Chapter 10: Head, Eyes, Ears, Nose, and Throat
Wilson: Health Assessment for Nursing Practice, 6th Edition

MULTIPLE CHOICE

1. A patient is admitted with edema of the occipital lobe following a head injury. The nurse correlates which finding with damage to this area?

a.	Ipsilateral ptosis
b.	Impaired vision
c.	Pupillary constriction
d.	Increased intraocular pressure

ANS: B
The occipital lobe contains the visual context. Ipsilateral ptosis (drooping of the eye lid) is controlled by the oculomotor cranial nerve (CN III) that is located in the midbrain. The nurse must correlate anatomy with function and assessment. Pupillary constriction is controlled by the oculomotor cranial nerve (CN III) that is located in the midbrain. This abnormality is associated with glaucoma rather than injury to the occipital lobe.

DIF: Cognitive Level: Analyze REF: p. 134
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

2. The nurse is taking a health history on a patient who reports frequent stabbing headaches occurring once a day lasting about an hour. Which statement by the patient is most indicative of cluster headaches?

a.	"I usually have nausea and vomiting with my headaches."
b.	"My whole head is constantly throbbing."
c.	"It feels like my head is in a vice."
d.	"The pain is on the left side over my eye, forehead, and cheek."

ANS: D
The description mentioned in option D is consistent with cluster headaches. Option A is descriptive of migraines rather than cluster headaches. Option B is descriptive of migraines rather than cluster headaches. Option C is descriptive of tension rather than cluster headaches.

DIF: Cognitive Level: Apply REF: p. 104 | p. 141
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

3. A patient reports having migraine headaches on one side of the head that often start with an aura and last 1 to 3 days. As a part of the symptom analysis, the patient

reports which associated symptoms of migraine headaches?

a.	Nausea, vomiting, or visual disturbances
b.	Nasal stuffiness or discharge
c.	Ringing in the ears or dizziness
d.	Red, watery eyes or drooping eyelids

ANS: A
Nausea, vomiting, or visual disturbances are symptoms associated with migraine headaches. Nasal stuffiness or discharge is a symptom associated with cluster headaches rather than migraine headaches. Ringing in the ears or dizziness is a symptom not associated with migraine headaches. Red, watery eyes or drooping eyelids are symptoms associated with cluster headaches rather than migraine headaches.

DIF: Cognitive Level: Analyze REF: p. 141
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

4. The nurse is taking a health history on a patient who reports frequent headaches with pain in the front of the head, but sometimes felt in the back of the head. Which statement by the patient is most indicative of tension headaches?

a.	"I usually have nausea and vomiting with my headaches."
b.	"My whole head is constantly throbbing."
c.	"It feels like my head is in a vice."
d.	"The pain is on the left side over my eye, forehead, and cheek."

ANS: C
Option C is descriptive of tension headaches, which is consistent with the rest of the data reported by the patient. Option A is descriptive of migraines rather than tension headaches. Option B is descriptive of migraines rather than tension headaches. Option D is consistent with cluster headaches rather than tension headaches.

DIF: Cognitive Level: Apply REF: p. 141
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

5. During symptom analysis, the nurse helps the patient distinguish between dizziness and vertigo. Which description by the patient indicates vertigo?

a.	"I felt faint, like I was going to pass out."
b.	"I just could not keep my balance when I sat up."
c.	"It seemed that the room was spinning around."

d.	"I was afraid that I was going to lose consciousness."

ANS: C
Option C is consistent with vertigo because it includes a sensation of motion. Option A is a description of lightheadedness, a form of dizziness. Option B is a description of disequilibrium, a form of dizziness. Option D is a description of syncope, a form of dizziness.

DIF: Cognitive Level: Analyze REF: p. 141
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

6. During symptom analysis, the nurse helps the patient distinguish between dizziness and vertigo. Which description by the patient indicates dizziness?

a.	"I felt faint, like I was going to pass out."
b.	"It felt like I was on a merry-go-round."
c.	"The room seemed to be spinning around."
d.	"My body felt like it was revolving and could not stop."

ANS: A
Option A is a description of lightheadedness, a form of dizziness. Option B is consistent with objective vertigo because it includes a sensation of motion. Option C is consistent with objective vertigo because it includes a sensation of motion. Option D is consistent with subjective vertigo because it includes a sensation of one's body rotating in space.

DIF: Cognitive Level: Analyze REF: p. 141
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

7. Which patient in the eye clinic should the nurse assess first?

a.	The patient who reports a gradual clouding of vision
b.	The patient who complains of sudden loss of vision
c.	The patient who complains of double vision
d.	The patient who complains of poor night vision

ANS: B
Sudden vision loss may indicate a detached retina and requires immediate referral. A gradual clouding of vision is a symptom of cataracts that develop slowly and do not require immediate assessment. Double vision is a symptom of cataracts that develop

slowly and do not require immediate assessment. Poor night vision is a symptom of cataracts that develop slowly and do not require immediate assessment.

DIF: Cognitive Level: Apply REF: p. 142
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

8. A patient complains of right ear pain. What findings does the nurse anticipate on inspecting the patient's ears?

a.	Redness and edema of the pinna of the right ear
b.	Report of pain when the nurse manipulates the right ear
c.	Bulging and red tympanic membrane in the right ear
d.	Increased cerumen in the right ear canal

ANS: C
Bulging and red tympanic membrane in the right ear is consistent with internal ear pain that may be associated with otitis media. Redness and edema of the pinna of the right ear is consistent with external ear pain that may be associated with otitis externa or swimmer's ear. Report of pain when the nurse manipulates the right ear is consistent with external ear pain that may be associated with otitis externa or swimmer's ear. Increased cerumen in the right ear canal is not consistent with internal ear pain.

DIF: Cognitive Level: Apply REF: p. 159 | p. 175
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

9. During the history, a patient reports watery nasal drainage from allergies. Based on this information, what does the nurse expect to find on inspection of the nares?

a.	Enlarged and pale turbinates
b.	Polyps within the nares
c.	High vascularity of the turbinates
d.	Dry and dull turbinates

ANS: A
Enlarged and pale turbinates are expected findings for allergic rhinitis. Polyps within the nares is not an expected finding. High vascularity of the turbinates is not an expected finding. Dry and dull turbinates is not an expected finding.

DIF: Cognitive Level: Apply REF: p. 176
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

10. A patient complains of nasal drainage and sinus headache. The nurse

suspects a nasal infection and anticipates observing which finding during examination?

a.	Foul-smelling drainage
b.	Purulent green-yellow drainage
c.	Bloody drainage
d.	Watery drainage

ANS: B
Purulent green-yellow drainage is consistent with a nasal or sinus infection. Foul-smelling drainage is consistent with a foreign object in the nose. Bloody drainage is consistent with trauma to the nose. Watery drainage is consistent with a nasal allergy.

