugular vein.			S5.1
2.	**Examine the Carotid pulse.**			
	a. Inspect neck for pulsation medial to the sternomastoid muscle			S5.1
	b. Press inside the medial border of a well relaxed sternomastoid muscle at the level of the cricoid cartilage by the left thumb or the index and middle fingers on the right carotid artery (opposite for the left)			S5.1
3.	**The heart**			
a	**Inspection:**			

	While on the client right side, Inspect appropriate points (aortic, pulmonic, 3rd left inter-space, tricuspid and mitral) on the anterior chest for any pulsation.	S5.1
	Instruct the patient to move on the left lateral decubitus area to inspect for the apical impulse.	S5.1
	Palpate same points (aortic, pulmonic, 3rd left inter-space, tricuspid and mitral) using finger pads on the anterior chest for any pulsation, using ball of the hand for the thrills.	S5.1
b	**Palpation**	
	a. Palpate for the apical impulse, if unable to detect it ask the client to exhale fully and stop breathing for few seconds. evaluate its location, diameter, amplitude. Note its location with respect to the mid-sternal line, mid-clavicular line, and anterior axillary line.	S5.1
	b. Palpate the left sternal border (3^{rd},4^{th} and 5^{th} ICS)	S5.1
	1. patient supine at 30°	
	2. place the tips of fingers in the 3^{rd},4^{th},and 5^{th} ICS trying to feel impulse. If unable to detect it ask the client to exhale fully and stop breathing for few seconds.	
	c. The epigastric area. press the index finger just under the rib cage and up toward the left shoulder trying to feel right ventricular pulsation.	S5.1
	d. The left and right 2^{nd} Interspaces . (Pulmonary and aortic arteries)	S5.1
	During held expiration feel for impulse.	
c	**Percussion**	
	Starting to the left on the chest Percuss from resonance toward cardiac dullness in the 3^{rd}, 4^{th}, 5^{th} and the 6^{th} interspaces.	S5.1
d	**Auscultation**	
	Listen for the first and second heart sounds (S1 and S2) at each auscultatory area (aortic, pulmonic, 3rd L interspace, tricuspid and mitral) using the **diaphragm** of the stethoscope for **S1 & S2** and the **bell for S3 & S4** or any added sounds.	S5.1

a. with the patient **supine**

b. then on the **left decubitus position**

c. with the patient **sitting up, leaning forward** ask the patient to exhale completely and stop breathing.

Note the intensity and splitting of S1 and S2.

Listen for extra heart sounds (e.g., S3 or S4).

Listen for any systolic and/or diastolic murmurs.

D Procedure Termination

a) Put client in comfortable position according to health status	S5.1
b) Provide patient with reassurance	S5.1
c) Return back equipments	S5.1
d) Wash hands	S5.1
e) Documents Findings	S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……/10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Respiratory System Assessment

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (stethoscope, measurement tape, pen)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Wash Hands			S5.1
	e) Provide privacy			S5.1
C.	**Procedure**			
1.	**Survey of the Thorax and respiration**			
.	a. observe the rate, rhythm, depth and effort of breathing.			S5.1
	b. Check the patient's color for cyanosis and the shape of the fingertips for clubbing and color.			S5.1
	c. Inspect the neck for supraclavicular retraction, and for contraction of the sternomastoid or other accessory muscles during inspiration. And position of the trachea			S5.1
	d. Listen to the patient's breathing.			S5.1
	e. observe the shape of the chest.			S5.1
	Transverse – Anterior-Posterior			
2.	**Examination of the posterior chest**			
a	**Inspection**			

a) Ask the patient to sit down with the arms folded across the chest with the hands resting on the opposite shoulders. S5.1

b) From a midline position behind the patient note the shape of the chest and the way in which it moves including : S5.1

a. deformities or asymmetry.

b. Abnormal retractions of the interspaces during inspiration (lower interspaces, supraclavicular retractions.)

