N155 PHYSICAL ASSESSMENT DOCUMENTATION GUIDE

Student____________________________  Date ________________

Client/Patient ___________________________Age ________Sex__________

Assessment of the Abdomen

Subjective Data: Appetite, Dysphagia, Food intolerance, Abdominal pain, Nausea/Vomiting, Bowel habits, Past abdominal history, Medications, Nutritional assessment.

Objective Data

Inspection
- Contour, symmetry, umbilicus, pigment changes
- Lesions
- Scars
- Distention
- Pulsations
- Hernia (while patient lifts head)

Auscultation (all quadrants)
- Bowel sounds
- Vascular Sounds - bruits

Palpation
- Light palpation
  - Tension of abdominal wall (soft, firm, hard)
  - Tenderness
  - Masses
- Deep palpation
  - Tenderness
  - Masses
  - Enlarged organs

Percussion
- CVA tenderness

Documentation: (Include both Subjective and Objective Data in Narrative Form)