



Fourth Edition

# Clinical Manual of Health Assessment

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**M** Mosby  
Year Book

St. Louis Baltimore Boston Chicago London Philadelphia Sydney Toronto

**Editor** Terry Van Schaik  
**Developmental Editors** Janet R. Livingston, Sally Adkisson  
**Project Manager** Patricia Tannian  
**Production Editor** Betty Hazelwood  
**Designer** David Zielinski

Fourth edition

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Previous editions copyrighted 1980, 1984, and 1988

Printed in the United States of America.

Mosby–Year Book, Inc.  
11830 Westline Industrial Drive  
St Louis, MO 63146

#### **Library of Congress Cataloging-in-Publication Data**

Bowers, Arden C.

Clinical manual of health assessment / Arden C. Bowers, June M. Thompson; with contributions by Mindi Miller.—4th ed.

p. cm.

Includes bibliographical references and index.

I. Nursing assessment. I. Thompson, June M., 1946–.  
II. Miller, Mindi. III. Title.

[DNLM: 1. Diagnosis. 2. Health. 3. Health Status. WB 200 B786c]

RT48.B68 1991

616.07'5—dc20

DNLM/DLC

for Library of Congress

ISBN 0-8016-0826-0

91-31339  
CIP

92 93 94 95 96 GW/VH 9 8 7 6 5 4 3 2 1



# Preface

This manual is designed for use in a clinical or laboratory setting as a procedural guide for students who are learning health assessment. Each chapter offers the knowledge necessary to proceed with a given portion of assessment, the explicit skills for the student to perform, and the expected findings that result from individual assessment efforts.

New to this edition are anatomy and physiology summaries for 13 clinical chapters. This inclusion permits students to review an applicable knowledge base before proceeding with the practice component of assessment.

Integrated into each clinical chapter, separate sections on age-group considerations for newborns, children, pregnant women, and older adults enable students to perform a thorough health assessment on all clients. These sections include some deviations from normal findings so that the student can be alert to common health problems specific to clients of each age group. Some information is repeated in the age-related sections so that the student can locate specific data for immediate clinical reference. Although this approach is somewhat redundant, it allows each section to stand alone.

The chapter on functional assessment includes a generic tool for assessing the capability of healthy and disabled clients of all ages to function satisfactorily within their given environments. This chapter addresses the aging population, the heightened awareness of problems faced by disabled people, and the trend toward self-care in the home and other alternatives to hospitalization. Functional assessment is meant to complement the traditional assessment approach.

The manual is divided into four areas: the total health data base chapter; 14 clinical chapters that present specific systems or body regions for study; the integration chapter, which offers a detailed outline of the entire health assessment process; and the functional assessment chapter. Each chapter can be used as a single unit of study. The 14 clinical chapters follow a consistent format, comprising the following sections:

1. *Vocabulary.* A list of defined terms associated with the system or region of study.
2. *Anatomy and physiology.* A review of anatomy and physiology that provides background needed to perform body-system assessment.

3. *Cognitive objectives.* An outline of defined learning needs.
4. *Clinical outline.* An outline of clinical entities that must be assessed.
5. *History.* An in-depth systemic or regional history that investigates common problems, complaints, and client risk potential.
6. *Clinical guidelines.* A procedural outline that includes examiner behaviors and clinical entities to be assessed, expected normal findings, and common deviations from normal findings. Throughout the manual this section is supported with illustrations.
7. *Clinical tips and strategies.* Notes and helpful hints for the beginning student regarding examination techniques and client behaviors.
8. *Sample recording: normal findings.* An example of a written description of normal findings.
9. *History and clinical strategies.* A discussion of approaches and additional history data for each age group: the newborn, the child, the child-bearing woman, and the older adult.
10. *Clinical variations.* A detailed outline of the examination procedure, anticipated normal findings, and commonly identified deviations for each age group: the newborn, the child, the child-bearing woman, and the older adult.
11. *Study questions.* A quiz section that demonstrates the student's understanding of manual material and monitors progress. Answers are provided at the end of the book.
12. *Suggested readings.* Additional readings complement the information in each chapter.