c. Impairment in respiratory movement on one or both sides (Unilateral lag)

b Palpation

1. a) Identify **tender areas** by palpating any area where pain has been reported or where lesions are evident. S5.1

b) Assess any observed abnormality such as masses

2. Test **Respiratory Expansion** by: S5.1

1. placing the thumbs about the level of and parallel to the 10^{th} ribs and the hands Grasping the lateral rib cage, sliding them medially a bit in order to raise loose skin folds between thumbs and the spine

2. Ask the patient to inhale deeply and watch for the divergence of the thumbs during inspiration, feeling for the range & symmetry of the respiratory movements. S5.1

3. Feel for **tactile fremitus** (palpable vibrations) S5.1

1. Using either the ball or the ulnar surface of the hand.

2. Use both hands to compare sides S5.1

3. Ask the patient to repeat the words “ninety-nine” or “ one, one, one.” If fremitus is faint ask the patient to speak more loudly. S5.1

4. Palpate and compare symmetrical areas of the lungs. S5.1

c Percussion

a) Percuss the posterior chest while the patient keeps both arms crossed in front of the chest. S5.1

b) Press the distal interphalangeal joint of the middle finger (pleximeter) firmly on the surfaces to be percussed avoiding surface contact by any other part of the hand. S5.1

c) With the middle finger of the other hand slightly flexed and relaxed strike over the pleximeter with a quick sharp but relaxed wrist motion, using the tip of the flexor finger not the finger pad. S5.1

d) Percuss the thorax in symmetrical locations from the apices to the lung bases. twice in each location, compare two areas S5.1

d. when percussing the lower posterior chest, stand somewhat to the side rather than directly behind the patient. S5.1

Identify the **level of diaphragmatic dullness** (during quiet respiration) S5.1

a. with the pleximeter finger held above and parallel to the expected level of the dullness, Percuss in progressive steps downward until dullness clearly replaces resonance. S5.1

b. Check the level of this change near the middle of the hemithorax and also more laterally putting a point by a pen on each level. S5.1

d Auscultation

Listen to **the breath sound** with the diaphragm of the stethoscope after instructing the patient to breathe deeply through an open mouth. S5.1

1. Bronchial: trachea.

2. Bronchovesicular: Primary Bronchi

3. Vesicular: Lungs.

1. Listen for **Bronchovesicular** sounds between Scapulae S5.1

2. Listen for the **Vesicular** sounds over the lungs S5.1

3. Listen for any added sounds S5.1

3. Examination of the Anterior chest

a Inspection

Ask the patient to lie down into a supine position with the arms abducted. If the patient has difficulty in breathing, he/she should be examined in the sitting position or with the head of the bed elevated at comfortable level. S5.1

Note the shape of the chest and the way in which it moves including : S5.1

a. Deformities or asymmetry.

b. Abnormal retractions of the lower interspaces during inspiration

c. Impairment in respiratory movement on one or both sides (Unilateral lag)

b **Palpation**

1	Identify **tender areas** by palpating any area where pain has been reported or where lesions are evident.	S5.1
	Assess any **observed abnormality** such as masses	S5.1
2	Test **Respiratory Expansion** by:	S5.1
	1. Placing the thumbs along each costal margins with the hands along the lateral rib cage. As positioning the hands slide them medially a bit in order to raise loose skin folds between thumbs.	
	2. Ask the patient to inhale deeply and watch for the divergence of the thumbs during inspiration, feeling for the range & symmetry of the respiratory movements.	S5.1
3	Feel for **tactile fremitus** (palpable vibrations)	S5.1
	1. Using either the ball or the ulnar surface of the hand. Fremitus is decreased or absent over the pericardium.	
	2. Use both hands to compare sides	S5.1
	3. Ask the patient to repeat the words “ninety-nine” or “ one, one, one.” If fremitus is faint ask the patient to speak more loudly.	S5.1
	4. Palpate and compare symmetrical areas of the lungs.	S5.1

