GENERAL PHYSICAL EXAMINATION

I. Preparation

1. Introduction

"مرحبا، انا _____ ، طالب/ة طب سنة رابعة، بدي اعمل اليوم فحص عام على حضرتك، ممكن تخبرني باسمك؟ "

2. Consent

"بتسمحلي ابدأ الفحص؟"

3. Explanation

رح نبدأ بفحص عام بعدين رح افحص الوجه واليدين والرقبة""

"او "رح افحص العقد الليمفاوية في الرقبة والكتفين وتحت الذراعين

4. Environment

"The room is clean, well-lit, quiet, and private."

5. Preparation

- Exposure
- Posture
- Chaperone
- Hand hygiene

“I will ensure correct exposure and correct posture.”

“I will offer a chaperone.”

“I will perform hand hygiene”

II. General Inspection

1. General Appearance

“The patient is alert, conscious, and oriented to time, place, and person.”

*Optional if asked (*Is it morning or evening? *Do you know where you are? *Do you know who I am?)*

“The patient is comfortable and is not in distress.”

“The patient is sitting/ laying comfortably on the examination bed.”

2. Clothing

“ His clothing is clean and appropriate”

3. Facial Expression

“ His facial expression is calm and appropriate.”

4. Breathing

“His Breathing is normal” (no respiratory distress, tachypnea, or effort on breathing)

5. Sounds

“No abnormal breathing sounds are present.” (No wheezing, no stridor)

6. Medical Equipment

“No medical equipment is attached to the patient.” (e.g. oxygen cannulae, face mask, IV lines, or monitoring devices)

7. Body Habitus

“The patient’s body habitus is appropriate, with weight proportionate to height.”

(Or describe if obese, overweight, underweight, cachectic, etc.)

8. Speech

“His speech is clear, and appropriate.”

“No hoarseness.”

9. General Odor

“No abnormal body odor.”

10. Posture & Gait

“Posture is normal.”

“Gait is normal.”

III. Vital Signs (only mention them)

No.	Vital Sign / Measurement	Method / Formula	Normal / Categories
1.	**Heart Rate**	Palpate the radial pulse for 1 minute.	**Normal:** 60–100 beats/minute
2.	**Respiratory Rate**	Continue holding the radial pulse while observing chest movement for 1 minute.	**Normal:** 12–20 breaths/minute
3.	**Temperature**	Thermometer	**Normal:** 36.5–37.5°C
4.	**Blood Pressure**	Manual (mercury) or digital BP cuff.	**Normal:** Approximately 120/80 mmHg
5.	**Oxygen Saturation**	Pulse Oximeter.	**Normal:** 95–100% on room air
6.	**Body Mass Index (BMI)**	**Formula:** Weight (kg) ÷ Height² (m²)	Underweight: <18.5 Normal: 18.5–24.9 Overweight: 25–29.9 Obese Class I: 30–34.9 Obese Class II: 35–39.9 Obese Class III: ≥40

IV. Head Examination

1. Face

“Normal Facial symmetry.”

“No facial swelling or plethora.”

“No visible hyperpigmentation or hypopigmentation.”

“No facial deformities.”

2. Hair

“Hair distribution and hairline are normal.”

Optional; (“No alopecia.”, “No evidence of trichotillomania.”)

3. Eyebrows

“No lateral thinning of the eyebrows.”

4. Forehead

“No wrinkles or other abnormalities on the forehead.”

5. Eyes

“No visible eye deformities.”

“No conjunctival pallor.” *Assess by pulling eyelid down.*

“No scleral jaundice.” *Assess by pulling eyelid up.*

“No exophthalmos.”

“No periorbital edema.”

V. Mouth Examination

“لوسمحت ممكن تفتح تمك وتطلع لسانك لبرا ”

1. Palate & Mucosa

“The palate is normal.” *Optional; (“No high arched palate.”)*

“No cyanosis.” = central

“No mucosal jaundice.”