The assessment procedures are elaborate and detailed. The format of the book guides the student through cognitive application, a sequence of skill maneuvers, and detailed descriptors of common findings within normal limits and of findings that extend beyond normal. The illustrations, photographs, and careful description of findings assist students in being accountable for the results of their assessment efforts. However, this text does not attempt to lead students to diagnoses. Giving meaning to the findings requires clinical practice, preceptorship, and further study.

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. The students 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.

To assist instructors further in assessing student prog-

ress, we have included a test bank with this edition. The test questions relate to the Cognitive Objectives, found at the beginning of each chapter in the book.

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.

***Arden C. Bowers***  
***June M. Thompson***



# 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 health history chapter (Chapter 1). Simultaneously, the examiner must be aware of the information provided in the chapter on general and mental status assessment (Chapter 2). 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 have used this manual in the laboratory setting for several years and have noted that predictable levels of learning are exhibited by the student. These phases must be acknowledged by both learner and teacher in designing and evaluating student progress.

A knowledge base is essential to the learner before psychomotor skills can be practiced. Anatomy and physiology supply the rationale for performing an examination and for the presence of normal findings. A cognitive introduction to the use of instruments and the practices of observation, palpation, auscultation, and percussion prepares the student for laboratory performance. Interviewing skills and analytical thinking are necessary prerequisites for acquiring an accurate and effective data base.

Much of the laboratory time is devoted to the mechanical aspects of the examination. Students need to concentrate on how to position the client (usually a fellow student) and how to maneuver their own bodies during the examination. They need to practice the skills

of percussion, auscultation, and palpation. The use of equipment and the sequence of maneuvers are frequently the focus of attention before any cognitive application can occur.

Some body systems require a great deal of psychomotor skill. For example, use of the ophthalmoscope is difficult, and much time is consumed in manipulating the instrument and the client's and examiner's bodies. We have found that deep palpation of the abdomen is a new experience for many students and that tactile awareness is an acquired skill. Giving *meaning* to the findings that result from the process of examination may not occur until after several practice sessions.

When the learner is comfortable with the physical maneuvers, attention can then be given to the findings and their significance. Learners must be encouraged to describe findings in concrete terms rather than to simply label a part as "normal" or "OK." Normal findings have variations, with many gray areas between normal and abnormal. Examiners must be precise about what they have found and be able to clearly convey descriptions to others. We have found that beginning students have a difficult time accounting for their findings. They benefit greatly by verbally describing their findings as they examine and by writing up the results of the examination in each laboratory session.

Simulated abnormal findings can be taught in a laboratory. For example, audiovisual equipment can demonstrate skin lesions or abnormal heart sounds. However, the real application of performing a full assessment and sorting the resultant data does not usually occur until the student practices in a clinical setting with a preceptor. It is our belief that knowing the significance of findings and responding to them with direct intervention or referral to others is a lifelong learning process.

The chapter on functional assessment requires a different framework for approach and analysis on the part of the student. Functional assessment bypasses body systems. It explores the capacity of an individual to manipulate his environment to his satisfaction. The client's "satisfaction" is dependent on his biological, psychosocial, and spiritual state, as well as the biological, psychosocial, and spiritual resources in his environment.

To analyze and intervene using functional information obtained from the client, the practitioner must be knowledgeable about nursing diagnoses and rehabilitation concepts.

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, a risk profile, and a functional profile should occur.

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.





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# CHAPTER

# 1

## Health history

### VOCABULARY

**active listening** State of selective attention and alertness that encompasses the skill of observation so that verbal and nonverbal cues are registered and clarified in an interaction; involves data absorption, retention, and exchange for clarification of meaning.

**assessment** Process of gathering and analyzing subjective and objective client data for summarization of a client's status.

**data base** Collection or store of information

**subjective** Portion of the client data that is supplied by the client; the client's perceptions of himself.

**objective** Portion of the client data that is perceived by the examiner through physical examination or obtained from other external sources (such as laboratory studies).

**empathic response** State of mind that enables one to view another as that person views himself; coupled with interviewing skills that enable an examiner to verbally or nonverbally respond to a client statement without coloring or altering the client's intended meaning.

**silence** A deliberate examiner response (sometimes very difficult for the examiner) to a client statement; allows time for client reflection.

