

Health history interview and physical assessment



Health history interview and physical assessment

Revised: April 21, 2026

■ Introduction

A registered nurse performs a comprehensive assessment when the patient is admitted to the facility and then reassesses the patient at an interval determined by the facility and the patient's condition. Reassessment focuses on the patient's health issues.^{1 2 3 4 5} A comprehensive assessment includes a thorough health history interview and physical assessment.

The health history interview includes the patient's primary concern, a history of the current illness, general medical and surgical histories, a family history, a social history, and a review of systems.

The physical assessment typically follows a methodical head-to-toe format. Patient preparation includes providing a clear explanation of the assessment as well as proper positioning and draping before and during the assessment. During this procedure, make every effort to recognize and respect the patient's feelings (particularly embarrassment and anxiety) and to provide comfort measures and follow appropriate safety precautions.

■ Equipment

Although equipment varies with the assessment's focus, the following equipment may be needed:

- Clean sheet or disposable paper (for examination table)
- Cotton-tipped applicators
- Disinfectant pad
- Drapes (sheet, bath blanket, or towel, as needed)
- Examination table with stirrups
- Facility-approved disinfectant
- Facility-approved pain assessment tool
- Facility-approved suicide risk assessment tool
- Gloves
- Key or coin
- Light source
- Nasal speculum or ophthalmoscope nasal attachment
- Ophthalmoscope
- Patient gown
- Penlight
- Percussion (reflex) hammer
- Pin
- Prepared page of color dots or plates
- Scale with height measurement bar
- Stethoscope
- Test tubes of odorous materials, such as coffee and chocolate
- Tongue blades

- Tuning fork
- Visual acuity chart
- Vital signs monitoring equipment
- Optional: equipment and supplies for specimen collection, labels, laboratory biohazard transport bags, laboratory request forms, other personal protective equipment, otoscope, warm water

■ Preparation of Equipment

Inspect all equipment and supplies. If a product is expired, is defective, or has compromised integrity, remove it from patient use, label it as expired or defective, and report the expiration or defect as directed by your facility.

■ Implementation

- Gather and prepare the necessary equipment and supplies.
- Adjust the temperature in the examination room and make sure that the lighting is adequate.
- Perform hand hygiene.^{[6][7][8][9][10][11]}
- Cover the examination table with a clean sheet or disposable paper.
- Provide privacy.^{[12][13][14][15]}
- Confirm the patient's identity using at least two patient identifiers.^[16]
- Explain the procedure to the patient and family (if appropriate) according to their individual communication and learning needs *to increase their understanding, allay their fears, and ensure cooperation.*^[17]
- Identify any cultural, religious, or spiritual beliefs that may affect the patient's perception of health, illness, and the approach to treatment.^[18]
- Ask the patient and caregiver how they prefer to receive health information. *Patients with low health literacy may have difficulty comprehending health information and participating in treatment.*^{[18][19][20]}
- Review the patient's health history *to obtain subjective data about the patient and insight into problem areas and subtle physical changes.*
- Investigate the patient's primary reason for seeking care. (See [Exploring a patient's symptoms.](#))

EXPLORING A PATIENT'S SYMPTOMS

To assess a patient's symptoms, use the mnemonic PQRST, which stands for provocative or palliative, quality or quantity, region or radiation, severity, and timing.^[21] Ask the patient the following series of questions about each symptom.

Provocative or palliative

- What were you doing when you first noticed the symptom?
- What seems to trigger the symptom? Stress? Position? Certain activities? An argument? (For a physical symptom, such as eye discharge: What seems to cause it or make it worse? For a psychological symptom, such as depression: Does the depression occur after specific events?)
- What relieves the symptom? Changing diet? Changing position? Taking medication? Being active?
- What makes the symptom worse?

Quality or quantity

- How would you describe the symptom? How does it feel, look, or sound?
- How much of the symptom are you experiencing now? Is it so intrusive that it prevents you from performing activities? Is it more or less than you have experienced at any other time?

Region or radiation

- Where does the symptom occur?
- Does the symptom spread?
- For pain: Does the pain travel down your back or arms, up your neck, or down your legs?

Severity

- How would you rate the symptom on a scale of 1 to 10, with 10 being the most severe?
- How bad is the symptom at its worst? Does it force you to lie down, sit down, or slow down?
- Does the symptom seem to be getting better, getting worse, or staying about the same?

Timing

- On what date and time did the symptom first occur?
- How did the symptom start? Suddenly? Gradually?
- How often do you experience the symptom? Continuously? Hourly? Daily? Weekly? Monthly?
- When do you usually experience the symptom? During the day? At night? In the early morning? Does the symptom awaken you? Does it occur before, during, or after meals? Does it occur seasonally?
- How long does an episode of the symptom last?

- Obtain biographic data, including the patient's name (including pronouns and preferred name), address, telephone number, sex assigned at birth, gender identity, age, birth date, birthplace, marital status, education, religion, occupation, race, nationality, and cultural background as well as the names of persons living with the patient and emergency contact information.^[22]^[23] Use the patient's name and pronouns consistently throughout the interview and assessment.^[23]

♦ **Clinical alert:** Stigma is a well-documented barrier to health treatment in various populations, contributing significantly to stress in underrepresented groups. The language used by all health care professionals matters. Patients perceive health care professionals as safe; therefore, any stigmatizing language may be traumatic for the patient and may have lasting negative effects.

