HELPFUL HINT

Review the physical assessment of the infant and child in a nursing health assessment textbook.

MATCHING KEY TERMS

Match the term with the correct definition.

1. _______ auscultation  a. Vibration perceptible on palpation or auscultation
2. _______ circumduction  b. Organized method of collecting data
3. _______ crepitation  c. Use of touch to determine temperature, moisture, and organ placement
4. _______ development  d. Circular movement of a limb or an eye
5. _______ fasciculation  e. Aggregate of subjective data that describes past and present health status
6. _______ fremitus  f. Tapping of the body to determine density, location, and size of organs
7. _______ growth  g. Elicitation and evaluation of sounds produced by body
8. _______ history  h. Observation to identify physical findings
9. _______ inspection  i. Dry, crackling sound or sensation
10. _______ obtund  j. Small, local, involuntary muscle contraction visible under the skin
11. _______ palpation  k. To render dull or blunt
12. _______ percussion  l. Change that occurs over time in functional, psychosocial, and cognitive behavior
13. _______ systematic assessment  m. Measurable physical and physiologic changes that occur over time

GENERAL APPROACHES TO PHYSICAL ASSESSMENT

Answer as either true (T) or false (F).

1. _______ It is appropriate to auscultate the heart, lungs, and abdomen while an infant is sleeping.
2. _______ Stranger anxiety makes the physical examination of an older infant more difficult.
3. _______ Parents should not be present during a young child’s physical examination.
4. _______ In all age-groups, uncomfortable procedures should be saved until the end of the examination.
5. _______ Adolescents should be allowed to participate in deciding who will be present during the physical examination.
6. _______ For adolescents, the physical examination proceeds from head to toe.
TECHNIQUES FOR PHYSICAL EXAMINATION

Fill in the blanks.

1. Using an ophthalmoscope is an example of ____________ inspection.
2. In palpating the lymph nodes for general assessment, the nurse uses the ________________.
3. In palpating the lymph nodes specifically for heat, the nurse uses the ________________.
4. When percussing the liver, the nurse would expect to hear __________ sounds.
5. The ________________ of the stethoscope is most effective in auscultating low-pitched sounds.

Match each type of history with its description.

6. ______ Complete history  a. Information about a specific problem is added to an existing database.
7. ______ Episodic history  b. Information about a child from conception to present.
8. ______ Well-interim history  c. Information gathered from last well visit to current visit.

Answer as either true (T) or false (F).

9. ______ Axillary temperatures are preferable to rectal temperatures because they are less invasive.
10. ______ The apical impulse is palpated to determine the position of the heart.
11. ______ All irregular heart rhythms in children require immediate attention.
12. ______ The respiratory rate in infants can be counted by observing the movement of the abdomen.
13. ______ An adolescent with a blood pressure of 120/80 mm Hg is considered to be pre-hypertensive.

14. Give two ways of measuring the length of an infant.
   a. ________________
   b. ________________

15. Why is the head circumference measured at every visit until the child is 3 years old?

Fill in the blanks.

16. All scales must be ________________ before use.
17. Chest circumference is measured at the ________________.
18. Midarm circumference is a measure of ________________ and ________________.
19. An adolescent who is 62 inches tall and weighs 120.5 pounds has a body mass index (BMI) of ________________.

20. To complete a growth chart on a child’s height, the nurse should do the following:
   a. Use a chart appropriate for the child’s ______ and ________________.
   b. Find the child’s age on the ________________ axis.
   c. Find the child’s height on the ________________ axis.
   d. Mark where the two lines ________________
   e. Note the ________________.
21. Increased thickness and pigmentation of the skin on the posterior neck, on the armpits, and behind the knees and elbows can indicate that a child might have __________________________.

22. On a child, the nurse assesses skin turgor on the __________ or __________.

23. Unusual hair loss is called __________________________; excessive hair growth is called __________________________.

24. When a child has head lice, nits are found on the __________________________.

25. Capillary refill should be within __________ seconds.

26. When assessing a child’s face, the nurse examines cranial nerves __________________________ and __________________________.

27. Frequent wiping of the nose indicates that the child probably has __________________________.

28. The philtrum is the __________________________.

29. How does the nurse examine cranial nerve XII (hypoglossal nerve)? __________________________

30. When eliciting the gag reflex with a tongue blade, the nurse is evaluating cranial nerve ________.

Match each test or chart with its description.

31. _______ Lea chart  a. Tests ability to hear via bone conduction
32. _______ Sweep test  b. Tests visual acuity in a 30-month-old child
33. _______ Ishihara cards  c. Test used to determine the extent of hearing loss
34. _______ Weber test  d. Tests color vision
35. _______ Snellen chart  e. Tests for hearing loss
36. _______ Pure tone test  f. Tests visual acuity in a 12-year-old child

Answer as either true (T) or false (F).

