**King Saud University**

**Collage of Nursing**

**Medical Surgical Nursing depart**

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| --- | --- | --- | --- | --- | --- |
| **Outline of an Adult Health History**  **Information** | | | **Practical Notes** | | |
| **1-Biographical Data**  Name Ethnicity  Address Religion  Telephone | Gender  Source of History Birth date & place | | |  Most of this information is on the name plate or chart   Indicate if a translator was used | |
| **2-Reason for Seeking Care**  This is a brief statement of the patient’s visit | | |  A concrete complaint recorded in the patients words – “pain since 2 days”   Symptom (subjective sensation)   Sign (Objective abnormality, either physical examination, or in a laboratory reports. | | |
| **3-Present Illness**  To obtain a chronological (time) narrative of the chief complaint of an ill person.  Final Summary include eight critical characteristics:  1**. Location, Region, radiation** | | |  Note precise site, point to the location.   Be specific e.g., “pain behind the eyes”  “is the pain localized or radiating”  “is the pain superficial or deep | | |
| **2. Character or quality**  **These are descriptive terms**  **Burning, sharp, dull, aching, gnawing, throbbing, shooting** | | |  Use images – “does blood in the stool look like sticky tar”?  “ does blood in vomitus look like coffee grounds”? | | |
| **3. Quantity or severity** | | | “ does the pain feel like pressure or squeezing?   Attempt to quantify the sign or symptom such as “profuse blood flow soaking five pads per hour” | | |
| **4. Timing**  **Onset, Duration, Frequency** | | |  When did the first symptom appear?   How long did the symptom last? (duration)   Was it steady (constant) or did it come and go during that time (intermittent), irregular   Did it resolve completely and reappear days or weeks later? | | |
| **5. Setting** | | |  Where the person or what was the person doing when the symptom started?   What brings it on? | | |
| **6. Aggravating or Relieving Factors** | | |  What makes the pain worse? Is it aggravated by weather, activity, food, medication, standing, bending, fatigue, time of day, season, etc?   What relieves it? (e.g., rest, medication, ice pack)   What is the effect of any treatment?   What have you tried?   What seems to help? | | |
| **7. Associated Factors** | | |  Is this primary symptom associated with others? (e.g., urinary burning)   Review this body system now rather than wait. | | |
| **8. Patient’s Perception** | | |  Find out the meaning of the symptom by asking how it affects daily activities.  “What do you think it means”?   This is important as this alerts you to potential anxiety. | | |
| **PQRSTU – mnemonic that will help remember all the points.**  **P – Provocative or palliative**  **Q – Quality or quantity**  **R – Region or radiation**  **S- Severity Scale**  **T – Timing**  **U – Understand Patient’s Perception** | | |  What brings it on?   How does it look, feel, sound?   Where is it? Does it spread anywhere?   How bad is it? (Scale 1-10) is it getting better or the same?   Onset – exactly when did it occur? Duration – how long did it last?   Frequency – how often does it occur?   What do you think it means? | | |
| **4-Past Health**  Past health events may have residual effect on the current health state | | | | | |
| -**Childhood illnesses** | |  Mumps, measles, rubella, chicken pox, pertussis. Ask about serious illness that may have sequelae at later life. (rheumatic fever, scarlet fever, and poliomyelitis) | | |
| -**Accidents or injuries**  **Serious or chronic illnesses** | |  Auto accidents, fractures, penetrating  wounds, head injury (especially associated with unconsciousness), and burns.   Diabetes, hypertension, heart disease, sickle-cell anemia, cancer, seizure disorder. | | |
| **-Hospitalizations** | |  Cause, name of hospital. How the condition was treated, how long the person was hospitalized, and the name of the physician. | | |
| -**Operations** | |  Type of surgery, date, name of the surgeon, and how the person recovered. | | |
| **-Obstetric history** | |  Number of pregnancies (gravida) number of deliveries, (full term), (pre-term), abortions, and number of children living. | | |
| **-Immunizations** | |  Measles, mumps-rubella, polio, diphtheria-pertussis-tetanus, hepatitis B, etc. | | |
| **-Last examination date** | |  Physical, dental, vision, hearing, EKG, chest X-ray examinations. | | |
| **Allergies** | |  Note both the allergen (medications, food, or contact agent, such as fabric or environmental agent) and the reaction (rash, itching, runny nose, watery eyes, difficulty breathing) | | |
| **Current medication** | |  Ask about vitamins, birth control pills, aspirin, antacids, prescription and over the counter medications. | | |
| **5-Family History**  To identify the presence of genetic | |  Heart disease, high blood pressure,  stroke, | | |
| traits or disease that has familial tendencies.  To assess exposure to a communicable disease in a family member.  To assess the individuals reactions to disease or death in the family.  To assess family relationships | | diabetes, blood disorders, cancer, sickle-cell anemia, arthritis, allergies, obesity, alcoholism, mental illness, seizure disorders, kidney disease, and tuberculosis.   Age of parents: Age and cause of death if deceased | | |
| **6-Personal / Social History**  **To develop an understanding of the patient as an individual and as a family member** | |  Cultural and religious traditions   Geographic location City vs. town   Be sensitive to cultural value of privacy   Males may answer for females | | |