Take care to use nonstigmatizing language.^[24] ♦

- Ask the patient to identify a support person *to provide emotional support, give comfort, and alleviate fear during the hospital stay.*^[18]
- Ask about health and illness patterns, family health history, and the condition of body systems.^[25]^[26]
- Complete an organ inventory, as indicated, *to help the patient feel comfortable talking about the body and to inform future care needs.*^[23]^[27]^[28]

♦ **Clinical alert:** Use a gender-affirming approach when conducting the physical examination. Base the physical examination on the anatomy that's present, not on assumptions about anatomy or identity.^[29] ♦

- Ask about medications that the patient takes, including prescription, over-the-counter, and herbal medications. Document the name of each medication along with the dose, frequency, route, time the patient last took the medication, and reason the patient takes the medication.^{[30] [31]}
- Ask about health promotion and protection patterns, including immunizations, personal habits, sleep and wake cycles, exercise, recreation, nutrition, stress level and coping skills, socioeconomic status, environmental health conditions, and occupational health hazards.
- Explore the patient's roles and relationship patterns, including self-concept, family roles and relationships, sexuality and reproductive patterns, social support systems, and other psychosocial considerations.
- Assess social drivers of health by asking whether the patient is experiencing food insecurity, housing instability, transportation difficulty, utility difficulty, or a threat to interpersonal safety *because these adverse social conditions can negatively affect health outcomes and increase healthcare utilization.*^[32]
- Screen the patient for suicide ideation using a brief, standardized, evidence-based screening tool, as appropriate.^[33]
- Explain the physical assessment, and answer any questions.
- Instruct the patient to void, if possible. Perform hand hygiene.^{[6] [7] [8] [9] [10] [11]} Put on gloves *to comply with standard precautions* and collect a urine specimen, if ordered.^{[34] [35] [36]} *Emptying the bladder increases patient comfort during the assessment.* If a specimen was obtained, remove and discard your gloves and perform hand hygiene.^{[6] [7] [8] [9] [10] [11] [34] [36]}
- Help the patient undress, as needed, and provide a gown.
- Measure and record the patient's height, weight (in kilograms), and vital signs.
- Assist the patient onto the examination table, if appropriate. Requirements for positioning and draping vary with the body system and region being assessed:
 - *To examine the head, neck, and anterior and posterior thorax*, have the patient sit on the edge of the examination table or bed.
 - *To examine the abdomen and cardiovascular system*, place the patient in a supine position and stand to the patient's right. For a patient with breasts, place a towel over the breasts and upper thorax during abdominal assessment. Pull the sheet down as far as the symphysis pubis, but no farther.
 - *To assess the genitourinary system*, have a patient with male anatomy stand, or assist a patient with female anatomy into the lithotomy position with the feet in the stirrups. Place a drape over the lower abdomen, thighs, and knees of a patient with female anatomy.^[29]
- Perform a physical assessment. (See [Performing a head-to-toe assessment.](#))
- Screen for and assess the patient's pain using facility-defined criteria that are consistent with the patient's age, condition, and ability to understand.^[37]
- Perform hand hygiene.^{[6] [7] [8] [9] [10] [11]}
- Put on gloves and, as needed, other personal protective equipment *to comply with standard precautions.*^{[34] [36]}
- Collect specimens, as ordered. Label them in the presence of the patient *to prevent mislabeling.*^[16]

- Place the specimens in a laboratory biohazard transport bag and send them immediately to the laboratory with the appropriate laboratory request forms (if necessary).^[36]
- Discard used supplies in appropriate receptacles.^[36]
- Remove and discard your gloves and, if worn, other personal protective equipment.^[36]
- Perform hand hygiene.^{[6] [7] [8] [9] [10] [11]}
- Clean and disinfect your stethoscope with a disinfectant pad.^{[38] [39]}
- Perform hand hygiene.^{[6] [7] [8] [9] [10] [11]}
- Put on gloves and, as needed, other personal protective equipment.^[36]
- Clean and disinfect other reusable equipment according to the manufacturer's instructions *to prevent the spread of infection*.^{[38] [39]}
- Remove and discard your gloves and, if worn, other personal protective equipment.^[36]
- Perform hand hygiene.^{[6] [7] [8] [9] [10] [11]}
- Document the procedure.^{[40] [41] [42] [43]}

PERFORMING A HEAD-TO-TOE ASSESSMENT

This chart provides guidelines for a systematic head-to-toe assessment. It groups assessment techniques by body region and nurse-patient positioning *to make the assessment as efficient as possible and to avoid tiring the patient*. The first column describes the assessment technique to use for each body system or region. The second column lists normal findings for adults. The third column reviews special considerations, including the purpose of the technique as well as nursing and developmental considerations.

Technique	Normal findings	Special considerations
<i>Head and neck</i>		
Inspect the patient's head. Note hair color, texture, and distribution. Palpate from the forehead to the posterior triangle of the neck for the posterior cervical lymph nodes.	Symmetrical, rounded, normocephalic head positioned at midline and erect with no lumps or ridges	• This technique can detect asymmetry, size changes, enlarged lymph nodes, and tenderness. • Wear gloves for palpation, if the patient has scalp lesions.
Palpate in front of and behind the ears, under the chin, and in the anterior triangle for the anterior cervical lymph nodes. 	Nonpalpable lymph nodes or small, round, soft, mobile, nontender lymph nodes	• This technique can detect enlarged lymph nodes.
Palpate the left and then the right carotid artery. 	Bilateral equality in pulse amplitude and rhythm	• This technique evaluates circulation through the carotid pulse. • Palpate the carotid arteries one at a time.

Auscultate the carotid arteries. 	No bruit on auscultation	Auscultation in this area can detect a bruit, a sign of turbulent blood flow.
Palpate the trachea.	Straight, midline trachea	This technique evaluates the trachea's position.
Palpate the suprasternal notch.	Palpable pulsations with an even rhythm	Palpation in this area allows evaluation of aortic arch pulsations.
Palpate the supraclavicular area.	Nonpalpable lymph nodes	This technique can detect enlarged lymph nodes.
Palpate the thyroid gland and auscultate for bruits. 	Thin, mobile thyroid isthmus with nonpalpable thyroid lobes	- Palpation detects thyroid enlargement, tenderness, or nodules. - Auscultation of a bruit may indicate hyperthyroidism.
Have the patient touch the chin to each shoulder, each ear to the corresponding shoulder, and the chin to the chest and then tip the head back as far as possible. 	Symmetrical strength and movement of neck muscles	These maneuvers evaluate range of motion (ROM) in the neck.
Place your hands on the patient's shoulders while the patient shrugs them against resistance. Then place your hand on the patient's left cheek and have the patient push against it; repeat on the right cheek.	Symmetrical strength and movement of neck muscles	This procedure checks cranial nerve XI (accessory nerve) functioning and trapezius and sternocleidomastoid muscle strength.
Have the patient smile, frown, wrinkle the forehead, and puff out the cheeks. 	Symmetrical smile, frown, and forehead wrinkles; equal puffing out of the cheeks	This maneuver evaluates the motor portion of cranial nerve VII (facial nerve).
Occlude one nostril externally with your finger while the patient breathes through the other. Repeat on the other nostril. 	Patent nostrils	This technique checks the patency of the nasal passages.