37. _______ Breathing is more diaphragmatic in a school-age child than in a toddler.

38. _______ Before auscultation of breath sounds, have a toddler sit upright on the parent’s lap.

39. _______ Normal breath sounds are called adventitious.

40. _______ The apical pulse is also called the point of maximal impulse (PMI).

41. _______ Auscultation of the heart is best done by listening with the bell of the stethoscope only.

42. _______ A pause between the closing of the pulmonic and aortic valves is a normal finding in children.

43. _______ Functional heart murmurs require immediate intervention.

44. _______ When should adolescent females start performing monthly breast self-examinations?

45. _______ To ascertain the absence of bowel sounds, the nurse listens to the area for up to ________ minutes.
46. Describe how to test for rebound tenderness.

47. How can the nurse decrease adolescent anxiety during a genital examination?

48. Why are adolescent males taught to do monthly testicular examinations?

Match each term with its description.

49. ______ lordosis
50. ______ Ortolani maneuver
51. ______ genu varum
52. ______ scoliosis
53. ______ kyphosis

   a. Performed until the child is 1 year old
   b. Common in young children
   c. Related to poor posture
   d. Bowleg
   e. Lateral nonpainful curvature of the spine

Answer as either true (T) or false (F).

54. ______ To evaluate neurologic functioning in a child younger than 5 years of age, use the DDST-II.
55. ______ The nurse should test all of the cranial nerves at the beginning of the physical examination.
56. ______ Obtunded is a term used to describe one of the altered levels of consciousness.
57. ______ As part of the neurologic examination, it is important to assess a toddler’s orientation to person, place, and time.
58. ______ Depression may alter a child’s ability to solve problems.
59. ______ Assessing a child’s ability to balance evaluates cerebellar function.
60. ______ Responses to eliciting the Babinski reflex depend on the child’s ability to walk.
61. ______ Neurologic “soft” signs are normal variants and require no further assessment.

STUDENT LEARNING ACTIVITY

1. Perform a complete history and physical assessment on an infant, a child, and an adolescent. Describe your findings clearly and coherently in writing.
STUDENT LEARNING APPLICATIONS

Enhance your learning by discussing your answers with other students.

During a physical assessment on an infant, child, or adolescent, many variables can alter either the process or the findings. Describe how you would handle a physical assessment in each of the following situations.

1. A toddler’s parents are not present during the examination.

2. A school-age child’s level of cognitive functioning is far below average.

3. An adolescent is experiencing moderately severe abdominal pain.

4. A 9-month-old infant is exhibiting a high degree of stranger anxiety.

5. A preschooler believes that undergoing the physical examination is punishment for being bad.

REVIEW QUESTIONS

Choose the correct answer.

1. A 1-year-old child is at the pediatrician’s office for a well-interim visit. When interviewing the parents, the nurse should
   a. obtain a complete history from conception to the present.
   b. record information about the child’s chief complaint.
   c. obtain a family history.
   d. gather data about what has occurred since the last visit.

2. Before auscultating a toddler’s lungs, the nurse should
   a. examine the child’s ears and throat.
   b. ask the parent(s) to leave the room.
   c. allow the child to examine the stethoscope.
   d. do none of the above.

3. The nurse begins auscultation of the abdomen in the
   a. RUQ.
   b. RLQ.
   c. LUQ.
   d. LLQ.

4. Which of the following is an abnormal finding?
   a. Posterior fontanel is flat and soft in an 8-month-old infant.
   b. A 7-month-old sits using hands for support.
   c. Breathing is abdominal in a 3-month-old child.
   d. A 5-year-old’s pupils dilate when focusing on a distant object.
5. Which of the following is a normal finding in a school-age child?
   a. Bone conduction is greater than air conduction.
   b. Cerumen is found in the external auditory meatus.
   c. Discharge is present in the ear canal.
   d. The tympanic membrane is stationary.

6. An assessment technique of the chest and lungs normally reserved for the advanced nursing practitioner is:
   a. inspection.
   b. auscultation.
   c. palpation.
   d. percussion.

7. The PMI is located at the fifth intercostal space in the midclavicular line after approximately age
   a. 2 months.
   b. 18 months.
   c. 4 years.
   d. 7 years.

8. An example of a “soft” neurologic sign is
   a. a short attention span.
   b. left handedness.
   c. nonmirroring movement of the extremities.
   d. none of the above.

9. Which of the following sounds occurs when parts of the lungs lose their lubricating fluid?
   a. High-pitched wheezing
   b. Pleural friction rub
   c. Rales
   d. Sonorous rhonchi

10. Which of the following reflexes is elicited by suddenly and briskly dorsiflexing the child’s foot and applying moderate pressure?
    a. Achilles
    b. Babinski
    c. Cremasteric
    d. Patellar