**Western Physical Assessment Proficiencies**

1. Non-verbal vs. verbal interview skills
2. Parts of a complete medical history Parts of a Complete Medical History

CC – Chief Complaint

HPI – History of Present Illness

PMI – Past Medical History

FH = Family History

Psychosocial History

ROS – Review of Systems (and Vitals)

1. What is a thorough PMI?
2. What are the CAGE questions?

**C** – Ever thought of **cutting** down drinking?

**A** – Ever **annoyed** over others criticism of drinking?

**G** – Ever felt **guilty** about drinking?

**E** – Ever had an “**eye opener**” drink first thing in the morning to get over the hangover?

1. Normal temperature ranges
2. Locations of pulses
3. Apical pulse
4. Normal respiratory rate range
5. Taking blood pressure
6. Skin differences infants vs. adolescents

Infants

Subcutaneous fat poorly developed

Skin smoother, less oily than adults

Eccrine glands function after 1 month

Apocrine glands do not function

Adolescents

Apocrine glands activated

Increased sebum production

Grow pubic and axillary hair

Facial hair in boys

1. Skin changes in pregnancy

Increased blood flow to skin , Increased sweat from sebaceous gland activity, Fat deposits, Stretch marks, Vascular spiders. Increased pigmentation

1. What is asked in a skin history assessment?
2. DD of skin cancer vs. normal mole with ABCDE
3. Assessing skin tugor

To determine turgor, pinch a fold of skin under the clavicle or on the forearm so the top skin separates from the underlying structure.

1. Appearance of normal nails vs. abnormal nails
2. Head inspection

Hair distribution and quantity

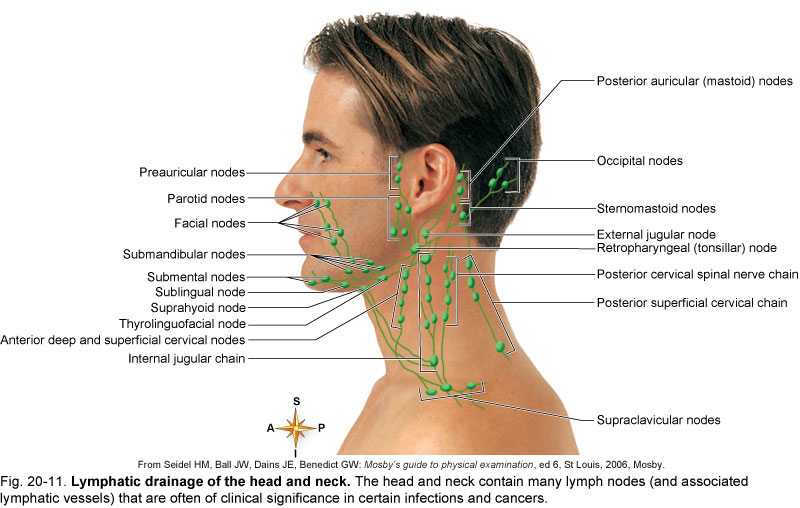
Scalp – scaling, nevi

Skull – size, contour

Face – expression, contours

Skin – color, pigmentation, hair distribution, lesions

1. Head and neck lymph nodes



1. Test for trigeminal neuralgia and Bell’s Palsy (muscles of mastication)
2. Weber’s Test vs. Rinne Test
3. General otoscope use
4. Eye inspection

General appearance, Conjunctiva, Lacrimal gland, Sclera, Orbital area, Eyelids, lashes, brows, Conjunctivae and sclera, Movement of eyes, strasbismus, nystagmus, Corneal clarity (shine light directly at persons eyes; should see equal reflection) , Iris – colored part , Pupils (round,regular,equal, 3-5mm) Pupillary light reflex- darken room, focus on distant object, shine light from the side results in direct light reflex and consensual light reflex

1. Visual acuity
2. Nose exam
3. Sinus exam
4. Transillumination
5. Oral cavity exam
6. Thyroid exam
7. Point out anterior and posterior thoracic landmarks
8. Point out thoracic reference lines

Anterior Chest (Midsternal line, Midclavicular line)

Posterior Chest (Vertebral line – Midspinal, Scapular line)

Lateral Chest (Anterior Axillary line, Posterior Axillary line, Mid–axillary)

1. Where are lung borders?
2. What are major parts of thoracic/chest exam?
3. Demonstrate tactile fremitus

Tactile Fremitus – palpable vibration of sound from the larynx (use palmer base of fingers, “99” or Blue Moon)

1. Demonstrate lung percussion and diaphragmatic expansion
2. Demonstrate lung auscultation
3. Lung rates (eupnea, tachypnea, bradypnea)
4. Questions to ask before breast exam

