POCKET COMPANION

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Physical Examination & Health Assessment

6th Edition

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Preface

The sixth edition of *Pocket Companion for Physical Examination and Health Assessment* is designed for two groups—those who need a practical clinical reference and those acquiring beginning assessment skills.

First, the *Pocket Companion* is intended as an adjunct to Jarvis' *Physical Examination and Health Assessment*, 6th edition. The *Pocket Companion* is a memory prompt for those who have studied physical assessment and wish a reminder when in the clinic. The *Pocket Companion* has all the essentials: health history points, exam steps for each body system, normal versus abnormal findings, heart sounds, lung sounds, neurologic checks. *The Pocket Companion* is useful when you forget a step in the exam sequence, when you wish to be sure your assessment is complete, when you need to review the findings that are normal versus abnormal, or when you are faced with an unfamiliar technique or a new clinical area. Its portable size and binding make it perfect for a lab coat pocket or community health bag.

Second, the *Pocket Companion*, 6th edition, is an independent primer of basic assessment skills. It is well suited to programs offering a beginning assessment course covering well people of all ages. The *Pocket Companion* has the complete steps to perform a health history and physical examination on a well person. It includes pertinent developmental content for pediatric, pregnant, and aging adult patients. Although the description of each exam step is stated concisely, there is enough information given to study and learn exam techniques. However, since there is no room in the *Pocket Companion* for theories, principles, or detailed explanations, students using the *Pocket Companion* as a beginning text must have a thorough didactic presentation of assessment methods as well as tutored practice.

The *Pocket Companion*, 6th edition, is revised and updated to match the revision of the parent text, *Physical Examination and Health Assessment*, 6th edition, including many new examination photos, abnormal findings photos, and full color art.

A companion chapter on the Bedside Assessment of the Hospitalized Adult has been added as Chapter 21, outlining the pertinent assessment steps detailed in Chapter 28 of the parent text, *Physical Examination and Health Assessment*, 6th edition.

For those times when readers need detailed coverage of a particular technique or finding, it is easily found through numerous cross-references to pages *in Physical Examination and Health Assessment*, 6th edition.

As you thumb through the *Pocket Companion,* note these features:

- Health history and exam steps are concise yet complete.

- Method of examination is clear, orderly, and easy to follow.
- Abnormal findings are described briefly in a column adjacent to the normal range of findings.
- Tables are presented at the end of chapters to fully illustrate important information.
- Selected Cultural Competencies information highlights this important aspect of a health assessment.
- Nursing diagnoses are provided fully for each region or system being assessed.
- Developmental Competencies content includes age-specific information for pediatric, pregnant, and aging adult groups.
- Summary checklists for each chapter form a cue card of exam steps to remember.
- Integration of the complete physical examination is presented in Chapter 20.
- Sample recording in Chapter 20 illustrates the documentation of normal findings.
- Selected artwork from *Physical Examination and Health Assessment*, 6th edition, illustrates the pertinent anatomy.

Acknowledgments

My thanks extend to Robin Carter, Executive Editor, Nursing, for her strong support and direction in this project. Thanks to Deanna Dedeke, Developmental Editor, for her skillful effort and determination in this project from start to finish. I am very grateful to Bridget Healy, Project Manager, and to Deborah Vogel, Publishing Services Manager, for their patient and attentive monitoring of every step in the production of the *Pocket Companion*.

Carolyn Jarvis

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CHAPTER

1

The Interview and Health History

The health history is important in beginning to identify the person's health strengths and problems and as a bridge to the next step in data collection, the physical examination.

The health history collects **subjective data,** what the person says about himself or herself. This is the first and the best chance a person has to tell you what *he* or *she* perceives his or her health state to be.

EXTERNAL FACTORS

Ensure Privacy. Aim for geographic privacy—a private room. If geographic privacy is not available, the "psychological privacy" afforded by curtained partitions may suffice as long as the person feels sure no one can overhear the conversation or interrupt.

Refuse Interruptions. You need this time to concentrate and to establish rapport.

Physical Environment

- Set the room temperature at a comfortable level.
- Provide sufficient lighting.
- Reduce noise.
- Remove distracting objects.
- Maintain the distance between you and the patient at 4 to 5 feet (twice an arm's length).
- Arrange equal-status seating. Both of you should be comfortably seated at eye level. Avoid sitting behind a desk or bedside table placed so that it looks like a barrier.
- Avoid standing.