DIF: Cognitive Level: Apply REF: p. 176
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

11. A patient complains of itching, swelling, and drainage from the eyes with a postnasal drip and sneezing. What type of nasal drainage does the nurse anticipate seeing during inspection of this patient's nares?

a.	Clear
b.	Malodorous
c.	Yellow
d.	Green

ANS: A
The patient has allergic rhinitis, which produces clear drainage. Malodorous drainage is associated with bacterial infection, which is not consistent with the history given by this patient. Yellow drainage is associated with bacterial infection, which is not consistent with the history given by this patient. Green drainage is associated with bacterial infection, which is not consistent with the history given by this patient.

DIF: Cognitive Level: Apply REF: p. 176
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

12. A patient reports a history of snorting cocaine and is concerned about his bloody nasal drainage. What does the nurse expect to see on inspection of his nose?

a.	Deviated septum
b.	Pale turbinates
c.	Perforated nasal septum
d.	Localized erythema and edema

ANS: C
Perforated nasal septum develops from cocaine use. Deviated septum may be from birth or trauma to the nose, but not from cocaine use. Pale turbinates are an indication of allergies. Localized erythema and edema are nonspecific and indicate inflammation somewhere in the nose.

DIF: Cognitive Level: Apply REF: p. 143 | p. 163
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

13. While taking a history, the nurse observes that the patient's facial cranial nerves (CN VII) are intact based on which behaviors of the patient?

a.	The patient's eyes move to the left, right, up, down, and obliquely during conversation.
b.	The patient moistens the lips with the tongue.
c.	The sides of the mouth are symmetric when the patient smiles.
d.	The patient's eyelids blink periodically.

ANS: C
Option C represents facial symmetry, which is controlled by the facial cranial nerve (CN VII). Option A represents movement of the extraocular muscles, which are controlled by the oculomotor, trochlear, and abducens cranial nerves (CN III, IV, and VI, respectively). Option B represents movement of the tongue, which is controlled by the hypoglossal cranial nerve (CN XII). Option D represents function of the oculomotor cranial nerve (CN III).

DIF: Cognitive Level: Apply REF: p. 145 | p. 164
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

14. To assess jaw movement of an adult patient, the nurse uses which technique?

a.	Asking the patient to open the mouth and then passively moving the patient's open jaw from side to side
b.	Placing two fingers in front of each ear and asking the patient to slowly open and close the mouth
c.	Asking the patient to open the mouth and to resist the nurse's attempt to close the mouth
d.	Using the pads of all fingers to feel along the mandible for tenderness and nodules

ANS: B
Option B is the correct technique for palpating the jaw. The patient's jaw movement should be active, not passive. Option C assesses strength of the jaw, which is not typically evaluated. Palpating under the middle of the mandible may reveal the submental lymph

node.

DIF: Cognitive Level: Apply REF: p. 146
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

15. The nurse palpates the patient's jaw movement, placing two fingers in front of each ear and asking the patient to slowly open and close the mouth. What additional request does the nurse ask the patient to do to assess the jaw?

a.	Clinch the jaws together as tightly as possible.
b.	Move the lower jaw from side to side.
c.	Open the mouth as wide as possible, like a yawn.
d.	Move the lower jaw forward and backward several times.

ANS: B
Option B is the technique to complete assessment of the motion of the jaw. Option A is not an assessment technique for the jaw. Option C was completed when the nurse asked the patient to open and close the mouth. Option D is not an assessment technique for the jaw.

DIF: Cognitive Level: Apply REF: p. 146
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

16. A patient is in a sitting position as the nurse palpates the temporal arteries and feels smooth, bilateral pulsations. What is the appropriate action for the nurse at this time?

a.	Auscultate the temporal arteries for bruits.
b.	Palpate the arteries with the patient in supine position.
c.	Document this as an expected finding.
d.	Measure the patient's blood pressure.

ANS: C
Option C is consistent with expected assessment. Option A is not necessary for this patient at this time. Option B is not necessary for this patient at this time. Option D will be done as a part of the assessment, but does not relate to the expected palpation of this patient's temporal arteries.

DIF: Cognitive Level: Apply REF: p. 146
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

17. What instructions does the nurse give the patient before using the Snellen visual acuity chart?

a.	"Remove your eyeglasses before attempting to read the lowest line."
b.	"Stand 10 feet from the chart and read the first line aloud."
c.	"Hold a white card over one eye and read the smallest possible line."
d.	"Squint if necessary to improve the ability to read the largest letters."

ANS: C
Option C is the appropriate technique for using the Snellen chart. Patients should wear their glasses when visual acuity is tested. The patient should stand 20 feet from the Snellen chart. The patient should not squint to see the chart.

DIF: Cognitive Level: Understand REF: p. 147
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

18. Which cranial nerve is assessed by using the Snellen visual acuity chart?

a.	Optic cranial nerve (CN II)
b.	Oculomotor cranial nerve (CN III)
c.	Abducens cranial nerve (CN IV)
d.	Trochlear cranial nerve (CN VI)

ANS: A
The optic cranial nerve (CN II) provides vision tested by the Snellen visual acuity chart. CN III controls pupillary constriction, eyelid movement, and eyeball movement. CN IV controls eyeball movement. CN VI controls eyeball movement.

DIF: Cognitive Level: Remember REF: p. 147
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

19. Which finding on assessment of a patient's eyes should the nurse document as abnormal?

a.	An Asian American patient with an upward slant to the palpebral fissure
b.	A Caucasian American patient whose sclerae are visible between the upper and lower lids and the iris
c.	An African-American patient who has off-white sclerae with tiny black dots of pigmentation near the limbus

d.	An American Indian patient whose pupillary diameters are 5 mm bilaterally

ANS: B
A Caucasian American patient whose sclerae are visible between the upper and lower lids and the iris has eyeball protrusion beyond the supraorbital ridge, which indicates exophthalmos caused by hyperthyroidism. An Asian American patient with an upward slant to the palpebral fissure has an expected racial variation. An African-American patient who has off-white sclerae with tiny black dots of pigmentation near the limbus has an expected racial variation. An American Indian whose pupils are 5 mm bilaterally is an expected finding.

