Physical examination sample pdf

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Documentation serves two very important purposes. First, it keeps you out of jail. Okay, okay, incarceration might not be totally realistic, but there are plenty of scenarios in which your actions as a healthcare provider might be called into question. And, in the medical world, if you didn't write it down, it didn't happen. Documenting your findings on a physical exam as well as the reasoning for your plan of care serves as a defense in the event another provider, patient etc. doesn't agree with your actions. Second, documentation helps with continuity of care. How annoying is it when you're expected to pick up where another provider left off only to find they left little more than two lines of handwritten chicken-scratch scrawled across the chart as to the patient's situation? Documenting your findings and plan for the patient allows other providers to continue caring for the individual in your absence. Or, it allows for others to provide care in conjunction with yours without interfering with your part of the care plan. Keep everyone in the loop by documenting exam findings and your next steps with the patient. It's important to note that, well, in real-life documenting a physical exam doesn't always happen exactly as you learned in school. Under pressure to be efficient, most providers abbreviate physical exam documentation to just the necessities. There is a fine balance between spending too much time on charting and including too little in your documentation. The amount you are paid for each patient encounter is based on your documentation, so cutting corners can directly affect your wallet. With time, you'll learn to strike a balance when it comes to how much or how little to include in your chart. In most cases, you do not need to examen and provide documentation for each and every body system. For purposes of a general overview, in this template we will give a down and dirty overview of each body system. In practice, you'll want to document primarily on systems relevant to the patient's history and presentation. Finally (disclaimer alert!), this post is not an exhaustive documentation reference. It's meant to be a practical tool you can use in the clinical setting. With certain patients, you may need to note findings that are not included in this sample write-up. General: Awake, alert and oriented. No acute distress. Well developed, hydrated and nourished. Appears stated age. Skin: Skin in warm, dry and intact without rashes or lesions. Appropriate color for ethnicity. Nailbeds pink with no cyanosis or clubbing. Head: The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring. Hair is of normal texture and evenly distributed. Eyes: Visual acuity is 20/20 without corrective lenses. Conjunctivae are clear without exudates or hemorrhage. Sclera is non-icteric. EOM are intact, PERRLA. Fundi appear normal including optic discs and vessels. No signs of nystagmus. Eyelids are normal in appearance without swelling or lesions. Ears: The external ear and ear canal are non-tender and without swelling. The canal is clear without discharge. The tympanic membrane is normal in appearance with normal landmarks and cone of light. Hearing is intact with good acuity to whispered voice. Nose: Nasal mucosa is pink and moist. The nasal septum is midline. Nares are patent bilaterally. Throat: Oral mucosa is pink and moist with good dentition. Tongue normal in appearance without lesions and with good symmetrical movement. No buccal nodules or lesions are noted. The pharynx is normal in appearance without tonsillar swelling or exudates. Neck: The neck is supple without adenopathy. Trachea is midline. Thyroid gland is normal without masses. Carotid pulse 2+ bilaterally without bruit. No JVD. Cardiac: The external chest is normal in appearance without lifts, heaves, or thrills. PMI is not visible and is palpated in the 5th intercostal space at the midclavicular line. Heart rate and rhythm are normal. No murmurs, gallops, or rubs are auscultated. S1 and S2 are heard and are of normal intensity. Respiratory: The chest wall is symmetric and without deformity. No signs of trauma. Chest wall is non-tender. No signs of respiratory distress. Lung sounds are clear in all lobes bilaterally without rales, ronchi, or wheezes. Resonance is normal upon percussion of all lung fields. Abdominal: Abdomen is