

Loyola University New Orleans
College of Nursing and Health
BSN-DNP and MSN-FNP Program
INTEGRATED PHYSICAL EXAM REQUIREMENTS

Students will complete a physical assessment on a fellow student, meeting all of the objective points indicated on this Integrated Physical Exam. Students are expected to complete the entire physical exam in a **strictly timed 30-minute** period. Students are allowed to use notecards for quick reference only. In order to ensure success, students are required to identify and state out loud the name of landmarks or physical body areas that are being inspected, palpated, percussed or auscultated. For example, when palpating the lymph nodes, the student is expected to state out loud each lymph node that is being palpated during the exam. See appendices for visual aids.

Introduction

- Introduce self by name and title.
- Provide explanation for physical exam

Head and Face (patient seated, face patient)

Inspection

- Make general survey of patient's condition (affect, orientation, coordination)
- Inspect *skin and hair* (lesions, rashes, pigmentation, hair distribution, etc)
- Symmetry of head and facial features
- Alignment, symmetry, and placement of *eyes*
- Configuration, position, and alignment of *ears*
- CN VII: frown, smile, wrinkle forehead, puff cheeks

Palpation

- Frontal and maxillary sinuses
- Temporomandibular joint
- Eyes and surrounding structures
- Ears and surrounding structures
- Test touch sensation over forehead, cheeks, and chin using cotton wisp (CN V)

Assessment of Eyes

- Visual acuity (CN II) using Snellen chart
- Corneal light reflex
 - Standing about 2 feet directly in front of the patient, shine a light into the patient's eyes and ask the patient to look at it. Inspect the light reflection in the corneas. They should be visible slightly nasal to the center of the pupils. The corneal reflections should be symmetric.
- Pupils
 - Examine reactions to light, direct, and consensual
- Six Cardinal Fields to test the extraocular muscles (CN III, IV, VI)
 - Ask the patient to follow your finger as you move through the six cardinal directions of gaze. Making a wide H in the air, lead the patient's gaze:
 1. To the patient's extreme right
 2. To the right and upward,
 3. Down on the right
 4. Without pausing in the middle, to the extreme left
 5. To the left and upward
 6. Down on the left

Assessment of Nose

- Use a light source to inspect the nares, turbinates, and nasal septum
- Palpate external nasal structures and passages
- Test patency

Assessment of Mouth

- Inspect mouth and pharynx using a tongue blade and light source.
- Inspect number, occlusion, and condition of teeth
- Inspect characteristics of lips, tongue, buccal mucosa, gums
- Inspect appearance of oropharynx, palate and tonsils
- CN IX (glossopharyngeal) and X (vagus): Patient says “ahh” using tongue blade and observe swallowing
- CN XII (hypoglossal): Move tongue from side to side. Test for articulation of the patient’s speech (light, tight, dynamite)

Neck (patient seated, face patient)

Inspection

- Inspect head position is midline. Inspect for lumps, lesions, or swelling
- Inspect the trachea for any deviation from midline position
- Inspect neck range of motion (ROM)- flexion, extension, lateral bending and rotation

Palpation

- Carotid pulses
- Trachea for midline placement
- CN XI (accessory nerve): Shoulder shrug with resistance
- Lymph node palpation
 1. Preauricular- in front of the ear
 2. Posterior auricular- superficial to the mastoid process
 3. Occipital- at the base of the skull posteriorly
 4. Tonsillar- at the angle of the mandible (if pulsating, you are near the carotid artery)
 5. Submandibular- midway between the angle and tip of the mandible.
 6. Submental- in the midline a few centimeters behind the tip of the mandible
 7. Superficial cervical- superficial to the sternocleidomastoid
 8. Posterior cervical- along the anterior edge of the trapezius
 9. Deep cervical chain- deep in the sternocleidomastoid and often inaccessible to examination.
Hook your thumb and fingers around either side the sternocleidomastoid muscle to find them
 10. Supraclavicular- deep in the angle formed by the clavicle and the sternocleidomastoid

Auscultation

- Carotid arteries (bruits)
- Temporal arteries (bruits)

