DOCUMENTATION

The following is a sample narrative documentation from assessment of the head and neck of a healthy adult.

Nurses Notes:

Subjective Data:

Denies problems with the head and neck, reports no current headache, no lesions, and no changes in skin or hair. Recalls no problem with swollen glands or breathing. No personal or family history of headache, allergy, or thyroid disease. Takes 2 Tylenol for occasional headache, that is once a week during busy season at work (1 month) and "maybe one a month." Headache is associated with lack of sleep or stress and relieved with single dose (2 tablets) of Tylenol. Weight has been constant for several years.

Objective Data:

Skull round with symmetrical protuberances. Skull nontender to palpation. Hair even distribution, scalp free of lesions, clean. Eyebrows symmetrical, equal distances of brow to pupil and outer canthus to pinna. Nose is midline with equal nasolabial folds. Lips symmetrical. Facial movement and expression symmetrical. Trachea mobile, midline with palpable C rings. TMJ movement smooth and symmetrical. Thyroid nonpalpable, rises with swallow. Lymph nodes of neck nonpalpable.

ASSESSMENT FORM

General Overview

Skull: *round, symmetrical*

Protuberances: *symmetrical*

Hair: *even distribution*

Scalp: *clean, no lesions*

Eyes

Brows: *symmetrical*

Distance Brow to Pupil: *equal*

Distance Outer Canthus to Pinna: *equal*

Nose

Position: *midline*

Deviation: *none, straight*

Nasolabial Folds: *equal*

Mouth

Lips: *symmetrical*

Neck

Trachea: *midline, mobile, C rings palpable*

Thyroid: *nonpalpable, rises with swallow*

Lymph Nodes

PALPABLE	NO	YES
Preauricular:	x	
Postauricular:	x	
Occipital:	x	
Retropharyngeal:	x	
Submaxillary:	x	
Submental:	x	
Superficial cervical:	x	
Deep cervical:	x	
Supraclavicular:	x	