DIF: Cognitive Level: Apply REF: p. 148 | p. 178
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

20. A nurse shines a light toward the bridge of the patient's nose and notices that the light reflection in the right cornea is at the 9 o'clock position and in the left cornea at the 9 o'clock position. What is the interpretation of this finding?

a.	The extraocular muscles of both eyes are intact.
b.	The cornea of each eye is transparent.
c.	The sclera of each eye is clear.
d.	The consensual reaction of both eyes is intact.

ANS: A
The reflection of the light in both eyes in the same location indicates muscles holding the eyes are symmetric. The reflection of the light in both eyes in the same location indicates muscles holding the eyes are symmetric. The reflection of the light in both eyes in the same location indicates muscles holding the eyes are symmetric. Consensual reaction involves constriction of pupils.

DIF: Cognitive Level: Apply REF: p. 149
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

21. How does a nurse assess movements of the eyes?

a.	By assessing peripheral vision
b.	By noting the symmetry of the corneal light reflex
c.	By assessing the cardinal fields of gaze
d.	By performing the cover-uncover test

ANS: C
This tests the movement of the eye in all directions, which assesses the functions of the

cranial nerves III (oculomotor), IV (abducens), and VI (trochlear). This tests the function of cranial nerve I (optic). This indicates symmetry of eye muscles. This is performed after the corneal light reflex is abnormal, indicating asymmetric eye muscles.

DIF: Cognitive Level: Understand REF: p. 151
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

22. On inspection of the external eye structures of an African-American patient, the nurse notices the sclerae are not white, but appear a darker shade with tiny black dots of pigmentation near the limbus. How does the nurse document this finding?

a.	As an indication of a type of anemia
b.	As a hordeolum or sty
c.	As jaundice
d.	As an expected racial variation

ANS: D
This is as an expected racial variation. This may cause a pale conjunctiva. This is an acute infection originating in the sebaceous gland of the eyelid. Jaundice is a yellow color of the sclera associated with liver or gallbladder disease.

DIF: Cognitive Level: Remember REF: p. 148
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

23. A nurse shines a light in the right pupil to test constriction and notices that the left pupil constricts as well. Based on these data, the nurse should take what action?

a.	Document this finding as an abnormal finding.
b.	Assess the patient for accommodation.
c.	Document this finding as a consensual reaction.
d.	Assess the patient's corneal light reflex.

ANS: C
This is a description of expected consensual reaction. This is a description of an expected finding—consensual reaction. Accommodation is not assessed in response to consensual reaction; it tests the function of the oculomotor cranial nerve (CN III). This item describes a consensual reaction rather than a corneal light reflex.

DIF: Cognitive Level: Apply REF: p. 150
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

24. When inspecting a patient's eyes, the nurse assesses the presence of cranial nerve III (oculomotor nerve) by observing the eyelids open and close bilaterally.

What other technique does a nurse use to test the function of this cranial nerve?

a.	Pupillary constriction to light
b.	Visual acuity
c.	Peripheral vision
d.	Presence of the red reflex

ANS: A
Cranial nerve III (oculomotor) controls pupillary dilation and constriction, as well as eyelid movement. Pupil dilation and ptosis may occur when CN III is impaired. Cranial nerve II (optic) provides vision. Cranial nerve II (optic) provides peripheral vision. The red reflex is not controlled by cranial nerve III, but is created by a light illuminating the retina.

DIF: Cognitive Level: Apply REF: p. 134 | p. 151
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

25. How does a nurse recognize normal accommodation?

a.	The patient has peripheral vision of 90 degrees left and right.
b.	The patient's eyes move up and down, side to side, and obliquely.
c.	The right pupil constricts when a light is shown in the left pupil.
d.	The patient's pupils dilate when looking toward a distant object.

ANS: D
Option D is an indication of accommodation. Normally a patient has 90 degrees peripheral vision temporally, but only 60 degrees nasally. Option A is an expected finding, but is not a test for accommodation. Option B is a test of extraocular muscle function in the six cardinal fields of gaze. Option C is an expected finding for consensual reaction, rather than accommodation.

DIF: Cognitive Level: Understand REF: p. 150
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

26. How does a nurse recognize a patient's mydriasis?

a.	The lens of each of the patient's eyes is opaque.
b.	There is involuntary rhythmical, horizontal movement of the patient's eyes.
c.	There is a white opaque ring encircling the patient's limbus.

d.	The patient's pupils are 7 mm and do not constrict.

ANS: D
Mydriasis is pupil size greater than 6 mm and the pupil fails to constrict. An opaque lens is an abnormality that occurs when cataracts are present. An involuntary rhythmical, horizontal movement of the patient's eyes is a description of nystagmus. A white opaque ring encircling the patient's limbus is a description of corneal arcus seen in patients older than 60 years of age.

DIF: Cognitive Level: Understand REF: p. 151
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

27. A nurse uses which technique to assess a patient's peripheral vision?

a.	The nurse asks the patient to keep the head still and by moving the eyes only, follow the nurse's finger as it moves side to side, up and down, and obliquely.
b.	The nurse covers one of the patient's eyes with a card and observes the uncovered eye for movement, then removes the card and observes the just uncovered eye for movement.
c.	With the patient and nurse facing each other and a card covering their corresponding eyes, the nurse moves an object into the visual field and the patient reports when the object is seen.
d.	The nurse shines a light on both corneas at the same time and notes the location of the reflection in each eye.

ANS: C
Option C is the confrontation test that tests peripheral vision. Option A tests extraocular muscle symmetry. The cover-uncover technique is performed when the corneal light reflex is asymmetric. Option D describes the corneal light reflex that tests the symmetry of the eye muscles.

DIF: Cognitive Level: Apply REF: p. 147
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

28. During an eye assessment, a nurse asks the patient to cover one eye with a card as the nurse covers his or her eye directly opposite the patient's covered eye. The nurse moves an object into the field of vision and asks the patient to tell when the object

can be seen. This assessment technique collects what data about the patient's eyes?

a.	Symmetry of extraocular muscles
b.	Visual acuity in the uncovered eye
c.	Peripheral vision of the uncovered eye
d.	Consensual reaction of the uncovered eye

ANS: C
Peripheral vision of the uncovered eye describes the confrontation test, which assesses peripheral vision. Symmetry is tested by the corneal light reflex. Visual acuity is tested using the Snellen chart. Consensual reaction is tested by noticing the pupillary constriction of one eye when a light is being shown into the other eye.

DIF: Cognitive Level: Apply REF: p. 147
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

29. During an eye examination of an Asian patient, a nurse notices an involuntary rhythmical, horizontal movement of the patient's eyes. How does a nurse document this finding?

a.	An expected racial variation
b.	Nystagmus
c.	Exophthalmus
d.	Myopia

ANS: B
An involuntary rhythmical, horizontal movement of the patient's eyes is a description of nystagmus. This is not a racial variation. Exophthalmus is the bulging of the eyeball forward, seen in patients with hyperthyroidism. Myopia is an elongated eyeball found in patients who are nearsighted.