c **Percussion**

	a) Percuss the anterior and lateral chest while the patient keeps both arms abducted. press the distal interphalangeal joint of the middle finger (pleximeter) firmly on the surfaces to be percussed avoiding surface contact by any other part of the hand	S5.1
	b. with the middle finger of the other hand slightly flexed and relaxed strike over the pleximeter with a quick sharp but relaxed wrist motion, using the tip of the flexor finger not the finger pad.	S5.1
	c. Percuss the thorax in symmetrical locations from the apices to the lung bases. twice in each location, compare two areas. In a woman to enhance percussion gently displace the breast with the left hand while percussing with the right	S5.1

d **Auscultation**

	Listen to the **breath sound** with the diaphragm of the stethoscope after instructing the patient to breathe deeply through an open mouth.	S5.1
	Listen for **tracheal** sounds at the suprasternal notch	S5.1
	Listen for **bronchial** sounds over the manubrium	S5.1

	Listen for **bronchovesicular** sounds at the 1st and 2nd interspaces. For primary bronchi	S5.1
	Listen for the **Vesicular** sounds over the lungs	S5.1
	Listen for any **added sounds**.	S5.1
D	**Procedure Termination**	
	a) Put client in comfortable position according to health status	S5.1
	b) Provide patient with reassurance	S5.1
	c) Return back equipments	S5.1
	d) Wash hands	S5.1
	e) Document findings	S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Breast and Axillae

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
1.	a) Current Symptoms			S5.1
2.	b) Past History			S5.1
3.	c) Family History			S5.1
4.	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
5.	Explain procedure to client.			S1.1
6.	Provide comfortable environment			S5.1
7.	Provide privacy.			S5.1
C.	**Procedure**			
	Examination of the breasts:			
	Inspection			
8.	Ask the patient to sit disrobed to the waist			S5.1
9.	inspect the breasts, with the arms at the sides, for			S5.1
	a. skin changes			
	b. symmetry			
	c. contour (masses, dimpling, flattening)			
	d. retractions			
10.	inspect the breasts, with the arms over the head, for			S5.1
	a. contour			
	b. retractions			
11.	inspect the breasts, with the arms pressed against the hips, for			S5.1

a. contour

b. retractions

12. inspect the breasts, with the arms pressed against the hips S5.1

a. contour

b. retractions

13. Inspect the nipple for: S5.1

a. size

b. shape (inversion)

c. direction (usually outward, downward)

d. rashes or ulceration

e. discharge

Palpation of the breasts

14. Ask the patient to lie down with a small pillow under the shoulder on the side of examination. And ask her to rest her arm over the head.(except if the breasts are small) S5.1

15. With the fingers flat on the breast compress the tissues gently in a rotary motion against the chest wall S5.1

16. Proceed systematically examining the entire breast from clavicle to inframammary fold, from midsternal line to posterior axillary line to the Axillae for the tail of the breast. Palpation for S5.1

a. The consistency of the tissue

b. Tenderness

c. Nodules

17. Palpate the nipples for elasticity, discharge S5.1

Examination of Lymph Nodes

Inspection

18. Inspect the skin of each axilla noting : S5.1

a. Rashes

b. Infection

c. Unusual pigmentation

Palpation

19.	To palpate left Axillae, ask the patient to relax with the arm down. Supporting the left wrist or hand with his/ her hand.	S5.1
20.	Cup together the fingers of the right hand and reach as high as possible toward the apex of the axilla with the fingers lying directly behind the pectoral muscle pointing toward the mid-clavicle. Warn the patient it will be uncomfortable. Press the fingers in toward the chest wall and slide them downward to feel **central nodes**.	S5.1

D Procedure Termination

21.	Put client in comfortable position according to health status	S5.1
22.	Provide patient with reassurance	S5.1
23.	Wash hands	S5.1
24.	Document findings	S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……/10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Abdomen Physical Assessment

