UCLA Fundamentals of Clinical Medicine
Physical Exam Skills Checklist

Student________________________Group_______

I.

A. **HEAD:**
   1. Examine the scalp, hair, bone configuration of skull
   2. Observe facial skin and musculature for symmetry of movement (C.N. VII).
   3. Palpate scalp thoroughly

B. **NECK:**
   1. Palpate the lymph nodes in the:
      a. Anterior triangles
      b. Supraclavicular areas
      c. Submandibular areas
      d. Posterior cervical nodes
   2. Palpate the carotid pulses
   3. Note the position of the trachea
   4. Palpate for size and movement of the thyroid gland (from behind)

C. **EYES:**
   1. Inspect eyelids, sclera, conjunctiva with penlight
   2. Determine extraocular movements in the six cardinal directions of gaze (C.N. III, IV). Note wrinkling of forehead with patient’s eyes in upward gaze (C.N. VII).
   3. Examine the direct and consensual pupillary reflexes to light in both eyes.
   4. Visual fields by confrontation
   5. Examine the retina with the ophthalmoscope
   6. Check for convergence and accommodation
   7. Patient positioned at height comfortable for examiner
   8. Inspect anterior structures with ophthalmoscope
   9. Inspect optic nerve
   10. Trace vessels in four quadrants
   11. Observe macula
   12. Estimate visual acuity (near or far) in each eye separately

D. **EARS:**
   1. Inspect pinnae
   2. Inspect external auditory canal, tympanic membrane with the otoscope
   3. Check hearing with wristwatch, whispering, or with tuning fork (C.N. VIII).
   4. Weber test
   5. Rinne Test
   6. Observe auricles and postauricular regions bilaterally
   7. Palpate auricles bilaterally
   8. Insert speculum without causing pain to the patient
   9. Stabilize otoscope upon insertion
   10. Test auditory acuity

E. **NOSE:**
   1. Use penlight to inspect septum and turbinates
   2. Inspect nasal vaults with nasal speculum or otoscope
   3. Insert speculum without causing pain to the patient
   4. Test for patency of both nasal passages
   5. Palpate for frontal sinus tenderness
   6. Palpate for maxillary sinus tenderness

F. **MOUTH:**
   1. Inspect:
      a. All mucous membranes
b. Salivary duct
c. The tonsils
d. The teeth
e. The gums
f. The pharynx

2. Test for symmetry of movement of soft palate and uvula with phonation (C.N. IX, X).
3. Look for deviation on tongue protrusion

G. POSTERIOR CHEST:
1. Inspect skin
2. Examine symmetry of chest wall movements with breathing
3. Examine for deviations or abnormalities of the spinal curvature
4. Finger-percuss upper, middle, and lower lung fields
5. Auscultate the upper, mid, lower lung fields.
6. Percuss spine and flanks with fist

H. LATERAL:
1. Percuss lateral lung fields bilaterally
2. Auscultate lateral lung fields bilaterally

I. ANTERIOR:
1. Percuss anterior lung fields
2. Percuss fields bilaterally and symmetrically
3. Auscultate anterior lung fields
4. Auscultate fields bilaterally and symmetrically
5. Auscultate apices in supraclavicular fossae

J. LUNGS:
1. Determine respiratory rate
2. Percuss anterior lung fields
3. Auscultate anterior and posterior lung fields
4. Check thoracic expansion
5. Percuss posterior lung fields
6. Percuss fields bilaterally and symmetrically
7. Measure excursion of the diaphragm
8. Use proper technique to measure maximum excursion of the diaphragm

K. HEART:
1. Determine radial pulse
2. Determine blood pressure in arms
3. Inspect the neck veins
4. Inspect and palpate precordium and apical impulse.
5. Auscultate the heart:
   a. Apex (mitral)
   b. Tricuspid area
   c. Left sternal border
   d. Pulmonic area
   e. Aortic area
6. Auscultate the apex with the ball of the stethoscope
7. Observe precordium
8. Palpate right ventricular area
9. Palpate apical area (5th ICS - left)
10. Observe neck veins with patient in recumbent position
11. Palpate with patient recumbent:
    a. Aortic area
    b. Pulmonic area
    c. Right ventricular area
    d. Apical area
12. Ask patient to roll to left lateral position
13. Relocate apex
14. Auscultate apex with bell
15. Auscultate apex with diaphragm

L. ABDOMEN:
   1. Inspect for bulges, masses and skin lesions
   2. Auscultate over the epigastrium for bowel sounds, and bruits
   3. Palpate gently (all quadrants)
   4. Palpate deeply (all quadrants)
   5. On inspiration, palpate superficially, then deeply for:
      a. Liver
      b. Spleen
   6. Finger-percuss over the four quadrants
   7. Finger-percuss over flanks
   8. Palpate the femoral pulses
   9. Palpate the inguinal area for lymph nodes
10. Patient is taught to relax abdominal musculature
11. Watch patient’s face as examine abdomen
12. Palpate Aorta

M. HANDS AND ARMS:
   1. Inspect both hands (dorsa and palms)
   2. Inspect and palpate both arms and forearms with clothing removed
   3. Palpate epitrochlear nodes
   4. Palpate axillary nodes
   5. Use proper technique to palpate axillary nodes
   6. Wash hands after palpating axillary nodes