**facilitative behaviors** Examiner behaviors (verbal or nonverbal) that encourage the client to continue.

EXAMPLES: Leaning forward, nodding head, maintaining eye contact, or saying, "Um-hum," "Yes," "Please go on," etc.

**reflection** Repetition of key words from the client's last statement to encourage elaboration.

EXAMPLE: The client says, "I feel as though I'm going to explode." The examiner responds, "Explode?"

**interpretive reflection** Rearrangement or rewording of the client's statement.

EXAMPLE: The client says, "When you have that much pain, you just want to give up." The examiner responds, "You feel frustrated and helpless."

**exacerbation** Increase in intensity of signs or symptoms.

**hypothesis** Formation of an idea that relates available information to a probable cause. (*Note:* In the context of research, *hypothesis* has a broader meaning.)

**incidence** The number of times an event occurs.

**precipitating factor** Event or entity that hastens the onset of another event.

EXAMPLE: Chronic overeating is a precipitating factor for obesity.

**predisposing factor (risk factor)** Event or entity that contributes to the cause of another event.

EXAMPLE: A family history of obesity increases the risk for obesity.

**problem list** Compilation of findings that appear at the end of the data base; may be diagnoses (medical or nursing), clusters of interrelated findings, or isolated findings that the examiner wishes to pursue but cannot label or attach to other findings.

EXAMPLE: *diagnoses*—herpes simplex, knowledge deficit; *clusters*—polydipsia, polyuria, polyphagia; *finding*—lower back pain.

### questions

**closed** Question posed in such a way that the respondent is directed toward a brief answer or a "yes" or "no"; does not encourage the respondent to elaborate.

EXAMPLE: "Has your back pain improved since the last visit?"

**open** A broadly stated question that encourages a free-flowing, open response.

EXAMPLE: "How has your back been feeling since your last visit?"

**directive** General term for a question or series of questions that leads the client in the questioner's channel of thinking. (*Note:* Most of the questions in the review of systems are directive.)

EXAMPLES: "Have you ever noticed blurred vision? Double vision?" "Do you see spots or floaters?"

**probing** Form of directive questioning that enables the examiner to pursue a line of thinking to prove or disprove a hypothesis.

**leading** A question worded in such a way that it suggests the answer to the respondent.

EXAMPLE: "Do you find that your chest pain radiates to your left arm or shoulder?" versus "Does your chest pain ever move around or locate in another area?"

**remission** Disappearance or diminishment of signs or symptoms.

**sign** Objective finding; one perceived by the examiner.

**significant negative** Absence of a finding that is often significant in clarifying the client's status.

EXAMPLE: A client with diagnosed congestive heart failure shows no sign of ankle edema. (This is significant and

should be reported as negative, or not present, because it clarifies the client's physical status for the reader.)

**suspended judgment** State of mind that permits the examiner to pose questions without allowing the answers to convey a meaning that would alter the completion or direction of the ensuing

questions; suspended meaning allows both the examiner and the client to maintain an open state of inquiry versus pursuing a narrowed line of questioning to support the meaning of a given answer.

**symptom** Subjective indicator or sensation perceived by the client.

## PRINCIPLES AND CONCEPTS

A health history is a compilation of client information (data) gathered through a systematic interview for the purpose of identifying and serving client needs. The mode and content of the interview and the ensuing data base will vary. The format presented in this text is known as the *long form*. It covers everything that an examiner could want to know about a client. Practitioners who use this format can spend from 1 to 3 hours collecting, compiling, and collating client data. The long form is known also as the *exhaustive method* for problem solving because its framework incorporates nonjudgmental descriptors of every aspect of the human condition. It does not urge the user to hypothesize about symptoms or to veer from the format to pursue an idea or a suspected diagnosis. The long form discourages straying from pure data collection and encourages the examiner to remain in a state of suspended judgment until all the facts have been gathered for sifting and analysis.

In clinical situations in which time and space are limited, the student may find the exhaustive method to be impractical. Seasoned preceptors may use a questioning mode, which quickly launches into specific probing questions. For example, if a client has presenting symptoms of weight loss, thirst, polyuria, and excessive hunger, the experienced examiner might immediately ask about a family history of diabetes, vaginal irritation, and skin infections. The exhaustive style would pursue a detailed symptom analysis (see box, p. 11) to clarify each symptom; family history and review of specific systems would come later. Each approach has advantages, depending on the (1) intent of the interview, (2) condition of the client, (3) knowledge base and experience of the examiner, (4) constraints of the clinical setting, and (5) expectations of the client.

