Course Number and Name: NUR 3010 Physical Assessment

Course Coordinator Name and email: Prof. P. Okumakpeyi, POkumakpeyi@citytech.cuny.edu

COURSE SYLLABUS

COURSE CODE & NAME: NUR 3010 Physical Assessment

CREDITS: 3 Credits

CLASS HOURS: 4 Hours per week
2 Hours of lecture, 2 Hours of Laboratory
5 Classes are Online
(Class meeting dates are in Course Schedule or Topical Outline)

PREREQUISITE: NUR 2230. Permission of Department

TEXTS: **Required Text(s)**

Bickley, L.S. (2013). *Bates' Guide to Physical Examination and History Taking (11th Ed.)* Philadelphia: Lippincott Williams & Wilkins.

Recommended Text(s)

American Nurses Association (2010). *Nursing: Scope & Standard of Practice.* Silver Springs, Maryland: American Nurses Association.

American Nurses Association. (2008). *Code of Ethics for Nurses with Interpretive Statements.* Silver Springs, Maryland: American Nurses Association

American Psychological Association. (2010). *Publication Manual of the American Psychological Association* (6th.ed.) Washington, DC: Author.

COURSE DESCRIPTION: Health assessment skills and techniques for the conduct of a comprehensive health history and physical exam are developed for generalist nursing practice. Students critically analyze interview data and assessment findings that relate to the specific needs of individuals concerning age and culture. The normal parameters of health findings are used to compare and contrast the findings. Discussion will include health screening across the life span, and associated health promotion practices as recommended by Healthy People 2020.

COURSE OBJECTIVES:

1. Demonstrate critical thinking skills when using knowledge gained from the study of nursing, humanities, biological and social sciences in the health assessment of culturally diverse clients across the life-span.

2. Utilize 21st century technology in the assessment and documentation of client data.

3. Use therapeutic communication skills in a caring manner, while conducting a health assessment, collecting data and performing health promotion counseling.

4. Conduct a holistic assessment of culturally diverse clients across the life-span.

5. Recognize the importance of collaboration with significant support people and members of the health care team in assisting diverse clients to achieve identified goals.

6. Recognize the role of the Baccalaureate prepared nurse in client assessment.

7. Identify evidence-based interventions for the health assessment of culturally diverse clients.

8. Demonstrate personal and professional accountability when taking a health history and performing a comprehensive physical assessment.

9. Identify strategies to promote life-long learning and participation in nursing organizations.

10. Discuss economic, social and political influences which affect the delivery of health care to clients in a global society.

TEACHING/ LEARNING METHODS:

The components of this course are: 1) theory which includes lecture/discussion, 2) college clinical laboratory, 3) discussion board and 4) online classes.

Theory. In the theory component, students will be expected to read assigned materials, use blackboard to review anatomy and physiology and to complete online assignments. **The online assignment should be completed by the due date in order for the student to be counted as present for that day's**

attendance. If it is not completed by the due date, the student will be given an Absence for that day. Students will attend class prepared to discuss the needs of culturally diverse clients across the life span as they relate to health history taking and the physical assessment. There will be a focus on health promotion and the health promotion recommendations of Healthy People 2020.

Clinical laboratory. There will be on-campus clinical laboratory experiences in a simulated clinical setting. Students will attend the lab prepared to discuss the skills and techniques as described in assigned readings. The Department of Nursing has been granted the use of the College Health Center as the clinical site for this course. Physical assessment skills will be introduced through the use of individual films, accompanied by an instructor demonstration with discussion. Students will conduct a health assessment and practice system physical assessment skills on a student partner. Audiovisuals (Bates Physical Assessment films) will be viewed as an introduction to the assigned system to be covered. Students will be in dyads to practice with direct supervision of an instructor who will observe the practice and skill level achieved by each student. Instructor feedback will be provided during clinical sessions. Students will be encouraged to practice each skill until mastery is achieved.

TEACHING/LEARNING METHODS
Blackboard Partially Online
Case Presentation
Lecture/Discussion
Multimedia
Physical Assessment Laboratory
Role Play
Student Presentation (Power Point)
Written Assignments

METHODS OF EVALUATION AND GRADING:

Attendance. The student will be permitted 2 absences for the semester. Per college policy, absences beyond policy limit will result in a grade, WU.
Participation. Students are expected to be prepared for and to participate actively in class and in online discussions.
Written papers. All written assignments will be submitted via blackboard email, safe assign and/or hard copy on the assigned date. **Late papers will receive a grade penalty of five points per week.** Papers must be typed and adhere to format. **APA style and form must be used for all papers. The Baccalaureate Program in Nursing adheres to the New York City College of Technology/CUNY Policy on Academic Integrity. This policy spells out in detail what constitutes Academic Integrity/Plagiarism.** All students are responsible for following this policy. This detailed policy can be found in the NYCCT 2011-2013 College Catalog (pages 64-65) or on the College Website www.citytech.cuny.edu.
Examinations. There will be a written midterm and final exam. Multiple choice and essay questions may be used in combination.
Evaluation of student clinical performance. Students will be given feedback regarding their performance at each clinical session. The final evaluation of the clinical laboratory will be based on satisfactory performance of physical examination skills. A physical assessment practicum will be held in the final weeks of the laboratory time. Each student will receive an appointment time and must bring a class partner on whom to demonstrate the assessment skills. All students must come to all scheduled classes whether they have an appointment for their practicum or not.

Clinical laboratory. Practicum. A physical assessment practicum will be scheduled for the final weeks of class, during class time. Students will sign up for an appointment. All students must come to all scheduled classes whether they have an appointment for their practicum or not. Each student must bring a class partner to his or her practicum. It does not have to be their assigned class partner. To achieve a satisfactory grade for the practicum physical assessment, a minimum grade of 80% is to be achieved. If a student fails to pass the practicum, there will be (1) additional opportunity to repeat the skill (s) test to achieve a satisfactory grade. Individual appointments will be made based on both the student and instructor's schedule. The evaluation forms for the practicum skills are in the back of this course outline, pages 23-31.

GRADING POLICY

Students must pass both the theory and lab to pass the course. Failure in either part constitutes a failure for the course. The academic grade recorded will be based on the numerical grade from the theory part of the course. The lab portion is pass/fail.

Grading Policy for all courses designated with the prefix NUR

Grade	Definition	Quality Points (Index)
A	93–100%	4.0
A-	90-92.9%	3.7
B+	87-89.9%	3.3
B	83-86.9%	3.0
B-	80–82.9%	2.7
C+	77–79.9%	2.3
C	75–76.9%	2.0
D	60–74.9%	1.0
F	Below 60	0.0

TECHNOLOGY REQUIREMENTS:

This course is .

H **Hybrid.** (Blended). Between 33% and 80% of scheduled class meetings are replaced with onlineactivities or virtual meetings.

Many students have been using Blackboard for many years and are familiar with the system. Below are the suggested minimum prerequisites that students should know/have for taking part in this course.

