PLAINWORK

NCLEX-RN Health Assessment Practice App: Physical Assessment Questions with Rationales

Free sample: 10 of 76 questions

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Sample

1. A client with chronic venous insufficiency reports ankle swelling that is worse by evening and improves after a night in bed. When explaining the underlying problem, which statement should the nurse make?

A. A. Every lymph channel in the groin has been removed.
B. B. The leg arteries are delivering too much blood toward the feet.
C. C. Capillary walls have become permanently thinner and leak fluid.
D. D. One-way valves in the leg veins no longer keep blood from pooling.

D. One-way valves in the leg veins no longer keep blood from pooling. — Veins carry blood back to the heart against gravity, using one-way valves and the squeeze of leg muscles. When valves fail, blood pools in dependent veins, venous pressure rises, and fluid shifts into surrounding tissue. Lying flat removes the gravity load, so swelling recedes overnight.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment; Potter & Perry, Fundamentals of Nursing

2. A client with a strained thigh muscle is asked to straighten the knee while seated. The client completes the full range of motion against gravity but cannot hold the position when the nurse applies any resistance. Which grade should the nurse document?

A. A. 3/5: full movement against gravity, no added resistance tolerated
B. B. 2/5: full movement only when gravity is eliminated
C. C. 4/5: full movement against gravity and some, but not full, resistance
D. D. 1/5: a visible flicker of contraction without joint movement

A. 3/5: full movement against gravity, no added resistance tolerated — On the 0 to 5 scale, grade 3 is full range of motion against gravity without resistance. Grade 4 is movement against gravity plus some resistance, and grade 5 is full resistance. Grade 2 needs gravity removed.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment; Bates' Guide to Physical Examination and History Taking

3. A client's left eye measures 20/80 on a Snellen chart, and the right eye measures 20/20. How should the nurse interpret the left-eye result?

A. A. The client can read detail at 80 feet that a typical eye reads at 20 feet
B. B. The left eye has retained eighty percent of normal vision
C. C. The client read eighty of one hundred letters correctly with that eye
D. D. At 20 feet the client sees only what a typical eye could still resolve at 80 feet

D. At 20 feet the client sees only what a typical eye could still resolve at 80 feet — The numerator is the distance of the client from the chart, and the denominator is the distance at which a typical eye can read the same line. A result of 20/80 means this eye needs to be at 20 feet to see what a typical eye sees from 80 feet, so acuity is reduced and a referral is warranted.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment; American Academy of Ophthalmology

4. A client with a new stroke has a diminished gag reflex. Before allowing any oral intake, the nurse recalls that the gag reflex depends on which pair of cranial nerves?

A. A. CN VII (facial) and CN VIII (vestibulocochlear)
B. B. CN IX (glossopharyngeal) and CN X (vagus)
C. C. CN X (vagus) and CN XII (hypoglossal)
D. D. CN V (trigeminal) and CN VII (facial)

B. CN IX (glossopharyngeal) and CN X (vagus) — Touching the back of the throat stimulates sensory fibers of the glossopharyngeal nerve, and the vagus nerve supplies the pharyngeal muscles that contract in response. A weak gag therefore points to impairment of CN IX and CN X and signals aspiration risk.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment; Bates' Guide to Physical Examination and History Taking

5. A 78-year-old client with no known lung disease attends a routine visit. Room-air oxygen saturation is 95%, respirations are 16 and unlabored, and prior visits recorded 94% to 96%. What is the nurse's best action?

A. A. Recheck the saturation every 15 minutes for an hour.
B. B. Notify the provider of acute hypoxemia right away.
C. C. Apply oxygen by nasal cannula until the reading reaches 100%.
D. D. Record the value and continue, since it matches the client's usual range.