History of breast masses and what was done about them

Pain or tenderness in the breasts and relation to the menstrual cycle

Discharge from the nipple

Inquire if the client performs breast self-examination

Estrogen replacement therapy

1. Breast inspection
2. Breast palpation
3. Protocol for high risk breast patients

For client’s who have a past history of breast masses, who are at high risk for breast cancer, examination in both a Supine and a Setting position is recommended

For palpation choose one of three patterns:

Concentric circles

Hands-of-the-clock or spokes-on-a-wheel

Vertical strips

1. Axillary exam
2. Parts of Cardiac Exam

Inspection, Palpation, Percussion, Auscultation

1. Names and locations of anterior chest surface landmarks
2. What would you inspect for a cardiac exam?
3. What exam findings present with arterial insufficiency

4 P’s of blocked arteries

Pulseless

Pallor

Pain

Paralysis

1. Homan’s sign - Thrombophlebitis (Homan’s Sign – calf pain with dorsiflexion)
2. PMI
3. Describe palpation edema scale
4. Bounding pulse vs. pulsus alternans vs. bigeminal pulse vs. pulsus paradoxis

Bounding pulse

A pulse that feels full and spring like on palpation as a result of an increased thrust of cardiac contraction or an increased volume of circulating blood within the elastic structures of the vascular system

Pulsus alternans

Alternating beats are so weak as to be undetected, causing apparent halving of the pulse rate

Bigeminal pulse

Two beats occur in rapid succession, the groups of two being separated by a longer interval

Pulsus Paradoxus

Strong on expiration, weak on inspiration

Present if difference in systolic pressure varies > 15 mm Hg between inspiration and expiration

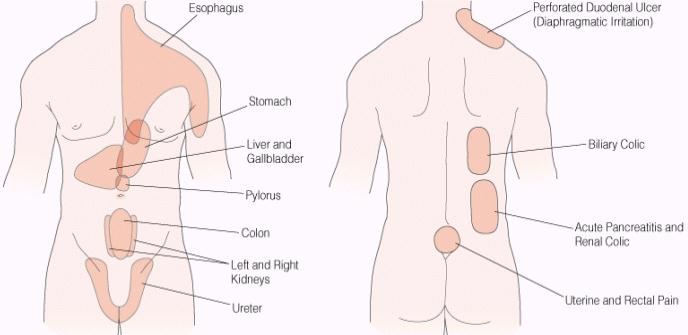
1. Cardiac auscultation
2. Location of pulses
3. Pulse grading

3 + Bounding

2 + Brisk, expected, normal

1 + Diminished, weaker than expected

0 Absent, unable to palpate

1. Edema grading
2. Allen test
3. Capillary refill test
4. Abdominal regions
5. Examples of referred pain
6. Parts of abdominal examination

LOOK - INSPECTION

LISTEN - AUSCULTATION

PERCUSS

PALPATE

1. Auscultation bowel sounds

Place the diaphragm over the abdomen to hear bowel sounds (borborygmi) which are long gurgles.

These sounds are transmitted across the abdomen so it is not necessary to listen at several places.

The normal frequency of sound is 5-34 sounds per minute.

1. Abdominal percussion
2. Liver and spleen palpation
3. Abdominal palpation
4. Signs for peritoneal inflammation
5. McBurney’s point
6. Aortic palpation
7. Demonstrate fluid wave
8. Location of different hernias
9. Tanner scale
10. Calculate EDC – estimated date of confinement
11. Indications for digital rectal exam
12. Describe orthopedic history
13. Demonstrate upper and lower extremity muscle strength
14. Joint bulging vs. joint ballottment
15. Cervical orthopedic exam
16. Cervical testing for vertebral artery compression vs. nerve root compression vs. disc
17. TMJ exam
18. Shoulder range of motion testing
19. Rotator cuff testing
20. Elbow exam
21. Varus vs. valgus stress testing
22. Tennis elbow vs. golf elbow tests
23. Tests for carpal tunnel
24. Major parts of neurological exam
25. Assess mental status
26. What is altered mental status?
27. What is altered level of consciousness?
28. AEIOU TIPS that may affect mental status
29. Cranial nerve examination
30. Test upper and lower extremity muscle strength
31. Demonstrate DTR
32. Demonstrate cutaneous reflexes
33. Demonstrate sensory nerve testing
34. Dermatone vs.myotone testing
35. What to look for in gaits
36. Demonstrate two point discrimination
37. Demonstrate stereogenesis

Stereogenesis – place a key or familiar object in patient’s hand and ask patient to identify

1. How to test for proprioception

Test proprioception – hold big toe by its sides between your thumb and index finger, pull it away from other toes, and move it up and down. Ask patient to identify the direction of movement.

1. Rhomberg test (Patient stands with feet together and arms forward, eyes closed, for 30-60 seconds without support. Loss of balance with eyed closed is +)
2. How to test for pain