KING SAUD UNIVERSITY
COLLEGE OF NURSING
MEDICAL SURGICAL DEPARTMENT

NURS 221

HEALTH ASSESSMENT (Practical)

Procedure Guide and Checklist

Health History, General survey and Examination Techniques

MODULE 1

Outline of an Adult Health History

HEALTH HISTORY FORMAT

I. BIOGRAPHICAL DATA

- Name, Address, Age, Date of Birth, Birthplace, Gender, Marital Status, Race, Ethnic Identity/Culture, Religion and Spirituality, Occupation
- Source of Information/Reliability: the usual source of information and the most reliable is the patient who is the primary source. Secondary sources of information include family members, healthcare professionals and others who can provide information about the patient's health status

II. PRESENT HEALTH OR ILLNESS

- The history of present health or illness includes information about all of the patient's current health-related issues, concerns, and problems. The history includes determination of the reason for seeking care from the time the symptoms first started until the time of admission/medical consult.
- And The patient's own words should be used to document the reason for contact

Final summary of any symptoms should include these eight critical characteristics:

. Location, Region, radiation

- Location :Be specific e.g., "pain behind the eyes"
- Radiation: "is the pain localized or radiating"
- "is the pain superficial or deep

2. Character or quality

- These calls for specific descriptive terms such as Burning, sharp, dull, aching, gnawing, throbbing, shooting
- Use images – " does blood in vomitus look like coffee grounds"?
- " does the pain feel like pressure or squeezing?

3. Quantity or severity

- Attempt to quantify the sign or symptom
- Quantify the symptoms of pain using the scale

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)

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.

You may find it helpful to organize this same question sequence into the mnemonic <u>PQRSTU</u> to help remember all the points.

P – Provocative or palliative; What brings it on? what make it better or worse?
Q – Quality or quantity; How does it look, feel, sound?
R – Region or radiation; Where is it? Does it spread anywhere?
S- Severity Scale; How bad is it? (Scale 1-10) is it getting better or the same?
T – Timing;

- Onset – exactly when did it occur?
- Duration – how long did it last?
- Frequency – how often does it occur?

U – Understand Patient's Perception; What do you think it means?

III. PAST HISTORY

- **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;** Auto accidents, fractures, penetrating wounds, head injury (especially associated with unconsciousness), and burns.
- **Serious or chronic illnesses;** 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.

IV. FAMILY HISTORY

- To identify the presence of genetic and highlight those diseases and conditions for which a patient may be at increased risk. (e.g. heart disease, high blood pressure, stroke, diabetes, blood disorders, cancer, sickle-cell anemia, arthritis, allergies, obesity)

V. PSYCHOSOCIAL HISTORY

- The psychosocial history includes information about the patient's occupational history, educational level, financial background, roles and relationships, ethnicity and culture, family, spirituality and self-concept.

VI. REVIEW OF BODY SYSTEM

GENERAL SURVEY

COMPONENTS OF THE GENERAL SURVEY:

A. PHYSICAL APPEARANCE:

- The patient's physical appearance provides immediate and important cues to the level of individual wellness. Beginning with the initial meeting, the nurse notes any factors about the patient's physical appearance that are in any way unexpected (e.g, skin color, facial features, signs of distress, body shape ad build, height and weight, nutrition, symmetry)

B. MENTAL STATUS:

- The nurse assess the patient's mental status while the patient is responding to questions and giving information about health history. The nurse notes the patient's affect and mood, level of anxiety, orientation and speech.
- The nurse assess patients for orientation to person, place and time. Patients should be able to typically state their name, location, the date, month, season and time of the day.

C. MOBILITY

- The nurse observes the patient's gait, posture, and range of motion. Normally, the patient walks in a rhythmic, straight, upright position with arms swinging at each side of the body. The shoulders are level and straight. Range of motion should be fluid and appropriate to the age of the patient.

D. PATIENT BEHAVIOR

- An assessment of the patient's behavior includes information about the following factors: dress and grooming, body odors, facial expression, mood and affect, ability to make eye contact and level of anxiety.