D. Record the value and continue, since it matches the client's usual range. — Older adults may sit slightly lower within the adult range, and the individual's baseline matters more than chasing a perfect number. A client without symptoms whose reading is unchanged needs documentation, not treatment.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment; Potter & Perry, Fundamentals of Nursing

6. A 14-month-old with fever, cough, red eyes, and a rash that began on the face and spread downward arrives at the clinic. The family returned from overseas travel last week and the child is unvaccinated. What protective equipment should the nurse use while taking vital signs?

A. A. A fit-tested N95 respirator, with the child moved to a closed single room
B. B. Surgical mask, gown, and gloves, with the door closed
C. C. Gloves alone, with hand hygiene between contacts
D. D. Standard precautions only, because the diagnosis is unconfirmed

A. A fit-tested N95 respirator, with the child moved to a closed single room — Fever with cough, conjunctivitis, and a descending rash in an unvaccinated child who has traveled suggests measles, which is transmitted by the airborne route. Staff who are immune wear a fit-tested N95 respirator, and the child is placed in an airborne infection isolation room or, if none, a closed single room.

Question and rationale by Plainwork. Reference: CDC Guideline for Isolation Precautions; American Academy of Pediatrics

7. A frightened 2-year-old sits on the caregiver's lap for a well-child visit. The nurse is planning the order of the physical assessment. Which approach will give the most reliable heart and respiratory rates?

A. A. Ask the child to lie flat and still on the table during counting.
B. B. Separate the child from the caregiver so the child focuses on the nurse.
C. C. Count respirations and the heart rate first while the child is calm on the caregiver's lap.
D. D. Start with the ear and throat examination so the frightening part is finished early.

C. Count respirations and the heart rate first while the child is calm on the caregiver's lap. — In toddlers, quiet measures such as respiratory rate and heart rate are obtained first, before any intrusive step, while the child is calm and seated with the caregiver. Rates are also counted for a full minute because they vary and may be irregular.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment; Potter & Perry, Fundamentals of Nursing

8. Rectal temperatures are routine for young febrile infants. Which infant should NOT have a rectal temperature taken?

A. A. A 2-month-old being evaluated for fever with no source
B. B. A 5-month-old receiving chemotherapy with a very low neutrophil count
C. C. A 4-month-old with mild diarrhea
D. D. A 7-month-old with a rash on the trunk

B. A 5-month-old receiving chemotherapy with a very low neutrophil count — Rectal thermometry can injure the mucosa and introduce bacteria, which is dangerous when the neutrophil count is very low. Oral, axillary, or temporal routes are used instead for neutropenic clients, and the provider is informed of any fever.

Question and rationale by Plainwork. Reference: Potter & Perry, Fundamentals of Nursing; Oncology Nursing Society

9. While palpating the head and neck lymph nodes, the nurse notes four different findings in four clients. Which finding requires follow-up by the provider?

A. A. A hard, fixed, painless node above the collarbone
B. B. A soft, tender, mobile node under the jaw in a client with a sore throat
C. C. Pea-sized, soft, nontender nodes in the groin
D. D. A warm, tender node beside an infected cut on the hand

A. A hard, fixed, painless node above the collarbone — Nodes that are hard, fixed to underlying tissue, and painless raise concern for malignancy, and a palpable supraclavicular node is considered abnormal until proven otherwise. Soft, mobile, tender nodes usually reflect infection nearby.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment; Bates' Guide to Physical Examination and History Taking

10. A parent tells the nurse, 'I'm worried about the shots my baby is due for today.' Which response best opens a respectful discussion?

A. A. Do you know the daycare will not accept unvaccinated children?
B. B. Children who skip shots can get seriously ill, and you need to understand that.
C. C. Vaccines are very safe, so there is nothing to worry about.
D. D. What worries you most? I would like to hear your thoughts.

> **D.** What worries you most? I would like to hear your thoughts. — An open, non-judgmental invitation lets the parent name the actual concern, which the nurse can then address with accurate information. Dismissing or pressuring the parent damages trust.
>
> Question and rationale by Plainwork. Reference: CDC, Communicating with Parents about Vaccines; Potter & Perry, Fundamentals of Nursing

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