

Health Assessment



made **Incredibly** *Visual!*[®]

Third Edition

Clinical Editor
Laura M. Willis



Wolters Kluwer

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made Incredibly *Visual!*[®]



Third Edition

Clinical Editor

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3rd Edition

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Health Assessment

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Third Edition

Dedication

This book is dedicated to students everywhere. My hope is that the information in this book will inspire you to become masters at health assessment.

And this book is dedicated, with gratitude and love, to Andrew, Dan, Steven, and my mom and dad: each of you have inspired me to be better at what I do every single day.

Gratefully,
Laura

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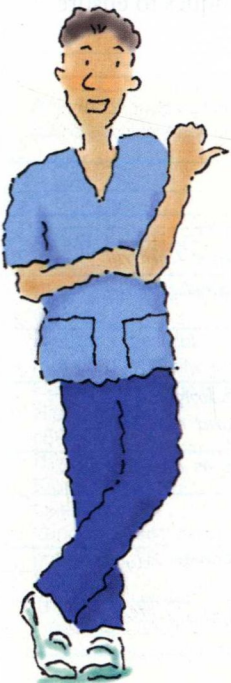
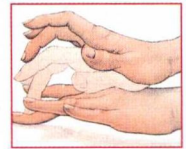
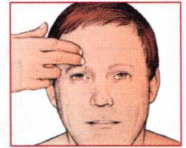
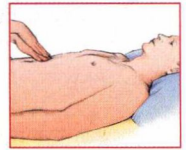
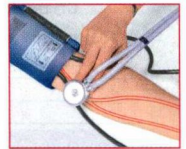
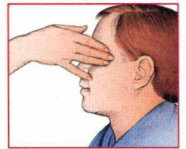
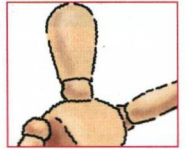
Fundamentals

2 Health history

6 Physical assessment

9 Documentation

10 Q&A



Health history

All assessments involve collecting two kinds of data: **objective** and **subjective**. The health history gathers subjective data about the patient.

Objective data (signs)

- Are observed during a physical examination
- Are verifiable
- Include findings such as a red, swollen arm in a patient

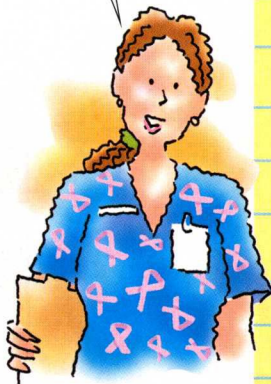
Subjective data (symptoms)

- Provided by the patient or "subject"
- Verified only by the patient
- Include statements such as "My head hurts" or "I have trouble sleeping"

Interviewing tips

The success of your patient interview depends on effective communication.

To make the most of your patient interview, create an environment in which the patient feels comfortable. Also, use the following techniques to ensure effective communication.



- ✓ Select a quiet, private setting.
- ✓ Choose a location where there is a comfortable temperature (not too warm or cold) and adequate lighting.
- ✓ Choose terms carefully and avoid using medical jargon.
- ✓ Speak slowly and clearly.
- ✓ Use effective therapeutic communication techniques, such as silence, facilitation, confirmation, reflection, and clarification.
- ✓ Use open-ended and closed-ended questions as appropriate.
- ✓ Use appropriate body language.
- ✓ Confirm patient statements to avoid misunderstanding.
- ✓ Summarize and conclude with "Is there anything else?"

Components of a complete health history

Biographical data

Name _____
Address _____
Date of birth _____

Advance directive explained: ☐ Yes ☐ No
Copy of Advance Directive on chart: ☐ Yes ☐ No
Preferred Language: _____

Chief complaint

History of present illness (include time frame, signs and symptoms)

Current medications

MEDICATION, DOSE, ROUTE	FREQUENCY	LAST DOSE	REASON FOR TAKING

Medical history

Allergies ☐ Tape ☐

- ☐ Medication: _____
- ☐ Food: _____
- ☐ Environmental: _____
- ☐ Blood reaction: _____
- ☐ Other: _____

Be sure to include prescription medications, over-the-counter medications, herbal preparations, and vitamins and supplements, birth control pills or implanted birth control, hormone therapy.

