Clinical manual of Health assessment

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CLINICAL MANUAL OF HEALTH ASSESSMENT

With love to
Terry, Donald, Bruce,
Spencer, and Martin

Preface

This manual is designed to be used in a clinical or laboratory setting as a procedural guideline for students who are learning health assessment. Each chapter outlines the knowledge necessary to proceed with a given portion of assessment, explicit skills for the student to perform, and expected findings that result from individual assessment efforts. Because of the procedural nature of the content, the knowledge base related to assessment is not offered. The student should refer to the suggested textbooks to prepare for successful use of this manual. Further learning is facilitated if a preceptor or clinical instructor is available as a resource to ensure proper interpretation and application of the written material.

Each chapter includes integrated information concerning the adult, the child, and the elderly client. Clinical and behavioral differences and similarities are presented in separate sections of each chapter for the reader's convenience. Some of the information is repeated in the separate, age-related sections so that the student can extract a specific portion for immediate clinical reference. Although this approach is somewhat redundant, it allows each section to stand alone.

The manual is divided into three major areas: the health data base chapter, fourteen clinical chapters that present specific systems or body regions for study, and the integration chapter, which offers a detailed outline of the entire health assessment process. Each chapter can be used as a single unit of study. The fourteen clinical chapters follow a consistent format, comprising the following thirteen sections:

1. *Cognitive objectives:* an outline of defined learning needs.
2. *Clinical objectives:* an outline of clinical entities that must be assessed.
3. *History in addition to data base:* an in-depth system or a regional history which investigates common problems, complaints, and client risk potential.
4. *Clinical guidelines:* a procedural outline including (a) examiner behaviors and clinical entities to be assessed, (b) expected normal findings, and (c) common deviations from normal findings. Throughout the manual this section is supported with illustrations.
5. *Clinical strategies:* notes and helpful hints for the beginning student regarding examination techniques and client behaviors.
6. *Sample recording:* an example of a written description of normal findings.
7. *History and clinical strategies associated with the pediatric client:* a discussion of approaches to the child and additional history data.
8. *Clinical variations associated with the pediatric client:* a detailed outline of the examination procedure for the child, anticipated normal findings, and commonly identified deviations.
9. *History and clinical strategies associated with the geriatric client:* a discussion of approaches to the older adult and additional history data.
10. *Clinical variations associated with the geriatric client:* a detailed outline of the examination procedure for the older adult, anticipated normal findings, and commonly identified deviations.
11. *Vocabulary:* a list of terms associated with the system or region of study. There is space available for the student to write definitions or interpretations of each term.
12. *Cognitive self-assessment:* a quiz section to demonstrate understanding of the related textbook and manual material and to monitor progress. The answers are provided at the end of the book.
13. *Suggested readings:* because of the procedural nature of this text, additional reading is necessary. The suggested reading list complements the information in each chapter of this manual.

The assessment procedures are elaborate and detailed throughout the manual. The beginning student

examiner must be exposed to an inclusive pattern of behavior for collecting subjective and objective data related to a client.

We have found that the clinical guidelines are extremely useful in the laboratory setting. We suggest to our students that they read aloud and discuss procedures while following along with a fellow student. They are asked to describe the procedure, their rationale for their behaviors, and the characteristics of the findings as they progress. They frequently complete a practice session by writing out their actual findings for one another to critique.

We wish to express sincere thanks to the individuals who assisted in the development of these materials and who participated as models for the photographs. We are especially grateful to Joanne Littell, who typed the manuscript, and to Ann Schreck, the photographer and illustrator.

June M. Thompson
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CLINICAL MANUAL OF HEALTH ASSESSMENT

Contents

Introduction

Assessment of an individual begins with careful, deliberate, and concrete observations of the whole person. Textbooks traditionally divide the remainder of the examination process into parts composed of body systems or regions. This division is convenient for the learner who functions cognitively and clinically in logically sequenced segments, gradually coordinating the segments to form a total process of assessment.

