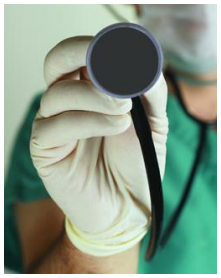
Physical- General

What is it?

- **Physical Examination** – or clinical examination is where a health care provider investigates the body for signs of disease, usually follows a medical history where the patient explains symptoms and together these aids in determining the correct diagnosis with a treatment plan, this data becomes a part of the medical history



  - **Generally Include**- laboratory tests, chest X-rays, pulmonary function testing, audiograms, full body CAT scanning, heart stress tests, EKGs, vascular age tests, urinalysis, prostate or mammogram exams depending on the sex
  - **Systematic Examination**- starts at the head and finishes at the extremities investigating the main organ systems by inspection, percussion, palpation and auscultation as neurological investigation and orthopedic examination and doing particular tests when a particular disease is suspected
  - **Vital Signs**- blood pressure, temperature, pulse, respiratory rate, pain
  - **Basic Biometrics**- height, weight, and pain
  - **Structure of the Examination Record**- organ systems as cardiovascular, lungs, breasts, abdomen, genitalia, musculoskeletal system, nervous system including mental status, head and neck/HEENT, and skin; vital signs, and an exam of the back and extremities, chest and lungs, eyes, and pelvic

    - **Abdominal Area**- abdomen, spleen, liver, kidneys, costo-vertebral angle, anal, rectum, inguinal hernia, stool sample
    - **Heart**- pulse, precardium, neck veins, suprasternal notch, edema
    - **Nervous System**- mental status, motor system, cranial nerves, sensory system, reflexes, cerebellar function and gait
    - **Lungs**- Auscultation, respiratory rate, trachea position, chest expansion and observation, voice transmission, chest percussion, chest percussion. Lung auscultation, etc…

What can I do?

- **See your Health Care Provider**- for more information
- **See a Registered Dietitian**- for help as needed