NUTRITIONAL ASSESSMENT

Upon completion of the general survey, the nurse will assess height, weight, and vital signs.

- The general survey is composed of four major categories of observation: physical appearance, mental status, mobility, and patient behavior.
- The nurse measures the patient's **height and weigh**t to establish baseline data and to help determine health status.

To measure height,

- the nurse uses a measuring stick attached to a platform scale.
- The patient should look straight ahead while standing as straight as possible with heels together and shoulders back.
- the nurse raises the height attachment rod above the patient's head, then extends and lowers the right-angled arm until it rests on the crown of the head.

To measure weight ;

- weigh the patient at the same time of day in the same kind of clothing (e.g., the examination gown) and without shoes.
- The nurse moves the large and small weights until the balance beam is level and takes the reading .

To measure Body Mass Index ;

- BMI is widely used to assess appropriate weight for height using the following formula: BMI = $\frac{\text{weight (kg)}}{\text{height}^2 \text{ (meters)}}$.
- Parameters have been established to delineate underweight, healthy weight, and overweight standards in adults as outlined in chart below.

TABLE 12.4 Classification of Body Mass Index (BMI) in Adults

BMI	CLASSIFICATION
<16	Severe underweight
16–16.99	Moderate underweight
17–18.49	Mild underweight
18.5–24.9	Normal
25–29.9	Overweight
30–34.9	Obese class 1
35–39.9	Obese class 2
≤40	Obese class 3

TABLE 12.5 Height–Weight Table with BMI Calculation

Locate the height of interest in the leftmost column and read across the row for that height to the weight of interest. Follow the column of the weight up to the top row that lists the BMI. BMI of 19–24 is the healthy weight range, BMI of 25–29 is the overweight range, and BMI of 30 and above is in the obese range.

BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
HEIGHT	WEIGHT IN POUNDS																
4′10″	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
4′11″	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
5′	97	102	107	112	118	123	128	133	138	143	148	153	158	163	158	174	179
5′1″	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
5′2″	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
5′3″	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
5′4″	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
5′5″	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
5′6″	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
5′7″	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
5′8″	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
5′9″	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
5′10″	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
5′11″	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
6′	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
6′1″	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
6′2″	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
6′3″	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
	Healthy Weight						Overweight					Obese					

Source: National Institutes of Health, National Heart, Lung, and Blood Institute (NIH/NHLBI). (n.d.). Body Mass Index Table. Retrieved from http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm

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NURS 221 HEALTH ASSESSMENT (PRACTICAL) PERFORMANCE CHECKLIST

Health History and General Survey

STUDENT'S NAME: _____ **RATING:** _____
STUDENT'S NUMBER: _____ **DATE PERFORMED:** _____

THE STUDENT NURSE SHOULD BE ABLE TO:

Performance Criteria	COMPETENCY LEVEL			
	Done Correctly	Done with Assistance	Not Done	COMMENTS
PREPARATION				
1. Prepare the necessary equipment.				
2. Review the interview note.				
3. Introduce self to the patient.				
4. Identify the patient.				
5. Explain the procedure.				
6. Ensure patient safety and privacy.				
7. Wash hands.				
I. OBTAINING A COMPREHENSIVE HEALTH HISTORY				
I. Components of patient history:				
a. Biographical Data				
b. Present Health / Illness ↳ Reason for seeking care				
c. Past History				
d. Family History				
e. Psychosocial History				
II. GENERAL SURVEY				
a. Physical Appearance				
↳ Skin color				
↳ Facial features				
↳ Body shape and build				
↳ Body symmetry				

↳ Height and weight				
↳ Nutrition				
↳ Signs of distress				
b. Mental Status				
↳ Affect and mood				
↳ Level of anxiety				
↳ Orientation and speech				
c. Mobility				
↳ Gait				
↳ Posture				
↳ Range of motion				
d. Patient Behavior				
↳ Dress and grooming				
↳ Body odor				
↳ Facial expression				
↳ Ability to make eye contact				
III. NUTRITIONAL STATUS				
✓ Measuring weight				
✓ Measuring height				
✓ Measuring *BMI				
IV. Vital Signs				
V. Document findings.				