DIF: Cognitive Level: Understand REF: p. 151
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

30. A nurse shines a light toward the bridge of the patient's nose and notices that the light reflection in the right cornea is at the 2 o'clock position and in the left cornea at the 10 o'clock position. Based on these data, the nurse should take what action?

a.	Document these findings as normal.
b.	Perform the cover-uncover test.
c.	Perform the confrontation test.
d.	Document these findings as abnormal.

ANS: B
The nurse is performing the corneal light reflex test and the findings are abnormal. Thus, when the corneal light reflex is asymmetric, the cover-uncover test is performed to determine which eye has the weak extraocular muscle(s). The findings are abnormal. The

light should appear in the same location in each cornea. The confrontation test is used to assess peripheral visual fields and is not appropriate to perform when the corneal light reflex is asymmetric. The asymmetric corneal light reflex is abnormal, but the cover-uncover test should follow the abnormal finding to determine which eye has the weak extraocular muscle(s).

DIF: Cognitive Level: Analyze REF: p. 149
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

31. During the history, a patient reports blurred vision, seeing double at times, and a glare from headlights from oncoming cars at night. Based on this information, what finding does the nurse expect to find on assessment of this patient's eyes?

a.	Anterior chamber depth is shallow.
b.	Red reflex is absent.
c.	Extraocular muscle movement is asymmetric.
d.	Retinal arteries are wider than retinal veins.

ANS: B
The symptoms suggest cataracts. The red reflex cannot be seen because the light cannot penetrate the opacity of the lens. Shallow anterior chamber depth occurs in glaucoma. Extraocular muscle movement is asymmetric. Cataracts affect the lens rather than the eye muscles. Retinal arteries are wider than retinal veins. Cataracts affect the lens rather than the retinal vessels.

DIF: Cognitive Level: Analyze REF: p. 154
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

32. What changes in using the ophthalmoscope should the nurse need to make when inspecting the eye of a patient who is nearsighted?

a.	Holding the ophthalmoscope in the right hand when inspecting the patient's right eye
b.	Using the grid light of the lens aperture to visualize the internal structures of the eye
c.	Rotating the diopter to the red (minus) numbers
d.	Asking the patient to look directly into the ophthalmoscope light

ANS: C
Option C compensates for the longer eyeball of a myopic patient. Option A is performed with all patients having an internal eye examination. Option B is used to estimate the size

of lesions. Option D is an instruction given to the patient to visualize the macula.

DIF: Cognitive Level: Apply REF: p. 154
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

33. After seeing the red reflex and retinal vessels through the ophthalmoscope, how does the nurse locate the optic disc?

a.	By rotating the diopter to the block (positive) numbers until the optic disc comes into focus
b.	By following the retinal vessels inward toward the nose until optic disc is seen
c.	By using the green beam light while looking outward toward the ear until the disc is seen
d.	By locating the macula and then looking temporally (toward the ear) until the disc is seen

ANS: B
Option B locates the optic disc. Option A is used for patients who are myopic. The green beam is used to identify retinal hemorrhages. The macula lies temporal to the optic disc; thus the optic disc is in the opposite direction.

DIF: Cognitive Level: Apply REF: p. 154
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

34. When using an ophthalmoscope to examine the internal eye, how does the nurse distinguish the retinal arteries from the retinal veins?

a.	The arteries are narrower than veins.
b.	The arteries are a darker red than veins.
c.	The arteries have no light reflex and the veins have a narrow band of light in the center.
d.	The arteries have prominent pulsations and veins have no pulsations.

ANS: A
The artery-to-vein width should be 2:3 to 4:5. Arteries are lighter red than veins. Arteries have a narrow band of light in the center and veins have no light reflex. Arteries show little to no pulsations and venous pulsations may be visible.

DIF: Cognitive Level: Understand REF: p. 155
TOP: Nursing Process: Assessment

MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

35. Which finding warrants a referral for additional evaluation?

a.	Earlobes hanging freely from the base of the pinna
b.	Ears having painless nodules less than 1 cm in diameter at the helix
c.	Ears measuring 8 cm in length
d.	Pinna is 20 degrees lower than the outer canthus of the eye

ANS: D
The pinna of the ear should align directly with the outer canthus of the eye and be angled no more than 10 degrees from a vertical position. Earlobes hanging freely from the base of the pinna is an expected finding. Option B is called a Darwin tubercle. It is a normal deviation and may be noted at the helix of the ear. A length of 8 cm is an expected finding.

DIF: Cognitive Level: Apply REF: p. 156
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

36. A nurse is assessing a patient who was hit at the base of the skull with a blunt instrument causing a skull fracture. What assessment finding does this nurse anticipate during the inspection?

a.	Tinnitus, vertigo, and dizziness
b.	Clear drainage from the ear and nose
c.	Loss of hearing and smell
d.	Purulent drainage from the ear and bloody drainage from the nose

ANS: B
Clear drainage from the ear and nose may occur after a basilar skull fracture. The clear drainage may be cerebrospinal fluid. Tinnitus, vertigo, and dizziness are subjective and gathered during the history rather than inspection. Although the patient may report having dizziness or vertigo, the finding of tinnitus is inconsistent with a basilar skull fracture. Loss of hearing and smell is inconsistent with a basilar skull fracture. Purulent drainage is inconsistent with a basilar skull fracture, and bloody drainage usually does not come from the nose, but may be seen from the ear.

DIF: Cognitive Level: Analyze REF: p. 157
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

37. An adult patient comes to the clinic complaining of right ear pain. What

technique does the nurse use to inspect this patient's auditory canal?

a.	Position the otoscope speculum 1.0 to 1.5 cm (about 0.5 inches) into the ear canal.
b.	Remove cerumen from each canal before inserting otoscope.
c.	Choose the smallest otoscope speculum that will fit the patient's ear comfortably.
d.	Pull the pinna slightly downward and backward before inserting the otoscope speculum.

ANS: A
Option A is the correct technique. Removing cerumen is not necessary. The largest speculum that comfortably fits in the ear canal is the one that should be chosen. For adults, the pinna is pulled up and backward to straighten the ear canal.