N. BACK:
   1. Palpate spinous processes of thoracic and lumber vertebrae
   2. Perform fist percussion of thoracic, lumbar, sacral vertebrae, and sacroiliac joints bilaterally

O. BREASTS (Female):
   1. Inspect both breasts:
      a. Patient sitting, arms at sides
      b. Patient sitting, arms above head
      c. Patient leaning forward
      d. Patient sitting, hands pressed to hips
   2. Palpate breasts with patient in sitting position:
      a. 4 quadrants
      b. Nipple
      c. Areola
   3. Palpate breasts with patients in recumbent position:
      a. 4 quadrants and tail
      b. Nipple
      c. Areola
      d. Attempt to express material from nipple
      e. Examine all areas completely and systematically

P. BREASTS (Male):
   1. Palpate all 4 quadrants of each breast
   2. Palpate nipples bilaterally
   3. Palpate areolae

Q. LOWER LIMBS:
   1. Inspect bilaterally with outer clothes removed
   2. Inspect feet including toes
   3. Palpate pulses bilaterally:
      a. Femoral
      b. Popliteal
      c. Posterior tibial
      d. Dorsalis pedis
4. Palpate inguinal lymph nodes
5. Auscultate for femoral bruit
6. Check for peripheral pitting edema
7. Use proper technique to check for pitting edema

II. NEUROLOGICAL-MUSCULOSKELETAL EXAM

A. MENTAL STATUS: (Can be done at any point in exam)
   1. Orientation: Time, place, person.
   2. Serial 7’s
   3. Memory: recent and past
   4. Information
   5. Abstract reasoning

B. PATIENT STANDING:
   1. Observe gait
   2. Have patient walk on toes
   3. Have patient walk on heels
   4. have patient hop on each foot
   5. Have patient do a deep knee bend
   6. Observe tandem gait (heel-to-toe)
   7. Perform Romberg test

C. SPINE:
   1. Test flexion by having patient bend at waist to touch toes
   2. Test extension by having patient bend backwards
   3. Have patient bend sideways
   4. Observe posture and curvatures
   5. Perform screening test for scoliosis
   6. Test flexion, extension, and rotation of neck

D. CRANIAL NERVES: (May have been done earlier in exam)
   1. Test Nerve I: Sense of smell (change in smell or taste)
   2. Test Nerve II:
      a. Visual acuity
      b. Visual fields
      c. Ophthalmoscopic (disc, blood vessels, retina)
   3. Test Nerves III, IV, VI:
      a. Pupillary reaction to light
      b. Extraocular movements
   4. Test Nerve V:
      a. Sensory function: test light touch on cornea
      b. Motor function: test contraction of masseter muscles or forced opening of mouth against resistance
   5. Test Nerve VII:
      a. Motor function in mimetic musculature of face
      b. Raise eyebrows or forced eyelid closing
      c. Show teeth, puff on cheeks, or smile
   6. Test Nerve VIII:
      a. Hearing (Done with EENT examination)
   7. Test Nerve IX and X:
      a. Observe elevation of palate vocalizing "ah"
   8. Test Nerve XI:
      a. Test rotation of patient’s head against resistance
      b. Test shoulder shrug against resistance
   9. Test Nerve XII:
      a. Observe midline protrusion of the tongue.

E. MOTOR STATUS:
   1. Examine functional groups of muscles for bulk, tone, consistency, and strength

F. UPPER LIMB:
1. Test for drift of outstretched arms with eyes closed
2. Test for distal strength on dorsiflexed wrist
3. Test patient’s grip bilaterally
4. Test fine rapid movements - fingers

G. LOWER LIMB: (mainly done with patient standing)
1. Have patient walk on toes
2. Have patient walk on heels
3. Have patient hop on each foot
4. Have patient do a deep knee bend
5. Test fine rapid movements - feet

H. Reflexes:
1. Deep tendon reflexes: (Test Symmetrically)
   1. Test biceps reflex
   2. Test brachioradialis reflex
   3. Test triceps reflex
   4. Test patellar reflex
   5. Test achilles reflex

I. Cutaneous Reflexes:
1. Test plantar reflex

J. Cerebellar Function:
1. Test rapid alternating movements - hands
2. Test finger-to-nose bilaterally
3. Test heel-to-shin bilaterally
4. Observe tandem gait - heel-to-toe (patient standing)

K. Sensory Status:
1. Test light touch or pin prick on both sides of trunk
2. Test light touch or pin prick on 4 limbs
3. Test position sense at least in feet
4. Test vibration sense in at least both ankles

L. Inguinal Area: Male Genitalia and Rectum:
1. Inspect:
   a. Penis (lift to examine under surface)
   b. Retract foreskin (or have patient retract)
   c. Meatus
   d. Scrotum
   e. Inguinal canal
2. Palpate:
   a. Penis
   b. Scrotum (testes, epididymis, and spermatic cord)
   c. Hernia examination (including inguinal canal)
3. Perform rectal examination:
   a. Inspect anus
   b. Exert pressure on external sphincter anteriorly and pause to allow sphincter to relax
   c. Palpate prostate
   d. Rotate examining finger through an arc of 360 degrees
   e. Perform stool guaiac test

(developed by M. Wilkes, M.D., Ph.D. & E. Milgrom, M.D. as a tool for self assessment and OSCE evaluation)