Childhood illnesses

ILLNESS	DATE

Previous hospitalizations

(Illness, accident or injury, surgery, blood transfusion)

LIST ALL	DATE

Health problems

	Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood problem (anemia, sickle cell, clotting, bleeding). . .	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Eye problem (cataracts, glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease (heart failure, MI, valve)	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>
Liver problem	<input type="checkbox"/>	<input type="checkbox"/>
Lung problem (asthma, bronchitis, emphysema, pneumonia, TB, shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers (duodenal, peptic).	<input type="checkbox"/>	<input type="checkbox"/>
Psychological disorder (depression, anxiety).	<input type="checkbox"/>	<input type="checkbox"/>

Name and phone numbers of next of kin or support network:

NAME	RELATIONSHIP	PHONE #

Obstetric history (females)

Last menstrual period _____
Gravida _____ Para _____

Menopause ☐ Yes (Date) _____

Sexual history (all patients)

Do have sex with ☐ men ☐ women _____
Preferred pronoun/gender identity _____

Ask about the patient's feelings of safety to help identify physical, psychological, emotional, and sexual abuse issues

Psychosocial history

Coping strategies _____

Feelings of safety _____

Social history

Tobacco Use ☐ No _____ ☐ Yes (# packs/day _____
years _____) (cigarettes, pipe, cigar) ☐ smokeless
tobacco (dip, chew) ☐ vapor user

Alcohol ☐ No ☐ Yes (type _____ amount/day _____)
(# years)

Illicit drug use ☐ No ☐ Yes (type _____) (# years)

Any recent changes in weight?

Religious and cultural observances

Activities of daily living

Diet and exercise regimen _____
Elimination patterns _____
Sleep patterns _____
Bathing and Dressing _____
Sleep/rest patterns _____
Work and leisure activities _____
Use of safety measures _____
(seat belt, bike helmet, sunscreen) _____