This manual proceeds in a logical fashion. The whole person is assessed (from a personal viewpoint) through the use of the data base chapter. Simultaneously, the examiner must be aware of the information provided in the chapter on general and mental status assessment. The examiner begins collecting objective data as soon as the client is encountered and throughout the history-taking session. Dress, mannerisms, general body movement and behavior are observed and noted as contributions to the final summary. Thereafter the student can proceed through the remaining clinical chapters, segment by segment, gradually using and synthesizing knowledge until all the parts are fitted together. The final chapter offers a detailed outline for fitting examiner behavior and clinical findings into a coordinated procedure and total summary.

We certainly acknowledge that human beings are more than the sum of their parts. They are dynamic entities interacting with the environment to attain or maintain a state of maximum well-being. As the student begins to pool information about a person, the development of a problem list, a client profile, and a risk profile should take place. The therapeutic application of the information in that final summary requires further professional knowledge beyond the scope and intent of this book. Recognizing client strengths, setting priorities with the client for seeking solutions to problems, and taking into account all the environmental variables that alter the client's state of well-being involve additional professional preparation.

This manual is designed to provide the student with an orderly, thorough method of collecting and categorizing accurate and well-defined data in preparation for subsequent professional care.

CHAPTER 1

Total health data base

Cognitive objectives

At the end of this unit the learner will demonstrate knowledge of the effective techniques and components of the health history by the ability to do the following:

1. Define the terms in the vocabulary section.
2. Discuss the rationale and options for examiner behaviors when gathering and analyzing health data for
   a. the well adult
   b. the well child
   c. the well elderly adult
   d. the ill (or symptomatic) client
3. Define the ten components of the adult data base.
4. List the sections and provide at least one example of relevant information gathered in each section of the social history.
5. List and define the eleven components of the analysis of a symptom.
6. Recognize the characteristics of the pediatric data base that are collected in addition to or as substitution for the adult data base.
7. Recognize the characteristics of the geriatric data base that are collected in addition to or as substitution for the adult data base.

Clinical objectives

At the end of this unit the learner will be able to do the following:

1. Demonstrate the application of effective nurse behaviors for establishing a nurse/client relationship during the data base collection session.
2. Conduct a systematic and accurate assessment of an individual's health status (adult, pediatric, geriatric) using a predesignated format.
3. Organize health assessment data to establish a preliminary problem list that accurately reflects the client's priorities, concerns, and physiological state.
4. Systematically record a full data base and subsequent problem list using a predesignated format.
5. Create a client profile that summarizes the lifestyle and the client's assessment of the ability to provide self-care.

Data base overview

The purpose of this chapter is to provide complete information about the subjective data that may be collected about the client. The reader might initially view this as overwhelming and repetitive in places; however, the subjective data available about overall health are vast and in many areas do overlap. The examiner must initially be exposed to this total information and then learn to use the data as a reference to individualize the information collected from each client. Not every client will need to be asked every question.

The examiner's goal is to develop a holistic subjective data profile about the client's health. This is an intellectual process and will depend on (1) the examiner's knowledge base, (2) the questions the examiner chooses to ask, (3) the method by which questions are asked, (4) the examiner's ability to interpret the responses, (5) the examiner's ability to synthesize and assign priority to all data collected, and (6) the philosophy and policies of the health agency (a full data base must be valued, read, and used).

The following format provides a method for collecting data about the client's physiological, psychological, and sociocultural health. It also includes questions about the client's past health and the health of the family. When integrated, the information becomes the client's *health data base*. The practitioner must analyze and organize the data base to formulate the following:

1. A subjective data problem list (including physiological symptoms and psychological, social, or environmental factors that concern the client and/or the examiner). This will later be com-

bined with the physical assessment problem list to develop a total problem list in the final write-up.
2. A risk profile (risk factors related to certain body systems are listed in subsequent chapters).
3. A client profile (a summary, from the *client's* viewpoint, of his life-style and ability to cope with self-care).