1. You should have access to and be able to use Internet Explorer, Mazilla Firefox, or Safari browsers**. Blackboard does not fully support AOL.**

2. You will need a City Tech e-mail account and should be comfortable using it. The college provides an e-mail account to all students. **Personal email accounts are not to be used.**
3. You need access to a computer with at least 256 MB RAM.
4. You should have the correct Java version downloaded/ installed – if necessary. The installation is automatic. You only need to do this the first time.

Technology Prerequisites

Many nursing students have been using Blackboard for many years and are familiar with the system. If you are new to Blackboard, Log into the beginners guide to Blackboard and take the student survey. Another option is to visit the open student lab in the General Building, sixth floor, room G 600. The phone number for the lab is (718) 254-8565. Below are the suggested minimum prerequisites that students should know/have for taking part in an online course.

5. The student should have access to and be able to use the Netscape and/or Internet Explorer browsers. Internet Explorer works best with Blackboard. AOL users should maximize the Internet Explorer browser and minimize AOL.
6. The student should have a Citytech email account and should be comfortable using it. **All communication will be through the student's Citytech email account.** The college provides an email account to all students.
7. You need access to a computer with at least 256 MB RAM and an Internet connection via a 56 K modem or, ideally, the college T1 line.

Net Etiquette

1. For private communication with instructor use POkumakpeyi@citytech.cuny.edu.
2. Do not say anything rude, hurtful or disrespectful online.
3. Use the formal rules of English when communicating online
4. Collaboration with other students is not permitted unless specifically requested by the instructor

Students are encouraged to go to G600 the Computer Student Lab, for assistance with Blackboard.

ATTENDANCE AND LATENESS:

College Policy states students can miss 10% of scheduled class time.

Attendance. The student will be permitted 2 absences for the semester. Per college policy, absences beyond policy limit will result in a grade, WU.

NEW YORK CITY COLLEGE OF TECHNOLOGY POLICY ON ACADEMIC INTEGRITY

Students and all others who work with information, ideas, texts, images, music, inventions, and other intellectual property owe their audience and sources accuracy and honesty in using, crediting, and citing sources. As a community of intellectual and professional workers, the College recognizes its responsibility for providing instruction in information literacy and academic integrity, offering models of good practice, and responding vigilantly and appropriately to infractions of academic integrity. Accordingly, academic dishonesty is

prohibited in The City University of New York and at New York City College of Technology and is punishable by penalties, including failing grades, suspension, and expulsion.

The Baccalaureate Program in Nursing adheres to this New York City College of Technology/CUNY Policy on Academic Integrity. This policy spells out in detail what constitutes Academic Dishonesty. All students are responsible for following this policy.

The detailed policy can be found in the NYCCT College Catalogue or on the college website www.citytech.cuny.edu. Two DVD's on plagiarism are available in the NELL Lab, 5th floor Pearl Building.

STUDENT SUPPORT SERVICES

Students with disabilities and/or learning differences are entitled to receive reasonable accommodations to support their learning in the college. After an intake appointment and assessment of student documentation, students who are registered with Student Support Services (A237) are entitled to receive reasonable accommodations to support their learning in the college. Services students may be entitled to include, but are not limited to, one on one tutoring, alternate format textbooks, American Sign Language interpreting, note taking, and access to various computer assistive technology for the enhancement of reading, writing, and creative design. Students may enroll with the program throughout the year and are responsible for alerting faculty to accommodations needed.

ASSIGNMENTS AND GRADING RUBRICS

Laboratory: Final Practical Exam is Pass/Fail

Theory:

Health History: Adult	10%
Health History/Physical Assessment: Child	20%
Midterm Exam	25%
Health Promotion (2020)/Cultural Power Point Presentation	10%
Final Exam	25%
Discussion Board/Online Assignments	10%

UNIT OBJECTIVES

UNIT I

Describe the role of the nurse and client during the interview process.
Identify factors that influence the client interview.
Describe three stages of the interview process.
Discuss the Health History Assessment tool.
Perform a health assessment using the Health History Assessment tool.
Collect information for a health history.

UNIT II
Identify developmental theories across the lifespan.
Discuss basic concepts associated with culturally competent assessments.
Describe the four specific diagnostic techniques for physical assessment.
List the equipment needed to perform a comprehensive physical assessment.

UNIT III
Review client's health history related to the integumentary system.
Use techniques of physical assessment to examine the client's integumentary system.
Review client's health history related to the head, neck and regional lymphatics.
Use techniques of physical assessment to examine the client's head, neck and regional lymphatics.

UNIT IV
Review the anatomy of the internal and external structures of the eye.
Perform an assessment of the eye.
Review client's health history related to the ears, nose, mouth and throat.
Perform an assessment of the ears, nose, mouth and throat.

UNIT V
Identify clients at risk for breast disease.
Review the anatomy of the breast and regional nodes.
Review client's health history related to the breast and regional nodes.
Perform an assessment of the breast and regional nodes.
Review the anatomy of the thorax and lungs.
Describe characteristics of normal and adventitious breath sounds.
Perform an assessment of the thorax and lungs.

UNIT VI
Review the anatomy and physiology of the heart and peripheral vasculature.
Review client's health history related to the cardiovascular system.
Perform an assessment of the heart and peripheral vasculature.

UNIT VII
Review the anatomy and physiology of the abdomen.
Review client's health history related to the gastrointestinal system.
Perform an assessment of the abdomen.
UNIT VIII
Review the anatomy and physiology of the neurological system.
Identify the functions of the cranial nerves.
Review client's health history related to the neurological system.
Perform an assessment of the neurological system.

UNIT IX
Review physical differences of children.

UNIT X
Review differences between pathology and normal age related changes.

TOPICAL OUTLINE

Week	Lecture/ Laboratory Overview	Assignment
Week 1	**Lecture: Introduction & Course Overview** **Introduction of Watson's Theory of Human Caring** **1.** Discussion of curricular organizing framework. 2. Human needs and carative factors 3. Providing a supportive, protective, and/or corrective environment. 4. Communication in a caring manner **The Patient Interview** a. Factors influencing the interview 2. Stages of the interview process 3. Communication techniques 4. Interviewing patients with special needs 5. In class films **Health History** 1. Components of a health history 2. Sexual history **Laboratory:** Health History & Interview	**Bates** **Chapters 1, 2, 3**
Week 2	**Lecture: Reasoning, Assessment & Plan** 1. Holistic health principles 2. Cultural considerations **Laboratory:** Physical assessment techniques and equipment 1. Inspection 2. Palpation 3. Percussion 4. Auscultation 5. List of equipment for physical exam **Special Assessments** 1. Developmental assessment 2. Cultural assessment 3. Nutritional assessment	**Bates** **Chapters 4, 5**
Week 3 ONLINE	**Lecture: Assessment of the Integumentary System** **Laboratory:** Review of anatomy & physiology	**Bates** **Chapter 6**

Changes with age
Techniques of examination
Practice of the skill
Screening for health promotion
Inspection of the integumentary system

Documentation of findings
1. Inspection of the integumentary system
2. Palpation of the integumentary system

Week 4	**Lecture: Assessment of the Head, Neck and Regional Lymphatics**	**Bates Chapter 7**

Laboratory:
Review of anatomy & physiology
Changes with age
Techniques of examination
Practice of the skill
Screening for health promotion
Documentation of findings
1. Inspection of the shape of the head, mouth, teeth.
2. Palpation of the head for contours, masses, depressions
3. Inspection of the face for symmetry, shape and features
4. Palpation and auscultation of the mandible
5. Inspection and palpation of the neck and thyroid gland

Week 5 Online	**Lecture: Assessment of the Eye**	**Bates Chapter 7**

Laboratory:
Review of anatomy & physiology
Changes with age
Techniques of examination
Practice of the skill
Screening for health promotion

Documentation of findings
1. Assess the eye for visual acuity, color vision, visual fields
2. Cardinal fields of gaze
3. Pupil Abnormalities
4. Funduscopy examination of retinal structures
5. Assessment of Optic Disc

Week 6	**Lecture: Assessment of the Ears, Nose, Sinuses**	**Bates Chapter 7**

Laboratory:
Review of anatomy & physiology
Changes with age
Techniques of examination

Practice of the skill
Screening for health promotion

Documentation of findings
1. Auditory Screening- Weber and Rinne Tests
2. Inspection of the external ear
3. Otoscopy assessment of the ear
4. External and internal inspection of the nose
5. Assessment of the sinuses

Week 7 **Lecture: Assessment of the Breasts and Regional Nodes and Thorax and Lungs** **Bates Chapters 8, 10**

Laboratory:
Review of anatomy & physiology
Changes with age
Techniques of examination
Simulations
Practice of the skill will be used
Screening for health promotion for lab

Documentation of findings
1. Inspection of the breasts (breast models)
2. Palpation of the breast (breast models)
3. Characteristics of common breast masses
4. Risk factors for breast cancer
5. Palpation of supraclavicular nodes and axillary nodes

Documentation of findings
1. Inspection of the thorax
2. Assessment: respirations-rate, pattern, depth, symmetry
3. Palpation of the thorax for crepitus, tactile fremitus
4. Percussion of the thorax for hyper-resonance, dullness
5. Auscultation of breath sounds
6. Identification of adventitious breath sounds

Week 8 ONLINE **Lecture: Assessment of the Heart and Peripheral Vasculature System** **Bates Chapter 9, 12**

Laboratory:
Review of anatomy & physiology
Changes with age
Techniques of examination
Practice of the skill
Screening for health promotion

Documentation of findings
1. Warning signs of imminent cardiovascular problems
2. Risk of cardiovascular problems
3. Inspection and factors for cardiovascular disease
4. Palpation of the precordium
5. Assessment of heart sounds
6. Palpation and auscultation of arterial pulses

7. Inspection and palpation of peripheral perfusion

Week 9	**Lecture: Assessment of the Abdomen** **Laboratory:** Review of anatomy & physiology Changes with age Techniques of examination Practice of the skill Screening for health promotion **Documentation of findings** 1. Four quadrant anatomic inspection of the abdomen for contour, symmetry, pigmentation and color, masses, pulsation 2. Auscultation for bowel sounds and vascular sounds 3. Percussion of four quadrants of abdomen 4. Light and deep palpation of the abdomen	**Bates Chapter 11**
Week 10 ONLINE	**Lecture: Assessment of Mental Status & Neurological System/ Cranial Nerves** **Laboratory:** Review of anatomy & physiology Changes with age Techniques of examination Practice of the skill Screening for health promotion **Documentation of findings** 1. Function and Assessment of the cranial nerves 2. Cognitive mental status screening	**Bates Chapters 16, 17**
Week 11	**Lecture: Assessment of Mental Status & Neurological System/Sensory System** 1. Pain, temperature 2. Vibration, stereognosis 3. Assessment of reflexes 4. Assessment of cerebellar function	**Bates Chapters 16, 17**
Week 12 ONLINE	**Lecture: Assessment of Children** 1. Physical Differences 2. Evaluating Children **Assessment of the Oldest Old** 1. Developmental needs 2. Theory of aging 3. Social & economic needs	**Bates Chapter 18, 20**
Week 13 5/6/15	**Practice/Review/Presentations** **Practicum by appointment.** All students are required to attend class	

Week 14 **Practice/Review/Presentations**
Practicum by appointment
All students are required to attend class

Week 15 **Final Examination**
Practicum by appointment

REFERENCES

Bersamin PhD, A., Stafford, PhD, R. S., & Winkleby, PhD, M. A. (2009). Predictors of Hypertension Awareness, Treatment, and Control in Mexican-American Women and Men. *Journal of General Internal Medicine24(*3), 521-7.

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Portes, A., Fernandez - Kelly, P. & Light, D. (2012, January 1). Life on the edge: immigrants confront the American health system. *Ethical and Racial Studies 35(*1*)*, 3-22.

Purnell, L.D. (2009). *Guide to Culturally Competent Health Care* (2nd ed.). Philadelphia: F.A. Davis Co.

Website for viewing PA films: At home: http://nursing.citytech.cuny.edu
On campus: http://10.13.60.15

User name: nu
Password: nu

PHYSICALASSESSMENT

NUR 3010

HEAD, FACE, MOUTH AND NECK

1. Shape of skull and head.
2. Proportion and position.
3, Hair
4. Scalp

1. Skull
2. Scalp

1. Shape and symmetry of face
2. Face
3. Neck

1. Lips
2. Buccal mucosa
3. Gums
4. Teeth
5. Parotid ducts
6. Submandibular ducts
7. Tongue – quality and movement
8. Saliva
9. Hard Palate
10. Soft palate – quality and movement
11. Tonsils

1. Neck Symmetry
2. Trachea

1. Masses
2. Nodes
   a) Preauricular
   b) Posterior auricular
   c) Occipital
   d) Tonsillar
   e) Submandibular
   f) Submental
   g) Superficial cervical chain
   h) Posterior cervical chain
   j) Deep cervical chain
   k) Supraclavicular nodes
3. Thyroid – anterior and posterior method

PHYSICAL ASSESSMENT

NUR 3010

EYES

Visual Acuity
Snellen Chart

1. Eyes, Eyelids and Eyebrows
   a) Alignment and symmetry
   b) Position and distribution of lashes
   c) Abnormalities
2. Lacrimal Ducts
   a) If appropriate – test for tearing
3. Conjunctive and Sclera
4. Cornea and Lens for Opacity
5. Pupil and Iris

1.Visual Fields
2. Pupil Response to Light
3. Pupil Response to Accommodation
4. Eye Alignment
5. Extra ocular Muscle Function

FUNDUS OF EYE
Examine with Ophthalmoscope
Inspect
Procedure:
   a) Place opposite hand on forehead of client
   b) Use hand to eye alignment
   c) Locate red reflex
   d) Focus ophthalmoscope
   e) Locate blood vessels of retina
   f) Assess optic disc size, shape and color
   g) Follow vessels from disc to 4 quadrants
   h) Observe size and structure of vessels
   i) Examine surrounding retina
   j) Observe macula

PHYSICAL ASSESSMENT

NUR 3010

EARS, NOSE AND SINUSES

External Ears

1. Auricle
2. External Canal

1. For Tenderness

Tympanum and External Canal

1. Examine with Otoscope
   a. Cerumen
   b. Canal
   c. Tympanum
      1) Color
      2) Shape
      3) Position

Procedure:
   1. Straighten ear canal
   2. Inspect
   3. Insert otoscope

Hearing

1. Estimate Auditory Acuity
2. Lateralization (Weber Test)
3. Bone/Air Conduction (Rinne Test)

Nose and Sinuses

1. Nose Symmetry
2. Interior Nasal Passage
   a) Mucosa
   b) Septum
   c) Turbinates

1. Patency of Nose

1. Frontal Sinus
2. Maxillary Sinus

PHYSICAL ASSESSMENT

NUR 3010

BREAST AND AXILLAE

Female Breast
1. Size
2.Shape
3. Symmetry
4. Color
5. Surfaces
6. Contour
7. Discharges

(Using Side to Side or
Circular Method)
1. Firmness
2. Abnormalities

Male Breast

1. Areola
2. Nipples

1. Abnormalities

Axillae

1. Skin Surfaces

1. Supraclavicular
2. Subclavicular
3. Central
4. Lateral
5. Pectoral
6. Subscapular (posterior)

PHYSICAL ASSESSMENT

NUR 3010

THORAX AND LUNGS

Posterior Chest

1. Shape
2. Symmetry
3. Respiration

1. Thoracic Expansion
2. Areas of Pain/Discomfort
3. Tactile Fremitus

1. Quality of Sounds
2. Type

1. Quality of Sounds
2. Location of Sounds
3. Type of Sound

Anterior Chest

1. Shape
2. Symmetry
3. Respiration

1. Thoracic Expansion
2. Areas of Pain/Discomfort
3. Tactile Fremitus

1. Quality of Sound
2. Type

1. Quality of Sounds
2. Location of Sounds
3. Type of Sound

PHYSICAL ASSESSMENT

NUR 3010

ABDOMEN

1. Skin
2.Contour
3. Symmetry

1. Bowel Sounds

2. Vascular Bruits
   a) R and L Iliac Artery-Lower quadrant
   b) R and L Renal Artery-upper quadrant
   c) Aorta-Midline

1. Areas to percuss
   a) Mid-Lower quadrant
   b) Liver (upper and lower borders)
   c) Gastric Air Bubble
   d) Spleen

1. Four Quadrants
   a) Light Pressure
   b) Deep Pressure
   c) Rebound Tenderness

2. Left Liver Border
   a) Liver Tenderness

3. Spleen

4. Kidney

5.Aortic Pulsation

PHYSICAL ASSESSMENT

NUR 3010

NECK, VESSELS AND HEART

Carotid Artery
1) Pulsations

1) Pulsations
2) Fullness
3) Rate
4) Rhythm
5) Thrills

1) Bruits

External Jugular Vein
1) Pulsations
2) Fullness

Chest and Precordium
1) Symmetry
2) Pulsations

1) Pulsations
2) Thrills
3) Areas of palpation
a) Aortic Area
b) Pulmonic area
c) Right Ventricular Area
d) Apex of Heart (PMI)
e) Epigastric Area

1. Assess
a) 1st and 2nd heart sounds
b) Extra heart sounds
c) Murmurs

2. Areas for Auscultation —
a) Aortic Area
b) Pulmonic Area
c) Right Ventricular area
d) Apex of Heart (PMI)

PHYSICAL ASSESSMENT

NUR 3010

MOTOR SYSTEM AND REFLEXES

1. Gait
   a) Arm-swing
   b) Body Posture

2. Cerebellar Function
   a) Heel to Toe (Tandem Walking)
   b) Romberg Test
   c) Rapid Hand Movements
   d) Touch Fingers to Thumb
   e) Point-to Point Testing
      1) Finger to Nose
      2) Heel to Foot
   f) Rapid Foot Movements

3. Lower Extremity Strength

   a) Hop in Place
   b) Shallow Knee Bends
   c) Planter Flexion
   d) Dorsiflexion

4. Upper Extremity Strength
   a) Arms Extended and Parallel
   b) Grip Test

5. Reflexes
   a) Biceps
   b) Triceps Reflex
   c) Brachioradialis Reflex
   d) Patellar Reflex
   e) Ankle Reflex
   f) Planter Reflex
   g) Ankle Clonus

PHYSICAL ASSESSMENT

NUR 3010

CRANIAL NERVES AND SENSORY FUNCTION

Olfactory
a) Identify Aromatic Substance

Optic
a) Visual Acuity
b) Visual Field Confrontation

Examination of Optic Disk

Oculomotor/ Trochlear/ Abduces
a) Pupil Reaction to Light
b) 6 Cardinal Fields of Vision
c) Pupil Accomodation

Trigeminal
a) Palpate/Observe/ Jaw Movement
b) Sharp/Dull; Light Touch

Facial
a) Inspect for Tics
b) Assess Movement of Eyebrows
Eyelids, lips and cheeks

Acoustic
a) Assess Auditory Acuity
b) Lateralization-Weber Test
c) Air-bone Conduction-Rinne Test

Glossopharyngeal/ Vagus
a) Observe Palate Function
b) Assess Gag Reflex

Spinal Assessory
a) Evaluate Strength of Trapezius
And Sternoclaidomastoid Muscles

Hypoglossal
a) Inspect Tongue for Deviations,
Assymetry and Atrophy

Assess Bilateral Sensations of Arms,
Anterior Trunk and Legs
a) Safety Pin
b) Cotton Wisps

NEW YORK CITY COLLEGE OF TECHNOLOGY
DEPARTMENT OF NURSING

NUR 3010

RUBRICS
FOR ONLINE ASSIGNMENTS

CONTENT	50%
ORGANIZATION	25%
STYLE/MECHANICS (SPELLING, GRAMMAR, PUNCTUATION, BIBLIOGRAPHY AND CORRECT USE OF APA FORMAT)	25%
TOTAL	100%

NEW YORK CITY COLLEGE OF TECHNOLOGY
DEPARTMENT OF NURSING

NUR 3010

RUBRICS FOR THE HEALTH HISTORY OF AN ADULT

INITIAL INFORMATION/IDENTIFYING DATA	5%
PRESENT ILLNESS	10%
PAST MEDICAL HISTORY	5%
PAST SURGICAL HISTORY	5%
FAMILY HISTORY (GENOGRAM: Narrative & Diagram)	5%
PSYCHOSOCIAL HISTORY	5%
REVIEW OF SYSTEMS (SUBJECTIVE DATA)	15%
STAGE OF DEVELOPMENT	5%
CULTURALLY APPROPRIATE CARE	5%
DIETARY HISTORY	5%
PROBLEM LIST (PRIORITIZE)	10%
SUMMARY (PRIORITIZE)	15%
STYLE/MECHANICS (SPELLING, GRAMMAR, PUNCTUATION, ORGANIZATION, BIBLIOGRAPHY AND CORRECT USE OF APA FORMAT)	10%
TOTAL	100%

NEW YORK CITY COLLEGE OF TECHNOLOGY
DEPARTMENT OF NURSING

NUR 3010

HEALTH HISTORY OF AN ADULT

INITIAL INFORMATION

1. Date and Time of History

IDENTIFYING DATA

1. Name
2. Address
3. Age
4. Date of birth
5. Birthplace
6. Gender
7. Marital Status
8. Race
9. Ethnic Identity/Culture
10. Religion and Spirituality
11. Occupation
12. Health Insurance
13. Source of history
14. Source of referral (if appropriate)

RELIABILITY:

CHIEF COMPLAINT (s) (CC): to establish the major specific reason for the individual's seeking professional health attention.

PRESENT ILLNESS (PI): to obtain all details related to the chief complaint.

1. Onset
   a. Date of onset
   b. Manner of Onset
   c. Precipitating and predisposing factors related to onset (emotional disturbance, physical exertion, fatigue, pregnancy, environment, injury, infection, toxins and allergens, or therapeutic agents)

2. Characteristics
   a. Character (quality, quantity, consistency, or other)
   b. Location and radiation (i.e. pain)
   c. Intensity or severity
   d. Timing (continuous or intermittent)

3. Course since onset
   a. Incidence
      (1) Single acute attack
      (2) Recurrent acute attacks
      (3) Daily occurrences
      (4) Periodic occurrences
      (5) Continuous chronic episodes
   b. Progress (better, worse, unchanged)
   c. Effect of therapy

Past Medical History:

Childhood:
1. Illness
2. Immunizations
3. Allergies

Adult:
1. Illness (physical, mental and emotional)
2. Substance Use (Alcohol, Smoking, Drug Abuse)
3. Adverse Drug Reactions
4. Medications: Name, dose, route, frequency, duration, and reason for administration.
5. Herbal Supplement/Over the Counter Drugs

Past Surgical History
1. Hospitalization
2. Outpatient Care
3. Transfusions

Family History:
1. Immediate Family (Narrative)
2. Extended Family (Narrative)
3. Genogram

Psychosocial History:
1. Occupational History
2. Education
3. Financial Background
4. Roles and Relationships
5. Children and ages
6. Sexual History
7. Exercise
8. Pets
9. Exposures (Asbestos, 9/11)

REVIEW OF SYSTEMS (ROS): to elicit information concerning any potential health problem.

Subjective Data

1. General – overall state of health, fatigue recent and/or unexplained weight gain or loss, period of time for either, contributing factors (change of diet, illness, and altered appetite), exercise tolerance, fevers (time of day), chills, night sweats (unrelated to climatic conditions), frequent infections, general ability to carry out activities of daily living.

2. Skin – pruritus, pigment or other color changes, acne, eruptions, rashes (location), tendency to bruising, petechiae, excessive dryness, general texture, disorders or deformities of nails, hair growth or loss, hair color change (for adolescent, use of hair dyes or other potentially toxic substances, such as hair straighteners).

3. Head, Eyes, Ears, Nose, Throat (HEENT)– headaches, dizziness, injury (specific details). Eyes: visual problems (ask about behaviors that indicate blurred vision, such as bumping into objects, clumsiness, sitting very close to television, holding a book close to the face, writing with head near desk, squinting, rubbing the eyes, bending the head in an awkward position), "cross-eye" (strabismus), eye infections, edema of lids, excessive tearing, use of glasses or contact lenses, date of last optic examination. Ears: earaches, discharge, and evidence of hearing loss (ask about behaviors such as need to repeat requests, loud speech, inattentive behavior), results of any previous auditory testing. Nose and sinuses: nosebleeds (epistaxis), constant or frequent running or stuffy nose, nasal obstruction (difficulty in breathing), sense of smell, sinus trouble. Throat: mouth breathing, gum bleeding, toothaches, tooth-brushing, use of fluoride, last visit to dentist, sore throats, difficulty in swallowing, choking (especially when chewing food, which may be caused by poor chewing habits), hoarseness or other voice irregularities.

4. Neck & Lymphatics – pain, limitation of movement, stiffness, difficulty in holding head straight (torticollis), thyroid enlargement, enlarged nodes or other masses.

5. Chest – breast enlargement, discharge, masses, enlarged axillary nodes (breast self –examination).

6. Respiratory – chronic cough, frequent colds (number per year), wheezing, shortness of breath at rest or on exertion, difficulty in breathing, sputum production, infections pneumonia, tuberculoses), date of last chest x-ray examination, date of last tuberculin test and type of reaction, if any.

7. Cardiovascular– cyanosis or fatigue on exertion, history of heart murmur or rheumatic fever, anemia, date of last blood count, blood type, recent transfusion.

8. Gastrointestinal –appetite, food tolerance, elimination habits, belching, flatulence, recent change in bowel habits (blood in stools, change of color, diarrhea, or constipation) nausea, and vomiting (if not associated with eating, it may indicate brain tumor or increase intra-cranial pressure) date and result of last colonoscopy.

9. Urinary – pain on urination, frequency, hesitancy, urgency, hematuria, nocturia, polyuria, unpleasant odor of urine, direction and force of stream, discharge, change in size of scrotum, date of last urinalysis, sexually transmitted disease (type of treatment) and testicular self-examination.

10. Genital- **Female:** menarche, date of last menstrual period, regularity or problems with menstruation, vaginal discharge, pruritus, date and result of last Pap test, date and result of last mammogram. **Male:** hernias, discharge from or sores on the penis, testicular pain or masses, sexually transmitted disease (type of treatment), birth control methods.

11. Peripheral Vascular- Intermittent claudication, leg cramps, varicose veins, past clots in the veins.

12. Musculoskeletal- range of motion.

13. Neurologic- history of head injury, seizure, tremor, loss of consciousness, balance problems, memory problems, and sense of touch and temperature.

14. Hematologic- Anemia, easy bruising or bleeding, past transfusions and /or transfusion reactions.

15. Endocrine-Thyroid trouble, heat or cold intolerance, excessive sweating, excessive thirst or hunger, change in glove or shoe size.

16. Psychiatric- Nervousness, tension, mood, including depression, memory change, suicide attempts, if relevant.

STAGE OF DEVELOPMENT	**ACTUAL FINDINGS**
ERICKSON	

Culturally Appropriate Care

Describe how you made your client feel more comfortable during the interview/health history.

DIETARY HISTORY

A nutritional assessment is an essential part of a complete health appraisal. Its purpose is to evaluate the client's nutritional status – the state of balance between nutrient expenditure and need.

What is the family's usual mealtime?
Do family members eat together or at separate times?
Who does the family grocery shopping and meal preparation?
How much money is spent to buy goods each week?
How is most food prepared – baked, broiled, fried, and other?
How often does the family or the client eat out?
What kind of restaurants do you go to?
What kind of foods do you typically eat at restaurants?
Do you eat breakfast?
Where do you eat lunch?
What are your favorite foods, beverages, and snacks?
What is the average amount eaten each day?
What foods are artificially sweetened?
What are your snacking habits?
When are sweet foods usually eaten?
What are your tooth brushing habits?
What special cultural practices are followed?
What ethnic foods are eaten?
What foods and beverages do you dislike?
Do you use bottled water for drinking?
Do you use a microwave for cooking and reheating foods?
How would you describe your usual appetite (hearty eater, picky eater)?
What are your feeding habits (eats by self, needs assistance, and special devices)?
Do you take vitamins or other supplements; do they contain iron or fluoride?
Are there any known or suspected food allergies?
Are you on a special diet?
Have you lost or gained weight recently?
Do you have any feeding problems (difficulty swallowing), any dental problems or appliances, such as dentures, that affect eating?

PROBLEM LIST

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

SUMMARY OF RECOMMENDATIONS

1._____

2._____

3._____

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9._____

10._____

Carefully check your paper, using the RUBRICS, before submitting it to SAFE ASSIGN.

NEW YORK CITY COLLEGE OF TECNOLOGY
DEPARTMENT OF NURSING

NUR 3010

RUBRICS FOR THE HEALTH HISTORY & PHYSICAL EXAMINATION OF A CHILD

INITIAL INFORMATION/IDENTIFYING DATA	5%
PRESENT ILLNESS	10%
PAST MEDICAL HISTORY	5%
PAST SURGICAL HISTORY	5%
FAMILY HISTORY (GENOGRAM: Narrative & Diagram)	5%
PSYCHOSOCIAL HISTORY	5%
REVIEW OF SYSTEMS (SUBJECTIVE DATA)	10%
GENERAL SURVEY/PHYSICAL ASSESSMENT (OBJECTIVE DATA)	10%
STAGE OF DEVELOPMENT	5%
TIPS FOR EXAMINING THE CHILD	5%
DIETARY HISTORY	5%
PROBLEM LIST (PRIORITIZE)	10%
SUMMARY (PRIORITIZE)	10%
STYLE/MECHANICS (SPELLING, GRAMMAR, PUNCTUATION, ORGANIZATION, BIBLIOGRAPHY AND CORRECT USE OF APA FORMAT)	10%
TOTAL	100%

NEW YORK CITY COLLEGE OF TECHNOLOGY
DEPARTMENT OF NURSING

NU 3010

HEALTH HISTORY AND PHYSICAL EXAMINATION OF A CHILD

INITIAL INFORMATION

1. Date and Time of History

IDENTIFYING DATA

1. Name/nickname
2. Address
3. Age
4. Date of birth
5. Birthplace
6. Gender
7. Race
8. Ethnic Identity/Culture
9. Religion
10. Health Insurance
11. Source of history
12. Source of referral (if appropriate)

RELIABILITY:

CHIEF COMPLAINT (s) (CC): to establish the major specific reason for the individual's seeking professional health attention.

PRESENT ILLNESS (PI): to obtain all details related to the chief complaint.

1. Onset
   a. Date of onset
   b. Manner of Onset
   c. Precipitating and predisposing factors related to onset (emotional disturbance, physical exertion, fatigue, pregnancy, environment, injury, infection, toxins and allergens, or therapeutic agents)

2. Characteristics
   a. Character (quality, quantity, consistency, or other)
   b. Location and radiation (i.e. pain)
   c. Intensity or severity
   d. Timing (continuous or intermittent,)

3. Course since onset
   a. Incidence
      (1) Single acute attack
      (2) Recurrent acute attacks
      (3) Daily occurrences
      (4) Periodic occurrences
      (5) Continuous chronic episodes
   b. Progress (better, worse, unchanged)
   c. Effect of therapy

Past Medical History:

1. Illness (physical, mental and emotional) (onset, symptoms, course, termination) (occurrence of complaints) (incidence of disease in other family members or in community)
2. Immunizations
3. Allergies (Hay fever, asthma, eczema) (Unusual reaction to foods, drugs, animal, plants or household products)
4. Substance Use (Alcohol, Smoking, Drug Abuse)
5. Adverse Drug Reactions
6. Medications: Name, dose, route, frequency, duration, and reason for administration.
7. Herbal Supplement/Over the Counter Drugs
8. Pregnancy (maternal) Importance of perinatal history depends on the child's age; the younger the child, the more important the perinatal history.
   a. Number (gravida/para)
   b. Labor and Delivery can be significant to the infant's health history i.e. prematurity, birth trauma.
   c. Weight and Length
   d. Time of regaining birth weight
   e. Apgar score
   f. Presence of congenital anomalies
   g. Date of discharge from nursery
9. Pregnancy (if appropriate)

Past Surgical History

1. Hospitalization
2. Outpatient Care
3. Transfusions
4. Emotional response to previous hospitalization
5. Circumstances and nature of injuries.

Family History:

1. Immediate Family
2. Extended Family
3. Genogram

Psychosocial History:

1. Occupational History
2. Education
3. Financial Background
4. Roles and Relationships
5. Children and ages
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7. Exercise
8. Pets
9. Exposures (Asbestos, 9/11)

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4. Neck & Lymphatics – pain, limitation of movement, stiffness, difficulty in holding head straight (torticollis), thyroid enlargement, enlarged nodes or other masses.

5. Chest – breast enlargement, discharge, masses, enlarged axillary nodes (breast self –examination).

6. Respiratory – chronic cough, frequent colds (number per year), wheezing, shortness of breath at rest or on exertion, difficulty in breathing, sputum production, infections pneumonia, tuberculoses), date of last chest x-ray examination, date of last tuberculin test and type of reaction, if any.

7. Cardiovascular– cyanosis or fatigue on exertion, history of heart murmur or rheumatic fever, anemia, date of last blood count, blood type, recent transfusion.

8. Gastrointestinal –appetite, food tolerance, elimination habits, belching, flatulence, recent change in bowel habits (blood in stools, change of color, diarrhea, or constipation) nausea, and vomiting (if not associated with eating, it may indicate brain tumor or increase intra-cranial pressure) date and result of last colonoscopy.

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11. Peripheral Vascular- Intermittent claudication, leg cramps, varicose veins, past clots in the veins.

12. Musculoskeletal- range of motion.

13. Neurologic- history of head injury, seizure, tremor, loss of consciousness, balance problems, memory problems, and sense of touch and temperature.

14. Hematologic- Anemia, easy bruising or bleeding, past transfusions and /or transfusion reactions.

15. Endocrine-Thyroid trouble, heat or cold intolerance, excessive sweating, excessive thirst or hunger, change in glove or shoe size.

16. Psychiatric- Nervousness, tension, mood, including depression, memory change, suicide attempts, if relevant.

PHYSICAL EXAMINATION: Objective Data

1. General Survey- Observe patient's general state of health, height, build, and sexual development. Obtain weight. Note posture, gait, and personal hygiene.

2. Vital Signs.
3. Skin- Observe skin of face. Identify lesions, noting their location, distribution, arrangement, type and color. Inspect and palpate.

4. Head, Eyes, Ears, Nose, Throat (HEENT)- Head: Examine the hair, scalp, skull, and face. Eyes: Check visual acuity and screen visual fields. Ears: Inspect auricles, canals, and drums. Nose and sinuses: Examine the external nose. Using a light and a nasal speculum, inspect the nasal mucosa, septum, and turbinates. Throat: Inspect lips, oral mucosa, gums, teeth, tongue, palate, tonsils and pharynx.