Ask about the patient's family medical history

Health maintenance history

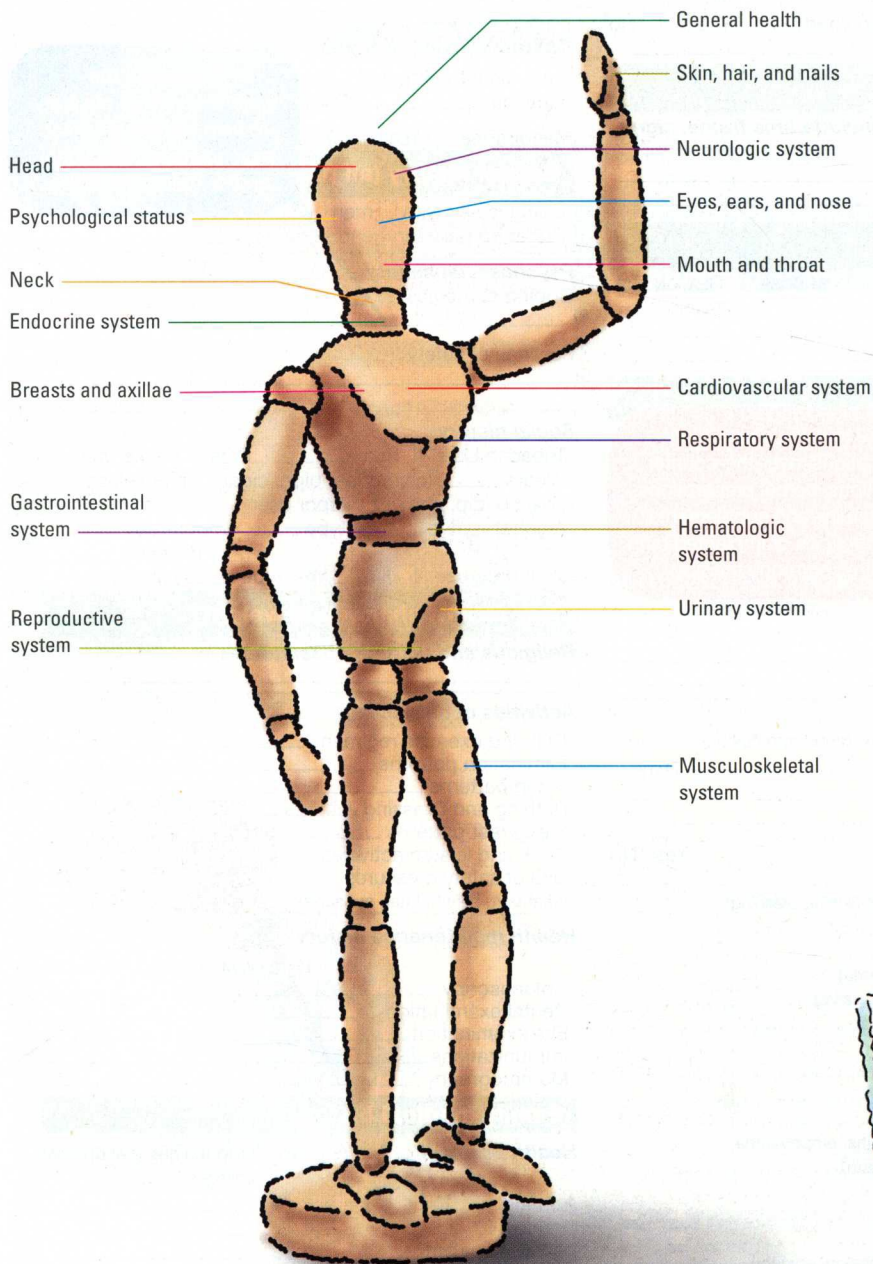
DATE OF MOST RECENT RESULTS

Colonoscopy _____
Dental examination _____
Eye examination _____
Immunizations _____
Mammography _____

Family medical history

Health problem	Yes	No	Who (parent, grandparent, sibling)
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease (heart failure, MI, valve disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	

Review of structures and systems



During the final part of the health history, ask about each body structure and system to make sure that important symptoms weren't missed. Start at the top of the head and work your way down to the toes.



If your patient is vague in describing the chief complaint, use your interviewing skills to discover how the current problem is related to abdominal distention. Now what? This flowchart will walk you through what to do next.

Evaluating a symptom

My stomach gets bloated.

Ask the patient to identify the symptom that's bothering him.

Form a first impression.

Does the patient's condition alert you to an emergency? For example, does he say the bloating developed suddenly? Does he mention that other signs or symptoms occur with it, such as sweating and light-headedness? (Indicators of hypovolemia)

Yes

Take a brief history

Perform a focused physical examination to quickly determine the severity of the patient's condition.

Do you have any other signs or symptoms?

No

Take a thorough history. Note GI disorders that can lead to abdominal distention.

Thoroughly examine the patient. Observe for abdominal asymmetry. Inspect the skin, auscultate for bowel sounds, percuss and palpate the abdomen, and measure abdominal girth.

Evaluate your findings. Are emergency signs or symptoms present, such as abdominal rigidity and abnormal bowel sounds?

Yes

Intervene appropriately to stabilize the patient, and notify the doctor immediately.

After the patient's condition stabilizes, review your findings to consider possible causes, such as trauma, large-bowel obstruction, mesenteric artery occlusion, and peritonitis.

No

Review your findings to consider possible causes, such as cancer, bladder distention, cirrhosis, heart failure, and gastric dilation.

Devise an appropriate care plan. Position the patient comfortably, administer ordered analgesics, and prepare the patient for diagnostic tests.

Physical assessment



Skill check

Assemble the necessary tools for the physical assessment. Then perform a general survey to form your initial impression of the patient. Obtain baseline data, including height, weight, and vital signs. This information will direct the rest of your assessment.

Got your tools?
Good.
Let's get to work!

Assessment tools

- Cotton balls
- Gloves
- Metric ruler (clear)
- Near-vision and visual acuity charts
- Ophthalmoscope
- Otoscope
- Penlight
- Percussion hammer
- Paper clip
- Scale with height measurement
- Skin calipers
- Specula (nasal and vaginal)
- Sphygmomanometer
- Stethoscope
- Tape measure (cloth or paper)
- Thermometer
- Tuning fork
- Wooden tongue blade
- Watch or clock with second hand



Measuring blood pressure

- Position your patient with upper arm at heart level and palm turned up.
- Apply the cuff snugly, 1" (2.5 cm) above the brachial pulse.
- Position the manometer at your eye level.
- Palpate the brachial or radial pulse with your fingertips while inflating the cuff.
- Inflate the cuff to 30 mm Hg above the point where the pulse disappears.
- Place the bell of your stethoscope over the point where you felt the pulse, as shown in the photo. (Using the bell will help you better hear Korotkoff sounds, which indicate pulse.)
- Release the valve slowly (for example, allow it to drop 2 to 3 mm Hg/second) and note the point at which Korotkoff sounds reappear. The start of the pulse sound indicates the systolic pressure.
- The sounds will become muffled and then disappear. The last Korotkoff sound you hear is the diastolic pressure.



