

# Head To Toe Assessment C

## Wash Hands

( ) Completed - Standard Precautions

## Introduction

( ) Completed - Introduce self & purpose of assessment to relieve anxiety and role function identification.

## Vital Signs

Pulse \_\_\_\_\_ Rate, Strength, Regularity  
Temperature \_\_\_\_\_ Oral, Rectal, Tympanic  
B / P \_\_\_\_\_ Respiration \_\_\_\_\_

## Orientation

( Oriented x 4 )

What year is this ? \_\_\_\_\_

Tell me your name ? \_\_\_\_\_

Tell me where you are ? \_\_\_\_\_

Tell me why you are here? \_\_\_\_\_

## Pupil Check

( PERRLA ) Pupils, Equal, Round, React to light, Accommodate

Sluggish ( ) No Change ( ) Brisk ( ) Normal ( )

Accommodation Yes ( ) No ( )

## Neck Veins

Patient at 45o angle ( )

Neck Veins Flat ( ) Distended ( )

## Heart Tones

Apical Pulse with Stethoscope

Rate ? \_\_\_\_\_ Rhythm ? \_\_\_\_\_

Clarity of Sounds ? \_\_\_\_\_ Abnormal? ( )

Explain ! \_\_\_\_\_

## Bilateral Checks

( Radial Pulses ) - Rate, Strength, Regularity

Right \_\_\_\_\_ Left \_\_\_\_\_

( Hand Strength ) - 2 fingers only

Right Stronger ( ) Left Stronger ( ) Equal ( )

( Pedal Pulses ) - Top of Foot

Right Foot \_\_\_\_\_ Left Foot \_\_\_\_\_

( Capillary Refill ) -On fingers or toes 3 seconds or less

Right Fingers ( ) sec. Left Fingers ( ) sec.

Right Toes ( ) sec. Left Toes ( ) sec. Delay or abnormal refill return ? Yes ( ) ie., \_\_\_\_\_

## Skin

Skin Turgor - 1 to 3 second return, on Sternum

Return was ( ) sec. Abnormal ( ) sec.

Skin Color - Check on inside of Lip or

Conjunctiva

Lip ( ) Conjunctiva ( )

Pink ( ) Pale ( ) Jaundice ( ) Cyanotic ( )

Skin Temperature - Use back of hand to check

Hot ( ) Warm ( ) Cool ( )

## Breath Sounds

Assess anterior and posterior and :  
take deep breaths, do not move sta  
patients part.

Clear Bilaterally ( ) Left only ( ) Rig

Both poor bilaterally ( ) ie., \_\_\_\_\_

Good air flow ( ) Poor air flow ( )

## Bowel Sounds

Assess all 4 quadrants, do not touc  
disrupt normal sounds. If irregular,  
Umbilicus is  
midpoint.

( Stomach ) - Check for condition

Soft ( ) Hard ( ) Distended ( ) Other

RUQ Active ( ) Absent ( ) Hyperact

RLQ Active ( ) Absent ( ) Hyperacti

LUQ Active ( ) Absent ( ) Hyperacti

LLQ Active ( ) Absent ( ) Hyperacti

## Peripheral Edema

Edema is found in dependent area  
finger by pressing down. Observe t

Feet Yes ( ) No ( ) Pitting ( ) R ( ) L

Hands Yes ( ) No ( ) Pitting ( ) R ( )

Sacrum Yes ( ) No ( ) Pitting ( ) Ind

## Assessing For Pain

Where is the pain ? \_\_\_\_\_

How long has it lasted ? \_\_\_\_\_

Does the pain travel anywhere ? \_\_\_\_\_

What makes it feel better ? \_\_\_\_\_

What makes pain worse ? \_\_\_\_\_

Descrip. of pain ? Sharp ( ) Stabbin

On a scale of 1 - 10, 10 being the v

## Skin Breakdown Check

Check entire body for redness or s

Normal ( ) Abnormal ( ) Explain cos

effected. \_\_\_\_\_

## Homan's Sign

Ask patient to dorsiflex both feet.

Pain in right calf Yes ( ) No ( )

Pain in both calves Yes ( ) No ( )

## Closure

Let the patient know you are finish

Bedrails up ( ) Bed in low position ( )

# SAMPLE CHARTING ENTRY

# Head To Toe Nursing Assessment Documentation

**J Ma**



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