Inspect the internal nostrils using a nasal speculum or an ophthalmoscope handle with a nasal attachment.	Moist, pink to red nasal mucosa without deviated septum, lesions, or polyps	This technique can detect edema, inflammation, and excessive drainage.
Palpate the nose. 	No bumps, lesions, edema, or tenderness	This technique assesses for structural abnormalities in the nose.
Palpate and percuss the frontal and maxillary sinuses. If palpation and percussion elicit tenderness, assess further by transilluminating the sinuses.	No tenderness on palpation or percussion	These techniques are used to elicit tenderness, which may indicate sinus congestion or infection.
Palpate the temporomandibular joints as the patient opens and closes the jaws.	Smooth joint movement without pain; correct approximation	This action assesses the temporomandibular joints and the motor portion of cranial nerve V (trigeminal nerve).
Inspect the oral mucosa, gingivae, teeth, and salivary gland openings using a tongue blade and a penlight.	Pink, moist, smooth oral mucosa without lesions or inflammation; pink, moist slightly irregular gingivae without sponginess or edema; 32 teeth with correct occlusion	- This technique evaluates the condition of several oral structures. - Slight gingival swelling may be normal during pregnancy.
Observe the tongue and the hard and soft palates.	Pink, slightly rough tongue with a midline depression; pink to light red palates with symmetrical lines	Observation provides information about the patient's hydration status and the condition of the observed oral structures.
Ask the patient to stick out the tongue.	Midline tongue without tremors	This procedure tests cranial nerve XII (hypoglossal nerve).

Ask the patient to say "Ahh" while sticking out the tongue. Inspect the visible oral structures.	Symmetrical rise in the soft palate and uvula during phonation; pink, midline, cone-shaped uvula; +1 tonsils (both tonsils behind the pillars)	Phonation ("Ahh") checks portions of cranial nerves IX and X (glossopharyngeal and vagus nerves). Lowering the tongue aids viewing.
Test the gag reflex using a tongue blade. 	Gagging	Gagging during this procedure indicates that cranial nerves IX and X are intact.
Place the tongue blade at the side of the tongue while the patient pushes it to the left and right with the tongue.	Symmetrical ability to push tongue blade to the left and right	This action tests cranial nerve XII.
Test the sense of smell using a test tube of coffee, chocolate, or another familiar substance.	Correct identification of smells in both nostrils	- This action tests cranial nerve I (olfactory nerve). - Ensure that the patient keeps the eyes closed during the test.
Eyes and ears		
Perform a visual acuity test using the standard Snellen eye chart or another visual acuity chart, with the patient wearing corrective lenses (if needed).	20/20 vision	This test assesses the patient's distance vision (central vision) and evaluates cranial nerve II (optic nerve).
Ask the patient to identify the pattern in a specially prepared page of color dots or plates.	Correct identification of pattern	This test assesses the patient's color perception.
Test the six cardinal positions of gaze.	Bilaterally equal eye movements without nystagmus	- This test evaluates the function of each of the six extraocular muscles and tests cranial nerves III, IV, and VI (oculomotor, trochlear, and abducens nerves). - Ensure that the patient holds the head still.
Inspect the external structures of the eyeballs (eyelids, eyelashes, and lacrimal apparatus).	Bright, clear, symmetrical eyes free from nystagmus;	This inspection allows detection of such problems as ptosis,

	complete closure of eyelids; no lesions, scaling, or inflammation	ectropion (outward-turning eyelids), entropion (inward-turning eyelids), and stytes.
Inspect the conjunctivae and sclerae.	Pink palpebral conjunctiva and clear bulbar conjunctiva without swelling, drainage, or hyperemic blood vessels; white, clear sclerae	• Inspection detects conjunctivitis and the scleral color changes that may occur with systemic disorders.
Inspect the cornea, iris, and anterior chamber by shining a penlight tangentially across the eyes.	Clear, transparent cornea and anterior chamber; illumination of total iris	• This technique assesses anterior chamber depth and the condition of the cornea and iris. • An older adult may exhibit a thin, grayish ring in the cornea (called <i>arcus senilis</i>).
Examine the pupils for equality of size, shape, reaction to light, and accommodation. 	Pupils equal, round, reactive to light and accommodation (PERRLA), directly and consensually	• Testing the pupillary response to light and accommodation assesses cranial nerves III, IV, and VI.
Observe the red reflex using an ophthalmoscope.	Sharp, distinct orange red glow	• Presence of the red reflex indicates that the cornea, anterior chamber, and lens are free from opacity and clouding.
Inspect the ear. Perform an otoscopic assessment, if indicated.	Nearly vertically positioned ears that line up with the eyes, match the facial color, are similarly shaped, and are in proportion to the face; no drainage, nodules, or lesions	• A patient with a dark skin tone may have darker orange or brown cerumen (earwax); a patient with lighter skin tone typically has yellow cerumen.
Palpate the ear and mastoid process. 	No pain, swelling, nodules, or lesions	• This assessment technique can detect inflammation or