Miss Fatema is a 40 years old female, came to the hospital complaining of abdominal pain in the right upper quadrant of abdomen, radiating to the back and left shoulder, The patient describe feeling of pain as colicky in nature and rating of pain is 8 , also its provoke after having a fried foods or fatty food and pain is relived by vomiting. During the pain attack cannot able to go to the bathroom.

**Now describe the patient chief compliant, following the PQRSTU mnemonic.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| P | Q | R | S | T | U |
|  |  |  |  |  |  |

**Instructions:** Fill in the blanks or mark in with interview findings

***I- Demographic data:***

Patient name: age:

Sex: marital status:

Spoken language: occupation:

Address: tel. No.:

Next of kin: relationship:

Address: tel. No.:

Source of data: □Patient □Family □Friend □Medical record

**III**- **Chief Complaint (patient exact words) (following PQRST mnemonic):**

Complain:…………………………….. Provoked by:……………………..

Palliated by:……………………Region………………………………….

Quality: …………………………………

Radiation: □ no □ yes (location):………………………………….

Severity: □ mild □ moderate □ severs scale (0-5)-------------

Timing: Onset -----------------□sudden--------------□ gradual ---------------- Frequency ---------- Duration ---------------

**IV- Present illness:**…………………………………

**V- Past history:**

Medical: □ no □yes (specify):…………………………….

Surgical: □ no □yes (specify):…………………………………

Mental illness: □ no □ yes (specify) ………………………………

Accidents and injuries: □no □yes (specify):………………….

Immunization: □ no □yes □unknown

Hospitalization: □ no □ yes Specify:………………

**VI- Family history:**

Deaths: □ no □ yes (cause): …………………relationship ………………..Age…………...

Diseases: □ no □ yes (specify) …………………relationship……………….. Age…………..

**VII- Psychosocial history:**

Educational level: □ illiterate □ elementary □ secondary □ higher education

Housing: □ tent □ apartment □ villa

Dependant relatives: □no:…………..relationship……………………

Home assistance: □no □yes

Home condition: □accommodates illness stage □ doesn’t accommodate illness stage

□ depression □ anxiety □ hostility □ withdrawal □ frequent change in mood.

**IIX**-**Current health status:**

1. smoking: □ no □ yes (no. packs): □ quit (date):

2. alcohol: □ no □ yes (amount):

3.allergies: □no □ yes

Medication (type):……….. reaction:…………..

Food (type):……………… reaction:…………..

Others (specify…………… reaction:…………..

4. Sleeping : night sleep(no of hours)………….

Am. naps: □ no □ yes (hrs):………….. P.m. naps: □ no □yes (hrs):

5- Medication taken at home: □ no □ yes (specify): ………………….

6- Performed special exercise: □no □yes,……………….

7.daily activity level: □low □moderate □high

**8 - Activity-exercise:**

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Dependent | Needs assistance | Independent |
| Ambulating |  |  |  |
| Hygiene |  |  |  |
| Dressing-grooming |  |  |  |
| Feeding |  |  |  |
| Toileting |  |  |  |

\*Assertive devices: □ wheelchair □sticks □ crutches □dentures □prosthesis

***9- Review of body systems:***

**1-Integuementry Systems:**

□ Rashes □ lumps □ Itching□ Dryness□ Color changes

□ Changes in hair or nails □ other …………….

**2-Head and neck:**

***Head:***

□ Headache □ injury □ dizziness □ other …………….

***Eyes:***

□ Glasses □ Contact lenses □ Pain □ Redness □ Blurred vision □ Double vision

□ Glaucoma □ Cataract □ other …………….

***Ears:***

□ Tinnitus □ Pain □ Discharge □ Hearing aids

***Nose and sinuses:***

□ Discharge □ Itching □ Bleeding □ other …………….

***Mouth and throat:***

□Bleeding gums □ Denture □ Dryness □ Sore tongue □ Sore throat

***Neck***:

□lumps □ Swollen glands □ pain□ stiffens □ other …………….

**3-Breasts:**

□ Lumps □ Pain □ Nipple discharge □ Self-examination practice □ other …………….

**4-Respiratory System:**

□ Cough □ Sputum □ Heamoptesis □ Dyspnea □ Wheezing□ Asthma □ Bronchitis □ Tuberculosis □ other …………….

**5-Cardiovascular System:**

□ Increased B.P□ Mummers□ Chest pain □ Palpitation □ Edema □ other …………….