There are three phases to each interview: an introduction, a working phase, and a termination (or closing).

INTRODUCING THE INTERVIEW

Address the patient using his or her surname. Introduce yourself and state your role in the agency (if you are a student, say so). If you are gathering a complete history, give the reason for this interview.

THE WORKING PHASE

The working phase is the data-gathering phase. It involves your questions to the patient and your responses to what the patient has said. There are two types of questions: open-ended and closed (or direct). Each type has a different place and function in the interview.

Open-Ended Questions

An open-ended question asks for narrative information. It states the topic to be discussed, but only in general terms. Use it to begin the interview, to introduce a new section of questions,

and whenever the person introduces a new topic. Examples are "Tell me why you have come here today" and "What brings you to the hospital?"

Closed or Direct Questions

Closed or direct questions ask for specific information. They elicit a one- or two-word answer, a "yes" or "no," or a forced choice. Use direct questions after the person's narrative to fill in any details he or she may have omitted. Also use direct questions when you need many specific facts, such as when asking about past health problems or during the review of systems.

Responses

As the person talks, your role is to encourage free expression but not let him or her wander. The following responses help you gather data without cutting the person off.

Facilitation. Your facilitative response encourages the patient to say more, to continue with the story, e.g., "mm-hmm," "go on," "continue," "uh-huh," or simply nodding.

Silence. Your silence communicates that the patient has time to think, to organize what he or she wishes to say without interruption from you. Silence also gives you a chance to observe the person unobtrusively and to note nonverbal cues.

Reflection. A reflective response echoes the patient's own words. Reflection involves repeating part of what the person has just said. It focuses further attention on a specific phrase and helps the person continue in his or her own way.

Empathy. An empathic response recognizes a feeling and puts it into words. It names the feeling and allows its expression. When you use an empathic response, the patient feels accepted and can deal with the feeling openly. Empathic responses include saying, "This must be very hard for you" and just placing your hand on the person's arm.

Clarification. Use the clarification response when the patient's word choice is ambiguous or confusing, e.g., "Tell me what you mean by 'tired blood.'"

Confrontation. In this case, you have observed a certain action, feeling, or statement, and you now focus the person's attention on it. This can focus on a discrepancy: "You say it doesn't hurt, but when I touch you here, you grimace." It can also focus on the patient's affect: "You look sad" or "You sound angry."

Interpretation. An interpretive response is based not on direct observation (as is confrontation) but on your inference or conclusion. Interpretation links events, makes associations, or implies cause: "It seems that every time you feel the stomach pain, you have had some kind of stress in your life."

Explanation. With these statements, you share factual and objective information. This may be for orientation to the agency setting: "Your dinner comes at 5:30 PM"; or it may be to explain cause: "The reason you cannot eat or drink before your blood test is that the food will change the test results."

Summary. This is a final review of what you understand the patient has said. It condenses the facts and presents a survey of how you perceive the patient's health problem or need.

CLOSING THE INTERVIEW

The meeting should end gracefully. To ease into the closing, ask the patient, "Is there anything else you would like to mention?" Give the person a final opportunity for self-expression. Then give a summary or recapitulation of

what you have learned during the interview. This is a final statement of what you and the patient agree his or her health state to be.

TEN TRAPS OF INTERVIEWING

Nonproductive, defeating verbal messages are messages that restrict the patient's response. They are obstacles to obtaining complete data and to establishing rapport.

1. Providing False Reassurance. Such statements as, "Now don't worry, I'm sure you will be all right" are courage builders that relieve *your* anxiety and give you a false sense of having provided comfort. For the patient, however, these statements close off communication. They trivialize anxiety and effectively deny further discussion.

2. Giving Unwanted Advice. A person describes a problem to you, ending with, "What would you do?" If you answer, "If I were you, I'd . . . ," you have shifted the accountability for decision-making from the patient to you. The person has not worked out his or her own solution and has learned nothing about himself or herself.