These data will serve as a constant resource for comparison as the client changes and provides new information in future assessments.

The collection of the data base may occur during one or more contact periods. The examiner must initially assess the reason for the client's visits and the severity of the concern. The examiner may decide to use an abbreviated history form during the client's initial visit (symptom analysis is discussed under *clinical strategies*) and to reschedule another appointment period to collect the total data base. Each client cared for deserves to have a total data base collected at some early point during his association with the agency or clinic. Each year following that time the data base must be updated.

Following is an outline of the components included in the total health data base:

Data base outline

1. Biographical data
2. Reason for visit
3. Present health status
4. Current health statistics
   a. Immunizations
   b. Allergies
   c. Last examinations
5. Past health status
   a. Childhood illnesses
   b. Serious or chronic illnesses
   c. Serious accidents or injuries
   d. Hospitalizations, operations
   e. Emotional health
   f. Obstetrical health
6. Family history
7. Review of physiological systems/regions
   a. General
   b. Nutritional
   c. Integumentary
   d. Head
   e. Eyes
   f. Ears
   g. Nose, nasopharynx, and paranasal sinuses
   h. Mouth and throat
   i. Neck
   j. Breast
   k. Cardiovascular
   l. Respiratory
   m. Hematolymphatic
   n. Gastrointestinal
   o. Urinary
   p. Genital
   q. Musculoskeletal
   r. Central nervous system
   s. Endocrine
   t. Allergic and immunological
8. Psychological history
   a. General status
   b. Interpersonal relationships
   c. Activities of daily living
   d. General coping skills
   e. Occupations
   f. Stressors/changes
   g. Stressors/coping skills
   h. Response to illness
   i. Psychiatric counseling history
   j. Anxiety
   k. Depression
   l. Personality changes
   m. Medications or specific techniques for stress
   n. Habits
   o. Financial status
9. Health maintenance efforts
   a. General statement
   b. Exercise
   c. Dietary regulations
   d. Mental health
   e. Cultural or religious practices
   f. Frequency of physical, dental, and vision health assessment
10. Environmental health
    a. General assessment
    b. Employment
    c. Home
    d. Neighborhood
    e. Community

Expanded data base outline

BIOGRAPHICAL DATA

1. Name
2. Age
3. Race
4. Culture
5. Address
6. Marital status
7. Children and family in home
8. Occupation
9. Means of transportation to health care facility, if pertinent
10. Description of home; size and type of community

REASON FOR VISIT

One statement that describes the reason for the client's visit, or the chief complaint. State in the client's own words.

PRESENT HEALTH STATUS

1. General health status of the client in the past 1 year, 5 years, now
2. Summary of client's current major health concerns
3. If illness is present, include (symptom analysis) history (pp. 10 and 11)
   a. When was client last well
   b. Date of problem onset
   c. Character of complaint
   d. Nature of problem onset
   e. Course of problem
   f. Client's hunch of precipitating factors
   g. Location of problem
   h. Relation to other body symptoms, body positions, and activity
   i. Patterns of problem
   j. Efforts of client to treat
   k. Coping ability
4. Current medications
   a. Type (prescription, over-the-counter drugs, vitamins, etc.)
   b. Prescribed by whom
   c. Amount per day
   d. Problems

CURRENT HEALTH STATISTICS

1. Immunization status (note dates or year of last immunization)
   a. Tetanus, diphtheria
   b. Mumps
   c. Rubella
   d. Polio
   e. Tuberculosis tine test
   f. Influenza
2. Allergies (describe agent and reactions)
   a. Drugs
   b. Foods
   c. Contact substances
   d. Environmental factors
3. Last examinations (note physician/clinic, findings, advice, and/or instructions)
   a. Physical
   b. Dental
   c. Vision
   d. Hearing
   e. ECG
   f. Chest radiograph
   g. Pap smear (females)

PAST HEALTH STATUS

Although each of the following is asked separately, the examiner must summarize and record the data *chronologically*.