Chest (patient seated, face patient)

Inspection (anterior)

- Skin, shape (A:P diameter), symmetry of chest movement, rate, depth, regularity, ease of respirations

Percussion (anterior)

- Quality and symmetry (note resonance, hyperresonance, dullness)

Auscultation (anterior)

- Symmetrical comparison of anterior chest walls

Heart (patient seated, face patient)

Inspection

- Visible pulsations, or lifts

Palpation

- Point of maximal impulse (PMI)
- All cardiac areas for heaves, thrills

Auscultation

- Listen to all five cardiac areas with diaphragm and bell in the sitting position

Head and Neck (patient seated, behind patient)

- Inspect and palpate head/hair/scalp
- Palpate thyroid with swallow

Chest (patient seated, behind patient)

Inspection (posterior/lateral)

- Skin, shape (A:P diameter), symmetry of chest movement, rate, depth, regularity, ease of respirations

Palpation (posterior/lateral)

- Tactile fremitus for symmetry and quality

Percussion (posterior/lateral)

- Quality and symmetry (note resonance, hyperresonance, dullness)
- CVA tenderness

Auscultation (posterior/lateral)

- Symmetrical comparison of posterior and lateral walls
- Egophony
- Whispered pectoriloquy

Abdomen (patient supine)

Inspection

- Shape, contour, symmetry

Auscultation

- Bowel sounds in all four quadrants
- Abdominal aorta, renal, and iliac arteries for bruits

Percussion

- Percuss in each quadrant to determine the distribution of tympany and dullness
- Percuss liver span at MCL
- Percuss splenic dullness

Palpation

- Light and deep palpation for all four quadrants
- Palpate the liver and spleen

Lower extremities (patient supine)

Inspection

- Skin color, consistency, texture, temperature and moisture
- Hair distribution, texture, quality
- Nail condition and angle

Palpation

- Capillary refill
- Edema of extremities (grade edema)
- Popliteal pulse
- Posterior tibial pulse
- Dorsalis pedis pulse

Assessment

- Active ROM of lower extremities
 - Hip- internal and external rotation, flexion, extension, adduction and abduction
- Muscle strength of hips
- Vibratory sensation
- Plantar reflex
- Heel to shin

Lower extremities (patient seated, face patient)

Percussion

- Patellar reflex
- Achilles reflex

Assessment

- Active ROM of lower extremities

- Knee- flexion and extension
- Ankle- plantar and dorsiflexion
- Muscle strength of the knees and ankles

Upper extremities (patient seated, face patient)

Inspection

- Skin color, consistency, texture, temperature and moisture
- Hair distribution, texture, quality
- Nail condition and angle

Palpation

- Capillary refill
- Edema of extremities (grade edema)
- Radial pulses
- Brachial pulses

Assessment

- Active ROM of upper extremities
 - Shoulder- adduction, abduction, internal rotation, and external rotation
 - Elbow- flexion and extension, supination/pronation
 - Wrist- flexion and extension, ulnar and radial deviation
- Muscle strength of the neck, shoulder, elbow, and hands
- Rapid alternating movements
- Finger to nose
- Finger to finger