3. Using Authority. "Your doctor/nurse knows best" is a response that promotes dependency and inferiority.

4. Using Avoidance Language. People use euphemisms, such as "passed on," to avoid reality or to hide their feelings.

5. Engaging in Distancing. Distancing is the use of impersonal speech to put space between a threat and oneself, e.g., "There is a lump in *the* left breast."

6. Using Professional Jargon. Use of jargon sounds exclusionary and paternalistic. You need to adjust your vocabulary to the patient but should avoid sounding condescending.

7. Using Leading or Biased Questions. Asking such questions as, "You don't smoke, do you?" implies that one answer is "better" than another.

8. Talking Too Much. Some examiners associate helpfulness with how much they talk. They think they have met the patient's needs. Just the opposite is true.

9. Interrupting. Often, when you think you know what the person will say, you interrupt and cut him or her off.

10. Using "Why" Questions. The adult's use of "why" questions usually implies blame and condemnation, and puts the patient on the defensive.

Nonverbal Skills

Nonverbal messages that are productive and enhancing to the relationship are those that show attentiveness and unconditional acceptance. Defeating and nonproductive nonverbal behaviors are those of inattentiveness, authority, and superiority (Table 1-1).

THE HEALTH HISTORY: THE ADULT

Biographical Data

This information includes name, address, telephone number, age, birth date, birthplace, sex, marital status, race, ethnic origin, and occupation, usual and present.

Source of History

The history may be provided by the patient or by a substitute.

Reason for Seeking Care

This is a brief spontaneous statement in the patient's own words that describes the reason for the visit.

TABLE 1-1 Nonverbal Behaviors of the Interviewer

Positive	Negative
Appropriate professional appearance	Appearance objectionable to patient
Equal-status seating	Standing
Close placement to patient	Sitting behind desk, far away, turned away
Relaxed open posture	Tense posture
Leaning slightly toward person	Slouched back
Occasional facilitation gestures	Critical or distracting gestures: pointing finger, clenched fist, finger-tapping, foot-swinging, looking at watch
Facial animation, interest	Bland expression, yawning, tight mouth
Appropriate smiling	Frowning, lip biting
Appropriate eye contact	Shifting eyes, avoiding eye contact, focusing on notes
Moderate tone of voice	Strident, high-pitched tone
Moderate rate of speech	Rate too slow or too fast
Appropriate touch	Too frequent or inappropriate touch

Present Health or History of Present Illness

This is a chronologic record of the reason for seeking care, from the time of the onset of the symptoms until now. Start when the person first noticed the symptoms and work forward to the present. Your final summary of any symptom the patient has should include these *critical characteristics,* organized into the mnemonic PQRSTU to help remember all the points.

- **P. Provocative or palliative.** What brings it on? What were you doing when you first noticed it? What makes it better? Worse?
- **Q. Quality or quantity.** How does it look, feel, sound? How intense/severe is it?
- **R. Region or radiation.** Where is it? Does it spread anywhere?
- **S. Severity scale.** How bad is it (on a scale ranging from 1 to 10)? Is it getting better, worse, staying the same?
- **T. Timing.** Onset—Exactly when did it first occur? Duration—How long did it last? Frequency—How often does it occur?
- **U. Understand** *patient's perception* of the problem. What do you think it means?

Past Health

Childhood Illnesses. Measles, mumps, rubella, chickenpox, pertussis, strep throat, rheumatic fever, scarlet fever, and poliomyelitis.

Accidents or Injuries

Serious or Chronic Illnesses. Diabetes, hypertension, heart disease, sickle-cell anemia, cancer, and seizure disorder.

Hospitalizations and Operations

Obstetric History. The number of pregnancies (gravidity), number of deliveries in which the fetus reached viability (parity), number of incomplete pregnancies or abortions, and number of living children. This is recorded as G_P_Ab_Liv_ (e.g., G3 P2 Ab1 Liv 2).

Immunizations. All childhood immunizations (measles/mumps/rubella, poliomyelitis, diphtheria/pertussis/tetanus, hepatitis B, hepatitis A in selected areas, *Haemophilus influenzae* type b, and pneumococcal vaccine). Also note the last tetanus immunization, last tuberculosis skin test, and last flu shot.

Last Examination Date. The most recent physical, dental, vision, hearing, electrocardiogram, and chest x-ray examinations.

Allergies. Medication, food, environmental agent. Note reaction.