1. Childhood illnesses: rubeola, rubella, mumps, pertussis, scarlet fever, chickenpox, strep throat
2. Serious or chronic illnesses: scarlet fever, diabetes, kidney problems, hypertension, sickle cell anemia, seizure disorders, blood infections
3. Serious accidents or injuries: head injuries, fractures, burns, other trauma
4. Hospitalizations: elaborate, reason for, location, primary care providers, duration
5. Operations: what, where, when, why, by whom
6. Emotional health: past problems, help sought, support persons
7. Obstetrical history
   a. Complete pregnancies: number, pregnancy course, postpartum course, and condition, weight, and sex of each child
   b. Incomplete pregnancies: duration, termination, circumstances (including abortions and stillbirths)
   c. Summary of complications

FAMILY HISTORY

Family members include the client's blood relatives, spouse, and children. Specifically the interviewer should inquire about the client's maternal and paternal grandparents, parents, aunts, uncles, spouse, and children, as well as about the general health, stress factors, and illnesses of other family members. Questions should include a survey of the following:

Cancer	Retardation
Diabetes	Alcoholism
Heart disease	Endocrine diseases
Hypertension	Sickle cell anemia
Epilepsy (or seizure disorder)	Kidney disease
Emotional stresses	Unusual limitations
Mental illness	Other chronic problems

The most concise method to record these data is by a family tree. Fig. 1-1 is an example.

REVIEW OF PHYSIOLOGICAL SYSTEMS

The purpose of this component of the data base is to collect information about the body regions or systems and their function.

1. General—reflect from client's previous description of current health status.
   a. Fatigue patterns
   b. Exercise and exercise tolerance
   c. Weakness episodes
   d. Fever, sweats
   e. Frequent colds, infections, or illnesses