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	CLO
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Gather equipment (stetheoscope)			S5.1
	b) Provide comfortable environment			S5.1
	c) Explain procedure to client.			S1.1
	d) Wash Hands			S5.1
	e) Provide privacy			S5.1
C.	**Procedure**			
I	**Inspection of the abdomen**			
	1. Stand on the right side of the patient			S5.1
1.	a) Inspect the **skin** for scars, striae, dilated veins, rashes and lesions.			S5.1
2.	b) The **umbilicus** for contour, location any signs of inflammation or hernia.			S5.1
3.	c) The **contour of the abdomen**; flat, protuberant or scaphoid. Symmetry, bulging flanks, visible organs or masses.			S5.1
4.	d) **Peristalsis** : may be visible normally in very thin people			S5.1
II	**Auscultation of the abdomen**			
1.	Auscultate for bowel sounds using the diaphragm of the stethoscope, begin in the RLQ and proceed to all other quadrants of abdomen. Listen for up to 5 minutes to confirm presence of bowel sounds in each quadrant.			S5.1

III **Percussion of the abdomen**

1	Lightly percuss all the quadrants of the abdomen either using clockwise or up and down sequences to elicit amount of dullness, tympany, resonance or hyperresonance.	S5.1

IV **Palpation of the abdomen**

1	Light palpation: abdomen is palpated lightly first to assess any tenderness by using **pads of fingertips** in light dipping motions and avoid short jabs.	S5.1
2	Deep palpation: After surveying the abdomen lightly. Try to identify **abdominal masses** or areas of **deep tenderness**. If masses are felt, note: location, size, shape, consistency, tenderness, pulsations, mobility with respiration or with hand. If patient is obese or rigid, use 2 hands to palpate, place one on top of other and feel with lower hand.	S5.1

Special tests:

a. **Palpating the Liver (Hooking Technique)**

	a) Stand to the right of the patient's chest.	S5.1
	b) Place both hands side by side on the right abdomen below the border of the liver dullness.	S5.1
	c) Press in with fingers and up toward the costal margin.	S5.1
	d) Ask the patient to take a deep breath.	S5.1

b. **To assess possible acute cholecystitis (Murphy's Sign)**

	a) Hook the left thumb or the fingers of the right hand under the costal margin at the point where the lateral border of the rectus muscle intersects with the costal margin.	S5.1
	b) Ask the patient to take a deep breath	S5.1
	c) Watch the patient's breathing and note the degree of tenderness.	S5.1

c. **Assessing Kidney Tenderness**

	a) Palpate by the fingertips in each costovertebral angel.	S5.1
	b) If no tenderness in (a), place the ball of one hand in the costovertebral angle and strike it with the ulnar surface of the fist.	S5.1

d. **Ascites**

d 1. **Mapping for ascites**

	a) With the patient supine	S5.1
	b) Percuss outward in several directions from the central area of tympany and map the border between tympany and dullness.	S5.1
d 2.	**Test for shifting dullness** (after mapping)	
	a) ask the patient to turn onto one side	S5.1
	b) Percuss and mark the borders of tympany and dullness again	S5.1
d 3.	**Test for a fluid wave**	
	a) Ask the patient or an assistant to press the edges of both hands firmly down the midline of the abdomen	S5.1
	b) Tap sharply on the flank with the fingertips, feel on the opposite flank for an impulse transmitted through the fluid.	S5.1
e.	**Assess for Possible Appendicitis**	
e.1	**Rebound tenderness**	
	Press deeply and evenly in the right lower quadrant. Quickly withdraw the fingers. Ask the patient when pain is felt more.	S5.1
e.2	**Rovsing's sign and referred rebound tenderness**	
	Press deeply and evenly in the left lower quadrant. Quickly withdraw the fingers.	S5.1
e.3	**Psoas Sign**	
	Place hand just above the patient's right knee. Ask the patient to raise that thigh against hand. Ask the patient to turn onto the left side. Extend the patient's right leg at the hip.	S5.1
e.4	**Obturator Sign**	
	a) Flex the patient's right thigh at the hip, with the knee bent.	S5.1
	b) Rotate the leg internally at the hip by stabilizing the thigh with one hand and grasping the ankle with the other and swing the lower leg laterally.	S5.1
D	**Procedure Termination**	
15.	a) Put client in comfortable position according to health status	S5.1
16.	b) Provide patient with reassurance	S5.1

17. c) Return back equipment S5.1

18. d) Wash hands S5.1

19. e) Document findings S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….