Percussion

- Biceps reflex
- Triceps reflex
- Brachioradialis reflex

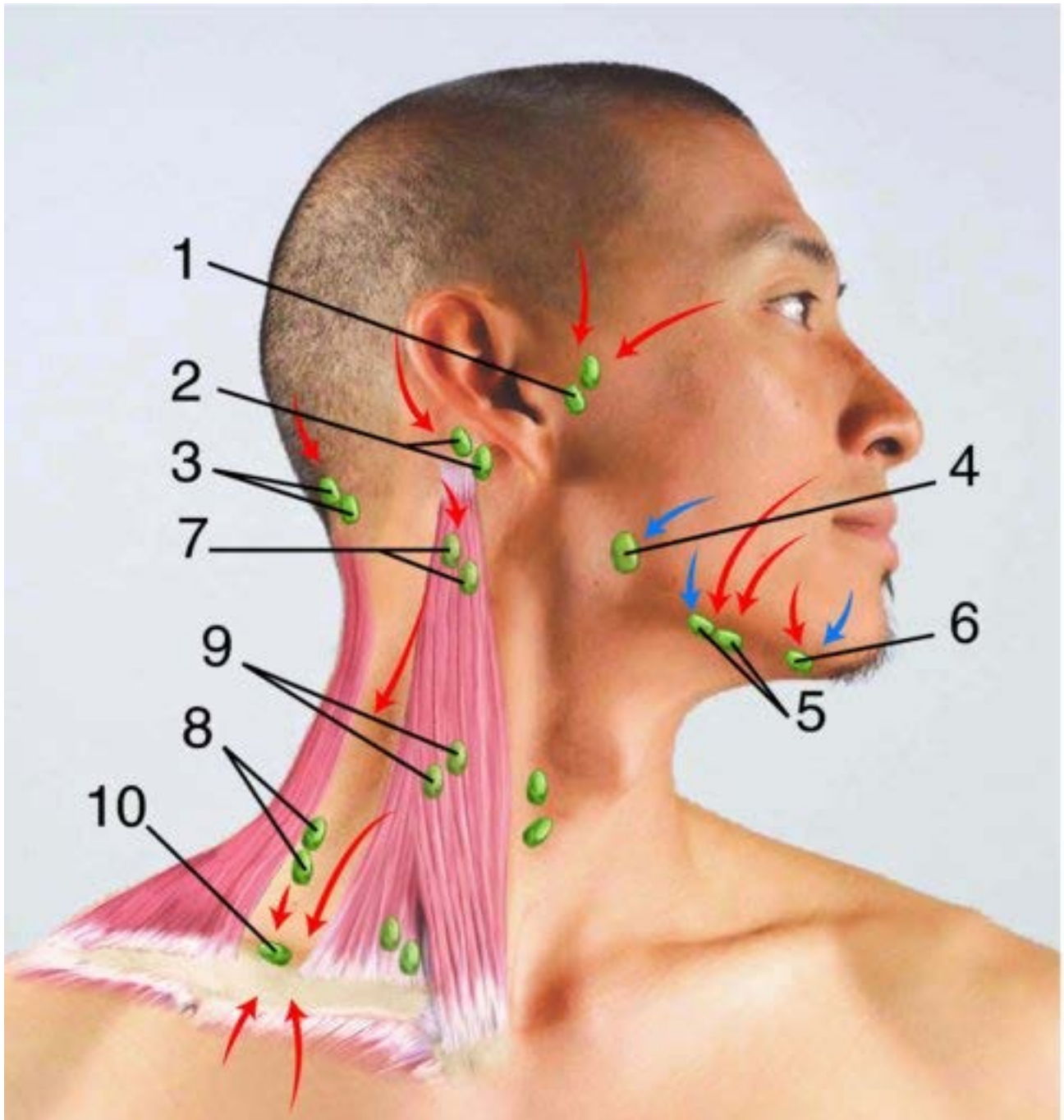
Spine (patient stands)

Inspection

- Posture- alignment of extremities and spine
- Gait, walk heel to toe, walk on heels/toes
- Pronator drift

Assessment

- Active ROM of spine- flexion, extension, rotation, and lateral bending
- Scoliosis test (stand behind patient)
- Romberg's test (stand behind patient)