Tips for interpreting vital signs

- Analyze vital signs during the same interaction with the patient. Two or more abnormal values may provide clues to the patient's problem. For example, a rapid, thready pulse along with low blood pressure may signal shock.
- If you obtain an abnormal value, assess the vital sign again to make sure it's accurate.
- Remember that normal readings vary with the patient's age. For example, temperature decreases with age, and respiratory rate can increase with age.
- Remember that an abnormal value for one patient may be a normal value for another, which is why baseline values are so important.



Physical assessment techniques

When you perform the physical assessment, you'll use four techniques: **inspection**, **palpation**, **percussion**, and **auscultation**. Use these techniques in this sequence **except when you perform an abdominal assessment**.

Because palpation and percussion can alter bowel sounds, the sequence for assessing the abdomen is **inspection**, **auscultation**, **percussion**, and **palpation**.

1

Inspection

Inspect each body system using vision, smell, and hearing to assess normal conditions and deviations. Observe for color, size, location, movement, texture, symmetry, odors, and sounds as you assess each body system.



2

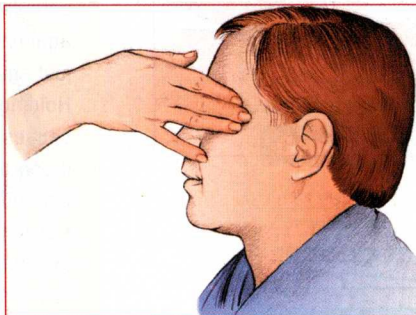
Palpation

Palpation requires you to touch the patient with different parts of your hands, using varying degrees of pressure. Because your hands are your tools, keep your fingernails short and your hands warm. Wear gloves when palpating mucous membranes or areas in contact with body fluids. Palpate tender areas last.

Types of palpation

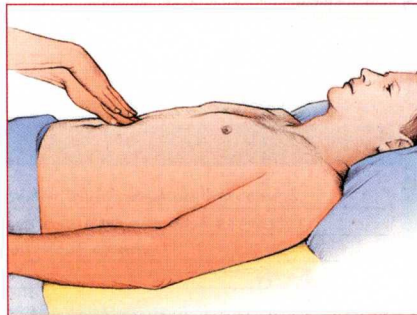
Light palpation

- Use this technique to feel for surface abnormalities.
- Depress the skin 1/2" to 3/4" (1.5 to 2 cm) with your finger pads, using the lightest touch possible.
- Assess for texture, tenderness, temperature, moisture, elasticity, pulsations, superficial organs, and masses.



Deep palpation

- Use this technique to feel internal organs and masses for size, shape, tenderness, symmetry, and mobility.
- Depress the skin 1 1/2" to 2" (4 to 5 cm) with firm, deep pressure.
- Use one hand on top of the other (bimanual palpation) to exert firmer pressure, if needed.



3

Percussion

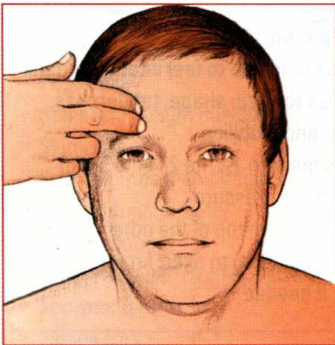
Percussion involves tapping your fingers or hands quickly and sharply against parts of the patient's body to help you locate organ borders, identify organ shape and position, and determine if an organ is solid or filled with fluid or gas.

Types of percussion

Direct percussion

This technique reveals tenderness; it's commonly used to assess an adult patient's sinuses. Here's how to do it:

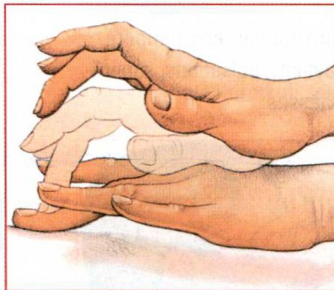
- Using one or two fingers, tap directly on the body part.
- Ask the patient to tell you which areas are painful, and watching for facial signs of discomfort such as wincing or grimacing.