CHECKLIST: Assessment of the Nervous System

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Wash hands			S5.1
	b) Gather equipment (Tuning fork (128-256Hz), safety pin, cotton, tongue blade, reflex hammer)			S5.1
	c) Provide comfortable environment			S5.1
	d) Explain procedure to client.			S1.1
	e) provide privacy			S5.1
C.	**Procedure**			
1.	**Assess mental status by**			S5.1

a. **Language**: Whether client has difficulty speaking.

b. **Orientation:** Whether client is oriented to person, place and time.

c. **Memory:** Listen for lapses in memory in terms of immediate, recent and remote memory.

d. **Attention span and calculation**: Check this by asking the client to recite alphabet or to count backward from 100. Test the calculating ability of client in terms of simple addition, subtraction, division and multiplication.

e. **Level of consciousness**: Apply Glasgow Coma Scale in clients with altered consciousness.

2. Examining the Cranial Nerves

I - Olfactory: S5.1

a) Make sure that each nasal passage is open by compressing one side of the nose and asking the patient to sniff through the other.

b) Ask the patient to close both eyes S5.1

c) Occlude one nostril and test smell in the other. S5.1

d) Repeat on the opposite side. S5.1

II - Optic:

Test visual acuity.

a) Ensure placement of the Snellen chart at an appropriate height for the client. S5.1

b) Position the client exactly 20 feet (6 meters) from the chart.

c) Ask the client to close one eye using the opaque card and to read the line at 6/6

d) Repeat the process for the other eye

e) Repeat process with both eyes

III – Oculomotor, IV –Trochlear, VI – Abducens..

Test papillary reactions

a) Darken the room S5.1

b) Ask the patient to look into a distance

c) Shine a bright light obliquely into each pupil in turn.

d) Look for direct and consensual reaction.

e) If the reaction to light is impaired test the near reaction in normal room light:

* Hold a finger or a pencil about 10cm from the patient's eye.

* Ask the patient to look alternately at it and into the distance directly behind it.

Extra-ocular muscle movements S5.1

a) Stand about two feet (60cm) in front of the client

b) Ask the client to follow the movement of the penlight only with the eyes.

c) Starting in the midline, move the penlight to the extreme left, then straight up then down. Position the penlight again in the midline, move it to the extreme right, straight up then down.

V –Trigeminal

Motor

a. Palpate the temporal and masseter muscles S5.1

b. Ask the patient clinches the teeth. Note muscle strength.

Sensory:

a) Test the forehead, cheeks and jaw on each side for pain sensation while patient eyes are closed S5.1

b) If There is abnormality confirm it by testing temperature sensation

c) Then test for light touch, ask the patient to respond whenever skin is touched

d) **(CN V + VII)**Test the corneal reflex

*Ask the patient to look up and away. Approaching from the other side, out from the patient's line of vision, and avoiding the eyelashes, touch the cornea with a fine wisp of cotton.

VII -Facial:

a) Have the patient raise the eyebrows S5.1

b) Frown.

c) Close the eyes and resist their being opened

d) Have the patient show his/her teeth, smile, and puff out his/her cheeks.

VIII -Acoustic

Assess hearing (whisper)

S5.1

a) Stand 1-2 feet (30-60 cm) behind the client

b) Ask the client to place one finger on the tragus of the left ear and move it back

c) Whisper a word with 2 distinct syllables toward the clients right ear.

d) Ask the client to repeat the word back.

e) Repeat the test for the left ear.

If Hearing loss is present test for

lateralization (Weber's test)

a) Strike the tuning fork (use 512Hz or 256Hz tuning fork) softly with the back of the hand and place the vibrating fork in the center of the client's head or forehead. S5.1

b) Ask whether the client hears the sound better

in one ear or the same in both ears

IX – Glossopharyngeal X –Vagus

a) Note any hoarseness of the voice. S5.1

b) Ask the patient to say "ah." Note the upward movement of the soft palate and

the inward movement of the posterior pharynx

c) Note the gag reflex

XI - Spinal Accessory

a) Have the patient shrug the shoulders upward against hands. Note strength and contraction of trapezii. S5.1

b) Have the patient turn the head against the observer's hand (s). Observe the contraction of the sternomastoid and note the force of movement against hand.