Current Medications. All prescription and over-the-counter medications, including laxatives, vitamins, birth control pills, aspirin, and antacids.

Family History

The age and health or the age and cause of death of blood relatives, such as parents, grandparents, and siblings. The age and health of spouse and children. Specifically, any family history of heart disease, high blood pressure, stroke, diabetes, blood disorders, cancer, sickle-cell anemia, arthritis, allergies, obesity, alcoholism, mental illness, seizure disorder, kidney disease, or tuberculosis. Construct a family tree, or genogram, to show this information clearly and concisely (Fig. 1-1, p. 6).

Review of Systems

General Overall Health State. Present weight (gain or loss, period of time, by diet or other factors), fatigue, weakness or malaise, fever, chills, and sweats or night sweats.

Skin. History of skin disease (eczema, psoriasis, hives), pigment or color change, change in mole, excessive dryness or moisture, pruritus, excessive bruising, and rash or lesion.

Health Promotion. Amount of sun exposure.

Hair. Recent loss, change in texture.

Nails. Change in shape, color, or brittleness.

Head. Unusually frequent or severe headache, any head injury, dizziness (syncope), or vertigo.

Eyes. Difficulty with vision (decreased acuity, blurring, blind spots); eye pain; diplopia (double vision); redness or swelling; watering or discharge; and glaucoma or cataracts.

Health Promotion. Glasses or contact lens use, last vision check or glaucoma test, and ways of coping with vision loss.

Ears. Earaches, infections, discharge and its characteristics, tinnitus, or vertigo.

Health Promotion. Hearing loss, hearing aid use, effect of hearing loss on daily life, exposure to environmental noise, and method of cleaning ears.

Nose and Sinuses. Discharge and its characteristics, unusually frequent or severe colds, any sinus pain, nasal obstruction, nosebleeds, allergies or hay fever, or change in sense of smell.

Mouth and Throat. Mouth pain, frequent sore throat, bleeding gums, toothache, lesion in mouth or tongue, dysphagia, hoarseness or voice change, or altered taste. History of tonsillectomy.

Health Promotion. Pattern of daily dental care, use of prosthesis (dentures, bridge), and last dental checkup.

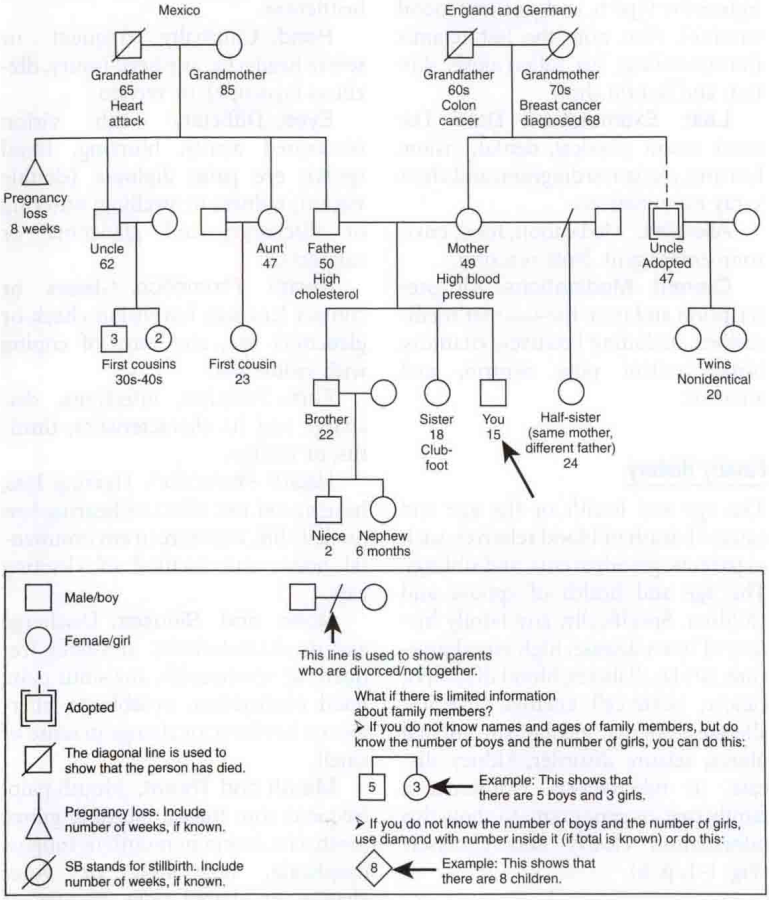
Neck. Pain, limitation of motion, lumps or swelling, enlarged or tender nodes, or goiter.

