Tikrit University

College of Nursing

Basic Nursing Sciences

Second Year - 2023-2024

Health assessment and physical examination

(Assessment)

by:

Nabaa Thamir Mahmood

Assessment

Assessment The first and most important step of the nursing process, assessment involves collecting all the relevant information needed to solve a health problem. All the remaining steps of this process depend heavily on the accuracy of this information

Assessment includes:

- Gathering data(Type of data)
- subjective data Said by patient
- What the patient say about him self during history taking ?
- Symptoms
- objective data observe by nurse
- What you observed as a nurse by inspection, palpation, Percussion, Auscultation
- sings

- When your patient (or his family or friends) provides information you can't verify by observation or measurement, consider it subjective data
- In short, symptoms. A patient's complaint of pain would be an example of a symptom.
- Objective data, or signs, can be verified. If a patient complains of a sore arm, for example, you may see a red, swollen area that feels warm. Although his complaint of pain is subjective, the redness, warmth, and swelling that you observe are objective signs of his health problem.

Method of assessment

- Health history (sub data)
- Physical assessment (object data)

Definition of health history

- Systematic of collection of subjective data
- Which stated with cline

Phases of taking health history

Two phases; -

- The interview phase
- Recording phase

Guideline for taking nursing history

- Communicate and negated property with Client
- Listen more than take
- Observe nonverbal communication e g, body language, voice tone, and appearance.
- Balance between allowing a Clint to talk in stricture.

Guideline for taking nursing history

- Private, comfortable and quite environment
- Allow to patent to state problem and expectation for interview
- Orient the patent the stricture and purposes and expectation of the patent

Type of nursing health history

- Complete health history: taken in initial visit to health care fascinated
- Interval health history: collect information visit following the initial data base is collected.
- Problem focus health history: collect date about specific problem.

Biographic data

Includes basic characteristics about the patient, such as

1.Full name

2. contact information

3.birthdate

4.age

5. gender and preferred pronouns

6. allergies

7.languages spoken and preferred language

8.relationship status

9. Occupation

10.resuscitation status

Chief complaint

Ask the patient why he's seeking health care. Then record his exact words and place them in quotation

marks. A properly recorded chief complaint would be "I've had a headache for 3 days." "States that he has been sick" would be an improperly recorded chief complaint.

History of present illness

That means asking the right health history questions, conducting a physical examination based on the history data you collect, and analyzing the possible causes of the patient's problem. One aid to asking the right questions about any chief complaint is the PQRST mnemonic device. This aid will help you to explore complaints systematically and collect the specific information.

Medical history

Ask the patient about his previous illnesses and injuries. Note the dates of significant treatments and any surgeries the patient has undergone. Find out too if the patient has any allergies. In particular, ask him about allergies to antibiotics, such as penicillin, and to sulfa drugs. Is the patient taking any prescription or over-the-counter drugs? Make a list of all prescribed drugs and their dosage

Family history

Information about the general health of the patient's blood relatives helps to identify his risk of developing certain disorders. Ask the patient if any family members have a history of Alzheimer's disease, cancer, diabetes mellitus (or other endocrine or metabolic problems), hypertension, heart disease, seizures, sickle cell anemia, or kidney disease. Also ask whether any relatives have chronic conditions or unusual limitations (for instance, being bedridden because of paralysis from a cerebrovascular accident)

Psychosocial history

Try to determine how the patient feels about himself. How does he see his place in society and his relationships with others? Ask about his occupation, educational level, financial status, and responsibilities. Ask too about his sexual practices. How has the patient coped with medical or emotional crises in the past? Has he experienced recent changes in his life or has he noticed any changes in his personality or behavior? Does he receive adequate emotional support from family and friends?