XII –Hypoglossal

S5.1

Note any fasciculation of the tongue Have the patient stick out the tongue and move it from side to side. Note any asymmetry, deviation, or atrophy

3. MOTOR FUNCTION TEST: (Gross & Fine motor function test)

I. GROSS MOTOR FUNCTION TESTS S5.1

a. Assess walking gait of the client.

b. Romberg test

i. Remove sharp and harmful objects from around the area of exam

ii. Ask the patient to stand with feet together and eyes open

iii. Close both eyes for (20-30) seconds without support while stay near the patient to prevent falling.

c. **Test for Pronator Drift**

i. Ask the client to stand I for 20-30 seconds with both arms straight forward, palms up, and with eyes closed

ii. Instruct the patient to keep arms up and eyes shut tap the arms briskly downward.

iii. **Heel to toe walking**

iv. **Toe or heel walking**

II. FINE MOTOR FUNCTION TESTS

Rapid Alternating Movements

Arms

a) Show the patient how to strike one hand on the thigh, raise the hand, turn it over, and then strike the back of the hand down on the same place. Urge the patient to repeat these alternating movements as rapidly as possible. S5.1

b) Show the patient how to tap the distal joint of the thumb with the tip of the index finger again as rapidly as possible.

Legs S5.1

Ask the patient to tap the examiner's hands with the ball of each foot in turn as quickly as possible.

Point to point movements

Arms

a) Ask the patient to touch the examiners index finger and then his /her nose alternatively several times S5.1

b) Move the finger about so that the patient has to alter directions and extend the arm fully to reach it

c) Hold finger in one place so that the patient can touch it with one arm and finger outstretched

d) Ask the patient to raise the arm over the head and lower it again to touch the finger

e) After several repeats, ask the patient to close both eyes and try several more times

Legs

S5.1

a) Ask the patient to place one heel on the opposite knee, and then run it down the shin to the big toe

b) Repeat with the patients eyes closed

c) Repeat on the other side.

Romberg Test

S5.1

a) Remove sharp and harmful objects from around the area of exam

b) Ask the patient to stand with feet together and eyes open

c) Close both eyes for (20-30) seconds without support while stay near the patient to prevent falling.

Test for Pronator Drift

a) ask the client to stand I for 20-30 seconds with both arms straight forward, palms up, and with eyes closed S5.1

b) Instruct the patient to keep arms up and eyes shut

c) Tap the arms briskly downward.

4. The Sensory system

Pain

a) Instruct the patient to close eyes S5.1

b) use a safety pin substituting the blunt end for the point as a stimulus

c) Ask the patient to report whether it is “sharp” or “dull” and to compare sides.

Temperature

a) Omitted if pain sensation is normal S5.1

b) Using a test tube filled with hot and another with cold water or a tuning fork heated or cooled by water, touch the skin and ask the patient identify “hot” or “cold”.

Light touch

a) With a wisp of cotton, touch the skin lightly, avoiding pressure. S5.1

b) Ask the patient to respond whenever a touch is felt

c) Compare one area with another

Vibration

a) Tap a tuning fork (128-256Hz) on the heel of hand S5.1

b) Place it over a distal interphalangeal joint of the patient's finger

c) Then over the interphalangeal joint of the big toe

d) Ask what the patient feels

e) If not sure whether it is pressure or vibration ask the patient to tell when vibration stops, then touch the fork to stop it.

f) If vibration sense is impaired, proceed to more proximal bony prominences.

Position

a) Grasp the patients big toe, holding it by its sides between thumb and index finger S5.1

b) Pull it away from the other toes to avoid friction

c) Demonstrate "up" and "down"

d) With the patient's eyes closed, ask for a response of "up" or "down" when moving the toe in a small arc.

e) In similar fashion test position in fingers

5. Discriminative Sensation

1. Stereognosis

a) ask the client to close eyes S5.1

b) Place a familiar object in the patient's hand

c) Ask the patient to tell what it is.

