PHYSICAL EXAMINATION

Definition: A physical examination is an evaluation of the body and its functions using inspection, palpation (feeling with the hands), percussion (tapping with the fingers), and auscultation (listening). A complete health assessment also includes gathering information about a person's medical history and lifestyle, doing laboratory tests, and screening for disease

Observation: The action or process of closely observing or monitoring something or someone. It includes the measuring of one's vital signs of Blood pressure, temperature, pulse and respiration. It involves use of instruments such as thermometer, sphygmomanometer and a watch.

Inspection is a visual examination of the patient;

Palpation is done when the person doing the assessment places their fingers on the body to determine things like swelling, masses, and areas of pain. Palpation can include light and deep palpation.

Percussion is tapping the patient's bodily surfaces and hearing the resulting sounds to determine the presence of things like air and solid masses affecting internal organs. The sounds that are heard with percussion are resonance which is a hollow sound, flatness which is typically hear over solid things like bone, hyper resonance which is a loud booming sound, and tympani which is a drum type sound.

Auscultation is listening to an area of the body using a stethoscope. For example, bowel sounds, lung sounds and heart sounds are auscultated with a stethoscope. The sounds that are heard with auscultation are classified and described according to their duration, pitch, intensity and quality. For example, the duration of a breath sound can be described in terms of seconds of duration or it can be described as having a longer duration of inspiration than expiration. The intensity can be describe as loud or soft and quiet; the pitch is described as a high pitched sound to a dull and low pitched sound.

Purpose of a Physical Examination.

- ✓ Gather baseline data about the patient's health status.
- ✓ Support or refute subjective data obtained in the health history.
- ✓ It aids in making diagnoses.
- ✓ Make clinical judgments about a patient's changing health status and management.
- ✓ Evaluate the outcomes of care.

Indication for a physical examination

- ✓ All patients who come to the hospital for the first time.
- ✓ Sick or unwell client.
- ✓ Routine checkup/ wellness clinic.

Equipment

Equipment required to do a physical examination are as follows:

- Sphygmomanometer
- Thermometer
- Watch with a second hand.
- Pen and notebook.
- Stethoscope
- Tape measure

Procedure:

1. Assemble your equipment.
2. Wash your hands. Greet and identify the patient. Explain what you are going to do. Provide for privacy. Begin with the 5 Vital Signs: Temperature, Pulse, Blood Pressure, Respiration and Pain. Ask the patient how he/she feels and observe the environment. As you assess the body by systems, observe for such things as non-verbal cues, mobility and ROM.
3. General appearance:

- Affect/behavior/anxiety
- Level of hygiene
- Body position
- Patient mobility
- Speech pattern and articulation

4. Skin:

As you examine all body systems you need to make note of the status of the Integumentary System for any breaks in the skin, scars, lesions, wounds, redness, or irritation. Assess the turgor, color, temperature and moisture of the skin.

5. Assess HEENT/Neuro:

Head: Shape and symmetry; condition of hair and scalp

Eyes: Conjunctiva and sclera, pupils; reactivity to light and ability to follow your finger or a light

Ears: Hearing aids, pain? Speak in a whisper: can he hear you and comprehend? Turn away to make sure he isn't reading your lips.

Nose: Drainage, congestion, difficulty breathing, sense of smell

Throat and Mouth: Mucous membranes, any lesions, teeth or dentures, odor, swallowing, trachea, lymph nodes, tongue.

6. Chest:
    - Inspect: Expansion/retraction of chest wall/work of breathing and/or accessory muscle use
      Jugular distension
    - Auscultate: For breath sounds anteriorly and posteriorly
      Apices and bases for any adventitious sounds
      Apical heart rate
    - Palpate: For symmetrical lung expansion
7. Abdomen:
    - Inspect: Abdomen for distension, asymmetry
    - Auscultate: Bowel sounds (RLQ)
    - Palpate: Four quadrants for pain and bladder/bowel distension (light palpation only)
    - Check urine output for frequency, colour, odour.
    - Determine frequency and type of bowel movements.
8. Extremities:
- Inspect: Arms and legs for pain, deformity, edema, pressure areas, bruises
    - Compare bilaterally
- Palpate: Radial pulses Pedal pulses: dorsalis pedis and posterior tibial
- CWMS and capillary refill (hands and feet)
- Assess handgrip strength and equality.
- Assess dorsiflex and plantarflex feet against resistance (note strength and equality).
- Check skin integrity and pressure areas.
9. Back area (turn patient to side or ask to sit up or lean forward):
    - Inspect back and spine.
    - Inspect coccyx/buttocks.

10. Report and document assessment findings and related health problems according to agency policy.

Focus Physical Examination

This involves evaluation of a specific part of the body and its functions using inspection, palpation, percussion, and auscultation. In this case, only the body system affected by the problem is examined. For example; in a patient with a case of pneumonia, a focus physical examination will involve only the respiratory system, as it is the primary system affected by the disease. In a case of fracture, the skeletal system is evaluated. The bone(s) of the affected area is or are examined.