DIF: Cognitive Level: Apply REF: p. 158
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

38. A nurse examines a patient's auditory canal and tympanic membrane with an otoscope and observes which finding as normal?

a.	Clear fluid lining the auditory canal
b.	A firm tympanic membrane without fluctuation with puffs of air
c.	A small hole within the cone of light
d.	A shiny, translucent tympanic membrane

ANS: D
A shiny, translucent tympanic membrane is an expected finding. Clear fluid or bloody drainage following a head injury may indicate a basilar skull fracture. An expected response is that the tympanic membrane slightly fluctuates with puffs of air. A cone of light is expected, but a hole indicates perforation.

DIF: Cognitive Level: Apply REF: p. 159
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

39. A nurse observes a student using the whisper test to screen a patient with hearing loss. Which behavior by the student requires a corrective comment from the nurse?

a.	Instructing the patient to cover the ear not being tested
b.	Standing beside the patient on the side of the ear being tested

c.	Shielding the mouth to prevent the patient from reading lips
d.	Whispering one or two syllable words and ask the patient to repeat what is heard

ANS: B
The student nurse should stand 1 to 2 feet in front or to the side of the patient. Options A, C, and D are the correct techniques.

DIF: Cognitive Level: Apply REF: p. 160
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

40. A nurse reads in the history that a patient has a new onset of acute otitis media. Based on this information, how does the nurse expect this patient's tympanic membrane to appear?

a.	Dull
b.	Shiny
c.	Red
d.	Blue to deep red

ANS: C
Option C indicates infection in the middle ear, such as otitis media. Option A indicates fibrosis or scarring. Option B is normal for the tympanic membrane. Option D indicates blood behind the tympanic membrane, which may have occurred secondary to injury.

DIF: Cognitive Level: Apply REF: p. 175
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

41. During the Rinne test, a nurse determines that the patient hears the tuning fork held on the mastoid process for 15 seconds and hears the tuning fork held in front of the ear for 30 seconds. The same results are found in both ears. Based on this finding, what is the most appropriate response of the nurse?

a.	Repeat the test again using a 2000 Hz tuning fork.
b.	Tell the patient that this represents an expected finding.
c.	Refer the patient for additional testing to detect hearing abnormality.
d.	Perform a Weber test to confirm the findings of the Rinne test.

ANS: B
Option B is a normal finding. Air conduction (30 seconds) is twice as long as bone conduction (15 seconds). Options A, C, and D are unnecessary because the finding of the

Rinne test was normal.

DIF: Cognitive Level: Analyze REF: p. 161
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

42. During a Weber test, a patient with right ear hearing loss reports hearing sound louder in the right ear than the left ear. What results should the nurse expect to find from this patient during a Rinne test?

a.	Air conduction will be twice as long as bone conduction (2:1 ratio).
b.	Air conduction will be 1.5 times as long as bone conduction (1.5:1 ratio).
c.	Bone conduction will be longer than air conduction.
d.	Bone conduction will be equal to air conduction.

ANS: C
Option C from the Rinne test indicates a conduction hearing loss, which is consistent with the finding from the Weber test described in the question. Option A is an expected finding. Option B is consistent with a sensorineural hearing loss, but this patient has a conduction hearing loss based on the results of the Weber test. Option D is not consistent with the conductive hearing loss described.

DIF: Cognitive Level: Analyze REF: p. 176
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

43. Which finding indicates that this patient has a sensorineural hearing loss?

a.	The patient hears sound by air conduction longer than by bone conduction.
b.	The patient hears sound from a vibrating tuning fork in the affected ear only.
c.	The patient hears normal conversation at 40 dB and a whisper at 20 dB.
d.	The patient hears the rubbing of fingers together from a distance of 4 inches from each ear.

ANS: A
In the Rinne test, hearing sound from a vibrating tuning fork longer by air conduction than by bone conduction is consistent with a sensorineural hearing loss. Option B from the Weber test is consistent with a conduction hearing loss. Option C is an expected finding using audiometry. Option D is an expected finding using the finger rubbing screening hearing test.

DIF: Cognitive Level: Apply REF: p. 176
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

44. How does the nurse perform a Weber test to assess hearing function?

a.	Whispers three to four words into the patient's ear and asks him to repeat the words heard
b.	Places a vibrating tuning fork in the middle of the head and asks the patient if the sound is heard the same in both ears
c.	Places a set of headphones over both ears, plays several tones, and asks the patient to identify the sounds
d.	Places a vibrating tuning fork on the mastoid process and asks the patient to signal when he can no longer hear the sound

ANS: B
Technique B describes the Weber test. Technique A describes the whisper test. Technique C describes the use of an audiometer. Technique D describes part of the Rinne test.

DIF: Cognitive Level: Apply REF: p. 160
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

45. How does the nurse perform a Rinne test of hearing function?

a.	Whispers several words to the patient and requests that the patient repeat the words heard
b.	Places a vibrating tuning fork in the middle of the head and asks the patient if the sound is heard the same in both ears or if it is louder in one ear than the other
c.	Places a set of headphones over both ears, plays several tones, and asks the patient to identify the sounds
d.	Places a vibrating tuning fork on the mastoid process until the patient no longer hears it, and then moves it in front of the ear until the patient no longer hears it

ANS: D
Technique D describes the Rinne test. Technique A describes the whisper test. Technique

B describes the Weber test. Technique C describes the use of an audiometer.

DIF: Cognitive Level: Apply REF: p. 161
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

46. A nurse assessing the hearing of a patient with presbycusis expects which finding on a test for hearing?

a.	Bone conduction will be longer than air conduction on the Rinne test (BC > AC).
b.	Air conduction will be longer than bone conduction on the Rinne test (AC > BC).
c.	Sound lateralizes to the affected ear on the Weber test.
d.	Sound lateralizes to both ears equally on the Weber test.

ANS: B
Option B indicates a sensorineural health loss, the most common cause of presbycusis. Option A indicates a conduction hearing loss, rather than a sensorineural hearing loss. Option C indicates a conduction hearing loss, rather than a sensorineural hearing loss. Option D is a normal finding on this test.

DIF: Cognitive Level: Analyze REF: p. 176
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

47. While taking a history, the nurse notices that the patient's family member repeats most of the questions to the patient in a loud voice. Based on this information, what finding does the nurse anticipate when assessing this patient's hearing using an audioscope?

a.	5 dB hearing loss at all frequencies
b.	10 dB hearing loss at all frequencies
c.	20 dB hearing loss at all frequencies
d.	40 dB hearing loss at all frequencies

ANS: D
A 40 dB loss in all frequencies causes moderate difficulty in hearing normal speech. A 5 dB hearing loss at all frequencies is not tested by an audioscope. A 10 dB loss in high frequencies results in difficulty hearing quiet sounds, such as a heartbeat. A 20 dB loss in high frequencies results in difficulty hearing high-pitched consonants, such as a whisper.