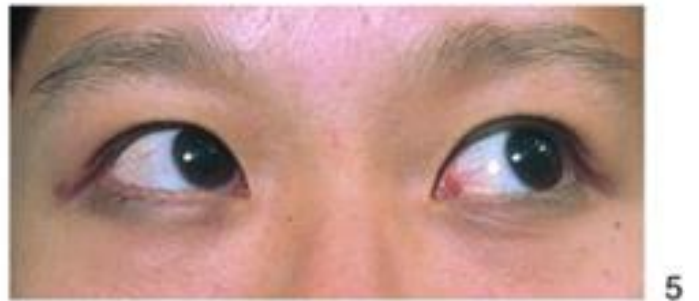
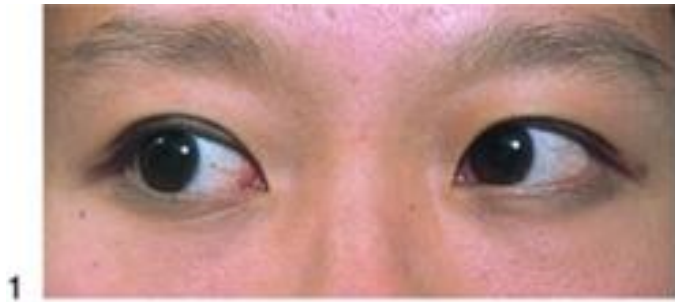
Sequence for examining lymph nodes

Appendix 2



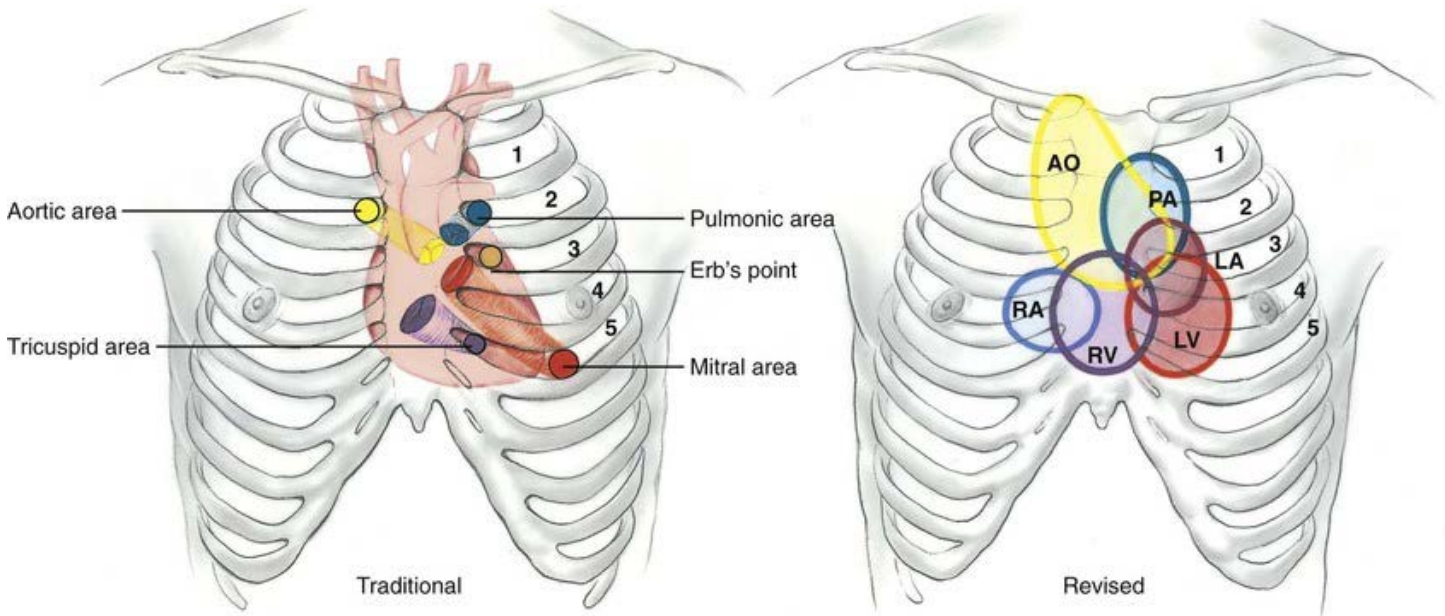
Inspect light reflection in the corneas

Appendix 3



Testing extraocular movements

Appendix 4



Auscultatory areas on the chest wall

Appendix 5

Carotid pulse



Brachial pulse



Radial pulse



Appendix 6

Popliteal pulse



Posterior tibial pulse



Dorsalis pedis pulse



Appendix 7



Press the middle finger firmly on the chest wall.

