Head To Toe Assessment

Fully Editable

Vitals

Safety

CV

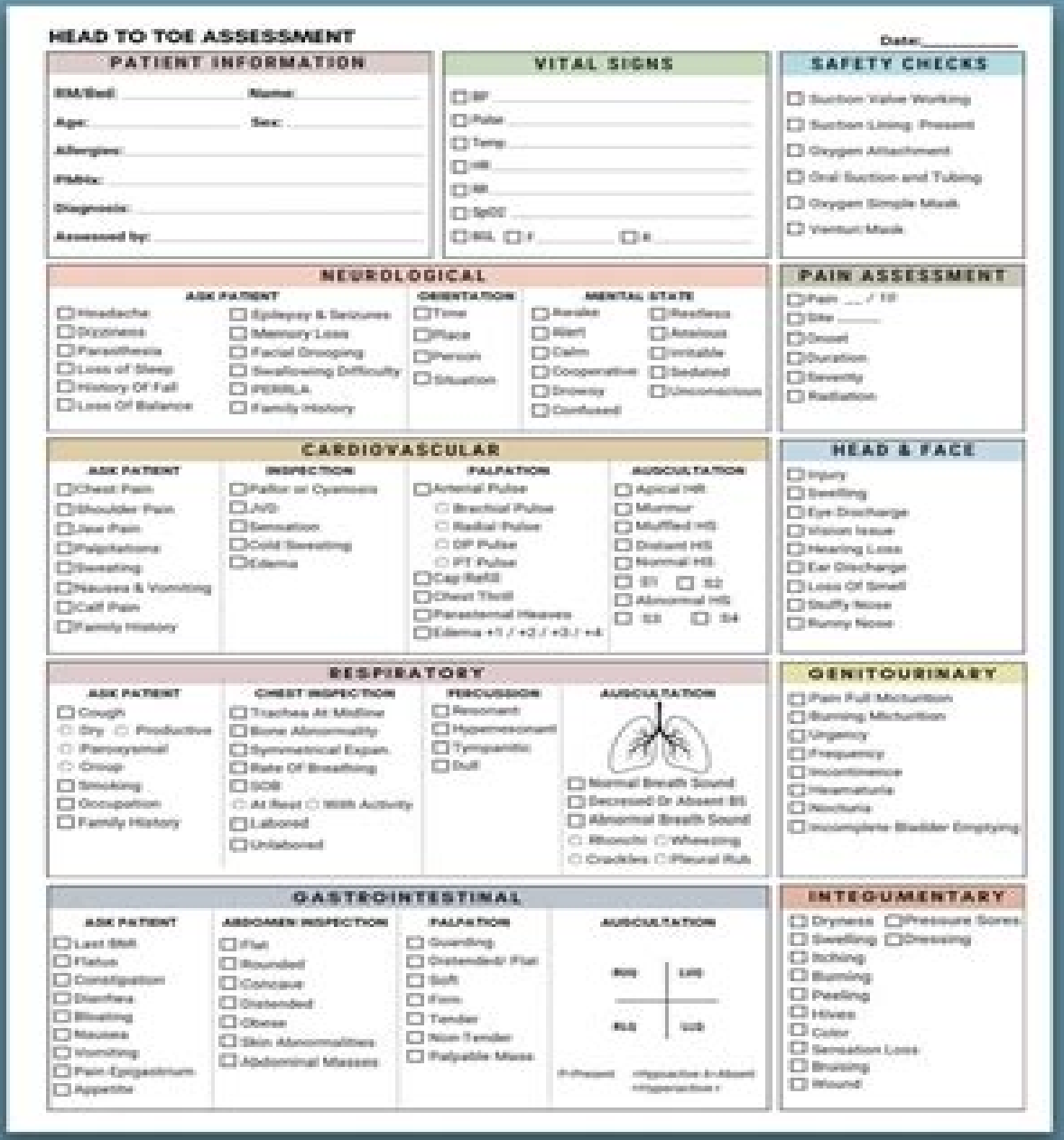
Head

Resp

Skin

GI

GU



HEAD TO TOE ASSESSMENT

Date:_____

PATIENT INFORMATION

BM/Bed: _____ Name: _____

Age: _____ Sex: _____

Allergies: _____

PMHx: _____

Diagnosis: _____

Assessed by: _____

VITAL SIGNS

- ☐ BP _____
- ☐ Pulse _____
- ☐ Temp _____
- ☐ HR _____
- ☐ RR _____
- ☐ SpO2 _____
- ☐ BGL ☐ F _____ ☐ K _____

SAFETY CHECKS

- ☐ Suction Valve Working
- ☐ Suction Lining Present
- ☐ Oxygen Attachment
- ☐ Oral Suction and Tubing
- ☐ Oxygen Simple Mask
- ☐ Venturi Mask