### Intent of the Interview

Medical inquiry has traditionally focused on exploration of *effects* (symptoms), which leads to *cause* (diagnosis), which leads to *cure*. The intent is to spend a minimum amount of time lingering on the effects and to quickly check hunches (hypotheses) about causes (suspected diseases), which leads to prescriptions for

treatment. Reaching the stage of checking hunches can sometimes be accomplished quickly if the symptoms are localized (e.g., earache). If the client has broad or vague presenting symptoms (e.g., fatigue or weight loss), the examiner remains longer in a state of suspended judgment to clarify such factors as onset and duration, before asking probing, directive questions. The physician will branch off into an area of questioning to prove or disprove a hypothesis. If probing in this fashion disproves the hunch, the physician returns to nonjudgmental inquiry to get more information until another hypothesis forms, which leads to further probing.

Nursing inquiry frequently elicits more information about the effects. The nurse is interested in how the client functions within his environment. Pathological factors are relevant, but nurses recognize that causes may stem from such conditions as environmental influences, family relationships, or the client's coping skills. Nurses tend to inquire more closely and broadly about effects and to remain in suspended judgment for a longer time to gather this information.

Boundaries between traditional medical and nursing modes are no longer distinct. Physicians, especially those in primary care settings, are being taught and urged to gather a broad data base and to give more attention to the client effects. Nurses have extended into some of the medical functions and are posing questions in the traditional medical mode to uncover disease. Many professional people are becoming more holistically oriented. The holistic philosophy demands that the examiner acquire complete information about each client because the philosophy holds that illness cannot be separated from wellness and both are entrenched in the client's environment and life-style.

Some practitioners have a completely nondirective approach, which is often used in a psychological interview. The client is asked the reason for the visit and is encouraged to give information in whatever order and pace he devises. Probing and confrontation are deliberately delayed to give the client total freedom of expression.

Regardless of approach, it is extremely important that the examiner understand the *purpose* of the interview.

The history format is intended to be flexible and to be used as a vehicle for effective, efficient information gathering.

### Condition of the Client

Urgency dictates expediency. A client with severe pain should not be subjected to a prolonged history. Biographical data may be delayed to pursue the chief complaint, followed by a symptom analysis and selected system review. This approach enables the examiner to hypothesize quickly and identify the cause, which leads to prompt alleviation of pain. A client with depression might be given more time to freely divulge feelings and surrounding circumstances without interference from the examiner. An elderly client with multiple symptoms, a long history of illness and hospitalizations, and numerous problems at home would benefit from a full data base (exhaustive) approach.

### Knowledge Base and Experience of the Examiner

To hypothesize about causes, one must have a store of knowledge to draw from, since human perceptions are narrowed by lack of knowledge and experience. A beginner cannot invent directive questions that lead to diagnosis. Therefore students are urged to prolong the state of suspended judgment and to get full details about clients. The process of hypothesizing channels one's thinking and perceptions into a specific area and shuts out extraneous information. Lack of knowledge blurs the difference between what is extraneous and what is significant. Students should have experience with gathering a full data base. In this way they learn the value of each component of the history, and they give themselves and the client more time to sift through the facts to arrive at a series of findings.

### Constraints of the Clinical Setting

Practitioners with nondirective approaches or holistic beliefs can become frustrated (and ineffective) in a clinic setting that allocates 30 minutes for each client appointment. Time and space can dictate a philosophy and practice mode regardless of examiner intent or client condition. If cost-effectiveness calls for rapid patient turnover, the examiner must either function accordingly within that value system, change the system, or become creative in accomplishing his intent. A full data base can be gathered over time. In some instances clients can complete portions of the history at home or in the waiting room. It is pointless to record a full data base if no one is going to read it or use the information. Gathering such data also is misleading to the client if identified problems are not followed up. Students sometimes become frustrated when they cannot use a full data base in a real-life setting. Yet it is a valuable lesson

to be knowledgeable about the potential for a complete history and to have to relinquish portions of it for expediency. The student is aware of what is missing and may choose to question the value of expediency.