		infection. It may also uncover other abnormalities, such as nodules and lesions.
Perform the whispered voice test or the watch tick test on one ear at a time.	Whispered voice heard at a distance of 1' to 2' (30 to 61 cm); watch tick heard at a distance of 5" (13 cm)	This test provides a gross assessment of cranial nerve VIII (acoustic nerve).
Perform the Weber test using a 512- or 1024-Hz tuning fork.	Tuning fork vibrations heard equally in both ears or in the middle of the head	- This test differentiates conductive from sensorineural hearing loss. - The sound is heard best in the ear with conductive loss.
Perform the Rinne test using a 512- or 1024-Hz tuning fork.	Tuning fork vibrations heard in front of the ear for as long as they are heard on the mastoid process	This test helps differentiate conductive from sensorineural hearing loss.
Posterior thorax		
Observe the skin, bones, and muscles of the spine, shoulder blades, and back as well as symmetry of expansion and accessory muscle use.	Even skin tone; symmetrical placement of all structures; bilaterally equal shoulder height; symmetrical expansion with inhalation; no accessory muscle use	Observation provides information about lung expansion and accessory muscle use during respiration. It may also detect a deformity that can alter ventilation, such as scoliosis.
Assess the anteroposterior and lateral diameters of the thorax.	Lateral diameter up to twice the anteroposterior diameter (2:1)	- This assessment may detect abnormalities, such as an increased anteroposterior diameter (barrel chest may be as low as 1:1). - Normal anteroposterior diameters vary with age.

Palpate down the spine.	Properly aligned spinous processes without lesions or tenderness; firm, symmetrical, evenly spaced muscles	This technique detects pain in the spine and paraspinal muscles. It also evaluates the muscles' consistency.
Palpate over the posterior thorax.	Smooth surface; no lesions, lumps, or pain	This technique helps detect musculoskeletal inflammation.
Assess respiratory excursion. 	Symmetrical expansion and contraction of the thorax	This technique checks for equal expansion of the lungs.
Palpate for tactile fremitus as the patient repeats the word "ninety-nine." 	Equally intense vibrations of both sides of the chest	Palpation provides information about the content of the lungs; vibrations increase over consolidated or fluid-filled areas and decrease over gas-filled areas.
Percuss over the posterior and lateral lung fields. 	Resonant percussion note over the lungs that changes to a dull note at the diaphragm	- This technique helps identify the density and location of the lungs, diaphragm, and other anatomic structures. - Percussion may produce hyperresonant sounds in a patient with chronic obstructive pulmonary disease or in an older adult <i>because of lung tissue hyperinflation.</i>
Percuss for diaphragmatic excursion on each side of the posterior thorax.	Excursion from 1¼" to 2¼" (3 to 5.7 cm)	This technique evaluates diaphragm movement during respiration.
Auscultate the lungs through the posterior thorax as the patient breathes slowly and deeply through the mouth. Also auscultate lateral areas. 	Bronchovesicular sounds (soft, breezy sounds) between the scapulae; vesicular sounds (soft, swishy sounds) about two notes lower than bronchovesicular	Lung auscultation helps detect abnormal fluid or mucus accumulation as well as obstructed passages.

	sounds) in the lung periphery	
Anterior thorax		
Observe the skin, bones, and muscles of the anterior thoracic structures as well as symmetry of expansion and accessory muscle use during respiration.	Even skin tone; symmetrical placement of all structures; symmetrical costal angle of less than 90 degrees; symmetrical expansion with inhalation; no accessory muscle use	• Observation provides information about lung expansion and accessory muscle use. It may also detect a deformity that can prevent full lung expansion, such as pigeon chest.
Inspect the anterior thorax for lifts, heaves, or thrusts. Also check for the apical impulse.	No lifts, heaves, or thrusts; apical impulse not usually visible	• Apical impulse may be visible in a thin or young patient.
Palpate over the anterior thorax. 	Smooth surface; no lesions, lumps, or pain	• This technique helps detect musculoskeletal inflammation.
Assess respiratory excursion.	Symmetrical expansion and contraction of the thorax	• This technique checks for equal expansion of the lungs.
Palpate for tactile fremitus as the patient repeats the word "ninety-nine."	Equally intense vibrations on both sides of the chest, with more vibrations in the upper chest than in the lower chest	• Palpation provides information about the content of the lungs.
Percuss over the anterior thorax. 	Resonant percussion notes over lung fields that change to dull notes over the diaphragm	• This technique helps identify the density and location of the lungs, diaphragm, and other anatomic structures. • Percussion may produce hyperresonant sounds in an older adult <i>because of lung tissue hyperinflation.</i>
Auscultate the lungs through the anterior thorax as the patient breathes slowly and deeply through the mouth. Also auscultate lateral areas.	Bronchovesicular sounds (soft, breezy sounds) between the scapulae; vesicular	• Lung auscultation helps detect abnormal fluid or mucus accumulation.

	sounds (soft, swishy sounds about two notes lower than bronchovesicular sounds) in the lung periphery	
Inspect the breasts and axillae with the patient's hands resting at the sides of the body, placed on the hips, and raised above the head.	Symmetrical, convex, similar-looking breasts with soft, smooth skin and bilaterally similar venous patterns; symmetrical axillae with varying amounts of hair but no lesions; nipples at the same level on the chest and of the same color	• This technique evaluates the general condition of the breasts and axillae and detects such abnormalities as retraction, dimpling, and flattening. • Expect to see enlarged breasts with darkened nipples and areolae and purplish linear streaks if the patient is pregnant.
Palpate the axillae with the patient's arms resting against the side of the body.	Nonpalpable nodes	• This technique detects nodular enlargements and other abnormalities.
Palpate the breasts and nipples with the patient lying supine.	Smooth, relatively elastic tissue without masses, cracks, fissures, areas of induration (hardness), or discharge	• This technique evaluates the consistency and elasticity of the breasts and nipples and may detect nipple discharge. • A premenstrual patient may exhibit breast tenderness, nodularity, and fullness. • A pregnant patient may discharge colostrum from the nipple and may exhibit nodular breasts with prominent venous patterns.
Inspect the neck for jugular vein distention with the patient lying supine at a 45-degree angle.	No visible pulsations	• This technique is useful in estimating central venous pressure.
Palpate the precordium for the apical impulse.	Palpable apical impulse in the apical area (fifth intercostal space at the midclavicular line)	• This action evaluates the size and location of the left ventricle.

