General Assessment

1. A nurse is admitting a new client to the medical unit. Which of the following is the most important assessment finding to document?

A. The client's weight.

B. The client's temperature.

C. The client's blood pressure.

D. The client's respiratory rate.

2. A nurse is assessing a client's pain level. Which of the following pain scales is most appropriate for use with an adult client who is alert and oriented?

A. The Faces pain scale.

B. The FLACC pain scale.

C. The Numeric pain rating scale.

D. The Wong-Baker FACES pain scale.

Head, Neck, and Face

1. A nurse is assessing a client's pupils. Which of the following findings is most concerning?

A. The pupils are equal, round, and reactive to light and accommodation.

B. The pupils are dilated and fixed.

C. The pupils are unequal in size.

D. The pupils are constricted and sluggishly reactive to light.

2. A nurse is assessing a client's neck. Which of the following findings is most concerning?

A. The lymph nodes are palpable and slightly enlarged.

B. The neck is supple and without tenderness.

C. The trachea is deviated to the right.

D. The thyroid gland is enlarged.

Thorax and Lungs

1. A nurse is auscultating a client's lungs. Which of the following findings is most concerning?

A. The lungs are clear to auscultation.

B. There are rhonchi in the bases of both lungs.

C. There is wheezing throughout both lungs.

D. There is a pleural rub.

2. A nurse is assessing a client's respiratory effort. Which of the following findings is most concerning?

A. The client is using accessory muscles to breathe.

B. The client's respiratory rate is 20 breaths per minute.

C. The client is using a pursed-lip breathing technique.

D. The client is able to speak in full sentences without difficulty.

Abdomen

1. A nurse is palpating a client's abdomen. Which of the following findings is most concerning? A. The abdomen is soft and non-tender. B. The abdomen is guarding. C. The abdomen is distended. D. The abdomen is tympanitic.

2. A nurse is assessing a client's bowel sounds. Which of the following findings is most concerning?

A. The bowel sounds are hypoactive.

B. The bowel sounds are hyperactive.

C. The bowel sounds are absent.

D. The bowel sounds are rushing.

Extremities

1. A nurse is assessing a client's peripheral pulses. Which of the following findings is most concerning?

A. The pulses are equal, strong, and regular.

B. The pulses are weak and thready.

C. The pulses are unequal.

D. The pulses are absent.

2. A nurse is assessing a client's capillary refill. Which of the following findings is most concerning?

A. The capillary refill is less than 2 seconds.

B. The capillary refill is greater than 3 seconds.

C. The capillary refill is delayed.

D. The capillary refill is pulsating.

Neurological Assessment

1. A nurse is assessing a client's mental status. Which of the following findings is most concerning?

2. A. The client is alert and oriented to person, place, and time.

3. B. The client is confused and disoriented.

4. C. The client is agitated and combative.

5. D. The client is lethargic and difficult to arouse.

6. A nurse is assessing a client's motor function. Which of the following findings is most concerning?

A. The client is able to move all of their extremities against resistance.

B. The client has hemiparesis.

C. The client has foot drop.

D. The client has ataxia.