### Expectations of the Client

A client with a painful ingrown toenail wants relief. He does not expect to discuss the condition of his neighborhood or his relationship with significant others. Because many clinics have an episodic care modality, clients have been conditioned to present tangible symptoms for diagnosis and treatment. They do not expect a 3-hour interview, even if they have multiple problems, and they may be confused or annoyed by a long interview. Other clients do expect adequate time for relaying all of their circumstances, and they benefit from such attention. Some clients expect a leisurely interview session and have difficulty with efficient conveyance of information. It is extremely important that the examiner, the client, and the health agency are clear about *why* the history is being taken. If an examiner has only 15 minutes, this information should be shared with the client at the onset. People generally become more efficient when they know that time is limited. If the interview will be lengthy, the client should be prepared and accepting of this.

With most histories both the examiner and the client benefit if the examiner is nondirective for the first 5 to 10 minutes of the interview. The client is asked the reason for the visit and allowed to freely convey information in his own fashion. This requires active listening, observing, and empathic skills on the part of the questioner. The practitioner can make observations about the client's behaviors and verbal styles, as well as gain spontaneous information from the client. This approach also establishes a condition of trust between client and professional. At the same time, the client is observing the examiner. He needs to know that he has the examiner's full attention and concern. A state of suspended judgment broadens the examiner's perceptions and increases openness for inflow of data; it allows for patient priorities to be identified. It is human nature to hypothesize and to probe. The examiner must be aware when he or she is doing this and acknowledge that directive questions are being posed. Otherwise the client can easily be steered into a thinking channel that diverts from his original one.

At some point the history taking moves into a probing style (hypothesis generation and follow-up). It may go back and forth between probing, asking nonjudgmental questions, allowing free flow of conversation, and more probing. The questioner must judge the importance of being nondirective versus redirecting the client to answer specific questions. Sometimes practitioners with nondirective styles need to learn to interrupt and retrace



a line of thinking. Directive people must concentrate and develop a facilitative style to permit client expression. This practice is both an art and a science.

A model for clinical problem solving is shown in Fig. 1-1. Note that the history-taking aspect of problem solving is contained in the first four steps of the process. Step 3 denotes the shift from nonjudgmental to directive questioning. This may precede step 2 in certain situations or may not occur until the entire history has been taken.

The expanded data base outline that follows 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:

- 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 combined with the physical assessment problem list to develop a total problem list in the final write-up.

- A risk profile (risk factors related to certain body systems are listed in subsequent chapters).
- A client profile (a summary, from the *client's* viewpoint, of his life-style and ability to cope with self-care).

