General Assessment

Introduction
Focused general assessment begins with taking a 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 type 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 distress, noting type and response.

- Vital Signs
    - Measure height and weight to determine body mass index (BMI).
    - Measure blood pressure in both upper extremities, ensuring properly sized cuff.
        - Isolated hypertension may be situational, such as "white coat syndrome."
        - Home BP monitoring may reveal better control.
    - Measure orthostatic blood pressure if indicated.
    - Examine pulse rate and rhythm by palpating the radial pulse.
        - Normal rate falls between 60-90 beat 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.
    - Measure and note temperature.
        - 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 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 defined as a predicted response to noxious stimulus.
    - Chronic pain 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 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.