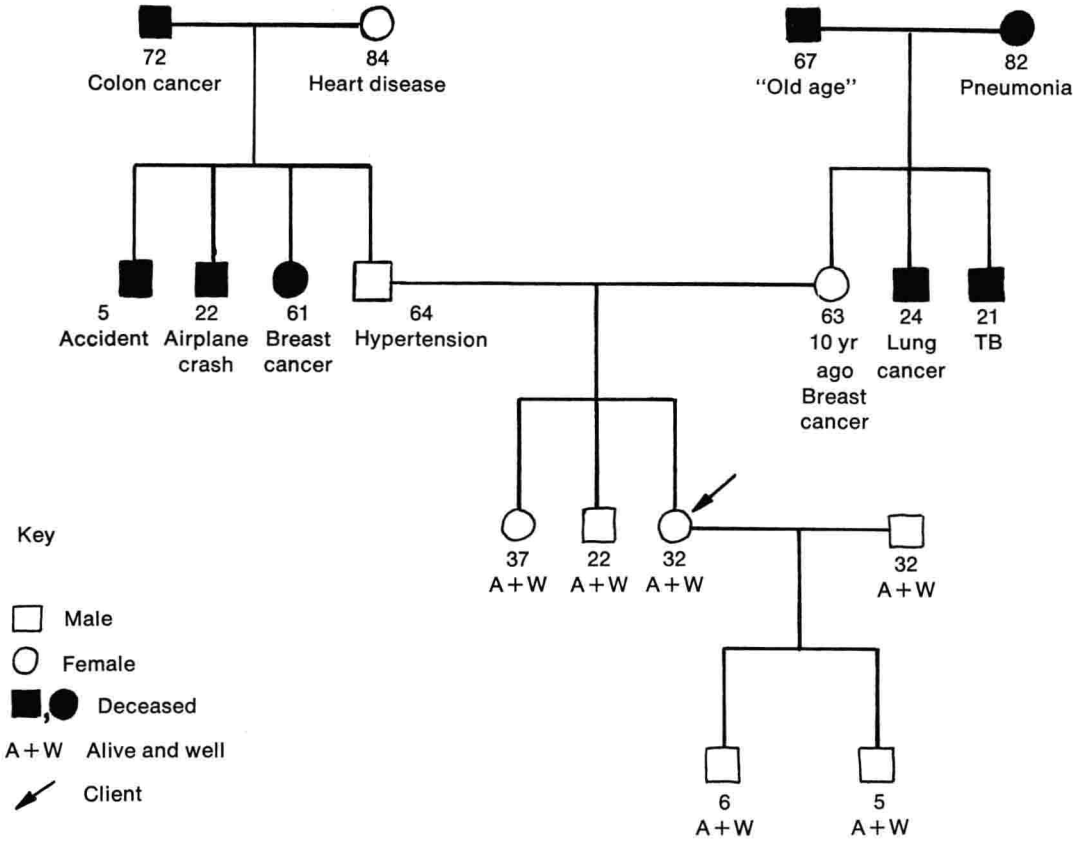

Fig. 1-1. Sample family tree (identifying grandparents, parents, aunts and uncles, siblings, spouse, and children).

f. Ability to carry out activities of daily living

2. Nutritional
   a. Client's average, maximum, and minimum weights during past month, 1 year, 5 years
   b. History of weight gains or losses (time element; specific efforts to change weight)
   c. Twenty-four–hour diet recall (helpful to mail client chart to fill in prior to visit) (Fig. 1-2)
   d. Current appetite
   e. Who buys, prepares food?
   f. Who does client normally eat with?
   g. Is client able to afford preferred food?
   h. Does client wear dentures? Is chewing a problem?
   i. Client's self evaluation of nutritional status
3. Integumentary
   a. Skin
      (1) Skin disease or skin problems or lesions (wounds, sores, ulcers)
      (2) Skin growths, tumors, masses
      (3) Excessive dryness, sweating, odors
      (4) Pigmentation changes or discolorations
      (5) Pruritus (itching)
      (6) Texture changes
      (7) Temperature changes
   b. Hair
      (1) Changes in amount, texture, character
      (2) Alopecia (loss of hair)
      (3) Use of dyes
   c. Nails
      (1) Changes in appearance, texture
4. Head
   a. Headache (characteristics, including frequency, type, location, duration, care for)
   b. Past significant trauma
   c. Dizziness
   d. Syncope
5. Eyes
   a. Discharge (characteristics)
   b. History of infections, frequency, treatment
   c. Pruritus (itching)
   d. Lacrimation, excessive tearing
   e. Pain in eyeball
   f. Spots (floaters)
   g. Swelling around eyes
   h. Cataracts, glaucoma

	Food eaten	Amount	Calories
Breakfast			
Lunch			
Dinner			
Snacks			
Total			

Fig. 1-2. Twenty-four–hour diet record.

i. Unusual sensations or twitching
j. Vision changes (generalized or vision field)
k. Use of corrective or prosthetic devices
l. Diplopia (double vision)
m. Blurring
n. Photophobia
o. Difficulty reading
p. Interference with activities of daily living

6. Ears
   a. Pain (characteristics)
   b. Cerumen (wax)
   c. Infection
   d. Hearing changes (describe)
   e. Use of prosthetic devices
   f. Increased sensitivity to environmental noise
   g. Vertigo
   h. Ringing and cracking
   i. Care habits
   j. Interference with activities of daily living
7. Nose, nasopharynx, and paranasal sinuses
   a. Discharge (characteristics)
   b. Epistaxis
   c. Allergies
   d. Pain over sinuses
   e. Postnasal drip
   f. Sneezing
   g. General olfactory ability
8. Mouth and throat
   a. Sore throats (characteristics)
   b. Lesions of tongue or mouth (abscesses, sores, ulcers)
   c. Bleeding gums
   d. Hoarseness
   e. Voice changes
   f. Use of prosthetic devices (dentures, bridges)
   g. Altered taste
   h. Chewing difficulty
   i. Swallowing difficulty
   j. Pattern of dental hygiene
9. Neck
   a. Node enlargement
   b. Swellings, masses
   c. Tenderness
   d. Limitation of movement
   e. Stiffness
10. Breast
    a. Pain or tenderness
    b. Swelling
    c. Nipple discharge
    d. Changes in nipples
    e. Lumps, dimples
    f. Unusual characteristics
    g. Breast examination: pattern, frequency
11. Cardiovascular
    a. Cardiovascular
       (1) Palpitations
       (2) Heart murmur
       (3) Varicose veins
       (4) History of heart disease
       (5) Hypertension
       (6) Chest pain (character and frequency)
       (7) Shortness of breath
       (8) Orthopnea
       (9) Paroxysmal nocturnal dyspnea
    b. Peripheral vascular
       (1) Coldness, numbness
       (2) Discoloration
       (3) Peripheral edema
       (4) Intermittent claudication
12. Respiratory
    a. History of asthma
    b. Other breathing problems (when, precipitating factors)
    c. Sputum production