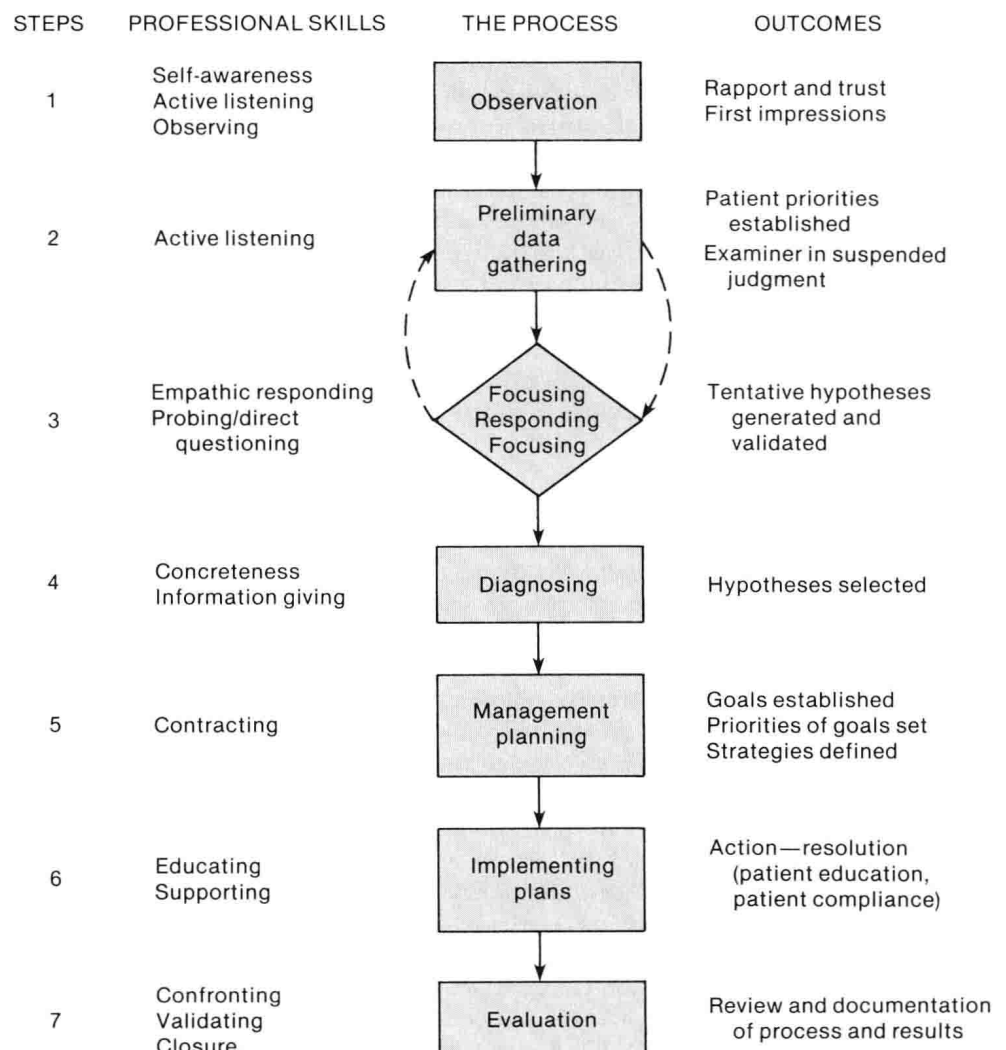
These data will serve as a constant resource for comparison as the client's condition changes and he provides new information in future assessments.

### COGNITIVE OBJECTIVES

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

- Apply the terms that are listed in the vocabulary section.
- Discuss the rationale and options for examiner behavior.

**Fig. 1-1** Clinical problem solving. (Modified from *Comprehensive humanistic health care*. The Ohio State University, Grant No. 713297, Health Resources Administration, Department of Health and Human Services, Cherry McPherson, chief investigator, 1980-1983.)



iors as they gather and analyze health data for the following:

1. Well person (does not belong in following categories)
  2. Well childbearing woman
  3. Well newborn
  4. Well child
  5. Well older adult
- Define the 10 components of the adult data base.
  - List the sections of the social history and provide at least one example of relevant information gathered in each section.
  - List and define the 11 components of the analysis of a symptom.
  - Recognize the characteristics of the newborn, the child, and the childbearing woman that are collected in addition to or as substitution for the adult data base.
  - Recognize the characteristics of the older adult that are collected in addition to or as substitution for the adult data base.

## CLINICAL OUTLINE

- At the end of this chapter the learner will conduct a systematic and accurate assessment of an individual's health status using the following format:
  1. Biographical data
  2. Reason for visit (chief complaint)
  3. Present health status (general summary and symptom analysis; also known as *history of present illness—HOPI*)
  4. Current health data
  5. Past health status
  6. Family history
  7. Review of physiological systems
  8. Psychosocial history
  9. Health maintenance efforts
  10. Environmental health status
- The learner will complete the assessment with the following:
  1. Problem list
  2. Risk profile
  3. Client profile

## EXPANDED CLINICAL OUTLINE

### FOR THE ADULT

#### Biographical Data

- Name
- Age
- Race
- Culture
- Address and telephone number
- Marital status
- Children and family in home (if not family, significant others)
- Occupation

- Means of transportation to health care facility if pertinent
- Description of home and size and type of community

#### Reason for Visit

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

#### Present Health Status

- Summary of client's current major health concerns
- If illness is present, record symptom analysis (see p. 11)
  1. When client was last well
  2. Date of problem onset
  3. Character of complaint
  4. Nature of problem onset
  5. Course of problem
  6. Client's hunch of precipitating factors
  7. Location of problem
  8. Relation to other body symptoms, body positions, and activity
  9. Patterns of problem
  10. Efforts of client to treat
  11. Coping ability