DIF: Cognitive Level: Apply REF: p. 162
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

48. A patient is being seen in the clinic for suspected nasal obstruction from a foreign body. The nurse recognizes which finding as most consistent with this diagnosis?

a.	Unilateral foul-smelling drainage
b.	Bilateral purulent green-yellow discharge
c.	Bilateral bloody discharge
d.	Unilateral watery discharge

ANS: A
Option A is consistent with presence of a foreign object in one side of the nose. Option B is consistent with a nasal or sinus infection. Option C is consistent with localized trauma, such as a nasal fracture. Option D is consistent with a history of head injury and may indicate skull fracture.

DIF: Cognitive Level: Apply REF: p. 143 | p. 162
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

49. In assessing a patient with head injury, the nurse should be most concerned with which finding?

a.	Pain on palpation of the scalp
b.	Unilateral clear, watery nasal discharge
c.	A scalp laceration at the sight of injury
d.	Complaints of dizziness

ANS: B
Unilateral clear, watery nasal discharge may be cerebrospinal fluid, indicating a skull fracture. Pain on palpation of the scalp is expected after a head injury and is not a cause for concern. A scalp laceration at the sight of injury is expected after a head injury and is not a cause for concern. Complaints of dizziness is expected after a head injury and is not a cause for concern.

DIF: Cognitive Level: Understand REF: p. 158 | p. 162
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

50. A patient complains of a lesion in his nose. Which technique does a nurse use to inspect the nasal mucosa?

a.	Inserts a nasal speculum horizontally into the patient's affected nares
b.	Inserts a nasal speculum obliquely into the patient's affected nares
c.	Uses a light source from the ophthalmoscope
d.	Inserts a nasal speculum vertically into the patient's affected nares

ANS: B
Option B is the appropriate technique for inspecting the nares. Horizontal insertion puts pressure on the nasal septum, which is painful. The alternate light source is from an otoscope, rather than an ophthalmoscope. The otoscope has an ear speculum that can be used when a nasal speculum is unavailable. Vertical insertion obstructs the nurse's view of the internal nares.

DIF: Cognitive Level: Understand REF: p. 162
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

51. When inspecting a patient's nasal mucous membrane, which finding does the nurse expect to see?

a.	Deep pink turbinates
b.	Red, edematous mucous membranes
c.	Septum that angles to the left
d.	Clear exudate

ANS: A
Deep pink turbinates are expected for a nasal inspection. Red, edematous mucous membranes indicate a local infection within the nose. Septum that angles to the left is abnormal. Clear exudate occurs with nasal allergies.

DIF: Cognitive Level: Understand REF: p. 163
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

52. A patient comes to the clinic for evaluation after a sinus infection. To evaluate the therapy, the nurse uses transillumination to assess the sinuses and notes which finding indicating recovery from a frontal sinus infection?

a.	The soft palate illuminates brightly when the light source is placed against the lateral nose.
b.	No illumination is noted when the light source is placed firmly against the lateral nose.
c.	A bright glow illuminates the hard palate when the light source is placed against each temporal bone.
d.	A reddish light is noted above the eyebrows when the light is placed against each supraorbital rim.

ANS: D
Finding a reddish light above the eyebrows when the light is placed against each supraorbital rim is consistent with frontal sinuses free of infection. Option A describes

incorrect technique for transillumination. An absence of a glow during transillumination of the sinuses may indicate that the sinuses are congested. Option C describes incorrect technique for transillumination.

DIF: Cognitive Level: Apply REF: p. 163 | p. 176
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

53. A nurse suspects the patient has an infection of the maxillary sinuses. How can this suspicion be confirmed?

a.	Using a flashlight to illuminate the floor of the mouth
b.	Pressing gently with both thumbs into the eyebrow ridges
c.	Applying firm pressure with the thumbs below the cheekbones
d.	Standing behind the patient and asking him or her to slowly rotate the head

ANS: C
Option C palpates the maxillary sinuses to detect tenderness, which may indicate sinus congestion or infection. To transilluminate the maxillary sinuses, the nurse places the source of light lateral to the nose, just beneath the medial aspect of the eye, and looks through the patient's open mouth for illumination of the hard palate. Option B palpates the frontal sinuses rather than the maxillary sinuses. Option D is not a correct technique to confirm infection of the maxillary sinuses.

DIF: Cognitive Level: Apply REF: p. 163
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

54. After assessment of the nose and paranasal sinuses, which finding requires further investigation by the nurse?

a.	Nasal septum off the midline
b.	Nose in the midline of the face
c.	Middle turbinates deep pink in color
d.	Noiseless exchange of air from each naris

ANS: A
A deviated septum is an abnormal finding that needs further investigation. Option B is an expected finding. Options C and D are normal findings.

DIF: Cognitive Level: Understand REF: p. 163
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

55. When inspecting a patient's posterior wall of the pharynx and tonsils, a nurse documents which finding as abnormal?

a.	Both tonsils have a smooth surface.
b.	Left and right tonsils meet at the midline.
c.	Left and right tonsils extend beyond the posterior pillars.
d.	Both tonsils have a glistening appearance.

ANS: B
Option B indicates an enlargement documented as 4+. A smooth surface is expected for the tonsils. Options C and D are expected findings for the tonsils.

DIF: Cognitive Level: Apply REF: p. 166 | p. 167
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

56. Wearing gloves, the nurse grasps the patient's tongue with a gauze pad and palpates a small, firm nodule on the left side of the tongue. Based upon this finding, what is the nurse's appropriate response?

a.	Document that the patient's tongue is normal on palpation.
b.	Inspect the left submandibular salivary glands for redness.
c.	Ask the patient to move the tongue in all directions.
d.	Palpate cervical and submental lymph nodes for enlargement.

ANS: D
The nodules may indicate a malignancy of the tongue, which may also cause enlarged cervical or submental lymph nodes. The nodule is not an expected finding. The salivary glands are not affected by a nodule of the tongue. Option C assesses the hypoglossal cranial nerve or movement of the tongue, which is not related to the nodule found.

DIF: Cognitive Level: Analyze REF: p. 167
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

57. A nurse assesses neck range of movement of several adults. Which patient has an expected range of motion of the neck?

a.	Patient A is unable to resist the nurse's attempt to move the head upright.
b.	Patient B bends the head to the right and left (ear to shoulder) 15 degrees.

c.	Patient C flexes chin toward the chest 45 degrees.
d.	Patient D hyperextends the head 30 degrees from midline.

