University of the Philippines Manila
The Health Sciences Center
COLLEGE OF NURSING
WHO Collaborating Centre for Leadership in Nursing Development
Commission on Higher Education Center of Excellence
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Assessing the Skin and Head

Instructions: Check the appropriate column below based on whether the procedure was observed or performed on the client or not. State reason if the procedure was not observed nor performed. Document your findings under the Findings column. Refer to the PE Guide or the Study Guide in documenting your PE findings.

ASSESSING THE SKULL & FACE	Obs/Perf.		Findings
	Yes	No	
1. Inspect the skull for size, shape, and symmetry.			
2. Palpate the skull for nodules or masses and depressions.			
3. Inspect the facial features.			
4. Inspect the eyes for edema and hollowness.			
5. Note symmetry of facial movements. • Ask the client to elevate the eyebrows, frown, or lower the eyebrows, close the eyes tightly, puff the cheeks, and smile and show the teeth.			
ASSESSING THE EYE STRUCTURES & VISUAL ACUITY	**Obs/Perf.**		**Findings**
	Yes	**No**	
External Eye Structures			
1. Inspect the eyebrows for hair distribution & alignment, any scaliness ofthe underlying skin, & movement. • Ask client to raise & lower eyebrows.			
2. Inspect the eyelashes for evenness of distribution and direction of curl.			
3. Inspect the eyelids for surface characteristics, position in relation to the cornea, ability to blink & frequency of blinking • Inspect the lower eyelids while the client's eyes are closed.			
4. Inspect the sclera & conjunctiva for color. Note vascular pattern against white scleral background, & any nodules or swelling. • To inspect sclera & palpebral conjunctiva (lining the eyelids): ask patient to look up as you depress both lower lids w/ thumbs exposing the sclera & conjunctiva. • For a fuller view of eye, in inspecting sclera & bulbar conjunctiva (lying over sclera): rest thumb & finger on the bones of the cheek & brow, respectively, then spread lids. Ask client to look up, down, & from side to side. • For inspection of upper palpebral conjunctiva in search of foreign body: evert upper eyelid.			
5. Inspect & palpate the lacrimal sac & nasolacrimal duct.			

6. Inspect the cornea for clarity and texture or any opacities in the lens that may be visible through the pupil. • Ask the client to look straight ahead. • Hold a penlight at an oblique angle to the eye, and move the light slowly across the corneal surface.			
7. Perform the corneal sensitivity (reflex) test to determine the function of the 5th (trigeminal) cranial nerve. • Ask the client to keep both eyes open & look straight ahead • Approach from behind and beside the client, and lightly touch the cornea w/ a corner of the gauze.			
8. Inspect each iris. Use the same oblique lighting used when testing the cornea.			
9. Inspect the pupils for size, shape, and symmetry.			
10. Assess pupillary reactions to light. • Ask patient to look into distance & shine a bright light obliquely into each pupil in turn. • Look for: a. direct reaction (pupillary constriction in same eye) b. consensual reaction (pupillary constriction in opposite eye)			
11.Assess each pupil's reaction to accommodation (near reaction) & convergence. • Hold finger or pencil about 10 cm from patient's eye. • Ask patient to look alternately at it & into the distance directly behind it. • Watch for pupillary constriction with near effort and dilation when looking at far object. • Move pencil toward client's nose & look for convergence of pupils.			
Visual Fields			
12. Assess peripheral visual fields.			
Extraocular Muscle Tests			
13.Assess six ocular movements to determine eye alignment and coordination. • Can only be performed on clients over 6 months of age.			
Visual Acuity			
14. Assess near vision by providing adequate lighting & asking client to read newspaper held at a distance of 14 in (36cm).			
15. Assess distance vision by asking client to stand 20 ft (6m) from Snellen chart & identify letters on the chart.			

16. Perform functional vision tests if the client is unable to see the top line (20/200) of Snellen's chart. • Light perception • Hand movements • Counting fingers			

ASSESSING THE EARS & HEARING	Obs/Perf Yes	Obs/Perf No	Findings
Auricles			
1. Inspect the auricles for color, symmetry of size, and position.			
2. Palpate the auricles for texture, elasticity, and areas of tenderness.			
External Ear Canal & Tympanic Membrane			
3. Using an otoscope, inspect the external ear canal for cerumen, skin lesions, pus, and blood.			
4. Inspect the tympanic membrane for color and gloss.			
Gross Hearing Acuity Tests			
5. Assess client's response to normal voice tones. If client has difficulty hearing the normal voice, proceed with the following tests: • Watch tick test. • Tuning fork tests a. Weber test: test for lateralization b. Rinne test: comparing air & bone conduction (normal-- AC>BC)			
ASSESSING THE NOSE & SINUSES			
Nose			
1. Inspect the external nose for any deviations in shape, size, or color and flaring, or discharge from the nares.			
2. Lightly palpate the external nose to determine any areas of tenderness, masses and displacements of bone and cartilage.			
3. Determine patency of both nasal cavities. • Ask the client to close the mouth, exert pressure on one naris, and breathe through the opposite naris. • Repeat the procedure to assess patency of the opposite naris			
4. Inspect the nasal cavities using a flashlight or a nasal speculum. • Observe for the presence of redness, swelling, growths, and discharge.			
5. Inspect the nasal septum between the nasal chambers.			
Facial Sinuses			
6. Palpate the maxillary and frontal sinuses for tenderness. • Press up on frontal sinuses from under bony brows, avoiding pressure from the eyes. • Then press up on maxillary sinuses.			
ASSESSING THE MOUTH & OROPHARYNX			
Lips and Buccal Mucosa			

