

## Head, Eyes, Ears, Nose, Throat (HEENT) Assessment

### Introduction

Most physical assessments begin at the top with the head, eyes, ears, nose, and throat (HEENT) assessment. The patient is typically positioned sitting upright, allowing the examiner to systemically work down through each body system. Many of these elements are included in the cranial nerve assessment.

### Assessing the Head

- Inspect the head and face for symmetry.
- Inspect the hair for color, distribution, and texture.
- Palpate the scalp and skull for tenderness and inspect for flaking, lesions, deformities, or tenderness.

### Assessing the Eyes

- Note position and alignment of the eyes and presence of discharge, irritation, and redness.
- Observe the eyelids.
  - Check for drooping of the upper eyelids (ptosis).
  - Check strength of upper eyelids by having patient squeeze their eyes shut. You should not be able to open the patient's eyelids ([cranial nerve VII](#)).
- Inspect sclera and conjunctiva of each eye; sclerae should be white and clear.
- Inspect each cornea, iris, and lens, checking for transparency.
- Compare the pupils and test each reaction to light.
  - Pupils are normally round and vary in size.
  - Use the mnemonic PERRLA (Pupils Equal, Round and Reactive to Light and Accommodation) to test pupil reflexes.
    - Test for reactivity to light.
      - Darken the room and shine a flashlight on each pupil. Normally, pupils constrict with light and dilate in the dark.
    - Test for accommodation (ability of the lens to adjust to objects at varying distances).
      - When moving an object close to the eye, the pupil will constrict; when moving an object away from the eye, the pupil will dilate.
- Assess extraocular movements for abnormalities.
  - Assess the 6 cardinal positions of the gaze: right, right up, right down, left, left up, left down.
  - Check for conjugate gaze (ability of the eyes to move in the same direction at the same time). Eyes normally move in unison, except when converging on an object that is moving closer.
  - Check for nystagmus, a condition in which the eyes move rapidly and uncontrollably side to side (horizontal nystagmus), up and down (vertical nystagmus), or in a circle (rotary nystagmus). This may be seen on lateral movement due to eye fatigue; watch for vertical nystagmus or prolonged nystagmus.
- Screen visual fields in both eyes: medially/laterally, superiorly/inferiorly ([cranial nerve II](#)).
- Perform a visual acuity test with the Snellen Chart ([cranial nerve II](#))

- For fundoscopic examination, use an ophthalmoscope to inspect the ocular fundi.
  - Check transparency of the anterior and posterior chambers.
  - Observe the red reflex of the retina; it can be observed by the clinician 1 foot from the eye in a dimly lit room.

### Assessing the Ears

- Examine each ear using an otoscope. Gently pull the pinna of the ear up and back to straighten the external canal.
  - Inspect the auricle, canal, and ear drum for color, symmetry, elasticity, tenderness, or lesions.
  - Inspect the external ear canal for color, drainage, cerumen (ear wax) buildup, canal edema, erythema, or masses.
  - Assess the tympanic membrane for color, shape, transparency, integrity, bulging, and scarring.
- Test auditory acuity in each ear with the whisper test ([cranial nerve VIII](#)).
  - Stand about 2 feet behind the seated patient.
  - Occlude the non-test ear with a finger.
  - Whisper a combination of three words of numbers and letters and ask the patient to repeat them back to you.
  - If acuity is decreased, perform the Weber and Rinne tests ([cranial nerve VIII](#)).

### Assessing the Nose and Sinuses

- Inspect the external nose for color, size, shape, symmetry, and presence of drainage, tenderness, and masses.
- Using a light and nasal speculum or otoscope, inspect the nasal passages for patency, nasal mucosa for color, nasal septum for deviation, and turbinates for color and swelling.
- Check the patency of each nare by asking the patient to occlude one nare and breathe through the other.
- Assess the patient's sense of smell ([cranial nerve I](#)) with an orange or lemon peel, coffee, vinegar, or essence bottles of vanilla or peppermint.
- Palpate the frontal and maxillary sinuses for tenderness and assess for signs of infection.

### Assessing the Throat (Mouth and Pharynx)

- Inspect:
  - Lips for color, moisture, masses, cracks, sores, fissures, and symmetry.
  - Oral mucosa for color, lesions, dryness/moisture, masses, and swelling.
  - Tongue for color, thickness, moisture, symmetry of movement left and right, and deviations from midline ([cranial nerve XII](#)). Palpate the tongue and floor of the mouth for masses and swelling.
  - Teeth for their general condition and evaluate if any are missing.
  - Gums for color, texture, swelling, retraction, and bleeding.
  - Uvula for movement, position, size, symmetry, and color.
  - Pharynx (hard and soft palate) for color, redness, inflammation, exudate, masses, and lesions.
  - Tonsils for size, color, inflammation, and exudate.
  - Salivary glands (parotid, sublingual, and submaxillary) for patency and signs of inflammation or redness.

- Check the patient's ability to swallow and their gag reflex ([cranial nerves IX and X](#)).
  - The thyroid is typically not visible. Assess for an enlarged thyroid gland at the suprasternal notch.

### Assessing the Neck

- Check neck muscles for symmetry, masses, swelling, and range of motion.
- Palpate cervical lymph nodes for signs of swelling or tenderness; cervical lymph nodes should not be fixed (unmovable) or palpable (unless the patient is very thin). Lymph nodes should be small and freely moving.
- Assess head and neck range of motion.
- Check trapezius muscle strength. Ask the patient to shrug their shoulders against your hands as you apply resistance ([cranial nerve XI](#)).
- Check cervical muscle strength. Ask the patient to turn their chin/jaw against your hand.
- Assess trachea for deviation; it should be midline.
- Evaluate thyroid gland noting enlargement or presence of nodules and masses; it should be smooth.
- Examine the carotid arteries as part of the [cardiac assessment](#), taking care to palpate the carotid arteries one at a time, noting symmetry, strength, amplitude, and presence of an abnormal thrill. Listen for bruits using the diaphragm of your stethoscope.
- Assess for cervical point tenderness along the posterior aspect of the neck.

### PEARLS

- Compare any new findings with the patient's past medical history.
- The elements of the HEENT assessment can be interwoven with the cranial nerve assessment.
- Ptosis may be congenital or caused by a disorder affecting the muscle tendon, muscle, or nerve of the eyelid. Unilateral ptosis with impaired extraocular movement suggests a compressive third cranial nerve palsy.
- A yellowish discoloration of the sclera indicates jaundice.
- Pain with movement of the auricle and tragus of the ear occurs in acute otitis externa (inflammation of the ear canal), but not in otitis media (inflammation of the middle ear).
- In viral rhinitis, the nasal mucosa is often red and swollen; in allergic rhinitis, it may be pale, bluish, or red.
- Tracheal deviation could be a serious sign of tension pneumothorax, pleural effusion, tumor, or goiter.

### References

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