Auscultate the aortic, pulmonic, tricuspid, and mitral areas for heart sounds. 	S₁ and S₂ heart sounds with a regular rhythm and an age-appropriate rate	- Auscultation over the precordium evaluates the heart rate and rhythm and can detect abnormal heart sounds, such as a murmur, gallop, or click. - A pregnant patient in the third trimester may have functional (innocent) heart murmurs.
Observe the abdominal contour.	Symmetrical flat or rounded contour	This technique determines whether the abdomen is distended or scaphoid.
Inspect the abdomen for skin characteristics, symmetry, contour, peristalsis, and pulsations.	Symmetrical contour with no lesions, striae, rash, or visible peristaltic waves	Inspection can detect an incisional hernia or an abnormality caused by bowel obstruction.
Auscultate all four quadrants of the abdomen. 	Normal bowel sounds in all four quadrants; no bruits	Abdominal auscultation can detect abnormal bowel sounds.
Percuss from below the right breast to the inguinal area down the right midclavicular line.	Dull percussion notes over the liver; tympanic notes over the rest of the abdomen	Percussion in this area helps evaluate the size of the liver.
Percuss from below the left breast to the inguinal area down the left midclavicular line.	Tympanic percussion notes	Percussion that elicits dull notes in this area can detect an enlarged spleen.
Palpate all four abdominal quadrants. 	Nontender organs without masses	Palpation provides information about the location, size, and condition of the underlying structures.
Palpate for the kidneys on each side of the abdomen.	Nonpalpable kidneys or solid, firm, smooth kidneys (if palpable)	This technique evaluates the general condition of the kidneys.

Palpate the liver at the right costal border.	Nonpalpable liver or smooth, firm, nontender liver with a rounded, regular edge (if palpable)	This technique evaluates the general condition of the liver.
Palpate for the spleen at the left costal border.	Nonpalpable spleen	This technique detects splenomegaly (spleen enlargement).
Palpate the femoral pulses in the groin.	Strong, regular pulses	Palpation assesses vascular patency.
Genitourinary system: Female anatomy		
Perform hand hygiene ^{6 7 8 9 10 11} and put on gloves. ^{34 36} With the patient in the lithotomy position, inspect the mons pubis, labia, and perineum. Separate the labia and inspect the labia minora, clitoris, urethral meatus, and vaginal opening. ⁴⁴	No inflammation, ulceration, swelling, or nodules; vaginal discharge (if present) that is clear to white and odorless ⁴⁴	- This procedure helps detect hormone changes and signs of infection or infestation.⁴⁴ - Inspection may also detect prolapse of the urethral mucosa.⁴⁴
With the labia separated by your middle and index fingers, ask the patient to bear down. ⁴⁴	Absence of vaginal wall bulging ⁴⁴	This procedure assesses for bulging of the vaginal walls that may occur with cystocele or rectocele.⁴⁴
Select a speculum of the appropriate size and shape and moisten it with warm water. Lubricate one finger with water and then apply downward pressure at the lower margin of the vaginal opening. With your other hand, insert the closed speculum past your finger. After the speculum has been inserted, remove your finger. Carefully open the speculum and rotate it until it cups the cervix. Inspect the cervix and note its color and position and the characteristics of its surface. Obtain specimens for cervical cytology, if ordered. Inspect the vagina as you withdraw the speculum slowly. ⁴⁴	Cervix free from nodules, masses, bleeding, and abnormal discharge with a shiny, pink, squamous epithelium and deep red, plushy, columnar epithelium; vagina free from signs of infection, inflammation, ulcers, and masses ⁴⁴	This procedure helps detect infection and cervical or uterine malignancy.⁴⁴
Perform a bimanual assessment. Lubricate the index and middle fingers of one of your gloved hands and, from a	Palpable ovaries (in premenopausal patient) about the	This procedure evaluates the uterine surfaces and

standing position, insert them into the vagina, exerting pressure primarily posteriorly. Then palpate the cervix, noting its position, shape, consistency, regularity, mobility, and tenderness. Next, place your other hand on the patient's abdomen midway between the umbilicus and the symphysis pubis. Note the size, shape, consistency, and mobility of the ovaries and identify tenderness or masses. Palpate each ovary. ^[44] Gently withdraw your fingers.	size of a walnut, felt on either side of the uterus; possible ovarian tenderness ^[44]	assesses for pelvic masses. About 3 to 5 years after menopause, the ovaries aren't palpable. Suspect an ovarian cyst or ovarian cancer, if you can palpate the ovary of a postmenopausal patient.^[44]
Change your gloves ^[34] ^[36] and perform a rectovaginal assessment. Place your index finger in the vagina and your middle finger in the rectum. Gently move these fingers toward each other and compress the posterior vaginal wall and the anterior rectal wall.	Rectal vault that's free from masses and a normally positioned uterus	The purpose of this portion of the assessment is to screen for pelvic lesions, colon cancer in those assigned female at birth who are age 50 and older, retroverted uterus, and problems with the uterosacral ligaments and cul-de-sac.
Genitourinary system: Male anatomy		
Have the patient stand, if possible, with a gown covering the chest and abdomen. Perform hand hygiene ^[6] ^[7] ^[8] ^[9] ^[10] ^[11] and put on gloves. ^[34] ^[36] Inspect the penis, including the skin, foreskin, and glans. If the foreskin is present, have the patient retract it. Note the location of the urethral meatus. ^[44]	Smegma, a cheesy white substance possibly present under the foreskin; penis free from nits, lice, drainage, excoriation, inflammation, ulcers, scars, and nodules; meatus that is at midline ^[44]	- This technique assesses for signs of infection, inflammation, ulcers, infestation, scars, and nodules.^[44] - If phimosis is present, the foreskin can't be retracted over the glans.^[44] - Hypospadias is the congenital ventral displacement of the meatus.^[44]
Compress the glans gently between your index finger and your thumb below. ^[44]	No discharge present ^[44]	This maneuver opens the urethral meatus to detect the presence of discharge.^[44]
Inspect the scrotum, including the skin and scrotal contours. ^[44]	Normal, wrinkled scrotal skin without	This technique may help identify inguinal hernia, hydrocele, scrotal