**6-Gastrointestinal System:**

□ Nausea □ vomiting □ Heart burn □ Heamatemisis □ Dysphagia □ Constipation

□ Diarrhea □ Distention □ Pain □ other …………….

**7-Urinary System:**

□ Polyuria.□ Nocturia. □ Dysuria.□ Hematuria.□ urgency.□ hesitancy.

□ Incontinence. □ stone.□ dribbling

**8-Musculskeletal System:**

□ Pain in joint or muscles.□ Stiffness.□ Arthritis.□ Limitation of motion.

□ Gout. □ Others (describe):

**9-Neurological System:**

□ Seizure.□ Weakness.□ Paralysis.□ Numbness.□ Tremors or other involuntary movements.

□ Others (describe):

**NURSES NOTES:** -------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**Name/Signature----------------**

**Date-----**

**King Saud University**

**Collage of Nursing**

**Medical-surgical Nursing**

**Adult Health assessment NUR 225**

**Performance Checklist**

**History taking**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Components of patient history** | Done  perfectly | poor | Not  done | mark |
| 1. Biographical data |  |  |  |  |
| 1. Chief complain |  |  |  |  |
| 1. History of present illness |  |  |  |  |
| 1. Past Health history |  |  |  |  |
| 1. Family history |  |  |  |  |
| 1. Functional Assessment |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Analysis of the symptoms | Done  perfectly | poor | Not  done | mark |
| When |  |  |  |  |
| What |  |  |  |  |
| Where |  |  |  |  |
| How |  |  |  |  |
| Describe |  |  |  |  |

History taking

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Components of medical history | Done  perfectly | poor | Not  done | Mark |
| 1. Childhood diseases and adult illnesses |  |  |  |  |
| 1. Accidents and Injuries |  |  |  |  |
| 1. Immunizations |  |  |  |  |
| 1. Hospitalizations and Surgeries |  |  |  |  |
| 1. Allergies |  |  |  |  |
| 1. Medications |  |  |  |  |
| 1. Transfusions |  |  |  |  |
| 1. Emotional status (Psychiatric attentions) |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Components of family history | Done  perfectly | poor | Not  done | Mark |
| 1. Any family member with illness |  |  |  |  |
| 1. Age of parents and cause of death |  |  |  |  |
| 1. Number and age of siblings |  |  |  |  |
| 1. History of chronic diseases |  |  |  |  |
| 1. Major genetic disorders |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Checklist performance** | **Student Performance** | | | | |
| **Data collection technique** | **Competent** | | **Not competent** | | **comment** |
|  | **Trial 1** | **Trial 2** | **Trial 1** | **Trial 2** |  |
| **A-Introduction phase of interview** |  |  |  |  |  |
| 1-prepare the physical environment  2- greet client and introduce self  3-call client by name  4-arrange comfortable equal status seating at eye level  5-put client in a comfortable position  6-establish verbal contact with client by stating the reason for interview  7-assess the client for: a-posture  b-speech  c-sings of distress  d-facial expression  e-dress, grooming,  hygiene |  |  |  |  |  |
| **B-Working phase of interview** |  |  |  |  |  |
| 8-ask open-ended question. |  |  |  |  |  |
| 9-use close-ended question to elicit specific information when indicated. |
| 10-ask one question at a time. |
| 11-use medical terminology free language to communicate with the client. |
| 12-use communication skills (facilitation, silence, reflection, empathy, clarification) to elicit information using clients’ frame of reference. |
| 13- React to clients’ non verbal messages. |
| 14-avoid nonproductive interview behaviors. |
| **c. Closure phase:** |  |  |  |  |  |
| 15.summarize collected data  16.provide conclusion of interview  17.offer client chance for final addition  18.thank the client  20.explain the next step (physical examination) |  |  |  |  |  |
| 21-document all data (biographic data, chief complaint, medical history, surgical history, psychosocial history, activities of daily living,  Review of body systems) following structured format correctly. |  |  |  |  |  |

1. The health history is:
2. A way of wasting time in the morning
3. One of the most important components of a physical assessment

c. Only carried out by the doctor

d. Only to be taken by the admitting nurse

2. One difficulty in obtaining a good history in Saudi Arabia is:

a. The patient asking too many questions

b. The language barrier

c. It takes up too much time of the nurse

d. The doctors

3. Data for the health history can be

a. Obtained from looking only at the old notes

b. Obtained from the doctors when they do their assessment

c. Obtained over a period of time

d. Obtained at the point of admission

4- Health history obtained which type of data:

1. Primary data
2. Secondary data
3. Subjective data
4. Objective data

5- A client reveals that her mother and father both had sensitive skin and developed many skin allergies. This information would come under which one of the following categories:

a. Family history

b. Present history

c. Past medical history

d. Lifestyle history