

# Head and Neck Assessment

## Patient Information

Name:

Date of Birth:

Medical Record Number:

Date/Time of Assessment:

## I. General Observations

Head Shape:

Facial Expressions:

## II. Cranial Nerve Assessment

**Cranial Nerve I (Olfactory):**

**Cranial Nerve II (Optic):**

**Cranial Nerve III, IV, VI (Oculomotor, Trochlear, Abducens)**

Pupillary Reaction:

Eye Movements:

**Cranial Nerve V (Trigeminal)**

Sensation:

Motor Function:

**Cranial Nerve VII (Facial):**

**Cranial Nerve VIII (Vestibulocochlear):**

**Cranial Nerve IX, X (Glossopharyngeal, Vagus)**

Swallowing:

Speech:

**Cranial Nerve XI (Accessory):**

**Cranial Nerve XII (Hypoglossal):**

## III. Oral Cavity Examination

Gums and Mucous Membranes:

Teeth:

Tongue:

Throat:

#### **IV. Thyroid Gland Examination**

Palpation:

Swallowing Test:

#### **V. Lymph Node Assessment**

Cervical Lymph Nodes:

Other Lymph Nodes (Specify):

#### **VI. Neck Assessment**

Range of Motion:

Stiffness:

#### **VII. Safety Measures**

Confirm Patient Identification:

Hand Hygiene:

#### **VIII. Additional Notes**

Previous Medical History:

Current Medications:

Patient Concerns/Complaints:

#### **IX. Recommendations and Follow-Up**

Further Evaluation Needed:

Next Follow-Up Appointment:

#### **X. Signature of Healthcare Professional**

Name:

Credentials:

Date/Time: