UNIT II

Nursing Data Collection, Documentation, and Analysis

3

COLLECTING SUBJECTIVE DATA

Collecting subjective data is an integral part of nursing health assessment. Subjective data consist of

- Sensations or symptoms
- Feelings
- Perceptions
- Desires
- Preferences
- Beliefs
- Ideas
- Values
- Personal information

These types of data can be elicited and verified only by the client. Subjective data provide clues to possible physiologic, psychological, and sociologic problems. They also provide the nurse with information that may reveal a client's risk for a problem as well as areas of strengths for the client.

The information is obtained through interviewing. Therefore, effective interviewing skills are vital to accurate and thorough collection of subjective data.

INTERVIEWING

Obtaining a valid nursing health history requires professional, interpersonal, and interviewing skills. The nursing interview is a communication process that has two focuses:

1. Establishing rapport and a trusting relationship with the client to elicit accurate and meaningful information and
2. Gathering information on the client's developmental, psychological, physiologic, sociocultural, and spiritual statuses to identify deviations that can be treated with nursing and collaborative interventions or strengths that can be enhanced through nurse–client collaboration.

Phases of the Interview

The nursing interview has three basic phases: introductory, working, and summary and closing phases. These phases are briefly explained by describing the roles of the nurse and client during each one.

Introductory Phase

After introducing himself to the client, the nurse explains the purpose of the interview, discusses the types of questions that will be asked, explains the reason for taking notes, and assures the client that confidential information will remain confidential. The nurse also makes sure that the client is comfortable (physically and emotionally) and has privacy. It is also essential for the nurse to develop trust and rapport at this point in the interview. This can begin by conveying a sense of priority and interest in the client. Developing rapport depends heavily on verbal and nonverbal communication on the part of the nurse. These types of communication are discussed later in the chapter.

Working Phase

During this phase, the nurse elicits the client's comments about major biographic data, reasons for seeking care, history of present health concern, past health history, family history, review of body systems for current health problems, lifestyle and health practices, and developmental level. The nurse then listens, observes cues, and uses critical thinking skills to interpret and validate information received from the client. The nurse and client collaborate to identify the client's problems and goals. The facilitating approach may be free-flowing or more structured with specific questions, depending on the time available and the type of data needed.

Summary and Closing Phase

During the summary and closing, the nurse summarizes information obtained during the working phase and validates problems and goals with the client (see Chapter 5). She also identifies and discusses possible plans to resolve the problem (nursing diagnoses and collaborative problems) with the client (see Chapter 6). Finally, the nurse makes sure to ask if anything else concerns the client and if there are any further questions.

Communication During the Interview

The client interview involves two types of communication—nonverbal and verbal. Several special techniques and certain general considerations will improve both types of communication and promote an effective and productive interview.

Nonverbal Communication

Nonverbal communication is as important as verbal communication. Your appearance, demeanor, posture, facial expressions, and attitude strongly influence how the client perceives the questions you ask. Never overlook this type of communication or take it for granted.

APPEARANCE

First take care to ensure that your appearance is professional. The client is expecting to see a health professional; therefore, you should look the part. Wear comfortable, neat clothes and a laboratory coat or a uniform. Be sure your name tag, including credentials, is clearly visible. Your hair should be neat and not in any extreme style; some nurses like to wear long hair pulled back. Fingernails should be short and neat; jewelry should be minimal.

DEMEANOR

Your demeanor should also be professional. When you enter a room to interview a client, display poise. Focus on the client and the upcoming interview and assessment. Do not enter the room laughing loudly, yelling to a coworker, or muttering under your breath. This appears unprofessional to the client and will have an effect on the entire interview process. Greet the client calmly and focus your full attention on her. Do not be overwhelmingly friendly or "touchy"; many clients are uncomfortable with this type of behavior. It is best to maintain a professional distance.

FACIAL EXPRESSION

Facial expressions are often an overlooked aspect of communication. Because facial expression often shows what you are truly thinking (regardless of what you are saying), keep a close check on your facial expression. No matter what you think about a client or what kind of day you are having, keep your expression neutral and friendly. If your face shows anger or anxiety, the client will sense it and may think it is directed toward him or her. If you cannot effectively hide your emotions, you may want to explain that you are angry or upset about a personal situation. Admitting this to the client may also help in developing a trusting relationship and genuine rapport.

Portraying a neutral expression does not mean that your face lacks expression. It means using the right expression at the right time. If the client looks upset, you should appear and be understanding and concerned. Conversely, smiling when the client is on the verge of tears will cause the client to believe that you do not care about his or her problem.

ATTITUDE

One of the most important nonverbal skills to develop as a health care professional is a nonjudgmental attitude. All clients should be accepted, regardless of beliefs, ethnicity, lifestyle, and health care practices. Do not act superior to the client or appear shocked, disgusted, or surprised at what you are told. These attitudes will cause the client to feel uncomfortable opening up to you and important data concerning his or her health status could be withheld.

Being nonjudgmental involves not "preaching" to the client or imposing your own sense of ethics or morality on him. Focus on health care and how you can best help the client to achieve the highest possible level of health. For example, if you are interviewing a client who smokes, avoid lecturing condescendingly about the dangers of smoking. Also, avoid telling the client he or she is foolish or portraying an attitude of disgust. This will only harm the nurse–client relationship and will do nothing to improve the client's health. The client is, no doubt, already aware of the dangers of smoking. Forcing guilt on him is unhelpful. Accept the client, be understanding of the habit, and work together to improve the client's health. This does not mean you should not encourage the client to quit; it means that how you approach the situation makes a difference. Let the client know you understand that it is hard to quit smoking, support efforts to quit, and offer suggestions on the latest methods available to help kick the smoking habit.

SILENCE

Another nonverbal technique to use during the interview process is silence. Periods of silence allow you and the client to reflect and organize thoughts, which facilitates more accurate reporting and data collection.

LISTENING

Listening is the most important skill to learn and develop fully in order to collect complete and valid data from your client. To listen effectively, you need to maintain good

eye contact, smile or display an open, appropriate facial expression, maintain an open body position (open arms and hands and lean forward). Avoid preconceived ideas or biases about your client. To listen effectively, you must keep an open mind. Avoid crossing your arms, sitting back, tilting your head away from the client, thinking about other things, or looking blank or inattentive. Becoming an effective listener takes concentration and practice.

In addition, several nonverbal affects or attitudes may hinder effective communication. They may promote discomfort or distrust. Display 3-1 describes communication to avoid.

Verbal Communication

Effective verbal communication is essential to a client interview. The goal of the interview process is to elicit as much data about the client's health status as possible. Several types of questions and techniques to use during the interview are discussed in the following sections.

OPEN-ENDED QUESTIONS

Open-ended questions are used to elicit the client's feelings and perceptions. They typically begin with the words

DISPLAY 3-1 COMMUNICATION TO AVOID

Nonverbal Communication to Avoid

Excessive or Insufficient Eye Contact: Avoid extremes in eye contact. Some clients feel very uncomfortable with too much eye contact; others believe that you are hiding something from them if you do not look them in the eye. Therefore, it is best to use a moderate amount of eye contact. For example, establish eye contact when the client is speaking to you but look down at your notes from time to time. A client's cultural background often determines how he feels about eye contact (see Cultural Variations in Communication for more information).

Distraction and Distance: Avoid being occupied with something else while you are asking questions during the interview. This behavior makes the client believe that the interview may be unimportant to you. Avoid appearing mentally distant as well. The client will sense your distance and will be less likely to answer your questions thoroughly. Also try to avoid physical distance exceeding 2 to 3 feet during the interview. Rapport and trust are established when the client senses your focus and concern are solely on the client and the client's health. Physical distance may portray a noncaring attitude or a desire to avoid close contact with the client.

Standing: Avoid standing while the client is seated during the interview. Standing puts you and the client at different levels. You may be perceived as the superior, making the client feel inferior. Care of the client's health should be an equal partnership between the health care provider and the client. If the client is made to feel inferior, he or she will not feel empowered to be an equal partner and the potential for optimal health may be lost. In addition, vital information may not be revealed if the client believes that the interviewer is untrustworthy, judgmental, or disinterested.

Verbal Communication to Avoid

Biased or Leading Questions: Avoid using biased or leading questions. These cause the client to provide answers that may or may not be true. The way you phrase a question may actually lead the client to think you want her to answer in a certain way. For example, if you ask "You don't feel bad, do you?" the client may conclude that you do not think she should feel bad and will answer "no" even if this is not true.

Rushing Through the Interview: Avoid rushing the client. If you ask the client questions on top of questions, several things may occur. First, the client may answer "no" to a series of closed-ended questions when he or she would have answered "yes" to one of the questions if it was asked individually. This may occur because the client did not hear the individual question clearly or because the answers to most were "no" and the client forgot about the "yes" answer in the midst of the others. With this type of interview technique, the client may believe that his individual situation is of little concern to the nurse. Taking time with clients shows that you are concerned about their health and helps them to open up. Finally, rushing someone through the interview process undoubtedly causes important information to be left out of the health history. A client will usually sense that you are rushed and may try to help hurry the interview by providing abbreviated or incomplete answers to questions.

Reading the Questions: Avoid reading questions from the history form. This deflects attention from the client and results in an impersonal interview process. As a result, the client may feel ill at ease opening up to formatted questions.

"how" or "what." An example of this type of question is "How have you been feeling lately?" These types of questions are important because they require more than a one-word response from the client and, therefore, encourage description. Asking open-ended questions may help to reveal significant data about the client's health status.

The following example shows how open-ended questions work. Imagine yourself interviewing an elderly male client who is at the physician's office because of diabetic complications. He mentions casually to you, "Today is the two-month anniversary of my wife's death from cancer." Failure to follow up with an open-ended question such as "How does this make you feel?" may result in the loss of important data that could provide clues to the client's current state of health.

CLOSED-ENDED QUESTIONS

Use closed-ended questions to obtain facts and to focus on specific information. The client can respond with one or two words. The questions typically begin with the words "when" or "did." An example of this type of question is "When did your headache start?" Closed-ended questions are useful in keeping the interview on course. They can also be used to clarify or obtain more accurate information about issues disclosed in response to open-ended questions. For example, in response to the open-ended question "How have you been feeling lately?" the client says, "Well, I've been feeling really sick at my stomach and I don't feel like eating because of it." You may be able to follow up and learn more about the client's symptom with a closed-ended question such as "When did the nausea start?"

LAUNDRY LIST

Another way to ask questions is to provide the client with a choice of words to choose from in describing symptoms, conditions, or feelings. This laundry list approach helps you to obtain specific answers and reduces the likelihood of the client's perceiving or providing an expected answer. For example, "Is the pain severe, dull, sharp, mild, cutting, or piercing?" "Does the pain occur once every year, day, month, or hour?" Repeat choices as necessary.

REPHRASING

Rephrasing information the client has provided is an effective way to communicate during the interview. This technique helps you to clarify information the client has stated; it also enables you and the client to reflect on what was said. For example, your client, Mr. G., tells you that he has been really tired and nauseated for 2 months and that he is scared because he fears that he has some horrible disease. You might rephrase the information by saying, "You are thinking that you have a serious illness?"

WELL-PLACED PHRASES

Client verbalization can be encouraged by well-placed phrases from the nurse. If the client is in the middle of explaining a symptom or feeling and believes that you are not paying attention, you may fail to get all the necessary information. Listen closely to the client during his or her description and use phrases such as "um-hum," "yes," or "I agree" to encourage the client to continue.

INFERRING

Inferring information from what the client tells you and what you observe in the client's behavior may elicit more data or verify existing data. Be careful not to lead the client to answers that are not true (see Verbal Communication to Avoid for more information). An example of inferring information follows: Your client, Mrs. J., tells you that she has bad pain. You ask where the pain is, and she says, "My stomach." You notice the client has a hand on the right side of her lower abdomen and seems to favor her entire right side. You say, "It seems you have more difficulty with the right side of your stomach" (use the word "stomach" because that is the term the client used to describe the abdomen). This technique, if used properly, helps to elicit the most accurate data possible from the client.

PROVIDING INFORMATION

Another important thing to consider throughout the interview is to provide the client with information as questions and concerns arise. Make sure you answer every question as well as you can. If you do not know the answer, explain that you will find out for the client. The more clients know about their own health, the more likely they are to become equal participants in caring for their health.

As with nonverbal communication, several verbal techniques may hinder effective communication (see Display 3-1).

Special Considerations during the Interview

Three variations in communication must be considered as you interview clients: gerontologic, cultural, and emotional. These variations affect the nonverbal and verbal techniques you use during the interview. Imagine, for example, that you are interviewing an 82-year-old woman and you ask her to describe how she has been feeling. She does not answer you and she looks confused. This older client may have some hearing loss. In such a case, you may need to modify the verbal technique of asking open-ended questions by following the guidelines provided under Gerontologic Variations in Communication (see Domarad & Buschmann, 1995).

Gerontologic Variations in Communication

Age affects and commonly slows all body systems to varying degrees. However, normal aspects of aging do not necessarily equate with a health problem, so it is important not to approach an interview with an elderly client assuming that there is a health problem. Older clients have the potential to be as healthy as younger clients.

When interviewing an elderly client, you must first assess hearing acuity. Hearing loss occurs normally with age, and undetected hearing loss is often misinterpreted as mental slowness or confusion. If you detect hearing loss, speak slowly, face the client at all times during the interview, and position yourself so that you are speaking on the side of the client that has the ear with better acuity. Do not yell at the client.

Older clients may have more health concerns than younger clients and may seek health care more often. Many times, older clients with health problems feel vulnerable and scared. They need to believe that they can trust you before they will open up to you about what is bothering them. Thus establishing and maintaining trust, privacy, and partnership with the older client is particularly important (Fig. 3-1). It is not unusual for elderly clients to be taken for granted and their health complaints ignored, causing them to become fearful of complaining. It is often disturbing to the older client that their health problems may be discussed openly among many health care providers and family members. Assure your elderly clients that you are concerned, that you see them as equal partners in health care, and that what is discussed will be between you, their health care provider, and them.

Speak clearly and use straightforward language during the interview with the elderly client. Ask questions in simple terms. Avoid medical jargon and modern slang.

Figure 3-1 Establishing and maintaining trust, privacy, and partnership with older adults sets the tone for effectively collecting data and sharing concerns.

However, do not talk down to the client. Being older physically does not mean the client is slower mentally. Showing respect is very important. However, if the older client is mentally confused or forgetful, it is important to have a significant other (e.g., spouse, child, close friend) present during the interview to provide or clarify the data.

Cultural Variations in Communication

Ethnic/cultural variations in communication and self-disclosure styles may significantly affect the information obtained (Andrews & Boyle, 1999; Giger & Davidhizar, 1995; Luckmann, 2000). Be aware of possible variations in the communication styles of yourself and the client. If misunderstanding or difficulty in communicating is evident, seek help from an expert, what some professionals call a "culture broker." This is someone who is thoroughly familiar not only with the client's language, culture, and related health care practices but also with the health care setting and system of the dominant culture. Frequently noted variations in communication styles include

- Reluctance to reveal personal information to strangers for various culturally-based reasons
- Variation in willingness to openly express emotional distress or pain
- Variation in ability to receive information (listen)
- Variation in meaning conveyed by language. For example, a client who does not speak the predominant language may not know what a certain medical term or phrase means and, therefore, will not know how to answer your question. Use of slang with non-native speakers is discouraged as well. Keep in mind that it is hard enough to learn proper language, let alone the idiom vernacular. The non-native speaker will likely have no idea what you are trying to convey.
- Variation in use and meaning of nonverbal communication: eye contact, stance, gestures, demeanor. For example, direct eye contact may be perceived as rude, aggressive, or immodest by some cultures but lack of eye contact may be perceived as evasive, insecure, or inattentive by other cultures. A slightly bowed stance may indicate respect in some groups; size of personal space affects one's comfortable interpersonal distance; touch may be perceived as comforting or threatening.
- Variation in disease/illness perception: Culture-specific syndromes or disorders are accepted by some groups (e.g., in Latin America, *susto* is an illness caused by a sudden shock or fright).
- Variation in past, present, or future time orientation (e.g., the dominant U.S. culture is future

oriented; other cultures may focus more on the past or present)
- Variation in the family's role in the decision-making process: A person other than the client or the client's parent may be the major decision maker about appointments, treatments, or follow-up care for the client.

You may have to interview a client who does not speak your language. To perform the best interview possible, it is necessary to use an interpreter. Possibly the best interpreter would be a culture expert (or culture broker). Consider the relationship of the interpreter to the client. If the interpreter is the client's child or a person of a different sex, age, or social status, interpretation may be impaired. Also keep in mind that communication through use of pictures may be helpful when working with some clients.

Emotional Variations in Communication

Not every client you encounter will be calm, friendly, and eager to participate in the interview process. Clients' emotions vary for a number of reasons. They may be scared or anxious about their health or about disclosing personal information, angry that they are sick or about having to have an examination, depressed about their health or other life events, or they may have an ulterior motive for having an assessment performed. Clients may also have some sensitive issues with which they are grappling and may turn to you for help. Some helpful ways to deal with various clients with various emotions are discussed in Display 3-2.

COMPLETE HEALTH HISTORY

The health history is an excellent way to begin the assessment process because it lays the groundwork for identifying nursing problems and provides a focus for the physical examination. The importance of the health history lies in its ability to provide information that will assist the examiner in identifying areas of strength and limitation in the individual's lifestyle and current health status. Data from the health history also provide the examiner with specific cues to health problems that are most apparent to the client. Then these areas may be more intensely examined during the physical assessment. When a client is having a complete, head-to-toe physical assessment, collection of subjective data usually requires that the nurse take a complete health history. The complete health history is modified or shortened when necessary. For example, if the physical assessment will focus on the heart and neck vessels, the subjective data collection would be limited to the data relevant to the heart and neck vessels.

Taking a health history should begin with an explanation to the client of why the information is being requested, for example, "so that I will be able to plan individualized nursing care with you." This section of the chapter explains the rationale for collecting the data, discusses each portion of the health history, and provides sample questions. The health history has eight sections:

- Biographic data
- Reasons for seeking health care
- History of present health concern
- Past health history
- Family health history
- Review of body systems (ROS) for current health problems
- Lifestyle and health practices profile
- Developmental level

The organization for collecting data in this text is a generic nursing framework that the nurse can use as is or adapt to use with any nursing framework. See Display 3-3 for a summary of the components of a complete client health history. This can be used as a guide for collecting subjective data from the client.

Biographic Data

Biographic data usually include information that identifies the client, such as name, address, phone number, gender, and who provided the information—the client or significant others. The client's birth date, Social Security number, medical record number, or similar identifying data may be included in the biographic data section.

When students are collecting the information and sharing it with instructors, addresses and phone numbers should be deleted and initials used to protect the client's privacy. The name of the person providing the information needs to be included, however, to assist in determining its accuracy. The client is considered the primary source and all others (including the client's medical record) are secondary sources. In some cases, the client's immediate family or caregiver may be a more accurate source of information than the client. An example would be an elderly client's wife who has kept the client's medical records for years or the legal guardian of a mentally compromised client. In any event, validation of the information by a secondary source may be helpful.

The client's culture, ethnicity, and subculture may begin to be determined by collecting data about date and place of birth, nationality or ethnicity, marital status, religious or spiritual practices, and primary and secondary languages spoken, written, and read. This information helps the nurse to examine special needs and beliefs that may affect the client or family's health care. A person's primary language is usually the one spoken in the family during early childhood and the one in which the person thinks. However, if the client was educated in another language from kindergarten on, that may be the primary language and the birth language would be secondary.

Gathering information about the client's educational level, occupation, and working status at this point in the

DISPLAY 3-2 INTERACTING WITH CLIENTS WITH VARIOUS EMOTIONAL STATES

When Interacting With an Anxious Client

- Provide the client with simple, organized information in a structured format.
- Explain who you are and your role and purpose.
- Ask simple, concise questions.
- Avoid becoming anxious like the client.
- Do not hurry and decrease any external stimuli.

When Interacting With an Angry Client

- Approach this client in a calm, reassuring, in-control manner.
- Allow him to ventilate feelings. However, if the client is out of control, do not argue with or touch the client.
- Obtain help from other health care professionals as needed.
- Avoid arguing and facilitate personal space so the client does not feel threatened or cornered.

When Interacting With a Depressed Client

- Express interest in and understanding of the client and respond in a neutral manner.
- Do not try to communicate in an upbeat, encouraging manner. This will not help the depressed client.

When Interacting With a Manipulative Client

- Provide structure and set limits.
- Differentiate between manipulation and a reasonable request.
- If you are not sure whether you are being manipulated, obtain an objective opinion from other nursing colleagues.

When Interacting With a Seductive Client

- Set firm limits on overt sexual client behavior and avoid responding to subtle seductive behaviors.
- Encourage client to use more appropriate methods of coping in relating to others.

When Discussing Sensitive Issues (for example, Sexuality, Dying, Spirituality)

- First be aware of your own thoughts and feelings regarding dying, spirituality, and sexuality; then recognize that these factors may affect the client's health and may need to be discussed with someone.
- Ask simple questions in a nonjudgmental manner.
- Allow time for ventilation of client's feelings as needed.
- If you do not feel comfortable or competent discussing personal, sensitive topics, you may make referrals as appropriate, for example, to a pastoral counselor for spiritual concerns or other specialists as needed.

health history assists the examiner to tailor questions to the client's level of understanding. In addition, this information can help to identify possible client strengths and limitations affecting health status. For example, if the client was recently downsized from a high-power, high-salary position, the effects of overwhelming stress may play a large part in his or her health status.

Finally, asking who lives with the client and identifying significant others indicates the availability of potential caregivers and support people for the client. Absence of support people would alert the examiner to the (possible) need for finding external sources of support.

Reason(s) for Seeking Health Care

This category includes two questions: "What is your major health problem or concerns at this time?" and "How do you feel about having to seek health care?" The first question assists the client to focus on his most significant health concern and answers the nurse's question, "Why are you

DISPLAY 3-3 NURSING HEALTH HISTORY FORMAT (USED FOR CLIENT CARE PLAN)

Biographical Data

Name
Address
Phone
Gender
Provider of history (patient or other)
Birth date
Place of birth
Race or ethnic background
Educational Level
Occupation
Significant others or support persons

Reasons of Seeking Health Care

Reason for seeking health care
Feelings about seeking health care

History of Present Health Concern

Character (How does it feel, look, smell, sound, etc.?)
Onset (When did it begin; is it better, worse, or the same since it began?)
Location (Where is it? Does it radiate?)
Duration (How long it lasts? Does it recur?)
Severity (How bad is it on a scale of 1 [barely noticeable] to 10 [worst pain ever experienced]?)
Pattern (What makes it better? What makes it worse?)
Associated factors (What other symptoms do you have with it? Will you be able to continue doing your work or other activities [leisure or exercise]?)

Past Health History

Problems at birth
Childhood Illnesses
Immunizations to date
Adult illnesses (physical, emotional, mental)
Surgeries
Accidents
Prolonged pain or pain patterns
Allergies

Family Health History

Age of parents (Living? Deceased date?)
Parent illnesses
Grandparent's Illnesses
Aunt's and uncle's age and illnesses
Children's age and illnesses or handicaps

Review of Systems for Current Health Problems

Skin, Hair and Nails: color, temperature, condition, rashes, lesions, sweating, hair loss dandruff
Head and Neck: headache, stiffness, difficulty swallowing, enlarged lymph nodes
Ears: pain, ringing, buzzing, drainage, difficulty hearing, exposure, to loud noises, dizziness
Eyes: pain, infections, vision, redness, tearing, halos, blurring, black spots, flashes, double vision
Mouth, Throat, Nose, and Sinuses: mouth pain, sore throat, lesions, hoarseness, nasal obstruction, sneezing, coughing, snoring, nosebleeds
Thorax and Lungs: pain, difficulty breathing, shortness of breath with activities, orthopnea, cough, sputum, hemoptysis, respiratory infections
Breasts and Regional Lymphatics: pain, lumps, discharge from nipples, dimpling or changes in breast size, swollen tender lymph nodes in axilla
Heart and Neck Vessels: chest pain or pressure, palpitations, edema, last blood pressure, last ECG
Peripheral Vascular: Leg or feet pain, swelling of feet or legs, sores on feet or legs, color of feet and legs
Abdomen: pain, indigestion, difficulty swallowing, nausea and vomiting. Gas, jaundice, hernias
Male Genitalia: painful urination, frequency or difficulty starting or maintaining urinary system, blood in urine, sexual problems, penile lesions, penile pain, scrotal swelling, difficulty with erection or ejaculation, exposure to sexually transmitted diseases
Female Genitalia: Pelvic pain, voiding pain, sexual pain, voiding problems (dribbling, incontinence) age of menarche or menopause (date of last menstrual period), pregnancies and types of problems, abortions, sexually transmitted diseases, hormone replacement therapy, birth control methods
Anus, Rectum, & Prostate: pain, with refection, hemorrhoids, bowel habits, constipation, diarrhea, blood in stool
Musculoskeletal: Pain, Swelling, red, stiff joints, strength of extremities, abilities to care for self and work
Neurological: mood, behavior, depression, anger, headaches, concussions, loss of strength or sensation, coordination, difficulty with speech, memory problems, strange thoughts or actions, difficulty reading or learning

continued

DISPLAY 3-3 NURSING HEALTH HISTORY FORMAT (USED FOR CLIENT CARE PLAN) *Continued*

Lifestyle & Health Practices

Description of a typical day (AM to PM)
24-hour dietary intake (foods and fluids)
Who purchases and prepares meals
Activities on a typical day
Exercise habits and patterns
Sleep and rest habits and patterns
Use of medications and other substances (caffeine, nicotine, alcohol, recreational drugs)
Self concept
Self-care responsibilities
Social activities for fun and relaxation
Social activities contributing to society
Relationships with family, significant others, and pets
Values, religious affiliation, spirituality
Past, current, and future plans for education
Type of work, level of job satisfaction, work stressors
Finances
Stressors in life, coping strategies used
Residency, type of environment, neighborhood, environmental Risks

Developmental Level

Young Adult: Intimacy versus Isolation
Middlescent: Generativity versus Stagnation
Older Adult: Ego Integrity versus Despair

here?" or "How can I help you?" Physicians call this the client's chief complaint (CC), but a more holistic approach for phrasing the question may draw out concerns that reach beyond just a physical complaint and may address stress or lifestyle changes.

The second question, "How do you feel about having to seek health care?" encourages the client to discuss fears or other feelings about having to see a health care provider. For example, a woman visiting a nurse practitioner states her major health concern: "I found a lump in my breast." This woman may be able to respond to the second question by voicing fears that she has been reluctant to share with her significant others. This question may also draw out descriptions of previous experiences—both positive and negative—with other health care providers.

History of Present Health Concern

This section of the health history takes into account several aspects of the health problem and asks questions whose answers can provide a detailed description of the concern. First, encourage the client to explain the health problem or symptom in as much detail as possible by focusing on the onset, progression, and duration of the problem; signs and symptoms and related problems; and what the client perceives as causing the problem. You may also ask the client to evaluate what makes the problem worse, what makes it better, which treatments have been tried, what effect the problem has had on daily life or lifestyle, what expectations are held about recovery, and what is the client's ability to provide self-care.

Because there are many characteristics to be explored for each symptom, a memory helper—known as a mnemonic—can help the nurse to complete the assessment of the sign, symptom, or health concern. Many mnemonics have been developed for this purpose (e.g., PQRST, COLDSPAR, COLDSTER, LOCSTAAM). The mnemonic used in this text is COLDSPA. You will see the following in the chapters in Unit 3:

Consider the following examples of what the nurse would ask a client with back pain. (*Note:* Although the questions presented here are clustered together for presentation purposes, keep in mind that you should ask only one question at a time.)

- "When did you first notice the pain in your back? How long have you experienced it? Has it become worse, better, or stayed the same since it first occurred?"
- "What does the pain feel like? Where does it hurt the most? Does it radiate or go to any other part of your body? How intense is the pain? Rate the pain on a scale of 1 to 10 with 1 being barely noticeable and 10 being the worst pain you have ever experienced. Do you have any other problems that seem related to this back pain?"
- "What do you think caused this problem to start?"
- "What makes your back hurt more? What makes it feel better? Have you tried any treatments to relieve the pain such as aspirin or acetaminophen (Tylenol) or anything else?"
- "How does the pain affect your life and daily activities?"
- "What do you think will happen with this problem? Do you expect to get well? What about your job? Do you think you will be able to continue working?"

The client's answers to the questions provide the nurse with a great deal of information about the client's problem and especially how it affects lifestyle and activities of daily living. This helps the nurse to evaluate the client's insight into the problem and the client's plans for managing it. The nurse can also begin to postulate nursing diagnoses from this initial information.

Problems or symptoms particular to body parts or systems are covered in the Nursing History section under "History of Present Health Concern" in the physical assessment chapters. Each identified symptom must be described for clear understanding of probable cause and significance.

Past Health History

This portion of the health history focuses on questions related to the client's past, from the earliest beginnings to the present. These questions elicit data related to the client's strengths and weaknesses in her health history. The client's strengths may be physical (e.g., optimal body weight), social (e.g., active in community services) emotional (e.g., expresses feeling openly), or spiritual (often turns to faith for support). The data may also point to trends of unhealthy behaviors such as being smoking or lack of physical activity. The information gained from these questions assists the nurse to identify risk factors that stem from previous health problems. Risk factors may be to the client or to his significant others.

Information covered in this section includes questions about birth, growth, development, childhood diseases, immunizations, allergies, previous health problems, hospitalizations, surgeries, pregnancies, births, previous accidents, injuries, pain experiences, and emotional or psychiatric problems. Sample questions include

- "Can you tell me how your mother described your birth? Were there any problems? As far as you know, did you progress normally as you grew to adulthood? Were there any problems that your family told you about or that you experienced?"
- "What diseases did you have as a child such as measles or mumps? What immunizations did you get and are you up to date now?" (See Display 3-4 for recommended immunizations.)
- "Do you have any chronic illnesses? If so, when was it diagnosed? How is it treated? How satisfied have you been with the treatment?"
- "What illnesses or allergies have you had? How were the illnesses treated?"
- "Have you ever been pregnant and delivered a baby? How many times have you been pregnant/delivered?"
- "Have you ever been hospitalized or had surgery? If so, when? What were you hospitalized for or what type of surgery did you have? Were there any complications?"
- "Have you experienced any accidents or injuries? Please describe them."
- "Have you experienced pain in any part of your body? Please describe the pain."
- "Have you ever been diagnosed with/treated for emotional or mental problems? If so, please describe their nature and any treatment received. Describe your level of satisfaction with the treatment."

How clients frame their previous health concerns suggests how they feel about themselves and is an indication of their sense of responsibility for their own health. For example, a client who has been obese for years may blame himself for developing diabetes and fail to comply with his diet, whereas another client may be very willing to share the treatment of her diabetes and success with an insulin pump in a support group. Some clients are very forthcoming about their past health status; others are not. It is helpful to have a series of alternative questions for less responsive clients and for those who may not understand what is being asked.

Family Health History

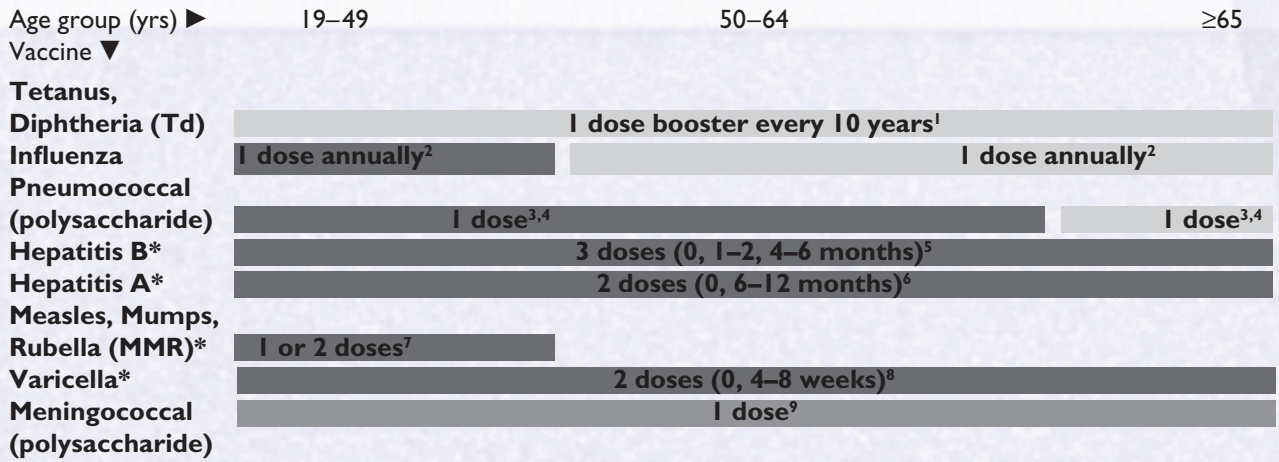
As researchers discover more and more health problems that seem to run in families and that are genetically based, the family health history assumes greater importance. In addition to genetic predisposition, it is also helpful to see other health problems that may have affected the client by virtue of having grown up in the family and being exposed to these problems. For example, a gene predisposing a person to smoking has not yet been discovered but a family with smoking members can affect other members in at least two ways. First, the second-hand smoke can compromise the physical health of nonsmoking members; second, the smoker may serve as a negative role model for children, inducing them to take up the habit as well. Another example is obesity; recognizing it in the family history can alert the nurse to a potential risk factor.

The family history should include as many genetic relatives as the client can recall. Include maternal and paternal grandparents, aunts and uncles on both sides, parents, siblings, and the client's children. Such thoroughness usually identifies those diseases that may skip a generation such as autosomal recessive disorders. Include the client's spouse but indicate that there is no genetic link. Identifying the spouse's health problems could explain disorders in the client's children not indicated in the client's family history.

Drawing a genogram helps to organize and illustrate the client's family history. Use a standard format so others can easily understand the information. Also provide a key to the symbols used. Usually female relatives are indicated by a circle and male relatives by a square. A deceased relative is noted by marking an X in the circle or square and listing the age at death and the cause of death. Identify all relatives, living or dead, by age and provide a brief list of

DISPLAY 3-4 RECOMMENDED ADULT IMMUNIZATION SCHEDULE BY VACCINE AND AGE GROUP (2004–2005)

Recommended Adult Immunization Schedule by Vaccine and Age Group
United States • October 2004–September 2005



From: http://www.cdc/nip/RECS/adult_schedule_2page.pdf

Note: The Recommended Adult Immunization Schedule is Approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

This schedule indicates the recommended age groups for routine administration of currently licensed vaccines for persons aged ≥19 years. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. Providers should consult manufacturers' package inserts for detailed recommendations.

For all persons in this group

For perrsons lacking documentation of vaccination or evidence of disease

For persons at risk (i.e., with medical/exposure indications)

1. Tetanus and diphtheria (Td). Adults, including pregnant women with uncertain history of a complete primary vaccination series, should receive a primary series of Td. A primary series for adults is 3 doses; administer the first 2 doses at least 4 weeks apart and the 3rd dose 6–12 months after the second. Administer 1 dose if the person received the primary series and if the last vaccination was received ≥10 years previously.

2. Influenza vaccination. The Advisory Committee on Immunization Practices (ACIP) recommends inactivated influenza vaccination for the following indications, when vaccine is available. *Medical indications:* chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]); and pregnancy during the influenza season. *Occupational indications:* health-care workers and employees of long-term–care and assisted living facilities. *Other indications:* residents of nursing homes and other long-term–care facilities; persons likely to transmit influenza to persons at high risk (i.e., in-home caregivers to persons with medical indications, household/close contacts and out-of-home caregivers of children aged 0–23 months, household members and caregivers of elderly persons and adults with high-risk conditions); and anyone who wishes to be vaccinated. For healthy persons aged 5–49 years without high-risk conditions who are not contacts of severely immunocompromised persons in special care units, either the inactivated vaccine or the intranasally administered influenza vaccine (FluMist®) may be administered (see *MMWR* 2004;53[No. RR-6]).

3. Pneumococcal polysaccharide vaccination. *Medical indications:* chronic disorders of the pulmonary system (excluding asthma); cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, or organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids; or cochlear implants. *Geographic/other indications:* Alaska Natives and certain American Indian populations. *Other indications:* residents of nursing homes and other long-term–care facilities (see *MMWR* 1997;46[No. RR-8] and *MMWR* 2003;52:739–40).

4. Revaccination with pneumococcal polysaccharide vaccine. One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or

continued

splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, or organ or bone marrow transplantation); or chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids. For persons aged ≥65 years, one-time revaccination if they were vaccinated ≥5 years previously and were aged <65 years at the time of primary vaccination (see *MMWR* 1997;46[No. RR-8]).

5. Hepatitis B vaccination. *Medical indications:* hemodialysis patients or patients who receive clotting factor concentrates. *Occupational indications:* health-care workers and public-safety workers who have exposure to blood in the workplace; and persons in training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions. *Behavioral indications:* injection-drug users; persons with more than one sex partner during the previous 6 months; persons with a recently acquired sexually transmitted disease (STD); all clients in STD clinics; and men who have sex with men. *Other indications:* household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff members of institutions for the developmentally disabled; inmates of correctional facilities; or international travelers who will be in countries with high or intermediate prevalence of chronic HBV infection for >6 months (http://www.cdc.gov/travel/diseases/hbv.htm) (see *MMWR* 1991;40[No. RR-13]).

6. Hepatitis A vaccination. *Medical indications:* persons with clotting factor disorders or chronic liver disease. *Behavioral indications:* men who have sex with men or users of illegal drugs. *Occupational indications:* persons working with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory setting. *Other indications:* persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A. If the combined Hepatitis A and Hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months (http://www.cdc.gov/travel/diseases/hav.htm) (see *MMWR* 1999;48[No. RR-12]).

7. Measles, mumps, rubella (MMR) vaccination. *Measles component:* adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥1 dose of MMR unless they have a medical contraindication, documentation of ≥1 dose, or other acceptable evidence of immunity. A second dose of MMR is recommended for adults who 1) were recently exposed to measles or in an outbreak setting, 2) were previously vaccinated with killed measles vaccine, 3) were vaccinated with an unknown vaccine during 1963–1967, 4) are students in postsecondary educational institutions, 5) work in health-care facilities, or 6) plan to travel internationally. *Mumps component:* 1 dose of MMR vaccine should be adequate for protection. *Rubella component:* Administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable and counsel women to avoid becoming pregnant for 4 weeks after vaccination. For women of childbearing age, regardless of birth year, routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Do not vaccinate pregnant women or those planning to become pregnant during the next 4 weeks. For women who are pregnant and susceptible, vaccinate as early in the postpartum period as possible (see *MMWR* 1998;47[No. RR-8] and *MMWR* 2001;50:1117).

8. Varicella vaccination. Recommended for all persons lacking a reliable clinical history of varicella infection or serologic evidence of varicella zoster virus (VZV) infection who might be at high risk for exposure or transmission. This includes health-care workers and family contacts of immuno-compromised persons; persons who live or work in environments where transmission is likely (e.g., teachers of young children, child care employees, and residents and staff members in institutional settings); persons who live or work in environments where VZV transmission can occur (e.g., college students, inmates, and staff members of correctional institutions, and military personnel); adolescents aged 11–18 years and adults living in households with children; women who are not pregnant but who might become pregnant; and international travelers who are not immune to infection. **Note:** Approximately 95% of U.S.-born adults are immune to VZV. Do not vaccinate pregnant women or those planning to become pregnant during the next 4 weeks. For women who are pregnant and susceptible, vaccinate as early in the postpartum period as possible (see *MMWR* 1999;48[No. RR-6]).

9. Meningococcal vaccine (quadrivalent polysaccharide for serogroups A, C, Y, and W 135). *Medical indications:* adults with terminal complement component deficiencies or those with anatomic or functional asplenia. *Other indications:* travelers to countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa and Mecca, Saudi Arabia). Revaccination after 3–5 years might be indicated for persons at high risk for infection (e.g., persons residing in areas where disease is epidemic). Counsel college freshmen, especially those who live in dormitories, regarding meningococcal disease and availability of the vaccine to enable them to make an educated decision about receiving the vaccination (see *MMWR* 2000;49[No. RR-7]). The American Academy of Family Physicians recommends that colleges should take the lead on providing education on meningococcal infection and availability of vaccination and offer it to students who are interested. Physicians need not initiate discussion of meningococcal quadrivalent polysaccharide vaccine as part of routine medical care.

diseases or conditions. If the relative has no problems, the letters "A/W" (alive and well) should be placed next to the age. Straight vertical and horizontal lines are used to show relationships. A horizontal dotted line can be used to indicate the client's spouse; a vertical dotted line can be used to indicate adoption. A sample genogram is illustrated in Figure 3-2.

After the diagrammatic family history, prepare a brief summary of the kinds of health problems present in the family. For example, the client in the genogram depicted in the accompanying figure has longevity, obesity, heart disease, hypertension (HTN), arthritis, thyroid disorders, non–insulin-dependent diabetes mellitus (NIDDM, also known as type 2 diabetes), alcoholism, smoking, myopia,

