

HEAD-TO-TOE ASSESSMENT

General Survey:

- Physical appearance
- Behavior
- Body structure
- Facial and speech
- Nutritional status
- Hygiene and dress
- Mobility

Vital Signs:

- Temperature
- Blood pressure
- Pulse
- Oxygen Saturation
- Respiration

Head and Face:

- **Head:**
 - Inspect for symmetrical and proportioned to body.
 - Assess for deformities, masses, and deformities.
- **Face:**
 - Features should be symmetrical and proportionate.
 - Assess for visual sensation and motor function by asking patient to read through a series of statements.



Neck:

- **Lymph Nodes:**
 - Inspect from lower neck and down the neck for enlarged nodes.
- **Thyroid:**
 - Inspect while instructing patient to swallow.
 - Assess for any enlargement or masses.
- **Trachea:**
 - Inspect for midline with no masses.

Eyes:

- Assess coordination by asking patient to move their eyes in the six cardinal directions.
- **PERVUS:** Equal size, equal color, reacted to light, and accommodation.
- Note any abnormal discharge or tenderness.



Ears:

- Check for lesions, deformities, and discharge.
- Tympanic membrane should be intact and translucent visible.

Nose:

- Inspect for midline and symmetry.
- Mucous membranes should be moist and pink.

Mouth:

- Lips should be pink, moist and smooth.
- Gums and mucous membranes should be pink with no lesions.
- Teeth should be clean, white, and smooth.

Throat:

- Uvula should be pink, moist, and about 1cm.
- Tonsils should be the same color as the surrounding area.



Lungs and Heart:

- Chest should be round, convex, and symmetrical.
- Inspect chest surface for lumps and scars.
- Percuss lungs and compare both sides.
- Auscultate lung sounds on both the anterior and posterior sides in 10-12 positions.
- Auscultate heart sounds:

- **Basal:** 2nd right intercostal space.
- **Apical:** 2nd left intercostal space.
- **Apical:** 2nd left intercostal space.
- **Tricuspid:** 5th left intercostal space.
- **Sternal:** 5th intercostal space at midclavicular line.

Abdomen:

- Inspect shape and symmetry.
- Auscultate bowel sounds in all 4 quadrants.
- Percuss all 4 quadrants.
- Palpate all 4 quadrants and assess for rebound tenderness.



Skin:

- Inspect skin color, texture, temperature, and presence of lesions.
- Assess color, firmness, texture, and capillary refill of nails.
- Assess tenderness and distribution of hair.

Peripheral Arteries:

- Assess strength and quality of pulses.
- Assess the presence of edema.
- **Lymph Nodes:**
 - 1+ : 2mm depression, rebound < 15 seconds
 - 2+ : 5-6mm depression, rebound < 15 seconds
 - 3+ : 8-10mm depression, rebound < 15 seconds
 - 4+ : 10-15mm depression, rebound < 15 seconds

Nursing Assessment Guide

Audrey C. Martins, Alison M. Martins



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