

Head To Toe Assessment

Fully Editable

Vitals

Safety

CV

Head

Resp

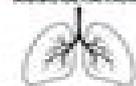
Skin

GI

GU

HEAD TO TOE ASSESSMENT

Date: _____

PATIENT INFORMATION		VITAL SIGNS		SAFETY CHECKS	
EM/Bed: _____	Name: _____	<input type="checkbox"/> BP _____	<input type="checkbox"/> RR _____	<input type="checkbox"/> Suction Valve Working	<input type="checkbox"/> Suction Lining Present
Age: _____	Sex: _____	<input type="checkbox"/> Pulse _____	<input type="checkbox"/> Temp _____	<input type="checkbox"/> Oxygen Attachment	<input type="checkbox"/> Oral Suction and Tubing
Allergies: _____		<input type="checkbox"/> HR _____	<input type="checkbox"/> SpO2 _____	<input type="checkbox"/> Oxygen Simple Mask	<input type="checkbox"/> Venturi Mask
PMdx: _____		<input type="checkbox"/> Sp _____	<input type="checkbox"/> Sa _____		
Diagnosis: _____		<input type="checkbox"/> S1 <input type="checkbox"/> S2 <input type="checkbox"/> S3 <input type="checkbox"/> S4			
Assessed by: _____					
NEUROLOGICAL					
ASK PATIENT		ORIENTATION	MENTAL STATE		PAIN ASSESSMENT
<input type="checkbox"/> Headache	<input type="checkbox"/> Epilepsy & Seizures	<input type="checkbox"/> Time	<input type="checkbox"/> Anxious	<input type="checkbox"/> Restless	<input type="checkbox"/> Pain ___ / 10
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Place	<input type="checkbox"/> Alert	<input type="checkbox"/> Anxious	<input type="checkbox"/> Site _____
<input type="checkbox"/> Parosmia	<input type="checkbox"/> Facial Drooping	<input type="checkbox"/> Person	<input type="checkbox"/> Calm	<input type="checkbox"/> Irritable	<input type="checkbox"/> Onset
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Swallowing Difficulty	<input type="checkbox"/> Situation	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Dejected	<input type="checkbox"/> Duration
<input type="checkbox"/> History Of Fall	<input type="checkbox"/> PERRLA		<input type="checkbox"/> Deny	<input type="checkbox"/> Unconscious	<input type="checkbox"/> Severity
<input type="checkbox"/> Loss Of Balance	<input type="checkbox"/> Family History		<input type="checkbox"/> Confused		<input type="checkbox"/> Radiation
CARDIOVASCULAR					
ASK PATIENT	INSPECTION	FALPATION	AUSCULTATION		HEAD & FACE
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Pallor or Cyanosis	<input type="checkbox"/> Arterial Pulse	<input type="checkbox"/> Apical I+T	<input type="checkbox"/> Murmur	<input type="checkbox"/> Injury
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> JVD	<input type="checkbox"/> Brachial Pulse	<input type="checkbox"/> Muffled I+T	<input type="checkbox"/> Muffled I+T	<input type="checkbox"/> Swelling
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Sensation	<input type="checkbox"/> Radial Pulse	<input type="checkbox"/> Distal I+T	<input type="checkbox"/> Normal I+T	<input type="checkbox"/> Eye Discharge
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Cold/Sweating	<input type="checkbox"/> PT Pulse	<input type="checkbox"/> Normal I+T	<input type="checkbox"/> S1 <input type="checkbox"/> S2	<input type="checkbox"/> Vision Issue
<input type="checkbox"/> Sweating	<input type="checkbox"/> Edema	<input type="checkbox"/> Cap Refill	<input type="checkbox"/> Abnormal I+T	<input type="checkbox"/> S3 <input type="checkbox"/> S4	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Nausea & Vomiting		<input type="checkbox"/> Chest Thrill			<input type="checkbox"/> Ear Discharge
<input type="checkbox"/> Calf Pain		<input type="checkbox"/> Paradoxical Heaves			<input type="checkbox"/> Loss Of Smell
<input type="checkbox"/> Family History		<input type="checkbox"/> Edema +1 / +2 / +3 / +4			<input type="checkbox"/> Stuffy Nose
RESPIRATORY					
ASK PATIENT	CHEST INSPECTION	PERCUSSION	AUSCULTATION		GENITOURINARY
<input type="checkbox"/> Cough	<input type="checkbox"/> Trachea At Midline	<input type="checkbox"/> Resonant			<input type="checkbox"/> Pain Full Micturition
<input type="checkbox"/> Dry <input type="checkbox"/> Productive	<input type="checkbox"/> Sterno Abnormally	<input type="checkbox"/> Hyporesonant	<input type="checkbox"/> Normal Breath Sound	<input type="checkbox"/> Decreased Or Absent S1	<input type="checkbox"/> Burning Micturition
<input type="checkbox"/> Parosymal	<input type="checkbox"/> Symmetrical Expan.	<input type="checkbox"/> Tympanic	<input type="checkbox"/> Abnormal Breath Sound	<input type="checkbox"/> Abnormal Breath Sound	<input type="checkbox"/> Urgency
<input type="checkbox"/> Croup	<input type="checkbox"/> Rate Of Breathing	<input type="checkbox"/> Dull	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Frequency
<input type="checkbox"/> Smoking	<input type="checkbox"/> SOB		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Occupation	<input type="checkbox"/> At Rest <input type="checkbox"/> With Activity		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Hematuria
<input type="checkbox"/> Family History	<input type="checkbox"/> Labored		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Nocturia
	<input type="checkbox"/> Unlabored		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Incomplete Bladder Emptying
GASTROINTESTINAL					
ASK PATIENT	ABDOMEN INSPECTION	FALPATION	AUSCULTATION		INTEGUMENTARY
<input type="checkbox"/> Last Stool	<input type="checkbox"/> Flat	<input type="checkbox"/> Guarding			<input type="checkbox"/> Dryness <input type="checkbox"/> Pressure Sores
<input type="checkbox"/> Flatus	<input type="checkbox"/> Rounded	<input type="checkbox"/> Distended/ Flat	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Swelling <input type="checkbox"/> Dressing
<input type="checkbox"/> Constipation	<input type="checkbox"/> Concave	<input type="checkbox"/> Soft	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Itching
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Distended	<input type="checkbox"/> Firm	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Burning
<input type="checkbox"/> Swelling	<input type="checkbox"/> Obese	<input type="checkbox"/> Tender	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Peeling
<input type="checkbox"/> Nausea	<input type="checkbox"/> Skin Abnormalities	<input type="checkbox"/> Non Tender	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Itches
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Masses	<input type="checkbox"/> Palpable Mass	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Color
<input type="checkbox"/> Pain Epigastrium			<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Sensation Loss
<input type="checkbox"/> Appetite			<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Bruising
			<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Wound

Example Head To Toe Nursing Assessment Guide

DP Hallahan



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