#### Current Health Data

- Current medications
  1. Type (prescription, over-the-counter drugs, vitamins, etc.)
  2. Prescribed by whom
  3. When first prescribed
  4. Amount per day
  5. Problems
- Allergies (description of agent and reactions)
  1. Drugs
  2. Foods
  3. Contact substances
  4. Environmental factors
- Last examinations (physician/clinic, findings, advice, and/or instructions)
  1. Physical
  2. Dental
  3. Vision
  4. Hearing
  5. ECG
  6. Chest radiograph
  7. Pap smear (females)
  8. Tuberculosis tine test
- Immunization status (dates or year of last immunization)
  1. Tetanus, diphtheria, pertussis
  2. Mumps
  3. Rubella
  4. Polio
  5. Influenza



## Past Health Status

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

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

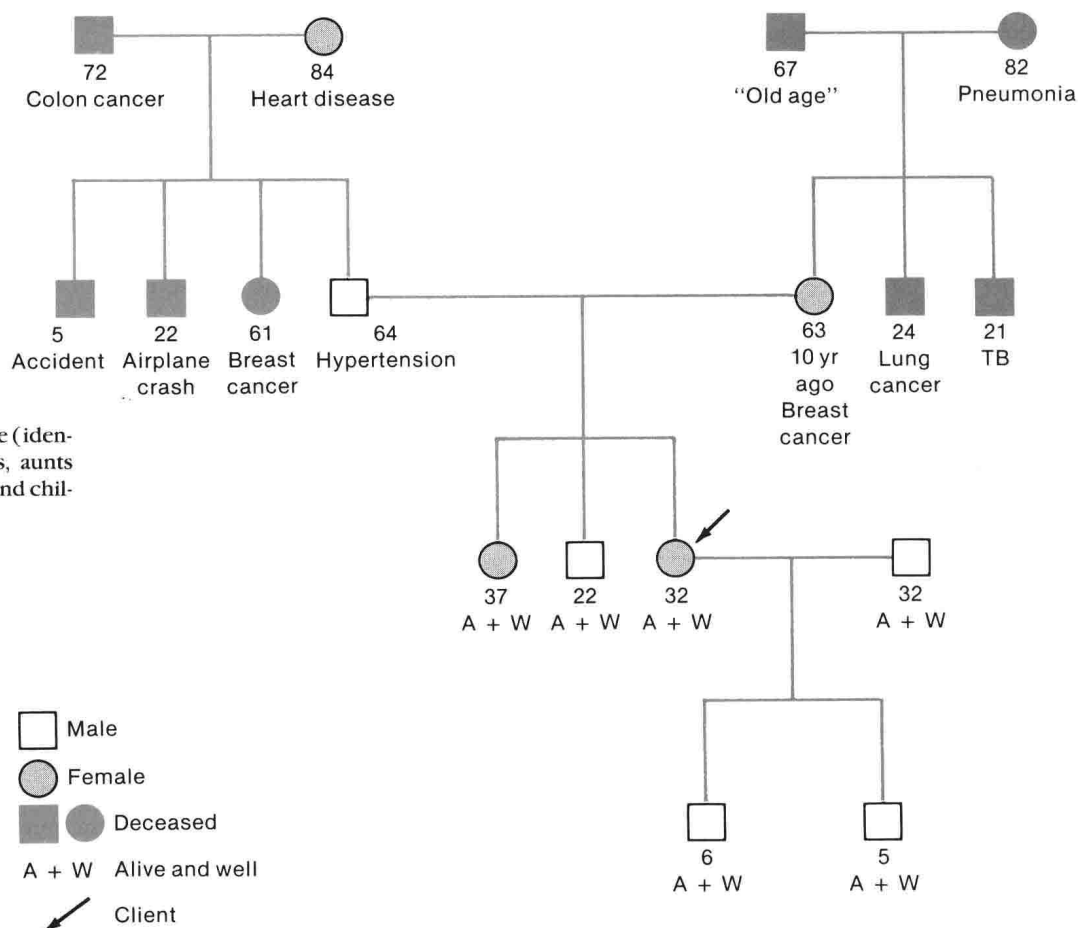
Alzheimer's disease  
Cancer  
Diabetes  
Heart disease  
Hypertension  
Epilepsy (or seizure disorder)  
Emotional stresses

Mental illnesses  
Developmental delay  
Alcoholism  
Endocrine diseases  
Sickle cell anemia  
Kidney disease  
Unusual limitations  
Other chronic problems

The most concise method to record these data is by a family tree. Fig. 1-2 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.