	lesions, swelling, lumps, or veins ⁴⁴	edema, epidermoid cysts, and skin cancer. A poorly developed scrotum may indicate an undescended testicle.⁴⁴
Palpate each testis and epididymis between your thumb and first two fingers. Note their size, shape, consistency, and tenderness. ⁴⁴	Nodular, cordlike epididymis; nonnodular testis ⁴⁴	- This procedure can help detect scrotal swelling caused by acute epididymitis, acute orchitis, spermatic cord torsion, or a strangulated inguinal hernia.⁴⁴ - Any painless nodule in the testis may indicate testicular cancer.⁴⁴
Upper extremities		
Observe the skin and muscle mass of the arms and hands.	Uniform color and texture with no lesions; elastic turgor; bilaterally equal muscle mass	The skin provides information about hydration and circulation. Muscle mass provides information about injuries and neuromuscular disease.
Ask the patient to extend the arms forward and then rapidly turn the palms up and down.	Steady hands with no tremor or pronator drift	This maneuver tests proprioception and cerebellar function.
Place your hands on the upturned forearms while the patient pushes up against resistance. Then place your hands under the forearms while the patient pushes down.	Symmetrical strength and ability to push up and down against resistance	This procedure checks the muscle strength of the arms.
Inspect and palpate the fingers, wrists, and elbow joints.	Smooth, freely movable joints with no swelling	An older adult may exhibit osteoarthritic changes.
Palpate the patient's hands to assess skin temperature.	Warm, moist skin with bilaterally even temperature	Skin temperature assessment provides data about circulation to the area.
Palpate the radial and brachial pulses.	Bilaterally equal rate and rhythm	Palpation of pulses helps evaluate peripheral

		vascular status.
Inspect the color, shape, and condition of the patient's fingernails. Test for capillary refill time. 	Pink nail beds with smooth, rounded nails; brisk capillary refill time (less than 3 seconds); no clubbing	Nail assessment provides data about the integumentary, cardiovascular, and respiratory systems as well as nutritional status.
Place two fingers in each palm and have the patient squeeze your fingers.	Bilaterally equal hand strength	This maneuver tests muscle strength in the hands.
Lower extremities		
Inspect the legs and feet for color, lesions, varicosities, hair growth, nail growth, edema, and muscle mass.	Even skin color; symmetrical hair and nail growth; no lesions, varicosities, or edema; bilaterally equal muscle mass	Inspection assesses adequate circulatory function.
Test for pitting edema in the pretibial area.	No pitting edema	This test assesses for excess interstitial fluid.
Palpate for pulses and skin temperature in the posterior tibial, dorsalis pedis, and popliteal areas.	Bilaterally even pulse rate, rhythm, and skin temperature	Palpation of pulses and temperature in these areas evaluates the patient's peripheral vascular status.
Perform the straight leg test on one leg at a time.	Painless leg lifting	This test checks for vertebral disk problems.
Palpate for crepitus as the patient abducts and adducts the hip. Repeat on the opposite leg.	No crepitus; full ROM without pain	This test checks for arthritic conditions.
Ask the patient to raise one thigh against the resistance of your hands. Repeat this procedure on the opposite thigh.	Easy lifting of each thigh against resistance	This maneuver tests the motor strength of the upper legs.
Ask the patient to push outward against the resistance of your hands.	Easy pushing of each leg against resistance	This maneuver tests the motor strength of the lower legs.
Ask the patient to pull backward against the resistance of your hands.	Easy pulling of each leg against resistance	This maneuver tests the motor strength of the

		lower legs.
<i>Nervous system</i>		
Lightly touch the ophthalmic, maxillary, and mandibular areas on each side of the patient's face with a cotton-tipped applicator and a pin.	Correct identification of sensation and location	This test evaluates the function of cranial nerve V (trigeminal nerve).
Touch the dorsal and palmar surfaces of the arms, hands, and fingers with a cotton-tipped applicator and a pin.	Correct identification of sensation and location	This test evaluates the function of the ulnar, radial, and medial nerves.
Touch several nerve distribution areas on the legs, feet, and toes with a cotton-tipped applicator and a pin.	Correct identification of sensation and location	This test evaluates the function of the dermatome areas randomly.
Place your fingers above the patient's wrist and tap them with a reflex hammer. Repeat on the other arm.	Normal reflex reaction	This procedure elicits the brachioradialis deep tendon reflex (DTR).
Place your fingers over the antecubital fossa and tap them with a reflex hammer. Repeat on the other arm.	Normal reflex reaction	This procedure elicits the biceps DTR.
Place your fingers over the triceps tendon area and tap them with a reflex hammer. Repeat on the other arm.	Normal reflex reaction	This procedure elicits the triceps DTR.
Tap just below the patella with a reflex hammer. Repeat this procedure on the opposite patella. 	Normal reflex reaction	This procedure elicits the patellar DTR.
Tap over the Achilles tendon area with a reflex hammer. Repeat this procedure on the opposite ankle.	Normal reflex reaction	This procedure elicits the Achilles DTR.
Stroke the sole of the patient's foot with the end of the reflex hammer handle.	Plantar reflex	This procedure elicits plantar flexion of all toes.
Ask the patient to demonstrate dorsiflexion by bending both feet upward against resistance.	Easy lifting against resistance in both feet	This procedure tests foot strength and ROM.
Ask the patient to demonstrate plantar flexion by bending both feet downward against resistance.	Easy pushing down against resistance in both feet	This procedure tests foot strength and ROM.