2. Number Identification (Graphesthesia)

a) Ask the patient to close eyes S5.1

b) With a blunt end of a pen or a pencil, draw a large numbering the patient's palm.

c) ask the patient to tell what it is.

3. Two-point discrimination

a) using the two ends of an opened paper clip, or the sides of two pins touch a finger pad in two places simultaneously S5.1

b) Alternate the double stimulus irregularly with a one- point touch.

c) Find the minimal distance at which the patient can discriminate one from two points.

4. Point Localization

a) Ask the patient to close eyes S5.1

b) Briefly touch a point on the patient's skin

ask the patient to open both eyes and point to the place touched

5. Extinction

a) Ask the patient to close eyes S5.1

b) Simultaneously stimulate corresponding areas on both sides of the body

ask where the patient feels the touch

6. Deep Tendon Reflexes

The Biceps Reflex

a) Flex the patient's arm at the elbow with the palm down. S5.1

b) Place the thumb or finger firmly on the biceps tendon.

c) Strike with the reflex hammer so that the blow is aimed directly through the digit toward the biceps tendon.

d) Observe for flexion at the elbow, and watch for and feel the contraction of the biceps muscle.

e) If unable to elicit a reflex, use the reinforcement.

The Triceps Reflex

a) Flex the patient's arm at the elbow with the palm toward the body, and pull it slightly across the chest S5.1

b) Strike the triceps tendon above the elbow

c) Use a blow directly form behind it

d) Watch for contraction of the triceps muscle and extension at the elbow

e) If unable to elicit a reflex, use the reinforcement.

The Supinator or Brachioradialis Reflex

a) Let the patient's hand rest on the abdomen or the lap with the forearm partly pronated S5.1

b) Strike the radius about (1-2) inches above the wrist

c) Watch for flexion and supination of the forearm

d) If unable to elicit a reflex, use the reinforcement.

The Knee reflex

a) With the patient sitting or lying down, and the knee flexed. S5.1

b) Briskly tap the patellar tendon just below the patella

c) Note contraction of the quadriceps with extension at the knee.

d) If unable to elicit a reflex, use the reinforcement.

The Planter Response

a) With an object such as a key or the wooden end of an applicator stick, stroke the lateral aspect of the sole from the heel to the ball of the foot, curving medially across the ball. S5.1

b) Note movement of the toes, normally flexion.

7. Meningeal Signs

Neck Mobility

a) Make sure there is no injury to the cervical vertebrae or cervical cord S5.1

b) With the patient supine, place the hands behind the patient's head and flex the neck forward, until the chin touches the chest if possible

Brudzinski's Sign

As flexing the neck, watch the hips and knees in reaction to the maneuver, normally should remain relaxed and motionless. S5.1

Kernig's Sign

a) Flex the patient's legs at both the hip and the knee S5.1

b) Then straighten the knee.

D Procedure Termination

a) Put client in comfortable position according to health status S5.1

b) Provide patient with reassurance S5.1

c) Return back equipments S5.1

d) Wash hands S5.1

e) Document findings S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……/10**
S5.1		8 Mark		

Name and Signature of Evaluator: ……

CHECKLIST: Musculoskeletal Assessment

Student's Name:_____ **ID # :** _____

No	Procedure Steps	Yes	No	C L O
A	**History Taking :**			
	a) Current Symptoms			S5.1
	b) Past History			S5.1
	c) Family History			S5.1
	d) Lifestyle and Health Practices			S5.1
B	**Preparation**			
	a) Wash hands			S5.1
	c) Provide comfortable environment			S5.1
	d) Explain procedure to client.			S1.1
	e) Provide privacy			S5.1
C	**Procedure**			
1	Observe gait and posture of the client.			S5.1
2	Inspect joints, muscles and extremities for size, symmetry and color			S5.1
3	Palpate joints, muscles and extremities for tenderness, edema, heat, nodules and creptitus.			S5.1
4	**Test Range of Motion of the following joints:**			
i.	**Range of Motion at the Shoulder**			
	a) Raise (abduct) the arms to shoulder level (90°), with palms facing down			S5.1
	b) Raise the arms to a vertical position above the head with the palms facing each other (External Rotation)			S5.1
	c) Place both hands behind the neck, with the elbows out to the side (external rotation and abduction).			S5.1
	d) Place both hands behind the small of the back (internal rotation and adduction)			S5.1