**Fig. 1-2** Sample family tree (identifying grandparents, parents, aunts and uncles, siblings, spouse, and children).

- General—reflect from client's previous description of current health status
  1. Fatigue patterns
  2. Exercise and exercise tolerance
  3. History of weakness episodes, if any
  4. History of fever, sweats, if any
  5. Frequency of colds, infections, or illnesses
  6. Ability to carry out activities of daily living
- Nutritional
  1. Client's average, maximum, and minimum weights during past month; 1 year; 5 years
  2. History of weight gains or losses (time element); specific efforts to change weight
  3. Twenty-four-hour diet recall, as on p. 14 (helpful to mail the client a chart to fill in before visit)
  4. Cultural and/or religious practices regarding intake
  5. Current appetite
  6. Extreme deviations in physical activity that would affect appetite (e.g., athletic or immobilization influences)
  7. Person(s) who buys and prepares food
  8. Person(s) client normally eats with
  9. Availability of money to buy preferred food
  10. Status of ability to chew; condition of teeth or dentures
  11. Client's self-evaluation of nutritional status
- Integumentary
  1. Skin
    - a. Skin disease, problems, lesions (wounds, sores, ulcers)
    - b. Skin growths, tumors, masses
    - c. Excessive dryness, sweating, odors
    - d. Pigmentation changes or discolorations
    - e. Pruritus (itching)
    - f. Texture changes
    - g. Temperature changes
  2. Hair
    - a. Changes in amount, texture, character
    - b. Alopecia (loss of hair)
    - c. Use of dyes
  3. Nails
    - a. Changes in appearance, texture
- Head
  1. Headache (characteristics, including frequency, type, location, duration, care for)
  2. Past significant trauma
  3. Dizziness
  4. Syncope
- Eyes
  1. Discharge (characteristics)
  2. History of infections, frequency, treatment
  3. Pruritus
  4. Lacrimation (excessive tearing)
  5. Pain in eyeball
  6. Spots (floaters)
  7. Swelling around eyes
  8. Cataracts, glaucoma
  9. Unusual sensations or twitching
  10. Vision changes (generalized or vision field)
  11. Use of corrective or prosthetic devices
  12. Diplopia (double vision)
  13. Blurring
  14. Photophobia
  15. Difficulty reading
  16. Interference with activities of daily living
- Ears
  1. Pain (characteristics)
  2. Cerumen (wax)
  3. Infection
  4. Hearing changes (describe)
  5. Use of prosthetic devices
  6. Increased sensitivity to environmental noise
  7. Vertigo
  8. Ringing and cracking
  9. Care habits
  10. Interference with activities of daily living
- Nose, nasopharynx, and paranasal sinuses
  1. Discharge (characteristics)
  2. Epistaxis
  3. Allergies
  4. Pain over sinuses
  5. Postnasal drip
  6. Sneezing
  7. General olfactory ability
- Mouth and throat
  1. Sore throats (characteristics)
  2. Tongue or mouth lesion (abscess, sore, ulcer)
  3. Bleeding gums
  4. Hoarseness
  5. Voice changes
  6. Use of prosthetic devices (dentures, bridges)
  7. Altered taste
  8. Chewing difficulty
  9. Swallowing difficulty
  10. Pattern of dental hygiene
- Neck
  1. Node enlargement
  2. Swellings, masses
  3. Tenderness
  4. Limitation of movement
  5. Stiffness
- Breasts
  1. Pain or tenderness
  2. Swelling
  3. Nipple discharge
  4. Changes in nipples
  5. Lumps, dimples
  6. Unusual characteristics
  7. Breast examination (pattern, frequency)