

HEAD TO TOE ASSESSMENT

Assessment Conducted by: _____

Date: _____

Time: _____

DOC 🩺

- Alert Drowsy Lethargic Stuporous Coma

Basic Equipments Check 🧰

- Gloves
- Thermometer
- Blood pressure cuff
- Watch
- Scale
- Penlight
- Stethoscope

General Status 📋

- Visual signs _____
- Heart rate _____
- Blood pressure _____
- Temperature _____
- Pulse symmetry _____
- Respiratory rate _____
- Pain (high) (normal)

Head 🧠

- Hair _____
- Face _____
- Nose _____
- Ears _____
- Mouth _____
- Mucous conjunct _____
- Mucosa _____
- Lesions _____
- Discoloration _____



Cardiac ❤️

- Palpate the carotid and temporal pulses bilaterally _____
- Listen to heartbeats _____

Upper Extremities 🦶

- Radial pulses equal, +2 _____
- Other _____
- Temperature VS. Trunk (warm/cool) _____
- Grip equal and strong _____
- Capillary refill <3 sec _____
- Ven filling rapid _____

Lower Extremities 🦶

- Hair present _____
- Edema _____
- Foot strength _____
- Homan's (+/-) Classification (+/-) _____
- Temperature VS. Trunk (warm/cool) _____
- Yellowed Thickened Ignored

General Assessment 📊

- Weight/Height _____
- BMI _____

Sample Nursing Documentation Head Toe Assessment

L Darling-Hammond



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