soft, symmetric, and non-tender without distention. There are no visible lesions or scars. The aorta is midline without bruit or visible pulsation. Umbilicus is midline without herniation. Bowel sounds are present and normoactive in all four quadrants. No masses, hepatomegaly, or splenomegaly are noted. Genital/Rectal: Normal rectal sphincter tone. No external masses or lesions. Stool is normal in appearance. guac negative. External genitalia is normal in appearance without lesions, swelling, masses or tenderness. Vagina is pink and moist without lesions or discharge. Cervix is non-tender without lesions or erosions. Uterus is anteflexed, non-tender and normal in size. Ovaries are non-tender without palpable masses or enlargement. Spine: Neck and back are without deformity, external skin changes, or signs of trauma. Curvature of the cervical, thoracic, and lumbar spine are within normal limits. Bony features of the shoulders and hips are of equal height bilaterally. Posture is upright, gait is smooth, steady, and within normal limits. No tenderness noted on palpation of the spinous processes. Spinous processes are midline. Cervical, thoracic, and lumbar paraspinal muscles are not tender and are without spasm. No discomfort is noted with flexion, extension, and side-to-side rotation of the cervical spine, full range of motion is noted. Full range of motion including flexion, extension, and side-to-side rotation of the thoracic and lumbar spine are noted and without discomfort. Straight leg raise test is negative bilaterally. Sensation to the upper and lower extremities is normal bilaterally. No clonus is noted. Grip strength is normal bilaterally. Dorsi/plantar flexion is normal bilaterally. Extremities: Upper and lower extremities are atraumatic in appearance without tenderness or deformity. No swelling or erythema. Full range of motion is noted to all joints. Muscle strength is 5/5 bilaterally. Tendon function is normal. Capillary refill is less than 3 seconds in all extremities. Pulses palpable. Steady gait noted. Naurological: The patient is awake, alert and oriented to person, place, and time with normal speech. Motor function is normal with muscle strength 5/5 bilaterally to upper and lower extremities. Sensation is intact bilaterally. Reflexes 2+ bilaterally. Cranial nerves are intact. Cerebellar function is intact. Memory is normal and thought process is intact. No gait abnormalities are appreciated. Psychiatric: Appropriate mood and affect. Good judgement and insight. No visual or auditory hallucinations. No suicidal or homicidal ideation. Document Like a Pro Documenting is an integral skill to tackle but it doesn't have to be a stressful one. As part of the ThriveAP virtual transition to practice curriculum there are discussions dedicated to professional development that can help develop your clinical confidence. Are you interested in a virtual continuing education opportunity that works with your NP fellowship? Learn more about the program accredited curriculum. VITALS: Reviewed. WEIGHT/BMI reviewed. GEN: Healthy appearing, well-developed, NAD. PSYCH: Good Judgment. AOx3. Normal memory, mood, and affect. HEENT -Head: NC/AT; -Eyes: PERRL, EOMI. No discharge or redness; -Ears: External ears are normal. Normal TMs. -Nose: Normal nares. -Mouth and throat: MMM. Normal gums, mucosa, palate,. Good dentition. NECK: Supple, with no masses. CV: RRR, no m/r/g. LUNGS: CTAB, no w/r/c. ABD: Soft, NT/ND, NBS, no masses or organomegaly. GU: N/A SKIN: Warm, well perfused. No skin rashes or abnormal lesions. MSK: No deformities or signs of scoliosis. Normal gait. EXT: No clubbing, cyanosis, or edema. NEURO: Ambulating with no limitations. Normal muscle strength and tone. No focal deficits. The links below are to actual H&Ps written by UNC students during their inpatient clerkship rotations. The students have granted permission to have these H&Ps posted on the website as examples. H&P 1 "77 yo woman – swelling of tongue and difficulty breathing and swallowing" H&P 2 "47 yo woman – abdominal pain" H&P 3 "56 yo man – shortness of breath" H&P 4 "82 yo man – new onset of fever, HTN, rigidity and altered mental status" H&P 5 "76 yo man – chest pain" H&P 6 "24 yo man – bilateral knee pain" H&P 7 "51 yo man – dyspnea on exertion" H&P 8 "47 yo woman – chest pain, SOB " H&P 9 "61 yo man – increased weakness and slurred speech"

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