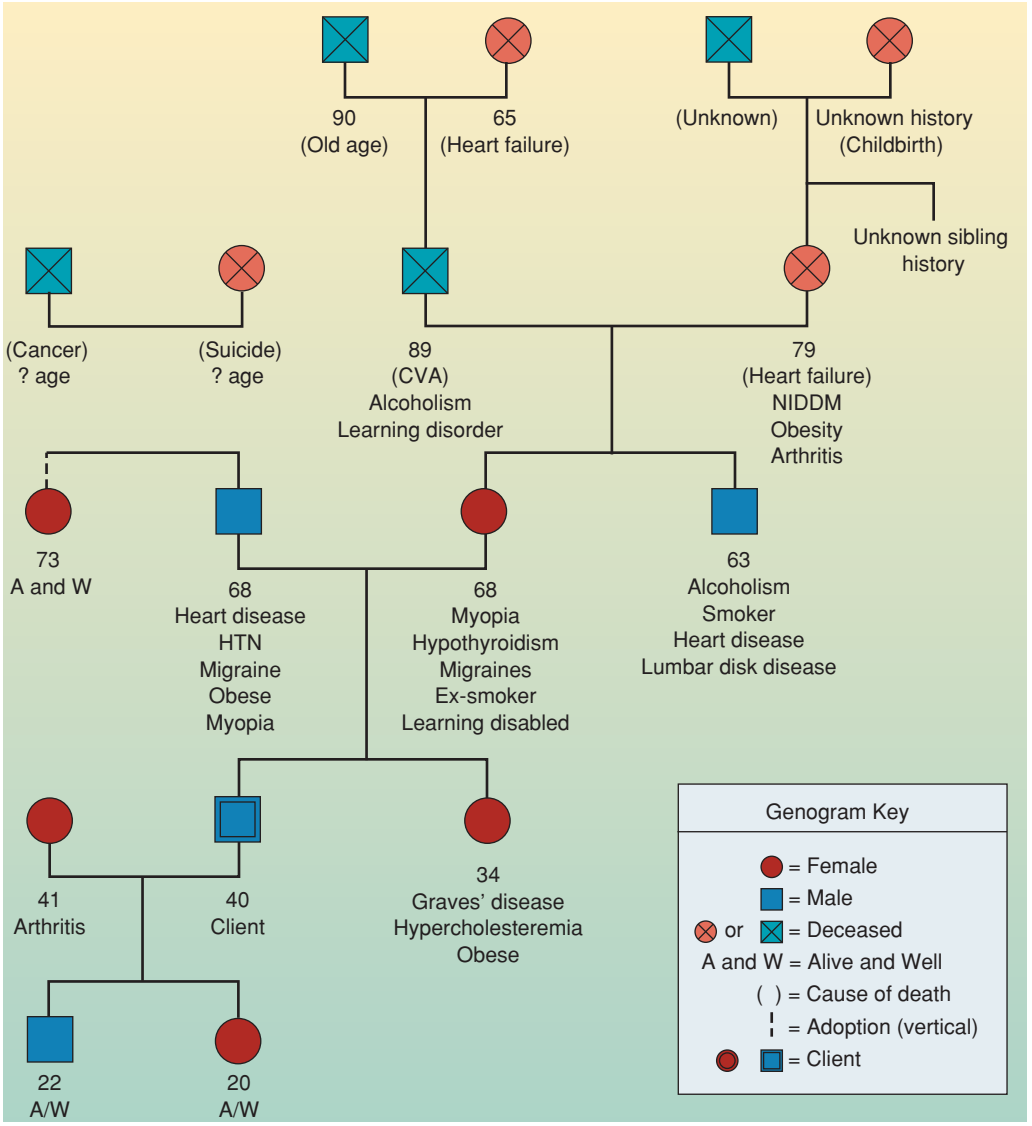


Figure 3-2 Genogram of a 40-year-old male client.

learning disability, hyperactivity disorder, and cancer (one relative) on his maternal side. On the client's paternal side are obesity, heart disease, hypercholesterolemia, back problems, arthritis, myopia, and cancer. The paternal history is not as extensive as the maternal history because the client's father was adopted. In addition, the client's sister is obese and has Graves' disease and hypercholesterolemia. His wife has arthritis; his children are both A/W.

Review of Systems (ROS) for Current Health Problems

In the review of systems (or review of body systems), each body system is addressed and the client is asked specific questions to draw out current health problems or problems from the recent past that may still affect the client or that are recurring. Care must be taken in this section to include only the client's subjective information and not the examiner's observations. There is a tendency, especially with more experienced nurses, to fill up the spaces with observations such as "erythema of the right eye" or "several vesicles on the client's upper extremities."

During the review of body systems, document the client's descriptions of her health status for each body system and note the client's denial of signs, symptoms, diseases, or problems that the nurse asks about but are not experienced by the client. For example, under the area "Head and Neck," the client may respond that there are no problems but on questioning from the nurse about headaches, stiffness, pain, or cracking in the neck with motion, swelling in the neck, difficulty swallowing, sore throat, enlarged lymph nodes, and so on, the client may suddenly remember that he did have a sore throat a week ago that he self-treated with zinc lozenges. This information might

not have emerged without specific questions. Also, if the lone entry "no problems" is entered on the health history form, other health care professionals reviewing the history cannot even ascertain what specific questions had been asked, if any.

The questions about problems and signs or symptoms of disorders should be asked in terms that the client understands, but findings may be recorded in standard medical terminology. If the client appears to have a limited vocabulary, the nurse may need to ask questions in several different ways and use very basic lay terminology. If the client is well educated and seems familiar with medical terminology, the nurse should not insult her by talking at a much lower level. The most obvious information to collect for each body part or system is listed below. See the physical assessment chapters for in-depth questions and rationales for each particular body part or system.

- *Skin, hair, and nails:* Skin color, temperature, condition, excessive sweating, rashes, lesions, balding, dandruff, condition of nails
- *Head and neck:* Headache, swelling, stiffness of neck, difficulty swallowing, sore throat, enlarged lymph nodes
- *Eyes:* Vision, eye infections, redness, excessive tearing, halos around lights, blurring, loss of side vision, moving black spots/specks in visual fields, flashing lights, double vision, and eye pain
- *Ears:* Hearing, ringing or buzzing, earaches, drainage from ears, dizziness, exposure to loud noises
- *Mouth, throat, nose, and sinuses:* Condition of teeth and gums; sore throats; mouth lesions; hoarseness; rhinorrhea; nasal obstruction; frequent colds; sneezing or itching of eyes, ears, nose, or throat; nose bleeds; snoring
- *Thorax and lungs:* Difficulty breathing, wheezing, pain, shortness of breath during routine activity, orthopnea, cough or sputum, hemoptysis, respiratory infections
- *Breasts and regional lymphatics:* Lumps or discharge from nipples, dimpling or changes in breast size, swollen or tender lymph nodes in axilla
- *Heart and neck vessels:* Last blood pressure, ECG tracing or findings, chest pain or pressure, palpitations, edema
- *Peripheral vascular:* Swelling, or edema, of legs and feet; pain; cramping; sores on legs; color or texture changes on the legs or feet
- *Abdomen:* Indigestion, difficulty swallowing, nausea, vomiting, abdominal pain, gas, jaundice, hernias
- *Male genitalia:* Excessive or painful urination, frequency or difficulty starting and maintaining urinary stream, leaking of urine, blood noted in urine, sexual problems, perineal lesions, penile drainage, pain or swelling in scrotum, difficulty achieving an erection and/or difficulty ejaculating, exposure to sexually transmitted infections
- *Female genitalia:* Sexual problems; sexually transmitted diseases; voiding problems (e.g., dribbling, incontinence); reproductive data such as age at menarche, menstruation (length and regularity of cycle), pregnancies, and type of or problems with delivery, abortions, pelvic pain, birth control, menopause (date or year of last menstrual period), and use of hormone replacement therapy
- *Anus, rectum, and prostate:* Bowel habits, pain with defecation, hemorrhoids, blood in stool, constipation, diarrhea
- *Musculoskeletal:* Swelling, redness, pain, stiffness of joints, ability to perform activities of daily living, muscle strength
- *Neurologic:* General mood, behavior, depression, anger, concussions, headaches, loss of strength or sensation, coordination, difficulty speaking, memory problems, strange thoughts and/or actions, difficulty learning

Lifestyle and Health Practices Profile

This is a very important section of the health history because it deals with the client's human responses, which include nutritional habits, activity and exercise patterns, sleep and rest patterns, use of medications and substances, self-concept and self-care activities, social and community activities, relationships, values and beliefs system, education and work, stress level and coping style, and environment.

Here clients describe how they are managing their lives, their awareness of healthy versus toxic living patterns, and the strengths and supports they have or use. When assessing this area, use open-ended questions to promote a dialogue with the client. Follow up with specific questions to guide the discussion and clarify the information as necessary. Be sure to pay special attention to the cues the client may provide that point to possibly more significant content. Take brief notes so that pertinent data are not lost and so there can be follow-up if some information needs clarification or expansion. If clients give permission and it does not seem to cause anxiety or inhibition, using an audiocassette recorder frees the nurse from the need to write while clients talk.

In this section, each area is discussed briefly then followed by a few sample questions.

Description of Typical Day

This information is necessary to elicit an overview of how the client sees his usual pattern of daily activity. The questions you ask should be vague enough to allow the

client to provide the orientation from which the day is viewed, for example, "Please tell me what an average or typical day is for you. Start with awakening in the morning and continue until bedtime." Encourage the client to discuss a usual day, which, for most people, includes work or school. If the client gives minimal information, additional specific questions may be asked to draw out more details.