5. Neck- Inspect and palpate the cervical lymph nodes and thyroid gland.

6. Back- Inspect and palpate the spine and muscles of the back.

7. Posterior Thorax and Lungs-Inspect, palpate, and percuss the chest. Listen to breath sounds.

8. Breasts, Axillae, and Epitrochlear Nodes- Inspect the breasts of an adolescent with her arms relaxed, then elevated, and then with her hands pressed on her hips. In either sex, inspect the axillae and feel for the axillary nodes. Feel for the epitrochlear nodes.

9. Anterior Thorax and Lungs-Inspect, palpate and percuss the chest. Listen to breath sounds.

10. Cardiovascular System-Observe the jugular venous pulsations. Inspect and palpate the carotid pulsations. Listen for carotid bruits. Listen for any abnormal heart sounds or murmurs.

11. Abdomen-Inspect, auscultate and percuss the abdomen. Palpate lightly, then deeply.

12. Lower Extremities-Examine the legs, assessing three systems (Peripheral Vascular System, Musculoskeletal System, Nervous System) with the patient supine, standing.

13. Nervous-Mental Status, Cranial Nerves, Motor System, Sensory System and Reflexes.

NORMAL FINDINGS (Use textbooks) **ACTUAL FINDINGS (Observation of child)**

Stage of Development (ERICKSON):

Physical

Motor

Social (Interaction with peers and adults. Participation in organized activities.)

Mental (Present grade school, scholastic achievement.)

Needs Assessment

Rest/Sleep

(1) Hours of sleep and arising.
(2) Duration of nocturnal sleep/naps

Elimination

(1) Age of toilet training
(2) Pattern of stools and urination; occurrence of enuresis

Activity

(1) Type of exercise

Psychosocial

a. Maternal-child interaction
b. Paternal-child interaction
c. Guardian (Grandparent)-child interaction
d. Cultural factors
e. Behavioral patterns
    (1) Nail biting
    (2) Thumb sucking
    (3) Pica
    (4) Rituals, such as "security blanket"
    (5) Unusual movements (head banging, rocking)
    (6) Temper tantrums
f. Social habits
    (1) Use/abuse of drugs, alcohol, coffee, or cigarettes
    (2) Usual disposition; response to frustration

Tips for Examining the Child

Describe what you did differently when examining the child.

DIETARY HISTORY

A nutritional assessment is an essential part of a complete health appraisal. Its purpose is to evaluate the client's nutritional status – the state of balance between nutrient expenditure and need.

What is the family's usual mealtime?
Do family members eat together or at separate times?
Who does the family grocery shopping and meal preparation?
How much money is spent to buy goods each week?
How is most food prepared – baked, broiled, fried, and other?
How often does the family or the client eat out?
What kind of restaurants do you go to?
What kind of foods do you typically eat at restaurants?
Do you eat breakfast regularly?
Where do you eat lunch?
What are your favorite foods, beverages, and snacks?
What is the average amount eaten each day?
What foods are artificially sweetened?
What are your snacking habits?
When are sweet foods usually eaten?
What are your tooth brushing habits?
What special cultural practices are followed?
What ethnic foods are eaten?
What foods and beverages do you dislike?
Do you use bottled water for drinking?
Do you use a microwave for cooking and reheating foods?
How would you describe your usual appetite (hearty eater, picky eater)?
What are your feeding habits (feeds self, needs assistance, and special devices)?
Do you take vitamins or other supplements; do they contain iron or fluoride?
Are there any known or suspected food allergies?
Are you on a special diet?
Have you lost or gained weight recently?
Do you have any feeding problems (difficulty swallowing); any dental problems or appliances, such as dentures, that affect eating?

PROBLEM LIST

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

SUMMARY OF RECOMMENDATIONS

1._____

2._____

3._____

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5._____

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7._____

8._____

9._____

10._____

Carefully check your paper, using the RUBRICS, before submitting it to SAFE ASSIGN.

RUBRICS
FOR THE
HEALTH PROMOTION (2020)/CULTURAL PRESENTATION

Percent of Theory Grade: 10%.

Title: Health Promotion Plan for *the Leading Health Objective* (*Leading Health Objective* that you have chosen is to be here) for Culture (*Culture* you are writing about is to be here).

Purpose: Students will create an original power point that explores the practices, beliefs, and customs of a culture, which will serve to strengthen cultural competency in interviewing, history taking and planning to promote health in diverse clinical settings in the USA. Students will develop a health promotion plan that may help close the gap in disparities in health care in the USA.

Required Format: (Power Point Presentation)

- Style/Mechanics (Spelling, Grammar, Punctuation, Organization and Correct Use of APA Format)
- Double spaced
- Font-12-point/Style-Arial
- References should not be more than 5 years old (at least 5 or more) **(20%)**

Process: Students will:

- Select a Culture in class.
- Identify and provide a brief synopsis of the (1) practices, (2) beliefs, (3) values and (4) customs of the Culture. Include (5) this cultures meaning of health and illness that may impact the interview and/or health history data collection process. **(25%)**

  Class Discussion: <u>February 4, 2015</u>
  Presentation Due: <u>May 6. 2015</u>

- Select a 2020 **<u>Leading Health Objective</u>** (see page 51) for your **selected culture**.
- Describe the **<u>Leading Health Objective</u>** and discuss why you selected this **Objective** for your **<u>selected culture</u>**. **(10%)**

  Class Discussion: <u>February 4, 2015</u>
  Presentation Due: <u>May 6, 2015</u>

- **<u>Outline</u>** five or more specific considerations for the interview and health history of a client of your **<u>selected culture</u>** in order to ensure that your interventions are culturally specific to the client. **(15%)**

Class Discussion: April 1, 2015
Presentation Due: May 6, 2015

- Develop a **Health Promotion Plan*** for the **leading health objective** that you have chosen, making sure the **Plan** is specific to the **selected culture**. The **Health Promotion Plan** should include (1) health promotion practices or behaviors of the people of the **selected culture** that need to be adapted or supported, (2) measures to improve the quality of life and life expectancy of the people of the **selected culture** and measures to close the gap that may exist for that cultural group. **(20%)**

Class Discussion: April 1, 2015
Presentation Due: May 6, 2015

- **In summary: Using your own words**, write about your progress in achieving understanding of what constitutes cultural competency in nursing practice. **(10%)**

The Power Point Presentation Due Date is May 6, 2015. Each student will present the Power Point in class on May 6, 2015.

In order to receive the 10% towards the final grade, each student will participate in the Class Discussions on September 10th and November 5th; the Power Point will be presented in class on May 6, 2015; and everything in the Rubrics will be included in the Power Point.

There will be a late penalty of 20 points if you do not participate in the Class Discussions on February 4th and April 1st or present your power point on May 6, 2015

.

***Suggestions for Health Promotion Plan:** Create a Community Center, Hospital Based Clinic or Community Health Clinic.

Lecture Guide

Healthy People 2020-Understanding and Improving Health

Background Information-Source (http://web.health.gov/healthypeople)

Healthy People 2020 Goals

The goals of Healthy People 2020 are designed to achieve:

- Increase years of life (life expectancy) and quality of life.

  a) Life expectancy can be achieved by helping individuals gain knowledge, motivation and opportunities that they need to make informed decisions about their health.
  b) Quality of life reflects a general sense of happiness and satisfaction with our lives and environment. General quality of life encompasses all aspects of life, including health, recreation, culture, rights, values , beliefs, aspirations, and the conditions that support a life containing these elements.

- Eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.

Premise: "The health of the individual is closely linked to community health-the health of the community and environment in which individuals live, work, and play. Likewise, community health is profoundly affected by the collective beliefs, attitudes, and behaviors of every one who lives in the community."

LEADING HEALTH OBJECTIVES

1. Physical Activity
2. Nutrition and Weight Status
3. Tobacco Use
4. Substance Abuse
5. Sexually Transmitted Diseases
6. Mental Health and Mental Disorders
7. Injury and Violence Prevention
8. Environmental Health
9. Immunization and Infectious Diseases
10. Access to Health Services

The Interview

The health history interview is a conversation with a purpose.
The purpose of the conversation is threefold: (1) to establish a trusting relationship; (2) to gather information; and (3) to offer information.

The interviewing process that generates client information requires knowledge of what you need to obtain, the ability to get that information, and interpersonal skills to allow you to respond to the client's feelings.

Considerations for taking a comprehensive health history

Environmental factors: Privacy, Space, Noise, Timing
Personal factors: Age, Cognitive
Special needs: Hearing, Fear, Age, Culture. Language
The professional—your own personality is key to making the client feel comfortable, trusting and provide information.

Exploring the Client's Perspective

- The client's thoughts about the nature of the cause of the problem.
- The client's feelings, especially fear, about the problem
- The client's expectations of the clinician and health care
- The effect of the problem on the client's life.
- Prior personal or family experienc3s that are similar.
- Therapeutic responses the client has already tried.

Techniques of Interviewing

Active listening- listening closely to what the patient says and being aware of the client's emotional state- using verbal and nonverbal skills to encourage the speaker to continue
Adaptive questioning – learning to adapt your questions to the client's verbal and nonverbal cues.

Adaptive Questioning: Options for Clarifying the Client's Story

- Direct questioning-from general to specific
- Questioning to elicit a graded response
- Asking a series of questions, one at a time
- Offering multiple choices for answers
- Clarifying what the client means

Nonverbal Communication – "Read the client"
Facilitation - nod your head, eye contact, Mm-hmm, go on.
Echoing - Repetition of the client's words encourages the client to express both factual details and feelings

Empathic responses - "I understand", That sounds upsetting", "You seem sad"
Validation - Legitimize or validate the client's emotional experiences
Reassurance – Identify and accept the client's feelings without offering reassurance at that moment.
Summarization –Giving a capsule summary lets the client know that you have been listening carefully.

GUIDELINES FOR WORKING WITH AN INTERPRETOR

- Choose a professional translator in preference to a hospital worker, volunteer or family member
- Orient the interpreter to the components you plan to cover in the interview
- Arrange the room so that you and the client have eye contact and can read each other's nonverbal cues
- Seat the interpreter next to you and allow the interpreter and the client to establish rapport
- Assess the client directly. Reinforce your questions with nonverbal behaviors
- Keep sentences short and simple. Focus on the most important concepts to communicate
- Verify mutual understanding by asking the client to report back what he/she has herd
- Be patient. The interview will take more time and may provide less information.

SPECIAL ASPECTS OF INTERVIEWING

Cultural Competence

Culture is a system of shared ideas, rules, and meanings that influences how we view the world, experience it emotionally, and behave in relation to other people.
The influence of culture is relevant to everyone.
Self-Awareness of clinicians in working with clients
Biases - are attitudes and/or feelings that we attach to perceived differences; for example, the way an individual relates to time, which can be a culturally determined phenomenon.

THE CAGE QUESTIONNAIRE

- Have you ever felt the need to **Cut down** on drinking?
- Have you ever felt **Annoyed** by criticism of drinking?
- Have you ever felt **Guilty** about drinking?
- Have you ever taken a drink first thing in the morning **(Eye Opener)** to steady your nerves or get rid of a hangover?

2 or more affirmative answers on cage suggests alcoholism

Lecture Guide

Health History Taking

The health history format is a structured framework for organizing client information in written or verbal form.

The comprehensive history includes:

- Identifying data and source of the history
- Chief Complaints
- Present Illness
- Past History
- Family History
- Personal and Social History
- Review of Systems

New clients often require a comprehensive health history

Other forms include:
- Focused or problem-oriented interview

Distinguishing Subjective from Objective Data:
Subjective Data = What a patient tells you. The history provided from Chief Complaint to Review of Systems
Objective Data = What you detect during the examination. All physical examination findings.

COMPONENTS OF THE HEALTH HISTORY

Identifying Data

- *Identifying data* – such as age, gender, occupation, marital status
- *Source of the history* – usually the patient, but can be family member, friend, letter of referral, or medical record
- If appropriate, establish *source of referral*, because a written report may be needed.

Reliability

- Varies according to the patient's memory, trust, and mood

Chief Complaint (s)

- The one of more concern causing the client to seek care.

Quote the patient's own words. "My stomach hurts and I feel awful".

Present Illness

- Amplifies the chief complaint, describes how each symptom developed
- Includes client's thoughts and feelings about the illness
- Pulls in relevant portions of the review of Systems
- May include medication (name, dose, route, and frequency of use), allergies (including specific reactions to allergens, relief factors, etc.), habits of smoking (how many per day/week etc.) and alcohol (type, frequency, amount, circumstances), because these are frequently pertinent to the present illness.

The principal symptoms should be described: 1) location; 2) quality; 3) quantity or severity; 4) timing; 5) setting in which they occur; 6) aggravating and relieving factors; 7) associated manifestations.

Past History

- Childhood illnesses
- Adult illnesses with dates for at least four categories: medical (e.g., diabetes, hypertension, hepatitis, asthma, HIV) with dates of onset; surgical (include dates, indications, and type of operation); obstetric/gynecologic OB history, menstrual history, birth control, sexual preference, and concerns about HIV); and psychiatric (include dates, diagnoses, hospitalizations, and treatments).
- Includes health maintenance practices such as immunizations, screening tests, lifestyle issues, and home safety.

Family History

- Outline or diagrams age and health, or age and cause of death, of siblings, parents, and grandparents
- Documents presence or absence of specific illnesses in family, such as hypertension, coronary artery disease, etc. [mention other specific, culturally related illnesses]

Personal and Social History

- Describes educational level of family of origin, current household, personal interests, and lifestyle. (occupation, last year of schooling, home situation and significant others, source of stress, both recent and long-term; important life experiences,, such as military, 9/11, ;leisure activities, hobbies, exercise, dies and safety measures, religious affiliation, and spiritual; beliefs; alternative health care practices

Review of Systems

- Documents presence or absence of common symptoms related to each major body system.

"Head to toe"

General
Skin
Head, Eyes, Ears, Nose, Throat (HEENT)
Neck
Breasts
Respiratory
Cardiovascular
Gastrointestinal
Urinary
Genital
Peripheral Vascular
Neurologic
Hematologic
Endocrine
Psychiatric