Using your finger, trace a one-digit number in the palm of the patient's hand.	Correct identification of traced number	This procedure evaluates the patient's tactile discrimination through graphesthesia.
Place a familiar object, such as a key or a coin, in the patient's hand.	Correct identification of object	This procedure evaluates the patient's tactile discrimination.
Observe as the patient walks with a regular gait, on the toes, on the heels, and heel to toe.	Steady gait, good balance, and no signs of muscle weakness or pain in any style of walking	This technique evaluates the cerebellum and motor system and checks for vertebral disk problems.
Inspect the scapulae, spine, back, and hips as the patient bends forward, backward, and from side to side. 	Full ROM, easy flexibility, and no signs of scoliosis or varicosities	Inspection evaluates the patient's ROM and detects musculoskeletal abnormalities, such as scoliosis.
Perform the Romberg test. Ask the patient to stand straight with both eyes closed and both arms extended with the palms facing up.	Steady stance with minimal weaving	This test checks cerebellar functioning and evaluates balance and coordination.

■ Special Considerations

- When assessing a patient who doesn't speak English, use interpreter services, as needed. When using an interpreter, speak directly to the patient and use language as if you were speaking directly to the patient. Observe cues that the patient provides through body language and tone of voice.^{[18] [19] [20]}
- Throughout the assessment process, provide augmentative and assistive devices for a patient with communication, sensory, or motor impairment as needed.^[18]
- The health care team should be familiar with the appropriate language and health care needs of transgender and gender-nonconforming patients.^[45] Special guidelines exist for the genital examination of transgender patients after gender-affirming surgery.^{[29] [46]}

■ Documentation

Documentation associated with health history interview and physical assessment includes:

- significant normal and abnormal findings in an organized manner, according to the related body systems, using your facility's recommended documentation format and system
- any cultural, spiritual, or religious needs that may affect care^[18]
- abnormal results
 - name of the practitioner notified
 - prescribed interventions
 - patient's response to those interventions
- teaching provided to the patient and family (if applicable)

- understanding of the teaching
- follow-up teaching needed.

This procedure has been reviewed by the Academy of Medical-Surgical Nurses.



■ Related Procedures

- [Health assessment, annual \(Advanced practice\), ambulatory care](#)
- [Health assessment, annual, pediatric \(Advanced practice\), ambulatory care](#)
- [Health history interview and physical assessment, long-term care](#)
- [Health history interview and physical assessment, pediatric](#)

■ Related UpToDate Patient Teaching Handouts

- [Healthy eating for adults](#)
- [Preventive health care for ages 18 to 39](#)
- [Preventive health care for ages 40 to 64](#)
- [Preventive health care for ages 65 and older](#)
- [Routine physical for adults](#)
- [Safe sex](#)
- [Talking to Kids About STIs](#)

■ References

[\(Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions\)](#)

1. Joint Commission. (2026). Standard PC.01.02.05. *Comprehensive accreditation manual for hospitals*. (Level VII)
2. Joint Commission. (2026). Standard PC.11.02.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
3. Joint Commission. (2026). Standard PC.01.02.03. *Comprehensive accreditation manual for hospitals*. (Level VII)
4. Accreditation Commission for Health Care. (2025). Standard 10.01.24. *Accreditation requirements for acute care hospitals*. (Level VII)
5. DNV Healthcare USA, Inc. (2025). NS.3.SR.2. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 25-1*. (Level VII)
6. Joint Commission. (2026). Standard NPG.05.03.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
7. Centers for Disease Control and Prevention. (2002). Guideline for hand hygiene in health-care settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *MMWR Recommendations and Reports*, 51(RR-16), 1–45. Retrieved February 2026 from <https://www.cdc.gov/mmwr/pdf/rr/rr5116.pdf> (Level VII)
8. World Health Organization (WHO). (2009). *WHO guidelines on hand hygiene in health care: First global patient safety challenge, clean care is safer care*. Retrieved February 2026 from https://iris.who.int/bitstream/handle/10665/44102/9789241597906_eng.pdf (Level VII)
9. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Infection prevention and control and antibiotic stewardship programs. 42 C.F.R. § 482.42.
10. Accreditation Commission for Health Care. (2025). Standard 07.02.05. *Accreditation requirements for acute care hospitals*. (Level VII)