Nutrition and Weight Management

Ask the client to recall what consists of an average 24-hour intake for her with emphasis on what foods are eaten and in what amounts. Also ask about snacks, fluid intake, and other substances consumed. Depending on the client, you may want to ask who buys and prepares the food and when and where meals are eaten. These questions uncover food habits that are health promoting as well as those that are less desirable. The client's answers about food intake should be compared with the guidelines illustrated in the "food pyramid" (See Nutritional Assessment Chapter). The food pyramid, developed by the U.S. Department of Agriculture, is designed to teach people what types and amounts of food to eat to ensure a balanced diet, to promote health, and to prevent disease. Consider reviewing the food pyramid with the client and explaining what a serving size is. The client's fluid intake should be compared with the general recommendation of six to eight glasses of water or noncaffeinated fluids daily. It is also important to ask about the client's bowel and bladder habits at this time (included in review of symptoms).

Sample questions include

- "What do you usually eat during a typical day? Please tell me the kinds of foods you prefer, how often you eat throughout the day, and how much you eat."
- "Do you eat out at restaurants frequently?"
- "Do you eat only when hungry? Do you eat because of boredom, habit, anxiety, depression?"
- "Who buys and prepares the food you eat?"
- "Where do you eat your meals?"
- "How much and what types of fluids do you drink?"

Activity Level and Exercise

Next, assess how active the client is during an average week either at work or at home. Inquire about regular exercise. Some clients believe that if they do heavy physical work at their job, they do not need additional exercise. Make it a point to distinguish between activity done when working, which may be stressful and fatiguing, and exercise, which is designed to reduce stress and strengthen the individual. Compare the client's answers with the recommended exercise regimen of regular aerobic exercise for 20 to 30 minutes at least three times a week. Explain to the client that regular exercise reduces the risk of heart disease, strengthens heart and lungs, reduces stress, and manages weight.

Sample questions include

- "What is your daily pattern of activity?"
- "Do you follow a regular exercise plan? What types of exercise do you do?"
- "Are there any reasons why you cannot follow a moderately strenuous exercise program?"
- "What do you do for leisure and recreation?"
- "Do your leisure and recreational activities include exercise?"

Sleep and Rest

Inquire whether the client feels he is getting enough sleep and rest. Questions should focus on specific sleep patterns such as how many hours a night the person sleeps, interruptions, whether the client feels rested, problems sleeping (e.g., insomnia), rituals the client uses to promote sleep, and concerns the client may have regarding sleep habits. Some of this information may have already been presented by the client, but it is useful to gather data in a more systematic and thorough manner at this time. Inquiries about sleep can bring out problems, such as anxiety, which manifests as sleeplessness, or inadequate sleep time, which can predispose the client to accidents. Compare the client's answers with the normal sleep requirement for adults, which is usually between 5 and 8 hours a night. Keep in mind sleep requirements vary depending on age, health, and stress levels.

Sample questions include

- "Tell me about your sleeping patterns."
- "Do you have trouble falling asleep or staying asleep?"
- "How much sleep do you get each night?"
- "Do you feel rested when you awaken?"
- "Do you nap during the day? How often and for how long?"
- "What do you do to help you fall asleep?"

Medication and Substance Use

The information gathered about medication and substance use provides the nurse with information concerning lifestyle and a client's self-care ability. Medication and substance use can affect the client's health and cause loss of function or impaired senses. In addition, certain medications and substances can increase the client's risk for disease. Because many people use vitamins or a variety of herbal supplements, it is important to ask which and how often. Prescription medications and these supplements may interact (e.g., garlic decreases coagulation and interacts with warfarin [Coumadin]).

Sample questions include

- "What medications have you used in the recent past and currently, both those that your doctor prescribed and those you can buy over the counter at a drug or grocery store? For what

purpose did you take the medication? How much (dose) and how often did you take the medication?"
- "How much beer, wine, or other alcohol do you drink on the average?"
- "Do you drink coffee or other beverages containing caffeine (e.g., cola)?" If so, how much and how often?
- "Do you now or have you ever smoked cigarettes or used any other form of nicotine? How long have you been smoking/did you smoke? How many packs per week? Tell me about any efforts to quit."
- "Have you ever taken any medication not prescribed by your healthcare provider? If so, when, what type, how much, and why?"
- "Have you ever used, or do you now use, recreational drugs? Describe any usage."
- "Do you take vitamins or herbal supplements? If so, what?"

Self-Concept and Self-Care Responsibilities

This includes assessment of how the client views herself and investigation of all behaviors that a person does to promote her health. Examples of subjects to be addressed include sexual responsibility; basic hygiene practices; regularity of health care checkups (i.e., dental, visual, medical); breast/testicular self-examination; and accident prevention and hazard protection (e.g., seat belts, smoke alarms, and sunscreen).

You can correlate answers to questions in this area with health-promotion activities discussed previously and with risk factors from the family history. This will help to point out client strengths and needs for health maintenance. Questions to the client can be open-ended but the client may need prompting to cover all areas.

Sample questions include

- "What do you see as your talents or special abilities?"
- "How do you feel about yourself? About your appearance?"
- "Can you tell me what activities you do to keep yourself safe, healthy, or to prevent disease?"
- "Do you practice safe sex?"
- "How do you keep your home safe?"
- "Do you drive safely?"
- "How often do you have medical checkups or screenings?"
- "How often do you see the dentist or have your eyes (vision) examined?"

Social Activities

Questions about social activities help the nurse to discover what outlets the client has for support and relaxation and if the client is involved in the community beyond family and work. Information in this area also helps to determine the client's current level of social development. Sample questions include

- "What do you do for fun and relaxation?"
- "With whom do you socialize most frequently?"
- "Are you involved in any community activities?"
- "How do you feel about your community?"
- "Do you think that you have enough time to socialize?"
- "What do you see as your contribution to society?"

Relationships

Ask clients to describe the composition of the family into which they were born and about past and current relationships with these family members. In this way, you can assess problems and potential support from the client's family of origin. In addition, similar information should be sought about the client's current family (Fig. 3-3). If the client does not have any family by blood or marriage, then information should be gathered about any significant others (including pets) that may constitute the client's "family."

Sample questions include

- "Who is (are) the most important person(s) in your life? Describe your relationship with that person."
- "What was it like growing up in your family?"
- "What is your relationship like with your spouse?"
- "What is your relationship like with your children?"
- "Describe any relationships you have with significant others."
- "Do you get along with your in-laws?"
- "Are you close to your extended family?"
- "Do you have any pets?"

Figure 3-3 Discussing family relationships is a key way to assess support systems.

- "What is your role in your family? Is it an important role?"
- "Are you satisfied with your current sexual relationships? Have there been any recent changes?"

Values and Belief System

Assess the client values. In addition, discuss the clients' philosophical, religious, and spiritual beliefs. Some clients may not be comfortable discussing values or beliefs. Their feelings should be respected. However, the data can help to identify important problems or strengths.

Sample questions include

- "What is most important to you in life?"
- "What do you hope to accomplish in your life?"
- "Do you have a religious affiliation? Is this important to you?"
- "Is a relationship with God (or another higher power) an important part of your life?"
- "What gives you strength and hope?"

Education and Work

Questions about education and work help to identify areas of stress and satisfaction in the client's life. If the client does not perceive that he has enough education or his work is not what he enjoys, he may need assistance or support to make changes. Sometimes discussing this area will help the client feel good about what he has accomplished and promote his sense of life satisfaction. Questions should bring out data about the kind and amount of education the client has, whether the client enjoyed school, whether he perceives his education as satisfactory or whether there were problems, and what plans the client may have for further education, either formal or informal. Similar questions should be asked about work history.

Sample questions include

- "Tell me about your experiences in school or about your education."
- "Are you satisfied with the level of education you have? Do you have future educational plans?"
- "What can you tell me about your work? What are your responsibilities at work?"
- "Do you enjoy your work?"
- "How do you feel about your coworkers?"
- "What kind of stress do you have that is work related? Any major problems?"
- "Who is the main provider of financial support in your family?"
- "Does your current income meet your needs?"

Stress Levels and Coping Styles

To investigate the amount of stress clients perceive they are under and how they cope with it, ask questions that address what events cause stress for the client and how they usually respond. In addition, find out what the client does to relieve stress and whether these behaviors or activities can be construed as adaptive or maladaptive. To avoid denial responses, nondirective questions or observations regarding previous information provided by the client may be an easy way to get the client to discuss this subject.