ii.	**Range of Motion at the Wrist**			
	a) Flexion: With the patient's forearm stabilized and supinated on a table, placing finger tips in the patient's palm, ask the patient to flex the wrist against gravity.			S5.1
	b) Extension : With the patient's forearm pronated, placing a hand on the patient's dorsal metacarpals, ask the patient to extend the wrist against gravity			S5.1
	c) Radial and ulnar deviation: with the palms down ask the patient to move the wrists laterally and medially.			S5.1
	d. Hyperextension			S5.1
	Assess for the Carpal Tunnel Syndrome			
	Phalen's Test 1. Hold the patient's wrists in acute flexion for 60 seconds. 2. Or ask the patient to press the backs of both hands together to form right angle			S5.1
iii.	**Range of Motion at the Hip**			
	a) Flexion: with the patient supine, place a hand under the patient's lumbar spine, ask the patient to bend each knee in turn up to the chest and pull it firmly against the abdomen (1. Knee flexed, 2. Knee extended)			S5.1
	b) Extension: with the patient face down, extend the thigh backward (or upward) + hyperextension)			S5.1
	c) Abduction: 1. Stabilize the pelvis by pressing down the opposite anterior superior iliac spine with one hand 2. With the other hand, grasp the ankle and abduct the extended leg until feeling the iliac spine move 3. If there's limited movement, stand at the foot of the table, grasp both ankles, and spread them maximally, abducting both extended legs at the hips for comparison.			S5.1
	d) Adduction: With the patient supine stabilize the pelvis, hold one ankle, and move the leg medially across the body and over the opposite extremity.			S5.1
	e) Rotation:			S5.1

	1. Flex the leg to (90°) at hip and knee, stabilize the thigh with one hand, grasp the ankle with the other, and swing the lower leg medially for external rotation at the hip. 2. Flex the leg to (90°) at hip and knee, stabilize the thigh with one hand, grasp the ankle with the other, and swing the lower leg laterally for internal rotation.			
	Assessing for Low back pain with radiation to the leg			
	1. With the patient supine, raise the patient's relaxed and straightened leg until pain occurs. 2. Then dorsiflex the foot.			S5.1
iv.	**Assessing The Knee**			
	The Bulge sign (minor fluids) 1. With the knee extended, place the left hand above the knee and apply pressure on the supra-patellar pouch, displacing or milking the fluid downward 2. Stroke downward on the medial aspect of the knee and apply pressure to force fluid into the lateral area. 3. Tap the knee just behind the lateral margin of the patella with the right hand.			S5.1
	The Balloon sign 1. Place the thumb and index of the right hand on each side of the patella 2. With the left hand, compress the supra-patellar pouch against the femur. 3. Feel for fluid entering into the spaces next to the patella under the right thumb and index.			S5.1
	Balloting the patella (major effusions) 1. Compress the supra-patellar pouch 2. " Ballotte" or push the patella 3. Watch for fluid returning to the supra-patellar pouch.			S5.1
v.	**Range of Motion at the Ankle**			
	a) Dorsiflex and plantar flex the foot at the ankle. b) Invert and evert the foot at the ankle.			S5.1

D	**Procedure Termination**			
	a) Put client in comfortable position according to health status			S5.1
	b) Provide patient with reassurance			S5.1
	c) Return back equipment			S5.1
	d) Wash hands			S5.1
	e) Document findings			S3.1

Result:

CLO	**Student Performance**			
S1.1		1 Mark		
S3.1		1 Mark	**Final Result**	**……./10**
S5.1		8 Mark		

Name and Signature of Evaluator: …….