

**NORTHEASTERN TECHNICAL COLLEGE  
PHYSICAL ASSESSMENT FORM**

Name \_\_\_\_\_

Patient's Initials \_\_\_\_\_

Date \_\_\_\_\_

Fill out completely. Identify findings by using your initials. Document any specifics in narrative notes at end of form.

ASSESSMENT AREAS	PLACE YOUR INITIALS IN THE APPROPRIATE BRACKETS
<b>Vital Signs</b>	AP:_____ T: _____ Route: _____ P: _____ R: _____ B/P _____ O2 sat _____
<b>I.D. Band On</b>	( ) Yes ( ) No
<b>Allergies</b>	List: _____
<b>Neurological</b>	( ) Alert ( ) Lethargic ( ) Withdrawn ( ) Cooperative ( ) Sedated ( ) Dizziness ( ) Memory changes ( ) Headaches ( ) Agitated Speech: ( ) Clear ( ) Slurred ( ) Aphasic ( ) Dysphasia Oriented: ( ) Person ( ) Place ( ) Time Disoriented: ( ) Person ( ) Place ( ) Time Other _____ Safety Measures: ( ) Fall precautions ( ) Alarms Type: _____
<b>Skin</b>	Temperature: ( ) Warm ( ) Cool ( ) Dry ( ) Diaphoresis Color: ( ) Normal for race ( ) Other: Describe _____ Turgor: ( ) Normal for Age ( ) Tenting Integrity: ( ) Intact ( ) Rash ( ) Decubiti ( ) Skin Tears Finger Nails (Describe) _____ Toe Nails (Describe) _____ Other: _____ ( ) Turn q2hrs ( ) Ted hose Type : _____ Wound care: Type of dressing/supplies needed and times: _____ _____ _____

<b>ASSESSMENT AREAS</b>	<b>PLACE YOUR INITIALS IN THE APPROPRIATE BRACKETS</b>
<b>Eyes</b>	Visual Acuity: ( ) Glasses ( ) Contacts Drainage: Color _____ Amount _____ ( ) Blurred vision ( ) Double vision ( ) Inflammation ( ) Pain ( ) Color blind ( ) Itching Lids: ( ) Swelling ( ) Crusting ( ) Drooping Pupils: ( ) PERRL Other _____
<b>Ears</b>	Hearing Loss: ( ) L ( ) R ( ) Hearing Aid ( ) Tinnitus ( ) Deaf Drainage: Color _____ Amount _____ Loss of balance: ( ) Yes ( ) No Pain: ( ) Yes ( ) No Other _____
<b>Nose</b>	( ) Congestion ( ) Sinus problems ( ) Nasal Flaring ( ) Nosebleeds ( ) Drainage Amount: _____ Other: _____
<b>Mouth</b>	( ) Change in Voice ( ) Halitosis ( ) Lesions ( ) Pain ( ) Ulcers ( ) Bleeding gums ( ) Edema of gums ( ) Decreased sense of taste ( ) Nausea ( ) Vomiting Condition of Teeth: ( ) Missing ( ) Loose ( ) Edentulous Dentures: ( ) Full ( ) Partial Other: _____
<b>Neck</b>	Neck Veins: ( ) Distended ( ) Non-distended ( ) Bilateral ( ) Unilateral ( ) Hoarseness ( ) Sore throat ( ) Swollen glands ( ) Stiffness Other _____

<b>Chest</b>	<input type="checkbox"/> Pain <input type="checkbox"/> Symmetry <input type="checkbox"/> Asymmetry <input type="checkbox"/> Barrel <input type="checkbox"/> Retractions Breath Sounds: <input type="checkbox"/> Present Bilaterally <input type="checkbox"/> Clear <input type="checkbox"/> Adventitious <input type="checkbox"/> Absent Wheeze: <input type="checkbox"/> Inspiratory <input type="checkbox"/> Expiratory <input type="checkbox"/> Audible Dyspnea: <input type="checkbox"/> With activity <input type="checkbox"/> At rest <input type="checkbox"/> Lying Down Cough: <input type="checkbox"/> None <input type="checkbox"/> Non-productive <input type="checkbox"/> Productive <input type="checkbox"/> Hemoptysis Color _____ Character _____ Amount _____ _____ <input type="checkbox"/> Night sweats Other _____ Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Easy <input type="checkbox"/> Deep <input type="checkbox"/> Labored <input type="checkbox"/> Nonlabored
<b>ASSESSMENT AREAS</b>	<b>PLACE YOUR INITIALS IN THE APPROPRIATE BRACKETS</b>
<b>Chest Con't</b>	<input type="checkbox"/> Orthopnea Other _____ <input type="checkbox"/> Oxygen Rate and method: _____ <input type="checkbox"/> Respiratory treatments Type: _____ <input type="checkbox"/> Tracheostomy Times for trach care: _____
<b>Abdomen</b>	<input type="checkbox"/> Tender <input type="checkbox"/> Non-tender <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Non-distended Bowel Sounds: <input type="checkbox"/> Present x 4 quadrants <input type="checkbox"/> Hypoactive <input type="checkbox"/> Hyperactive <input type="checkbox"/> Active <input type="checkbox"/> Absent: Location _____ Other _____ Diet: _____ Supplements: _____ Tube Feeding: <input type="checkbox"/> NGT <input type="checkbox"/> PEG Formula Name _____ Bolus Times: _____ Continuous Rate: _____ Water Flush: Amount: _____ Frequency: _____
<b>Genitourinary</b>	<input type="checkbox"/> Bladder Distention <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Dysuria <input type="checkbox"/> Nocturia <input type="checkbox"/> Urostomy <input type="checkbox"/> Indwelling foley Inserted: _____ <input type="checkbox"/> Condom cath <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Hx of Calculi <input type="checkbox"/> Hx UTI Urine Character: <input type="checkbox"/> Straw <input type="checkbox"/> Amber <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Bloody <input type="checkbox"/> Odor <input type="checkbox"/> Not observed Other _____
<b>Rectum/Bowel</b>	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Normal BM <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipated <input type="checkbox"/> Flatus <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Fecal Impaction <input type="checkbox"/> Rectal bleeding <input type="checkbox"/>

	<p>Ostomy</p> <p>Description of Stool: Frequency: _____</p> <p>Amount : ( ) Small ( ) Medium ( ) Large Color: ( ) Brown Other: _____</p>
<b>Reproductive</b>	<p>( ) Vaginal Discharge: Describe _____</p> <p>( ) Unusual Vaginal Bleeding ( ) Menopause ( ) Dysmenorrhea</p> <p>( ) Penile discharge ( ) Penile sores ( ) Testicular lumps ( ) Hernias</p> <p>( ) Breast cancer ( ) Nipple discharge Describe: _____</p>



