**Health History and Examination**

*Health Assessment of the Head, Neck, Eyes, Ears, Nose, Mouth, Throat, Neurological System, and the 12 Cranial Nerves Skin, Hair, Nails, Breasts, Peripheral Vascular System, Lymphatics, Thorax, Heart, Lungs, Musculoskeletal, Gastrointestinal, and Genitourinary Systems*

Save this form on your computer as a Microsoft Word document. You can expand or shrink each area as you need to include relevant data for your client.

|  |  |
| --- | --- |
| Student Name: | Date: |

|  |  |  |
| --- | --- | --- |
| Client/Patient Initials: | Sex: | Age: |
| Occupation of Client/Patient: | | |
| **Health History/Review of Systems**  *(Complete and systematic review of systems)* | | |
| Neurological System *(headaches, head injuries, dizziness, convulsions, tremors, weakness, numbness, tingling, difficulty speaking, difficulty swallowing, etc., medications):* | | |
| Head and Neck *(pain, headaches, head/neck injury, neck pain, lumps/swelling, surgeries on head/neck, medications):* | | |
| Eyes *(eye pain, blurred vision, history of crossed eyes, redness/swelling in eyes, watering, tearing, injury/surgery to eye, glaucoma testing, vision test, glasses or contacts, medications):* | | |
| Ears *(earache or other ear pain, history of ear infections, discharge from ears, history of surgery, difficulty hearing, environmental noise exposure, vertigo, medications):* | | |
| Nose, Mouth, and Throat *(discharge, sores or lesions, pain, nosebleeds, bleeding gums, sore throat, allergies, surgeries, usual dental care, medications):* | | |
| Skin, Hair and Nails *(skin disease, changes in color, changes in a mole, excessive dryness or moisture, itching, bruising, rash or lesions, recent hair loss, changing nails, environmental hazards/exposures, medications):* | | |
| Breasts and Axilla *(pain or tenderness, lumps, nipple discharge, rash, swelling, trauma or injury to breast, mammography, breast self-exam, medications):* | | |
| Peripheral Vascular and Lymphatic System *(leg pain, cramps, skin changes in arms or legs, swelling in legs or ankles, swollen glands, medications):* | | |
| Cardiovascular System *(chest pain or tightness, SOB, cough, swelling of feet or hands, family history of cardiac disease, tire easily, self-history of heart disease, medications):* | | |
| Thorax and Lungs *(cough, SOB, pain on inspiration or expiration, chest pain with breathing, history of lung disease, smoking history, living/working conditions that affect breathing, last TB skin test, flu shot, pneumococcal vaccine, chest x-ray, medications):* | | |
| Musculoskeletal System *(joint pain; stiffness; swelling, heat, redness in joints; limitation of movement; muscle pain or cramping; deformity of bone or joint; accidents or trauma to bones; back pain; difficulty with activity of daily living, medications)*: | | |
| Gastrointestinal System *(change in appetite – increase or loss; difficulty swallowing; foods not tolerated; abdominal pain; nausea or vomiting; frequency of BM; history of GI disease, ulcers, medications)*: | | |
| Genitourinary System *(recent change, frequency, urgency, nocturia, dysuria, polyuria, oliguria, hesitancy or straining, urine color, narrowed stream, incontinence, history of urinary disease, pain in flank, groin, suprapubic region or low back)*: | | |
| **Physical Examination**  *(Comprehensive examination of each system. Record findings.)* | | |
| Neurological System *(exam of all 12 cranial nerves, motor and sensory assessments):* | | |
| Head and Neck *(palpate the skull, inspect the neck, inspect the face, palpate the lymph nodes, palpate the trachea, palpate and auscultate the thyroid gland):* | | |
| Eyes *(test visual acuity, visual fields, extraocular muscle function, inspect external eye structures, inspect anterior eyeball structures, inspect ocular fundus):* | | |
| Ears *(inspect external structure, otoscopic examination, inspect tympanic membrane, test hearing acuity):* | | |
| Nose, Mouth, and Throat *(Inspect and palpate the nose, palpate the sinus area, inspect the mouth, inspect the throat):* | | |
| Skin, Hair and Nails *(inspect and palpate skin, temperature, moisture, lesions, inspect and palpate hair, distribution, texture, inspect and palpate nails, contour, color, teach self-examination techniques):* | | |
| Breasts and Axilla (*deferred for purpose of class assignment*) | | |
| Peripheral Vascular and Lymphatic System *(inspect arms, symmetry, pulses; inspect legs, venous pattern, varicosities, pulses, color, swelling, lumps):* | | |
| Cardiovascular System *(inspect and palpate carotid arteries, jugular venous system, precordium heave or lift, apical impulse; auscultate rate and rhythm; identify S1 and S2, any extra heart sounds, murmur):* | | |
| Thorax and Lungs *(inspect thoracic cage, symmetry, tactile fremitus, trachea; palpate symmetrical expansion;, percussion of anterior, lateral and posterior, abnormal breathing sounds):* | | |
| Musculoskeletal System *(inspect cervical spine for size, contour, swelling, mass, deformity, pain, range of motion; inspect shoulders for size, color, contour, swelling, mass, deformity, pain, range of motion; inspect elbows for size, color, contour, swelling, mass, deformity, pain, range of motion; inspect wrist and hands for size, color, contour, swelling, mass, deformity, pain, range of motion; inspect hips for size, color, contour, swelling, mass, deformity, pain, range of motion; inspect knees for size, color, contour, swelling, mass, deformity, pain, range of motion; inspect ankles and feet for size, color, contour, swelling, mass, deformity, pain and range of motion):* | | |
| Gastrointestinal System *(contour of abdomen, general symmetry, skin color and condition, pulsation and movement, umbilicus, hair distribution; auscultate bowel sound;, percuss all four quadrants; percuss border of liver; light palpation in all four quadrants– muscle wall, tenderness, enlarged organs, masses, rebound tenderness, CVA tenderness):* | | |
| Genitourinary System (*deferred for purpose of this class*) | | |
| **FHP Assessment** | | |
| Cognitive-Perceptual Pattern: | | |
| Nutritional-Metabolic Pattern: | | |
| Sexuality-Reproductive Pattern: | | |
| Pattern of Elimination | | |
| Pattern of Activity and Exercise: | | |
| Pattern of Sleep and Rest: | | |
| Pattern of Self-Perception and Self-Concept: | | |
| **Summarize Your Findings**  *(Use format that provides logical progression of assessment.)* | | |
| Situation *(reason for seeking care, patient statements):* | | |
| Background *(health and family history, recent observations):* | | |
| Assessment *(assessment of health state or problems, nursing diagnosis):* | | |
| Recommendation *(diagnostic evaluation, follow-up care, patient education teaching including health promotion education):* | | |