1. Inspect the outer lips for symmetry of contour, color, and texture. • Ask client to purse the lips as if to whistle.			
2. Inspect and palpate the inner lips and buccal mucosa for color, moisture, texture, and the presence of lesions.			
Teeth and Gums			
3. Inspect the teeth and gums while examining the inner lips and buccal mucosa.			
4. Inspect the dentures.			
• Ask client to remove complete or partial dentures. Inspect their condition, noting in particular broken or worn areas.			
Tongue/Floor of the Mouth			
5. Inspect the surface of the tongue for position, color, and texture. • Ask the client to protrude the tongue.			
6. Inspect tongue movement. • Ask the client to roll the tongue upward and move it from side to side.			
7. Inspect the base of the tongue, the mouth floor, and the frenulum.			
• Ask the client to place the tip of his tongue against the roof of the mouth.			
8. Palpate the tongue and floor of the mouth for any nodules, lumps, or excoriated areas.			
• Use a piece of gauze to grasp the tip of the tongue and, with the index finger of your other hand, palpate the back of the tongue, its borders, and its base.			
Salivary Glands			
9. Inspect salivary duct openings for any swelling or redness.			
Palates and Uvula			
10. Inspect the hard and soft palate for color, shape, texture, and the presence of bony prominences. • Ask the client to open his mouth wide and tilt his head backward. Then, depress tongue with a tongue blade as necessary, and use a penlight for appropriate visualization.			
11. Inspect the uvula for position and mobility while examining the palates. • To observe the uvula, ask the client to say "ah" so that the soft palate rises.			
Oropharynx and Tonsils			
12. Inspect the oropharynx for color and texture.			
• Inspect one side at a time to avoid eliciting the gag reflex. • To expose one side of the oropharynx, press a tongue blade against			

the tongue on the same side about halfway back while the client tilts his head back and opens the mouth wide. • Use a penlight for illumination, if needed.			
13. Inspect the tonsils for color, discharge, and size.			
14. Elicit the gag reflex by pressing the posterior tongue with a tongue depressor.			
15. Inspect and palpate the inner lips and buccal mucosa for color, moisture, texture, and the presence of lesions.			

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Assessing the Neck

Instructions: Check the appropriate column below based on whether the procedure was observed or performed on the client or not. State reason if the procedure was not observed nor performed. Document your findings under the Findings column. Refer to the PE Guide or the Study Guide in documenting your PE findings.

	Obs/Perf		Findings
	Yes	No	
Neck Muscles			
1. Inspect the neck muscles (sternocleidomastoid and trapezius) for abnormal swellings or masses. • Ask the client to hold her head erect.			
2. Observe head movement. Ask client to: • Move her chin to the chest (determines function of the sternocleidomastoid muscle). • Move her head back so that the chin points upward (determines function of the trapezius muscle). • Move her head so that the ear is moved toward the shoulder on each side (determines function of the sternocleidomastoid muscle). • Turn her head to the right and to the left (determines function of the sternocleidomastoid muscle).			
3. Assess muscle strength. Ask the client to: • Turn her head to one side against the resistance of your hand. • Repeat with the other side. • Shrug her shoulders against the resistance of your hands			
Lymph Nodes			
4. Palpate the entire neck for enlarged lymph nodes.			
Trachea			
5. Palpate the trachea for lateral deviation. • Place your fingertip or thumb on the trachea in the suprasternal notch. • Then move your finger laterally to the left and the right in spaces bordered by the clavicle, the anterior aspect of the sternocleidomastoid muscle, and the trachea.			
Thyroid Gland			

6. Inspect the thyroid gland. • Stand in front of the client. • Observe the lower half of the neck overlying the thyroid gland for symmetry and visible masses. • Ask the client to hyperextend her head & swallow. If necessary, offer a glass of water to make it easier for the client to swallow.			
7. Palpate the thyroid gland for smoothness. • Note any areas of enlargement, masses, or nodules.			
8. If enlargement of the gland is suspected: • Auscultate over the thyroid area for a bruit. • Use the bell-shaped diaphragm of the stethoscope.			