Sample questions include

- "What types of things make you angry?"
- "How would you describe your stress level?"
- "How do you manage anger or stress?"
- "What do you see as the greatest stressors in your life?"
- "Where do you usually turn for help in a time of crisis?"

Environment

Ask questions regarding the client's environment to assess health hazards unique to the client's living situation and lifestyle. Look for physical, chemical, or psychological situations that may put the client at risk. These may be found in the client's neighborhood, home, work, or recreational environment. They may be controllable or uncontrollable.

Sample questions include

- "What risks are you aware of in your environment such as in your home, neighborhood, on the job, or any other activities in which you participate?"
- "What types of precautions do you take, if any, when playing contact sports, using harsh chemicals or paint, or operating machinery?"
- "Do you believe you are ever in danger of becoming a victim of violence? Explain."

Developmental Level

Determining the client's developmental level is essential to complete the client's portrait. You do not need to ask the client additional questions unless major gaps in the data collection were found or clarification is needed. Instead, group and analyze the data obtained during the health history and compare them with normal developmental parameters (e.g., height, weight, Erikson's psychosocial developmental stages; see Schuster & Asburn, 1992). This requires integrating all that has been learned about the client by the health history and using critical thinking to position the client on a developmental continuum. It helps to determine any developmental impairments. Standard growth charts can be used to determine physical development. However, when assessing adults, the area most likely to yield delays or unresolved problems occurs in the psychosocial domain of development. The theorist Erik Erikson developed a psychosocial theory that identifies a

number of dichotomous concepts to describe growth from birth to death (Table 3-1). Although there are implied age ranges attached to these stages and it is hoped that a person might move through them in an orderly fashion, this does not always occur. Thus it is important to look at the client's behavior rather than age to identify the stage of development currently in progress.

Strong indicators that the client is functioning much below the usual behavior for her age range point to areas for possible nursing diagnoses (developmental delay) and nursing intervention. Sometimes a person skips one or more developmental levels and, at a later stage of maturity, goes back and successfully works through the missed levels. A thorough knowledge of the behaviors and approximate age levels provides the nurse with a powerful tool for assessing and helping a client grow to his or her full potential. Although accomplishment of all of the tasks in the stage before moving on is ideal, it is believed that partial resolution is adequate for health, growth, and development.

The psychosocial developmental stages of the young adult, middle-aged adult, and older adult are discussed in detail in the following sections. Each section is followed by important questions to ask yourself about the client to determine if she has accomplished all of the required tasks in a particular psychosocial developmental stage. If the adult client does not seem even to have advanced psychologically to the intimacy versus isolation stage, refer to the earlier stages discussed in Chapter 24.

Young Adult: Intimacy Versus Isolation

The young adult should have achieved self-efficacy during adolescence and is now ready to open up and become intimate with others. Although this stage focuses on the desire for a special and permanent love relationship, it also includes the ability to have close, caring relationships with friends of both sexes and a variety of ages. Spiritual love also develops during this stage. Having established an identity apart from the childhood family, the young adult is now able to form adult friendships with his parents and siblings. However, the young adult will always be a son or daughter.

If the young adult cannot express emotion and trust enough to open up to others, social and emotional isolation may occur. Loneliness may cause the young adult to turn to addictive behaviors such as alcoholism, drug abuse, or sexual promiscuity. Some people try to cope with this developmental stage by becoming very spiritual or social, playing an acceptable role, but never fully sharing who they are or becoming emotionally involved with others. When adults successfully navigate this stage, they have stable and satisfying relationships with important others.

Does the client

- Accept self: physically, cognitively, and emotionally?
- Have independence from the parental home?
- Express love responsibly, emotionally, and sexually?
- Have close or intimate relationships with a partner?
- Have a social group of friends?
- Have a philosophy of living and life?
- Have a profession or a life's work that provides a means of contribution?
- Solve problems of life that accompany independence from the parental home?

Middlescent: Generativity Versus Stagnation

During this stage, the middle-aged adult is able to share self with others and establish nurturing relationships. The adult will be able to extend self and possessions to others. Although traditionalists tend to think of generativity in terms of raising one's children and guiding their lives, generativity can be realized in several ways even without having children. Generativity implies mentoring and giving to future generations. This can be accomplished by producing ideas, products, inventions, paintings, writings, books, films, or any other creative endeavors that are then given to the world for the unrestricted use of its people.

Generativity also includes teaching others, children or adults, mentoring young workers, or providing experience and wisdom to assist a new business to survive and

TABLE 3-1 ERIK H. ERIKSON'S PSYCHOSOCIAL DEVELOPMENTAL LEVELS

Developmental Level	Basic Task	Negative Counterpart	Basic Virtues
1. Infant	Basic trust	Basic mistrust	Drive and hope
2. Toddler	Autonomy	Shame and doubt	Self-control and will power
3. Preschooler	Initiative	Guilt	Direction and purpose
4. Schoolager	Industry	Inferiority	Method and competence
5. Adolescent	Identity	Role confusion	Devotion and fidelity
6. Young adult	Intimacy	Isolation	Affiliation and love
7. Middlescent	Generativity	Stagnation	Production and care
8. Older adult	Ego-integrity	Despair	Renunciation and wisdom

(Erikson, E. H. [1963]. *Childhood and society* [2nd ed.]. New York: Norton.)

grow. Also implied in this stage is the ability to guide then let go of one's creations. Without this important step, the gift is not given and the stage does not come to successful completion. Stagnation occurs when the middle-aged person has not accomplished one or more of the previous developmental tasks and is unable to give to future generations. Sometimes severe losses may result in withdrawal and stagnation. In these cases, the person may have total dependency on work, a favorite child, or even a pet, and be incapable of giving to others. A project may never be finished or schooling completed because the person cannot let go and move on. Without a creative outlet, a paralyzing stagnation sets in. Successful movement through this stage results in a fuller and more satisfying life and prepares the mature adult for the next stage.

Does the client

- Have healthful life patterns?
- Derive satisfaction from contributing to growth and development of others?
- Have an abiding intimacy and long-term relationship with a partner?
- Maintain a stable home?
- Find pleasure in an established work or profession?
- Take pride in self and family accomplishments and contributions?
- Contribute to the community to support its growth and development?

Older Adult: Ego Integrity Versus Despair

When the middle-aged adult has accomplished at least partial resolution of the previous developmental tasks, she moves into the ego integrity versus despair stage. According to Erikson, a person in this stage looks back and either finds that life was good or despairs because goals were not accomplished. This stage can extend over a long time and include excursions into previous stages to complete unfinished business. Successful movement through this stage does not mean that one day a person wakes up and says, "My life has been good"; rather, it encompasses a series of reminiscences in which the person may be able to see past events in a new and more positive light.

This can be a very rich and rewarding time in a person's life, especially if there are others with whom to share memories and who can assist with reframing life experiences (Fig. 3-4). For some people, resolution and acceptance do not come until the final weeks of life but this still allows for a peaceful death. If the older person cannot feel grateful for his or her life, cannot accept those less desirable aspects as merely part of living, or cannot integrate all of the experiences of life, then the person will spend his or her last days in bitterness and regret and will ultimately die in despair.

Obviously mental or physical developmental delays can affect the smooth movement through Erikson's tasks. In fact, some may be entirely unachievable. However, it is important not to assume data not in evidence and assign

Figure 3-4 Older adulthood can be a rich and rewarding time to review life events.

a person to a lower level just because of other problems in development. Many such people are quite capable of advancing through all psychological stages. Rely on data collected, not on age or physical/mental accomplishments.

Does the client

- Adjust to the changing physical self?
- Recognize changes present as a result of aging, in relationships and activities?
- Maintain relationships with children, grandchildren, and other relatives?
- Continue interests outside of self and home?
- Complete transition from retirement at work to satisfying alternative activities?
- Establish relationships with others his or her own age?
- Adjust to deaths of relatives, spouse, and friends?
- Maintain a maximum level of physical functioning through diet, exercise, and personal care?
- Find meaning in past life and face inevitable mortality of self and significant others?
- Integrate philosophical or religious values into self-understanding to promote comfort?
- Review accomplishments and recognize meaningful contributions he or she has made to community and relatives?

SUMMARY

Collecting subjective data is a key step of nursing health assessment. Subjective data consist of information elicited and verified only by the client. Interviewing is the means by which subjective data are gathered. Two types of

communication are useful for interviewing: nonverbal and verbal. Variations in communication, such as gerontologic, cultural, and emotional variations, may be encountered during the client interview.

The complete health history is performed to collect as much subjective data about a client as possible. It consists of eight sections: biographic data, reasons for seeking health care, history of present health concern, past health history, family health history, review of body systems (ROS) for current health problems, lifestyle and health practices, and developmental level.

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