11. DNV Healthcare USA, Inc. (2025). IC.1.SR.3f. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 25-1*. (Level VII)
12. Accreditation Commission for Health Care. (2025). Standard 15.01.07. *Accreditation requirements for acute care hospitals*. (Level VII)
13. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Patient's rights. 42 C.F.R. § 482.13(c)(1).
14. Joint Commission. (2026). Standard RI.11.01.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
15. DNV Healthcare USA, Inc. (2025). PR.2.SR.5. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 25-1* (Level VII)
16. Joint Commission. (2026). Standard NPG.01.01.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
17. Joint Commission. (2026). Standard PC.12.02.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
18. Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved February 2026 from <https://www.downstate.edu/about/our-administration/office-of-diversity-inclusion/documents/A-Roadmap-for-Hospitals.pdf> (Level VII)
19. Joint Commission. (2026). Standard RI.11.02.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
20. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Patient's rights. 42 C.F.R. § 482.13.
21. Ciocco, M. (2015). *Fast facts for the medical-surgical nurse: Clinical orientation in a nutshell*. Springer Publishing Company.
22. Bosse, J. D., et al. (2015). Integrating sexual minority health issues into a health assessment class. *Journal of Professional Nursing*, 31(6), 498–507. Retrieved February 2026 from <https://doi.org/10.1016/j.profnurs.2015.04.007>
23. Human Rights Campaign Foundation. (n.d.). *Patient identification and data collection*. Retrieved February 2026 from <https://www.thehrcfoundation.org/professional-resources/patient-self-identification>
24. Shulman, G. P., et al. (2017). A review of contemporary assessment tools for use with transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Identity*, 4(3), 304–313. Retrieved February 2026 from <https://doi.org/10.1037/sgd0000233> (Level VII)
25. Alspach, J. G. (2011). The importance of family health history: Your patients' and your own. *Critical Care Nurse*, 31(1), 10–15. Retrieved February 2026 from <https://doi.org/10.4037/ccn2011240>
[Abstract](#) | [Complete Reference](#) | [Full Text](#)
26. Centers for Disease Control and Prevention. (n.d.). *Family health history*. Retrieved February 2026 from <https://www.cdc.gov/family-health-history/>
27. Greene, R., et al. (2020). *5 pearls on transgender health: Gender affirming care, episode I*. Retrieved February 2026 from <https://www.coreimpodcast.com/2020/03/18/5-pearls-on-transgender-health-gender-affirming-care-episode-1/>
28. Grasso, C., et al. (2021). Optimizing gender-affirming medical care through anatomical inventories, clinical decision support, and population health management in electronic health record systems. *Journal of the American Medical Informatics Association*, 28(11), 2531-2535. Retrieved February 2026 from <https://doi.org/10.1093/jamia/ocab080>
29. Wesp, L. (2016). *Transgender patients and the physical examination*. Retrieved February 2026 from <https://transcare.ucsf.edu/guidelines/physical-examination>
30. Joint Commission. (2026). Standard NPSG.14.04.01. *Comprehensive accreditation manual for hospitals*. (Level VII)

31. Accreditation Commission for Health Care. (2025). Standard 25.02.03. *Accreditation requirements for acute care hospitals*. (Level VII)
32. Centers for Medicare and Medicaid Services & Joint Commission. (2024). *The specifications manual for national hospital inpatient quality measures (version 5.15)*. Retrieved February 2026 from <https://www.qualitynet.org/inpatient/specifications-manuals#tab1>
33. Joint Commission. (2026). Standard NPG.08.01.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
34. Siegel, J. D., et al. (2007, revised 2024). *2007 guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings*. Retrieved February 2026 from <https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf> (Level VII)
35. Accreditation Commission for Health Care. (2025). Standard 07.02.04. *Accreditation requirements for acute care hospitals*. (Level VII)
36. Occupational Safety and Health Administration. (2019). *Bloodborne pathogens, standard number 1910.1030*. Retrieved February 2026 from <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030> (Level VII)
37. Joint Commission. (2026). Standard NPG.06.02.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
38. Rutala, W. A., et al. (2008, revised 2024). *Guideline for disinfection and sterilization in healthcare facilities, 2008*. Retrieved February 2026 from <https://www.cdc.gov/infection-control/media/pdfs/Guideline-Disinfection-H.pdf> (Level I)
39. Accreditation Commission for Health Care. (2025). Standard 07.04.01. *Accreditation requirements for acute care hospitals*. (Level VII)
40. Joint Commission. (2026). Standard RC.12.01.01. *Comprehensive accreditation manual for hospitals*. (Level VII)
41. Accreditation Commission for Health Care. (2025). Standard 10.00.03. *Accreditation requirements for acute care hospitals*. (Level VII)
42. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Medical record services. 42 C.F.R. § 482.24(b).
43. DNV Healthcare USA, Inc. (2025). MR.2.SR.1. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 25-1*. (Level VII)
44. Bickley, L., et al. (2025). *Bates' guide to physical examination and health history taking* (14th ed.). Wolters Kluwer.
45. American College of Obstetricians and Gynecologists. (2021, reaffirmed 2024). Health care for transgender and gender diverse individuals: Committee opinion no. 823. *Obstetrics and Gynecology*, 137(3), e75–e88. Retrieved February 2026 from <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals> (Level VII)
46. Meltzer, T., (2016). *Vaginoplasty procedures, complications and after care*. Retrieved February 2026 from <https://transcare.ucsf.edu/guidelines/vaginoplasty>

■ Additional References

- Ingram, S. (2017). Taking a comprehensive health history: Learning through practice and reflection. *British Journal of Nursing*, 26(18), 1033–1037. Retrieved February 2026 from <https://doi.org/10.12968/bjon.2017.26.18.1033>
[Abstract](#) | [Complete Reference](#)
- Jarvis, C., et al. (2024). *Physical examination & health assessment* (4th ed.). Elsevier Inc.
- Savoy, M., et al. (2020). Sexual health history: Techniques and tips. *American Family Physician*, 101(5), 286–293. Retrieved February 2026 from <https://www.aafp.org/pubs/afp/issues/2020/0301/p286.html>
- Toney-Butler, T. J., & Unison-Pace, W. J. (2023). Nursing admission assessment and examination. *StatPearls*. Retrieved February 2026 from <https://www.ncbi.nlm.nih.gov/books/NBK493211/>

Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions

The following leveling system is adapted from *Evidence-Based practice in nursing & healthcare: A guide to best practice*, Fifth edition, by Bernadette Mazurek Melnyk and Ellen Fineout-Overholt (2023).

Level I	Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs)
Level II	Evidence from well-designed single RCTs (experimental)
Level III	Evidence from well-designed nonrandomized controlled trials (quasi-experimental), systematic reviews of a complete body of evidence, and intervention studies using mixed methods
Level IV	Evidence from well-designed case-control and cohort studies (observational)
Level V	Evidence from systematic reviews of qualitative and descriptive studies
Level VI	Evidence from single descriptive and qualitative studies, evidence-based practice implementation, and quality improvement projects
Level VII	Evidence from expert opinion, expert committee reports, and literature reviews

Data from Gyatt, G., & Rennie D. (2002). *Users' guides to the medical literature*. American Medical Association; Harris, R. P., et al. (2001). *Current methods of the U.S. Preventative Services Task Force: A review of the process*. *American Journal of Preventative Medicine*, 20, 21-35.