NEUROLOGICAL

ASK PATIENT

- ☐ Headache
- ☐ Dizziness
- ☐ Paraesthesia
- ☐ Loss of Sleep
- ☐ History Of Fall
- ☐ Loss Of Ballance
- ☐ Epilepsy & Seizures
- ☐ Memory Loss
- ☐ Facial Drooping
- ☐ Swallowing Difficulty
- ☐ PERRLA
- ☐ Family History

ORIENTATION

- ☐ Time
- ☐ Place
- ☐ Person
- ☐ Situation

MENTAL STATE

- ☐ Awake
- ☐ Alert
- ☐ Calm
- ☐ Cooperative
- ☐ Drowsy
- ☐ Confused
- ☐ Restless
- ☐ Anxious
- ☐ Irritable
- ☐ Sedated
- ☐ Unconscious

PAIN ASSESSMENT

- ☐ Pain ___ / 10
- ☐ Site _____
- ☐ Onset
- ☐ Duration
- ☐ Severity
- ☐ Radiation

CARDIOVASCULAR

ASK PATIENT

- ☐ Chest Pain
- ☐ Shoulder Pain
- ☐ Jaw Pain
- ☐ Palpitations
- ☐ Sweating
- ☐ Nausea & Vomiting
- ☐ Calf Pain
- ☐ Family History

INSPECTION

- ☐ Pallor or Cyanosis
- ☐ JVD
- ☐ Sensation
- ☐ Cold/ Sweating
- ☐ Edema

PALPATION

- ☐ Arterial Pulse
  - ○ Brachial Pulse
  - ○ Radial Pulse
  - ○ DP Pulse
  - ○ PT Pulse
- ☐ Cap Refill
- ☐ Chest Thrill
- ☐ Parasternal Heaves
- ☐ Edema +1 / +2 / +3 / +4

AUSCULTATION

- ☐ Apical HR
- ☐ Murmur
- ☐ Muffled HS
- ☐ Distant HS
- ☐ Normal HS
- ☐ S1 ☐ S2
- ☐ Abnormal HS
- ☐ S3 ☐ S4

HEAD & FACE

- ☐ Injury
- ☐ Swelling
- ☐ Eye Discharge
- ☐ Vision Issue
- ☐ Hearing Loss
- ☐ Ear Discharge
- ☐ Loss Of Smell
- ☐ Stuffy Nose
- ☐ Runny Nose

RESPIRATORY

ASK PATIENT

- ☐ Cough
  - ○ Dry ○ Productive
  - ○ Paroxysmal
  - ○ Croup
- ☐ Smoking
- ☐ Occupation
- ☐ Family History

CHEST INSPECTION

- ☐ Trachea At Midline
- ☐ Bone Abnormality
- ☐ Symmetrical Expan.
- ☐ Rate Of Breathing
- ☐ SOB
  - ○ At Rest ○ With Activity
- ☐ Laboured
- ☐ Unlaboured

PERCUSSION

- ☐ Resonant
- ☐ Hyperresonant
- ☐ Tympanitic
- ☐ Dull

AUSCULTATION

- ☐ Normal Breath Sound
- ☐ Decreased Or Absent BS
- ☐ Abnormal Breath Sound
  - ○ Rhonchi ○ Wheezing
  - ○ Crackles ○ Pleural Rub

GENITOURINARY

- ☐ Pain Full Micturition
- ☐ Burning Micturition
- ☐ Urgency
- ☐ Frequency
- ☐ Incontinence
- ☐ Haematuria
- ☐ Nocturia
- ☐ Incomplete Bladder Emptying

GASTROINTESTINAL

ASK PATIENT

- ☐ Last Stool
- ☐ Flatus
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain Epigastrium
- ☐ Appetite

ABDOMEN INSPECTION

- ☐ Flat
- ☐ Rounded
- ☐ Concave
- ☐ Distended
- ☐ Obese
- ☐ Skin Abnormalities
- ☐ Abdominal Masses

PALPATION

- ☐ Guarding
- ☐ Distended/ Flat
- ☐ Soft
- ☐ Firm
- ☐ Tender
- ☐ Non Tender
- ☐ Palpable Mass

AUSCULTATION

P=Present —=Absent

INTEGUMENTARY

- ☐ Dryness ☐ Pressure Sores
- ☐ Swelling ☐ Dressing
- ☐ Itching
- ☐ Burning
- ☐ Peeling
- ☐ Hives
- ☐ Color
- ☐ Sensation Loss
- ☐ Bruising
- ☐ Wound

Nursing Assessment Guide Head To Toe

Kim Cooper, RN, MSN,Kelly Gosnell, RN, MSN

Nursing Assessment Guide Head To Toe:

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