- d. Hemoptysis
- e. Chronic cough (characteristics)
- f. Shortness of breath (precipitating factors)
- g. Night sweats
- h. Wheezing or noise with breathing

13. Hematolymphatic
    - a. Lymph node swelling
    - b. Excessive bleeding or easy bruising
    - c. Petechiae, ecchymoses
    - d. Anemia
    - e. Blood transfusions
    - f. Excessive fatigue
    - g. Radiation exposure
14. Gastrointestinal
    - a. Food idiosyncrasies
    - b. Change in taste
    - c. Dysphagia (inability or difficulty in swallowing)
    - d. Indigestion or pain (associated with eating?)
    - e. Pyrosis (burning sensation in esophagus and stomach with sour eructation)
    - f. Ulcer history
    - g. Nausea/vomiting (time, degree, precipitating and/or associated factors)
    - h. Hematemesis
    - i. Jaundice
    - j. Ascites
    - k. Bowel habits (diarrhea/constipation)
    - l. Stool characteristics
    - m. Change in bowel habits
    - n. Hemorrhoids (pain, bleeding, amount)
    - o. Dyschezia (constipation due to habitual neglect to respond to stimulus to defecate)
    - p. Use of digestive or evacuation aids (what, how often)
15. Urinary
    - a. Characteristics of urine
    - b. History of renal stones
    - c. Hesitancy
    - d. Urinary frequency (in 24-hour period)
    - e. Change in stream of urination
    - f. Nocturia (excessive urination at night)
    - g. History of urinary tract infection, dysuria (painful urination, urgency, flank pain)
    - h. Suprapubic pain
    - i. Dribbling or incontinence
    - j. Stress incontinence
    - k. Polyuria (excessive excretion or urine)
    - l. Oliguria (decrease in urinary output)
    - m. Pyuria
16. Genital
    - a. General
        - (1) Lesions
        - (2) Discharges
        - (3) Odors
        - (4) Pain, burning, pruritus (itching)
        - (5) Venereal disease history
        - (6) Satisfaction with sexual activity
        - (7) Birth control methods practiced
        - (8) Sterility
    - b. Males
        - (1) Prostate problems
        - (2) Penis and scrotum self-examination practices
    - c. Females
        - (1) Menstrual history (age of onset, last menstrual period [LMP], duration, amount of flow, problems)
        - (2) Amenorrhea (absence of menses)
        - (3) Menorrhagia (excessive menstruation)
        - (4) Dysmenorrhea (painful menses); treatment method
        - (5) Metrorrhagia (uterine bleeding at times other than during menses)
        - (6) Dyspareunia (pain with intercourse)
17. Musculoskeletal
    - a. Muscles
        - (1) Twitching
        - (2) Cramping
        - (3) Pain
        - (4) Weakness
    - b. Extremities
        - (1) Deformity
        - (2) Gait or coordination difficulties
        - (3) Interference with activities of daily living
        - (4) Walking (amount per day)
    - c. Bones and joints
        - (1) Joint swelling
        - (2) Joint pain
        - (3) Redness
        - (4) Stiffness (time of day related)
        - (5) Joint deformity
        - (6) Noise with joint movement
        - (7) Limitations of movement
        - (8) Interference with activities of daily living
    - d. Back
        - (1) History of back injury (characteristics of problems, corrective measures)
        - (2) Interference with activities of daily living
18. Central nervous system
    - a. History of central nervous system disease
    - b. Fainting episodes
    - c. Seizure
        - (1) Characteristics
        - (2) Medications
    - d. Cognitive changes
        - (1) Inability to remember (recent vs. distant)
        - (2) Disorientation