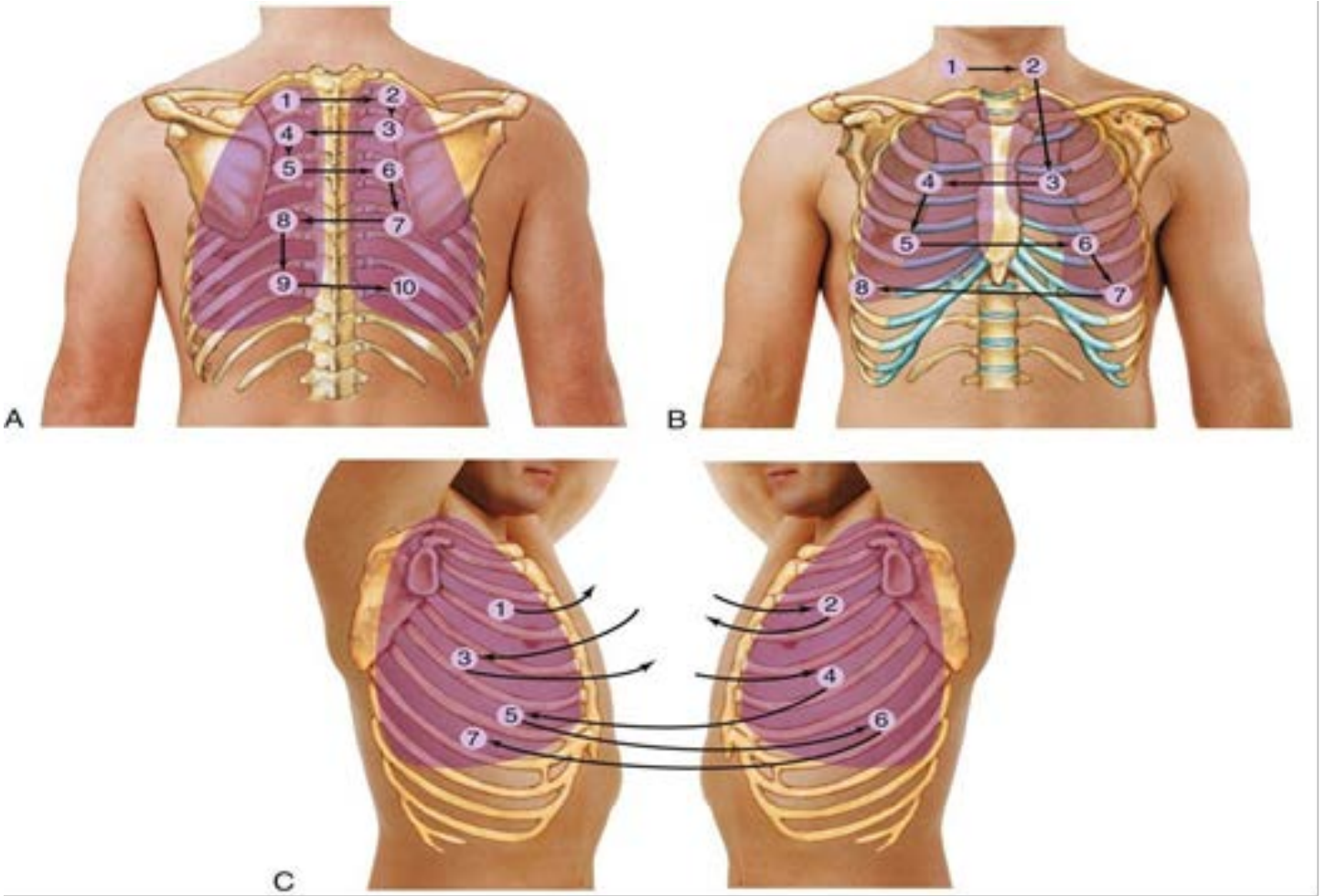


Strike the middle finger with the other hand.



Withdraw the striking finger quickly.

Appendix 8



- A. Posterior chest
- B. Anterior chest
- C. Lateral chest