ANS: C
Option C is an expected finding. Option A is abnormal. Option B is abnormal. The patient should be able to laterally bend the head 40 degrees from midline in each direction. The patient should be able to hyperextend the head 55 degrees from midline.

DIF: Cognitive Level: Understand REF: p. 169
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

58. What technique does a nurse use when palpating the right lobe of a patient's thyroid gland using the anterior approach?

a.	Pushes the cricoid process to the left with the right thumb
b.	Displaces the trachea to the right with the left thumb
c.	Manipulates the thyroid between the thumb and index finger
d.	Moves the sternocleidomastoid muscle to the right with the left thumb

ANS: B
Option B is the correct technique for palpating the thyroid gland using the anterior approach. Options A, C, and D are not correct techniques.

DIF: Cognitive Level: Understand REF: p. 169
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

59. What technique does a nurse use when palpating the right lobe of a patient's thyroid gland using the posterior approach?

a.	Pushes the cricoid process to the left with the right thumb and feels the right lobe with the left hand
b.	Uses the left hand to push the sternocleidomastoid muscle to the right and feels the lobe with the right hand
c.	Pushes the trachea to the right with the left hand and feels the right lobe with the right hand

d.	Places the fingers on either side of the trachea above the cricoid cartilage and feels the right lobe

ANS: C
Option C is the correct technique. Option A is not a correct technique. In the posterior approach, the right lobe is felt with the right hand. Option B is not a correct technique. The trachea, not the muscle, is moved to the side. Option D is not a correct technique. The fingers are placed below the cricoid cartilage.

DIF: Cognitive Level: Understand REF: p. 169
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

60. What instruction does a nurse give a patient to facilitate palpation of the right lobe of the thyroid gland?

a.	"Swallow for me one time."
b.	"Flex your head down and to the left."
c.	"Rotate your head to the right for me."
d.	"Hold your breath for a few seconds."

ANS: A
The patient is asked to swallow to make the thyroid lobe easier to palpate. Option B is incorrect to palpate the right lobe. The patient flexes the neck toward the side being palpated. Option C is incorrect to palpate the right lobe. The patient flexes the neck toward the side being palpated, but does not rotate the head. Option D is not part of the thyroid palpation.

DIF: Cognitive Level: Apply REF: p. 169
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

61. When palpating the right lobe of the patient's thyroid gland using the anterior approach, the nurse feels the tissue between which two structures?

a.	Sternocleidomastoid and the trapezius muscles
b.	Trapezius muscle and the trachea
c.	Cricoid process and the trachea
d.	Sternocleidomastoid muscle and the trachea

ANS: D
Option D is the correct location for palpating the thyroid gland using the anterior approach. Option A is not the correct location for palpating the thyroid gland using the anterior approach. Option B is not the correct location for palpating the thyroid gland using the anterior approach. Option C is not the correct location for palpating the thyroid

gland using the anterior approach.

DIF: Cognitive Level: Remember REF: p. 169
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

62. On palpation the nurse determines that the patient's left thyroid lobe is larger than the right thyroid lobe. What is the nurse's most appropriate action at this time?

a.	Refer the patient to the health care provider for further evaluation.
b.	Document that the patient's thyroid is normal on palpation.
c.	Palpate the left thyroid lobe again using very firm pressure.
d.	Ask the patient to flex the chin toward his chest and palpate again.

ANS: A
The nurse found an abnormality that needs referral for follow-up. Option B is not an appropriate action because the nurse found an abnormality. Repeating the examination will yield the same abnormal finding.

DIF: Cognitive Level: Analyze REF: p. 169
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

63. A teenager comes to the clinic complaining about the whiteheads and blackhead on his face interfering with his social life. During the examination the nurse palpates an enlarged submental lymph node. Where is this lymph node located?

a.	In front of the ear
b.	Under the mandible
c.	At the base of the skull
d.	Along the angle of the jaw

ANS: B
Option B is the location of the submental lymph node. Option A is the location of the preauricular lymph nodes. Option C is the location of the occipital lymph nodes. Option D is the location of the parotid lymph nodes.

DIF: Cognitive Level: Apply REF: p. 137
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

64. How does the nurse test the function of the patient's spinal accessory nerve (CN XI)?

a.	Ask the patient to stick out the tongue and move it side to side.
b.	Ask the patient to shrug the shoulders against the resistance of the nurse's hands.
c.	Ask the patient to open the mouth and observe the uvula rise when he says "ah."
d.	Ask the patient to move the chin to the chest and then up toward the ceiling.

ANS: B
Option B is the correct technique for assessing the spinal accessory cranial nerve (XI). Option A is a test of the hypoglossal cranial nerve (XII). Option C is a test for cranial nerves IX (glossopharyngeal) and X (vagus). Option D assesses the range motion of the neck.

DIF: Cognitive Level: Understand REF: p. 169
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

65. A patient complains of sore throat, pain with swallowing, fever, and chills. The nurse suspects tonsillitis and plans to palpate the anterior cervical lymph nodes. Where does the nurse place his fingers to palpate these nodes?

a.	In front of the ears
b.	Under the mandibles
c.	Along the angle of the mandibles
d.	Adjacent to the sternocleidomastoid muscles

ANS: D
Option D is the location of the anterior cervical lymph nodes. Option A is the location of the preauricular lymph nodes. Option B is the location of the submental and submandibular lymph nodes. Option C is the location of the parotid lymph nodes.

DIF: Cognitive Level: Understand REF: p. 170
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: System Specific Assessments

66. What instructions does the nurse give the patient before palpating the right supraclavicular lymph nodes?

a.	"Lean your head backward and toward the right as far as comfortably possible."
b.	"Lie supine and turn your head away from the right side."
c.	"Draw up your shoulders forward, and flex your chin toward the right side."

d.	"Sit up, raise both arms over your head, and flex your chin away from the right side."

ANS: C
Option C is the technique for palpating the supraclavicular nodes. Option A is incorrect. The patient should draw up (hunch) the shoulders forward rather than leaning back. The patient should be sitting, rather than lying down. The shoulders should be drawn up (hunched) forward, rather than raising the arms.

DIF: Cognitive Level: Apply REF: p. 170
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

67. A patient has had an infected facial wound for more than 3 months. How does the nurse expect the patient's enlarged lymph nodes to feel?

a.	Soft, edematous, and tender
b.	Round, tender, and movable
c.	Hard, nontender, and nonmobile
d.	Irregularly shaped, tender, and firm

ANS: B
Option B is a characteristic of enlarged lymph nodes associated with inflammation. Option A is not a characteristic of lymph nodes associated with inflammation. Option C is a characteristic of enlarged lymph nodes associated with a malignancy. Option D is not a characteristic of lymph nodes associated with inflammation.