Breast. Pain, lump, nipple discharge, rash, or breast disease.

Health Promotion. Breast self-examination method and frequency, last mammogram.

Drawing Your Family Tree

- Make a list of all of your family members.
- Use this sample family tree as a guide to draw your own family tree.
- Write your name at the top of your paper and date you drew your family tree.
- In place of the words father, mother etc., write the names of your family members.
- When possible, draw your brothers and sisters and your parents' brothers and sisters starting from oldest to youngest, going from left to right across the paper.
- If dates of birth or ages are not known, then estimate or guess ("50s," "late 60s").



1-1 A family tree, or genogram. *Adapted from the American Society of Human Genetics,* www.ashg.org, *2004.*

Axilla. Tenderness, lump or swelling, or rash.

Respiratory System. History of lung diseases (asthma, emphysema, bronchitis, pneumonia, tuberculosis); chest pain with breathing; wheezing or noisy breathing; shortness of breath; how much activity produces shortness of breath; cough; sputum (color, amount); hemoptysis; and toxin or pollution exposure.

Cardiovascular System. Precordial or retrosternal pain, palpitation, cyanosis, dyspnea on exertion (specify amount of exertion), orthopnea, paroxysmal nocturnal dyspnea,

nocturia, edema, and history of heart murmur, hypertension, coronary artery disease, or anemia.

Peripheral Vascular System. Coldness, numbness and tingling, swelling of legs (time of day and activity), discoloration in hands or feet, varicose veins or complications, intermittent claudication, thrombophlebitis, or ulcers.

Health Promotion. Amount of long-term sitting or standing, habit of crossing legs at the knees, use of support hose.

Gastrointestinal System. Appetite; food intolerance; dysphagia; heartburn; indigestion; pain (associated with eating); other abdominal pain; pyrosis (esophageal and stomach burning sensation with sour eructation); nausea and vomiting (character); vomiting blood; history of abdominal disease (ulcer, liver or gallbladder, jaundice, appendicitis, colitis); flatulence; frequency of bowel movements (any recent change); stool characteristics; constipation or diarrhea; black stools; rectal bleeding; or rectal conditions (hemorrhoids, fistula).

Health Promotion. Last serum cholesterol test, stool occult blood.

Urinary System. Frequency or urgency; nocturia (recent change), dysuria, polyuria, or oliguria; hesitancy or straining; narrowed stream; urine color (cloudy or presence of blood), incontinence; history of urinary disease (kidney disease, kidney stones, urinary tract infections, prostate disease); or pain in flank, groin, suprapubic region, or low back.

Health Promotion. Use of Kegel exercises after childbirth, measures to avoid or treat urinary tract infections.

Male Genital System. Penile or testicular pain, sores or lesions, penile discharge, lumps, or hernia.

Health Promotion. Testicular self-examination method and frequency.

Female Genital System. Menstrual history (age at menarche, last menstrual period, cycle and duration, amenorrhea or menorrhagia, premenstrual pain or dysmenorrhea, intermenstrual spotting); vaginal itching; discharge and its characteristics; age at menopause; menopausal signs or symptoms; or postmenopausal bleeding.

Health Promotion. Last gynecologic checkup and last Papanicolaou smear.

Sexual Health. Current sexual activity, level of sexual satisfaction of patient and partner, dyspareunia (for female); changes in erection or ejaculation (for male); use of contraceptive and satisfaction with it; any known or suspected contact with a partner who has a sexually transmitted infection (gonorrhea, herpes, chlamydia, venereal warts, HIV/AIDS, or syphilis).

Musculoskeletal System. History of arthritis or gout. Joint pain, stiffness, swelling (location, migratory nature), deformity, limitation of motion, or noise with joint motion. Muscle pain, cramps, weakness, gait problems, or problems with coordinated activities. Other pain (location and radiation to extremities), stiffness, limitation of motion, or history of back pain or disc disease.

