

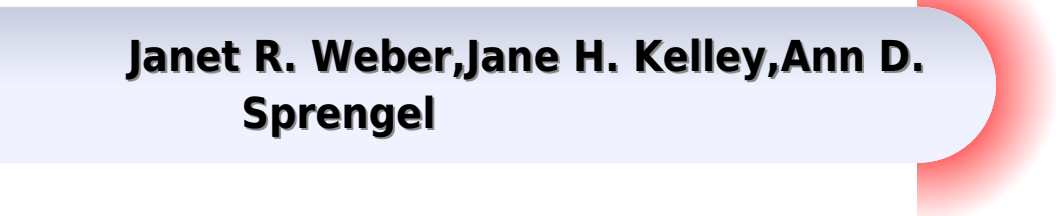
Health Assessment Study Guide

Health History

1. Define health and health assessment
 - a. Health: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity
 - b. Health assessment: health history - gather data from the patient/or family, past medical records, physical and psychological issues, social and cultural associations, environment, developmental level, and spiritual beliefs contributes to the history. Purpose: determine a patient's health status, risk factors, and need for education as a basis for developing a nursing plan of care
2. Differentiate between sign/symptom, subjective/ objective data
 - a. Sign is objective, what the practitioner observes. (color of skin, nails bed, mass on abdomen)
 - b. Symptom is subjective, what the patient reports (pain, headache)
3. Understand and demonstrate when to use open vs closed ended questions
 - a. Open the interview with a broad, open-ended question
 - b. End interview with close-ended questions (think cone)
4. Explain the components of the health assessment
 - a. Health history - interview
 - b. Physical exam
 - c. Purpose: determine a patient's health status, risk factors, and need for education as a basic for developing a nursing plan of care
 - d. Structure/order of the history:
 - i. The identifiers: name, date, age, time, gender, race, occupation, referral source, marital status, relationship status
 - ii. Chief complaint
 - iii. History of present illness
 1. OLDCART
 - iv. Past medical history
 1. Adult medical illness, surgery-procedures, childhood illnesses, trauma, more recent PE-screening. Last menstrual period, meds, allergies, transfusions, emotional status
 - v. Family history
 - vi. Personal and social history - personal status, habits, sexual history, home conditions, occupation, environment, military record, religious preference, access to care, sleep pattern, exercise, living situation, work environment/occupational history, relaxation, hobbies, nutrition, tobacco (PPD),

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**Janet R. Weber, Jane H. Kelley, Ann D.
Sprengel**



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Kelley, 2009-10-01 Now in its Fourth Edition Health Assessment in Nursing is a colorful user friendly introductory level health assessment text for RN level students Targeted to ADN and BSN programs this text presumes no prior knowledge of health assessment and is part of a suite that includes Lab Manual to Accompany Health Assessment in Nursing Nurses Handbook of Health Assessment and Weber Kelley s Interactive Nursing Assessment For this edition the COLDSPA mnemonic which guides students through investigation of symptoms has been revised to show specific applications to content in each chapter A sample application of COLDSPA is presented at the beginning of each chapter s Nursing History section and another accompanies each case study The Frail Elderly chapter has been streamlined with a stronger focus on the normal variations associated with assessment of elderly clients Includes DVD ROM

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