(3) Phobias
(4) Hallucinations
(5) Interference with activities of daily living

e. Motor-gait
(1) Coordinated movement
(2) Ataxia, balance problems
(3) Paralysis (partial vs. complete)
(4) Tic, tremor, spasm
(5) Interference with activities of daily living

f. Sensory
(1) Paresthesia (patterns)
(2) Tingling sensations
(3) Other changes

19. Endocrine
a. Diagnosis of disease states (thyroid, diabetes)
b. Changes in skin pigmentation or texture
c. Changes in or abnormal hair distribution
d. Sudden or unexplained changes in height and weight
e. Intolerance to heat or cold
f. Exophthalmos
g. Goiter
h. Hormone therapy
i. Polydipsia (↑ thirst)
j. Polyphagia (↑ food intake)
k. Polyuria (↑ urination)
l. Anorexia (↓ appetite)
m. Weakness

20. Allergic and immunological (Optional; use if client indicates allergic history. Note precipitating factors in each case.)
a. Dermatitis (inflammation or irritation of skin)
b. Eczema
c. Pruritus (itching)
d. Urticaria (hives)
e. Sneezing
f. Vasomotor rhinitis (inflammation and swelling of mucous membrane of nose; nasal discharge)
g. Conjunctivitis (inflammation of conjunctiva)
h. Interference with activities of daily living
i. Environmental and seasonal correlation
j. Treatment techniques

21. Does client have any other physiological problems or disease states not specifically discussed. If so, explore in detail (e.g., fatigue, insomnia, nervousness).

PSYCHOSOCIAL HISTORY

1. General statement of client's feelings about self
2. Feelings of satisfaction or frustration in interpersonal relationships
a. Home; occupants
b. Client's position in home relationships
c. Most significant relationship (in and out of home)
d. Community activities
e. Work or school relationships
f. Family cohesiveness patterns

3. Activities of daily living
a. General description of work, leisure, and rest distribution
b. Significant hobbies or methods of relaxation
c. Family demands
d. Community activities and involvement
e. During period of day/week is client able to accomplish all that is desired?

4. General statement about client's ability to cope with activities of daily living
5. Occupational history
a. Jobs held in past
b. Current employer
c. Educational preparation
d. Satisfaction with present and past employment
e. Time spent at work vs. time spent at play

6. Recent changes or stresses in client's life-style (e.g., divorce, moving, new job, family illness, new baby, financial stresses)
7. Patterns in which client copes with situations of stress
8. Response to illness
a. Does the client cope satisfactorily during own or others' illness?
b. Do the client's family and friends respond satisfactorily during periods of illness?

9. History of psychiatric care or counseling
10. Feelings of anxiety or nervousness (characteristics and coping mechanisms)
11. Feelings of depression (symptoms such as insomnia, crying, fearfulness, marked irritability or anger)
12. Changes in personality, behavior, or mood
13. Use of medications or other techniques during times of anxiety, stress, or depression
14. Habits
a. Alcohol
(1) Kinds (beer, wine, mixed drinks)
(2) Frequency per week
(3) Pattern over past 5 years, 1 year
(4) Drinking companions
(5) Alcohol consumption increased when anxious or stressed?

b. Smoking
(1) Kind (pipe, cigarette, cigar)
(2) Amount per week/day
(3) Pattern over past 5 years, 1 year
(4) Smoking with others