Health Promotion. Distance walked per day; effect of limited range of motion on daily activities, such as grooming, feeding, toileting, or dressing; and use of mobility aids.

Neurologic System. History of seizure disorder, stroke, fainting, or blackouts. Motor function: any weakness, tic or tremor, paralysis, or coordination problems. Sensory function: any numbness and tingling (paresthesia). Cognitive function: any memory disorder (recent or distant, disorientation). Mental status: nervousness, mood change, depression, or history of mental health dysfunction or hallucinations.

Hematologic System. Bleeding of skin or mucous membranes, excessive bruising, lymph node swelling, exposure to toxic agents or radiation, or blood transfusion and reactions.

Endocrine System. History of diabetes or diabetic symptoms (polyuria, polydipsia, polyphagia); history of thyroid disease; intolerance to heat and cold; change in skin pigmentation or texture; excessive sweating; relationship between appetite and weight; abnormal hair distribution; nervousness; tremors; or need for hormone therapy.

Functional Assessment (Activities of Daily Living)

Functional assessment measures a person's self-care ability in the areas of physical health; activities of daily living (ADLs), such as bathing, dressing, toileting, and eating; instrumental activities of daily living (IADLs), which are those needed for independent living, such as housekeeping, shopping, and cooking; nutritional status; social relationships and resources; self-concept and coping; and home environment. These questions provide data on the lifestyle and type of living environment to which the person is accustomed.

Self-Esteem/Self-Concept. Education (last grade completed, other significant training); financial status (income adequate for lifestyle and/or health concerns); and values and belief system (religious practices and perception of personal strengths).

Activity/Exercise. A daily profile reflecting usual daily activities. Ability to perform ADLs—independent or needs assistance. Ability to tolerate activity or to use prostheses or mobility aids. Leisure activities enjoyed and exercise pattern (type, amount per day or week, warm-up session, body's response to exercise).

Sleep/Rest. Sleep patterns, any sleep aids, or daytime naps.

Nutrition/Elimination. All food and beverages taken over the past 24 hours: "Is that menu typical?" Eating habits and current appetite. "Who buys food and prepares food? Are finances adequate for food? Who is present at mealtimes?" Any food allergy or intolerance. Daily intake of caffeine (coffee, tea, cola drinks).

Interpersonal Relationships/ Resources. Social roles: "What's your role in your family? How would you say you get along with family, friends, and co-workers?" Support systems composed of family and significant others: "To whom could you go for support with a problem at work, with your health, or a personal problem?" Amount of time spent alone: "Is this pleasurable or isolating?"

Coping and Stress Management. Stresses in life now and in the past year, any change in lifestyle or any current stress, and any steps taken to relieve stress.

Personal Habits. Alcohol: "When was your last drink of alcohol? How much did you drink that time? Have you ever had a drinking problem?" Smoking: "Do you smoke? At what age did you start? How many packs do you smoke per day? How many years have you smoked?" Street drugs: "Have you ever tried any drugs such as marijuana, cocaine, amphetamines, or barbiturates? How often do you use these drugs? How has usage affected your work or social relationships?"

Environment/Hazards. Housing and neighborhood (live alone, know neighbors, safety of area, adequate heat and utilities, access to transportation, involved in community services); and environmental health (hazards in workplace, hazards at home, use of seatbelts, geographic or occupational exposures, travel or residence in other countries).

Intimate Partner Violence. "How are things at home? Do you feel safe?" If the person responds to feeling unsafe, follow up with, "Have you ever been emotionally or physically abused by your partner or someone important to you? Within the last year, have you been hit, slapped, kicked, pushed, or shoved, or otherwise physically hurt by your partner or ex-partner? If yes, by whom? Number of times? Does your partner ever force you into having sex? Are you afraid of your partner or ex-partner?"

Occupational Health. "Please describe your job. Ever worked with any health hazard, asbestos, inhalants, chemicals, repetitive motion? Wear or use any protective equipment? Any work programs to monitor your exposure? Any health problems now you think are related to work? What do you like or dislike about your work?"

Perception of Health

"How do you define health? How do you view your situation now? What are your concerns? What do you think will happen in the future? What are your health goals? What do you expect from us as nurses, physicians, other health care providers?"