2. Mouth Odor

“Normal Breath odor.” *Optional; (No ketone smell, No fetor hepaticus, No faeculent odor, No foul-smelling breath)*

3. Tongue

“No abnormal tongue color.”

“No abnormal tongue size.”

“No toungue deviation.”

“No fasciculations.”

“No tongue masses.”

VI. Hand Examination

Inspection

1. Skin

“No hyperpigmentation or hypopigmentation.”

“No tobacco staining.”

2. Tremor & Deviation

”ممكن تمد ايديك لقدام؟“

“No ulnar or radial deviation.”

“No essential tremor”

”ممكن ترفع ايديك زي هيك“ 🦶

“No flapping tremor. (asterixis)

3. Muscle Wasting

”ممكن تلف ايدك هيك 🫲و هيك 🫱؟“

“No muscle wasting.” (Thenar, Hypothenar on palmar side, Intersseous on dorsal side)

4. Hand Color

“No pallor.”

“No peripheral cyanosis.”

5. Skin Changes

“No coarse skin.” =acromegaly

“No tight skin.” =scleroderma

6. Hand Deformities

“No deformities.”

7. Nails

“No nail changes.” (e.g. koilonychia, leukonychia, onycholysis, splinter hemorrhages)

Palpation

”تسمحلي افحص ايديك؟“

”في عندك أي مكان فيه وجع أو ألم؟“

Use the dorsum of your hand to palpate patient’s dorsum of hand.

1. Temperature

“Hands are of normal temperature.”

2. Tenderness

“No tenderness.”

3. Capillary Refill

Compress the nail bed then release. Normal if revascularized in <3s.

“Normal capillary refill time.”

4. Clubbing

Ask to see patients fingers and ask them to do the window, then do the fluctuation test

“Schamroth window is present.”

“Normal hyponychial angle.”

“Normal phalangeal depth ratio.”

“No excessive nail fluctuations.”

VII. Neck Examination

“No scars.”

“No neck masses.”

“No visible veins.”

Mention assessment of:

- Jugular venous pressure (JVP)
- Thyroid gland
- Carotid bruits

VIII. Skin Examination

“No jaundice.”

“No hyperpigmentation.”

“No hypopigmentation.”

“No peripheral cyanosis.”

“No ulcers.”

“No visible lumps or masses.”

If a Lump is Present (SPACE-SPIT)

Describe the lump using:

- **S** — Size. pull out your measuring tape
- **P** — Position
- **A** — Attachment (fixed or mobile)
- **C** — Consistency (soft, firm, hard, fluctuant)
- **E** — Edge (regular or irregular, well-defined or ill-defined)
- **S** — Surface (smooth or nodular) & Shape (round, oval, irregular)
- **P** — Pulsation, thrills, bruits mention the use of stethoscope for bruits
- **I** — Inflammation (redness, warmth, tenderness)
- **T** — Transillumination (positive or negative)

IX. Hydration

“There are no signs of dehydration.”

- Moist oral mucous membranes
- Normal skin turgor
- No history or evidence of decreased urine output

XI. Lymph Node Examination

”هلأ رح افحص العقد الليمفاوية في الرقبة، الكتفين وتحت الذراعين، هل بتسمحلي؟“

”عندك أي وجع في هاي المناطق؟“

Palpate systematically, one side at a time, compare sides. Maintain eye contact.

Anterior Examination

- Submental
- Submandibular
- Tonsillar
- Preauricular
- Deep cervical:
    - Upper
    - Middle
    - Lower
- Supraclavicular
- Scalene turn/tilt head towards the side to examine, and shrug their shoulders if necessary

Posterior Examination

Ask the patient to slightly flex their neck forward.

- Occipital
- Postauricular
- Posterior cervical
- Neck root (base of the neck)

Upper Limb Nodes

- Axillary lymph nodes
- Epitrochlear lymph nodes Use the same hand to examine, opposite hand to hold

“No palpable lymphadenopathy is detected.”

“The lymph nodes are not enlarged, tender, fixed, or matted.”