Indirect percussion

This technique elicits sounds that give clues to the makeup of the underlying tissue. Here's how to do it:

- Press the distal part of the middle finger of your nondominant hand firmly on the body part.
- Keep the rest of your hand off the body surface.
- Flex the wrist of your dominant hand.
- Using the middle finger of your dominant hand, tap quickly and directly over the point where your other middle finger touches the patient's skin.
- Listen to the sounds produced.



4

Auscultation

Auscultation involves listening for various breath, heart, and bowel sounds with a stethoscope.

Getting ready

- Provide a quiet environment.
- Make sure the area to be auscultated is exposed. (Auscultating over a gown or bed linens can interfere with sounds.)
- Warm the stethoscope head in your hand.
- Close your eyes to help focus your attention.

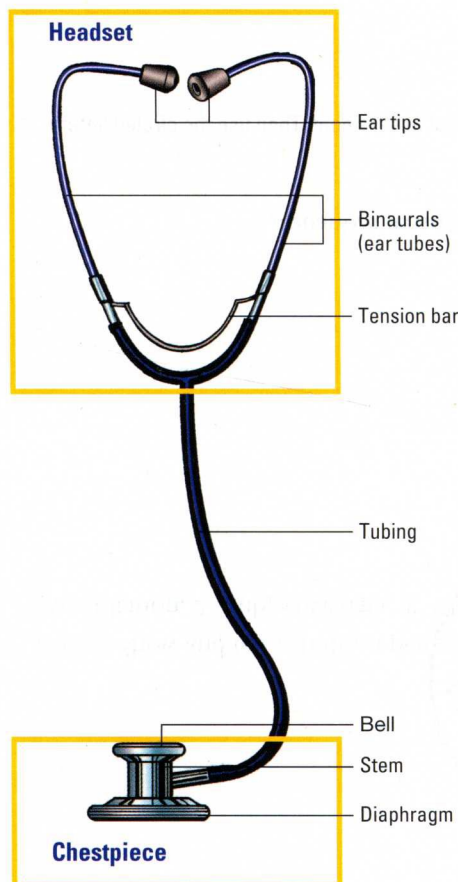
How to auscultate

- Use the diaphragm to pick up high-pitched sounds, such as first (S_1) and second (S_2) heart sounds. Hold the diaphragm firmly against the patient's skin, enough to leave a slight ring on the skin afterward.
- Use the bell to pick up low-pitched sounds, such as third (S_3) and fourth (S_4) heart sounds. Hold the bell lightly against the patient's skin, just enough to form a seal. Holding the bell too firmly causes the skin to act as a diaphragm, obliterating low-pitched sounds.
- Listen to and try to identify the characteristics of one sound at a time.

Documentation

Get to know your stethoscope

Your stethoscope should have snug-fitting ear tips, which you'll position toward your nose. The stethoscope should also have tubing no longer than 12" to 15" (38.1 cm) with an internal diameter not greater than 1/8" (0.3 cm). It should have both a diaphragm and bell. The parts of a stethoscope are labeled below.



Take note

Documenting initial assessment findings

Here's an example of how to record your findings on an initial assessment form.

General information

Name Henry Gibson

Age 55 Sex M Height 163 cm Weight 57 kg

T 37 ° C (oral) P 76 R 14 B/P (R) 150/90 sitting
(L) 148/88 sitting Pain Scale 3/10

Room <u>328</u>	Patient's stated reason for hospitalization <u>"To get rid of the pneumonia"</u>												
Admission time <u>0800</u>													
Admission date <u>4-28-100</u>	Allergies <u>Penicillin-hives</u> <u>Codeine-nausea</u>												
Doctor <u>Manzel</u>	Current medications <u>None</u>												
Admitting diagnosis: <u>Pneumonia</u>	<table border="1"> <thead> <tr> <th>Name</th> <th>Dosage</th> <th>Last taken</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name	Dosage	Last taken									
Name	Dosage	Last taken											

General survey

In no acute distress. Slender, alert, and well-groomed. Communicates well. Makes eye contact and expresses appropriate concern throughout exam.

C. Smith, RN