General Assessment

Introduction
Focused general assessment begins with taking a detailed health history regarding constitutional symptoms. This examination involves a general survey of the patient, measurement of vital signs, and pain assessment.

Optimal Patient Positioning

- Examine the patient in a position of their choosing to promote patient comfort.
- This may be performed with the patient fully dressed.

Exam methods

- Observational assessment
  - Note patient's level of consciousness, mood, and behavior, as well as any signs of distress.
  - Note patient's gait and any movement abnormalities, such as limping.
  - Include general appearance, grooming, dress, facial expressions, eye contact, odors, and posture.
  - Document the patient's description of their current state of health.
  - Describe the patient's distinguishing characteristics, such as tattoos, scars, amputations, or other unique features.
  - Observe for signs of distress, noting type and response.

- Vital signs
  - Measure height and weight to determine body mass index (BMI).
  - Measure blood pressure (BP) in both upper extremities, ensure to use a properly sized cuff.
    - Normal BP is less than 120/80 in adults
    - Isolated hypertension may be situational, such as "white coat syndrome."
    - Home BP monitoring may reveal better control.

Blood Pressure Categories for Adults			
Category	**Systolic (mm Hg)**		**Diastolic (mm Hg)**
Normal	Less than 120	and	Less than 80
Elevated	120 – 129	and	Less than 80
Stage 1 hypertension	130-139	or	80 - 89
Stage 2 hypertension	Greater than or equal to 140	or	Greater than or equal to 90

  - Measure orthostatic blood pressure if indicated.
  - Examine pulse rate and rhythm by palpating the radial pulse.
    - Normal heart rate falls between 60-90 beats per minute, although it may be altered due to medications or medical conditions.
    - Pulse should be counted for a full minute, particularly if irregular.

        - Rhythm should be regular. Abnormalities include “irregularly” irregular and “regularly” irregular.
    - Examine the quality of peripheral pulses.
        - Radial pulse is most commonly assessed due to accessibility.
        - Pulses should be strong, but not bounding.
    - Observe respiratory rate and quality of breathing.
        - Normal respiratory rate is 12-20 breaths per minute in an adult.
        - Breathing should be regular, although an occasional sigh is normal.
        - Observe for equal chest expansion on inspiration.
    - Measure and note temperature.
        - Normal temperature is 98.6° Fahrenheit (F) or 37° Celsius (C), but can range between 97° F (36.1° C) and 99° F (37.2° C)
        - Fever or pyrexia is an elevated temperature greater than 99° F
        - Hyperpyrexia is an extreme temperature greater than 106° F (41.1° C)
        - Hypothermia is an abnormally low temperature below 95° F (35° C)
        - Temperature may be measured in several ways.
            - Oral and rectal temperatures remain the most common, with oral temperatures usually slightly lower than the core temperature, and rectal temperatures being more accurate to the core temperature.
            - Temporal and tympanic temperatures can be variable and dependent on the user.
            - Axillary temperatures are the least accurate and take at least 5-10 minutes to register.

- Pain Assessment
    - Onset/timing
        - Note circumstances and timing of pain.
        - Note causes of pain.
    - Location
        - Note where the pain is located.
        - Note if the pain radiates to other areas.
    - Duration
        - Constant
        - Intermittent
    - Chronicity
        - Acute pain is defined as a predicted response to a noxious stimulus.
        - Chronic pain is defined as lasting longer than 1 month beyond illness/injury recovery, lasting longer than 3-6 months due to chronic illness.
    - Aggravating/alleviating factors
        - Note if the patient experiences relief or aggravation with movement, rest, cold/heat, etc.
        - Note if the pain has been relieved with any medications.
    - Type of pain
        - Somatic – emanates from muscles and soft tissues
        - Neuropathic – emanates from nerves
        - Visceral – emanates from deep structures/organs
        - Document the pain as the patient describes it.

- Severity
  - Utilize rating scales to assist in obtaining a baseline.
  - Utilize same scale to evaluate the effectiveness of interventions.
  - Note patient's baseline level of pain in those with chronic pain.

PEARLS

- Provide privacy for the patient; interview the patient alone to allow for personal questions they might be reluctant to discuss with others present.
- Orthostatic blood pressures may be indicated in patients presenting with syncope or near-syncope, dizziness, tachycardia, or palpitations.
- Ensure the use of a properly sized cuff, as erroneous values can be obtained with a cuff that is either too small or too large.
- In documenting the general assessment, be as descriptive as possible to create a visual depiction of the patient.
- Elicit from the patient what expectations they have for pain relief.

Reference:

Bickley, L. S., Szilagyi, P. G., Hoffman, R. M., & Soriano, R. P. (2021). Bate's Guide to Physical Examination and History Taking (13th ed.). Wolters Kluwer Health: Philadelphia.