DIF: Cognitive Level: Analyze REF: p. 170
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

68. A nurse's presentation to patients on risk factors for oral cancer includes which fact?

a.	The peak incidence of oral cancer is before 40 years of age.
b.	Women have a higher risk than men.
c.	Excessive alcohol consumption is a risk factor.
d.	Eating a low fiber diet is a risk factor.

ANS: C
Seventy-five to eighty percent of individuals who develop oral cancer consume excessive amounts of alcohol. There is increased incidence after age 40 with peak incidence between ages 64 and 74. There is a 2:1 men-to-women incidence. A low fiber diet increases the risk for colon cancer, but not oral cancer.

DIF: Cognitive Level: Understand REF: p. 143

TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Promotion Program

69. During the history, a 65-year-old male patient reports smoking two packs of cigarettes a day for more than 40 years. With this knowledge, what does the nurse expect during the examination of this patient's mouth?

a.	Cracks and erythema in the corners of the mouth
b.	Slightly rough papillae on the dorsal surface of the tongue
c.	Smooth or beefy, red-colored, edematous tongue
d.	Painless, nonhealing mouth ulcers

ANS: D
Option D may indicate oral cancer. Option A may be caused by vitamin B deficiencies. Option B is an expected finding on the tongue. Option C may be an indication of anemia.

DIF: Cognitive Level: Apply REF: p. 143 | p. 147
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Physiologic Adaptation: Alteration in Body Systems

MULTIPLE RESPONSE

1. During an examination of the head and neck of a healthy adult, the nurse expects which findings? (*Select all that apply.*)

a.	Small red lesions with white flakes scattered on the scalp.
b.	The head and facial bones are proportional for the size of the body.
c.	Depressions palpated on the right and left sides over the parietal bones.
d.	Head held flexed 15 degrees to the left.
e.	Face and jaw are symmetric and proportional.
f.	Temporomandibular joint moves smoothly.

ANS: B, E, F
Option B, E, and F are expected findings from an assessment of the head of a healthy adult. Small red lesions with white flakes scattered on the scalp is an abnormal finding. The scalp should be intact without lesion or flakes. Depressions palpated on the right and left sides over the parietal bones is an abnormal finding. Perhaps this patient had skull tongs from cervical traction at one time. Head held flexed 15 degrees to the left is an abnormal finding. The head should be erect.

DIF: Cognitive Level: Analyze REF: p. 145 | p. 146
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance

2. A nurse is assessing the eyes of a healthy 72-year-old adult. What findings does the nurse expect? (*Select all that apply.*)

a.	Bulbar conjunctiva pink and clear, with small red vessels noted
b.	Sclera yellow and moist, cornea transparent
c.	Extraocular movement tracking parallel with peripheral vision noted
d.	Newspaper held at 18 inches to see clearly
e.	Sclera visible between upper lid and iris
f.	Gray to white circle noted where the sclera merges with the cornea
g.	Light reflects on the cornea at 12 o'clock in each eye

ANS: A, C, G
Options A, C, and G are expected findings from an assessment of the eyes of a healthy adult. Sclera should be white and moist. Newspaper held at 18 inches to see clearly is due to presbyopia due to the patient's age. Patient must hold paper further away to see clearly. The upper lid should cover the upper part of the iris. Sclera is visible in hyperthyroidism. A gray to white circle is arcus senilis, which is an abnormal finding in older adults.

DIF: Cognitive Level: Apply REF: p. 149 | p. 151
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

3. During an eye assessment, the nurse asks the patient to keep the head stationary and by moving the eyes only follow the nurse's finger as it moves side to side, up and down, and obliquely. This assessment technique collects what data about which cranial nerves? (*Select all that apply.*)

a.	Cranial nerve II (optic)
b.	Cranial nerve III (oculomotor)
c.	Cranial nerve IV (trochlear)
d.	Cranial nerve VI (abducens)
e.	Cranial nerve V (trigeminal)

ANS: B, C, D
Cranial nerve III (oculomotor), cranial nerve IV (trochlear), and cranial nerve VI (abducens) provide muscle movement for the eyes. Cranial nerve II (optic) provides vision. Cranial nerve V (trigeminal) provides movement for the jaw and sensation for cornea, conjunctive, eyelids, teeth, tongue, and mouth.

DIF: Cognitive Level: Remember REF: p. 151
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

4. What findings does the nurse expect when assessing the ears of a healthy adult? (*Select all that apply.*)

a.	Cerumen noted in the outer ear canal
b.	Pinna located below the external corner of the eye
c.	Cone of light located in the 5 o'clock position in the left ear
d.	Ratio of air conduction to bone conduction 2:1
e.	Tympanic membrane pearly gray
f.	Whispered words repeated accurately

ANS: A, D, E, F
Options A, D, E, and F are all expected findings from an assessment of the ears of a healthy adult. The pinna should align with the outer canthus of the eye. Cone of light should be located in the 7 o'clock position in the left ear and the 5 o'clock position in the right ear.

DIF: Cognitive Level: Apply REF: pp. 158-161 | p. 171
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Techniques of Physical Assessment

5. Which findings does the nurse expect when assessing the mouth of a healthy adult? (*Select all that apply.*)

a.	Lips appear pink, smooth, moist, and symmetric.
b.	Teeth are white, yellow, or gray, with smooth edges.
c.	Exposed tooth neck and brown spots between teeth
d.	Slight roughness on the dorsum of the tongue
e.	Hard palate appears smooth, pale, and immovable.
f.	Mucous membranes are dry and intact.

ANS: A, B, D, E
Options A, B, D, and E are all expected findings from a mouth assessment of a healthy adult. Receding gums expose tooth neck and may indicate gingival disease. Brown spots may indicate caries. Dry and intact mucous membranes may indicate dehydration.

DIF: Cognitive Level: Analyze REF: pp. 164-166

TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

6. Nurses inquire about lifestyle behaviors in those patients with specific risk factors for cataracts. Which characteristics are associated with risk factors for cataracts? (*Select all that apply.*)

a.	Smoking more than 20 cigarettes a day
b.	Having parents with cataracts
c.	Chronic consumption of alcohol
d.	Having a chronic disease, such as diabetes mellitus
e.	Being Asian
f.	Being a man

ANS: A, C, D
Options A, C, and D are all risk factors for cataracts. Having parents with cataracts is not a genetic or familial disorder. Being Asian or a man are not risk factors, but being an African-American or being a woman are risk factors.

DIF: Cognitive Level: Apply REF: p. 142
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Promotion Programs