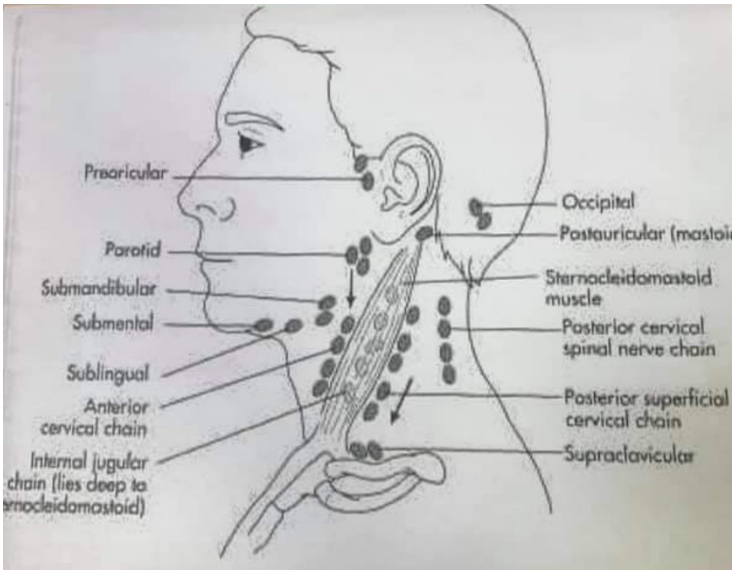
NR 509 Immersion – Physical Assessment Steps

1) Greet patient

2) Inspect face – **no discoloration or lesions present**

3) Inspect head – **midline, symmetrical**

4) Palpate lymph nodes:



- Preauricular
- Postauricular
- Occipital
- Tonsillar
- Submandibular
- Submental
- Anterior cervical
- Posterior cervical
- Supraclavicular

***No enlargement, equal bilaterally.**

5) **Cranial nerve #5 (TRIGEMINAL)**

- **Motor:** palpate masseter muscle and have patient clench teeth
  -no distortions, great strength
- **Sensory:** have patient close eyes and touch face with q-tip, have them verbalize where on face you are touching
  - Pt. verbalized appropriate areas that were touched. Cranial nerve # 5 is intact.

6) **Cranial nerve # 7 (FACIAL)**

- Facial expressions: smile, frown, puff cheeks—**symmetric and equal bilaterally,** pucker lips—**tight**

7) Inspect ears—**no nodules or skin lesions present, symmetrical**

- Use otoscope to inspect external auditory canal. Pull ear up and back.
  - No swelling, redness, drainage or cerumen.
  -Tympanic membrane is pearly gray, no effusion present in middle ear.

*Repeat on other side.

- Palpate pinnae & tragus - **no nodules or tenderness**

8) **Cranial nerve # 8 (ACOUSTIC)**

- Whisper test
  - Have patient cover one ear
  - Whisper 3 words
  - Repeat on other side

***Hearing intact bilaterally.**

9) Inspect eyes—**conjunctiva clear and pink, no drainage or lesions present; sclera white and clear.**

10) **Cranial nerve #2 (OPTIC)**

- Snellen eye chart—tests central vision
  - -Stand 6 feet away from patient.
  - -Have patient cover 1 eye and read smallest line.
  - -Repeat with other eye.
  - -Repeat with both eyes.

***Report as 20/20 vision in R eye, L eye, and both eyes.**

- Continuing assessment of cranial nerve # 2—test peripheral vision.
  - Stand at eye level with patient and have patient look straight ahead.
  - Test peripheral vision from behind shoulders, above head, and from below at waist.
- Continuing assessment of cranial nerve # 2—test pupillary response.
  - Use light on ophthalmoscope and ask patient to stare at your nose.
  - Come from side of eye to front.
- **Both pupils constrict, 2 to 3 cm in diameter, respond to light.**

11) **Cranial nerves #3 (OCULOMOTOR), #4 (TROCHLEAR), & #6 (ABDUCENS)**

- Star or "H" pattern—checking extraocular muscles of the eye
- **All extraocular movements are intact equally.**

12) Inspect nose—**midline, no obstructions, swelling or visible fractures**

- Use otoscope— tip nose up with thumb.
  - Inspect left turbinate—**pink & moist**
  - Angle inward to inspect septum—**midline, no swelling or bogginess**
  - Repeat on other side.

13) Palpate frontal and maxillary sinuses—**assess for tenderness**