For the purpose of this assignment, include: complete HPI, ROS, and physical exam Comprehensive Physical Exam of the Adult Patient 1. Elicit and document a patient history, including: Chief Complaint, History of Present Illness, Past Medical and Surgical History, Family History and Personal Social History. 2. Accurately document Subjective Abnormal Data. 3. Elicit a complete Review of Systems (ROS). 4. Demonstrate understanding the meaning of Pertinent Positives and Negatives. 5. Demonstrate the components of symptom analysis using the “Seven Attributes of a Symptom.” 6. Begin the practice of sequencing and coordinating the Comprehensive Physical Exam of the Adult Patient. 7. Identify anatomical landmarks of the human body pertaining to the systems listed below. 8. Correlate examination techniques of the following body systems using the correct sequence and anatomical landmarks in an adult patient: a. General Survey, Vital Signs, Pain g. Female Genitalia\* b. Behavior and Mental Status h. Anus Rectum and Prostate c. Skin, Hair, and Nails i. Musculoskeletal System d. Lymphatic System j. Nervous e. Head and Neck f. Thorax and Lungs b. Cardiovascular c. Breasts and Axilla d. Abdomen e. Peripheral Vascular f. Male Genitalia 8. Use correct terminology to record objective components of the physical examination findings. Hogan-Quigley, Palm, and Bickley: Bates' Nursing Guide to Physical Examination and History Taking, Second Edition • Chapters 1, 2, & 3. Review, “Seven Attributes of a Symptom” found on page 70-71. Please focus your reading for this unit on the sections of each chapter that detail system anatomical landmarks and general examination techniques. For the most part, this reading assignment, while extensive, is a review of material previously mastered at the undergraduate level. There is a tremendous amount of useful and important information in these chapters, which will become more useful as you gain skills and increase expertise in performing the physical exam. The goal of this course is to gain proficiency in the exam itself, and to be able to document your findings. As you read, keep this in mind.

The only way to become comfortable and proficient in physical exam skills is to practice them. We strongly suggest that you practice your assessment skills for each system at least 10 times on different classmates. Chapter 1: Introduction to Health assessment Chapter 4: The Health History Chapter 6: Physical examination Chapter 7 Beginning the Physical Examination: General Survey, Vital Signs, Pain Chapter :8 Nutrition Chapter 9: The Skin, Hair and Nails Chapter 10: The Head and Neck Page 7 of 25 Chapter 11: The EYES Chapter 12: Ears, Nose, Mouth and Throat Chapter 13: The Thorax and Lungs Chapter 14: The Cardiovascular System Chapter 10: The Breasts and Axillae Chapter 11: The Abdomen Chapter 15: The Peripheral Vascular System Chapter 16: The Gastrointestinal and renal System Male Genitalia and Hernia Chapter 14: Female Genitalia Chapter 15: The Anus, Rectum, and Prostate Chapter 16: The Musculoskeletal System Chapter 17: The Nervous System ASSESSMENTS 1. Using the guidelines presented in the “Components of the Health History” chapters 1& 4 from Hogan-Quigley, Palm, and Bickley: Bates' Nursing Guide to Physical Examination and History Taking, Second Edition text, obtain and document a complete ROS for a patient. Document Pertinent Positives and Negatives while taking this ROS, using the Components of the Health History in the Hogan-Quigley, Palm, and Bickley: Bates' Nursing Guide to Physical Examination and History Taking, Second Edition text, found under “Present Illness.” Include a thorough description of each positive finding on the elicited ROS. 2. Complete a separate one-page document and choose one of the Subjective Abnormal Findings mentioned by your patient in the CC, History of Present Illness, or Review of Systems. Document your understanding of how to use the “Seven Attributes” for symptom analysis found in the Hogan-Quigley, Palm, and Bickley: Bates' Nursing Guide to Physical Examination and History Taking, Second Edition text. 3. in a separate page provide a nursing care plan This assignment should be submitted to APD in Week 13. Review the Grading Rubric below which will guide you as you prepare to demonstrate proficiency in your documentation of the Review of Systems and the Seven Attributes of symptom analysis. Grading Rubric for the Comprehensive ASSESSMENT Graded Written Assignment Content Excellent (3.5 pts.) Documentation well done with all areas completely discussed from subjective perspective Satisfactory (1.75 pts.) Documentation missing some areas Unsatisfactory (0 pts.) Documentation poor, missing key areas. Identifying Data Source of History Chief Complaint Present Illness Medications Allergies Past Med Hx Past Surg Hx Family Hx Social Hx Lifestyle habits.

Overview Mental status Vital Signs/Wt./Ht/BMI ROS Appropriate ROS questions in each system area, including documentation of pertinent positives and negatives Missing some pertinent ROS or questions Lack of understanding of what history questions are appropriate and pertinent for this system or abnormal finding. Physical Exam Appropriate Physical examination questions in each system area, including Abnormal finding documentation of pertinent system Missing some pertinent Physical examination aspect Lack of understanding of Physical examination aspect Integument Head Face Eye Ears Nose /Sinuses Mouth/Pharynx Neck Chest Cardiovascular Breast Abdomen Peripheral Vascular Musculoskeletal Neurologic Total Points /100