

HEALTH HISTORY

PURPOSE

To provide the student with the opportunity to combine interviewing and documenting skills in one assignment. The student will, for a selected adult patient, complete a health history and perform a health risk assessment and document using a nurse's progress note format.

PREPARATION:

1. **READ THE ASSESSMENT FORM BEFORE THE EXPERIENCE.**
2. Review Lewis, pp. 39-52.
3. Refer to list of common medical abbreviations guide for appropriate terminology.

CRITERIA:

1. Respond to each item on the Health History.
2. Document current and accurate information on the assignment form using appropriate medical abbreviations and terminology.
3. Complete Health Risk Assessment page.
4. Write a Nursing Progress Note incorporating identified health risks and nursing plan that addresses the risk behaviors including pertinent information from the interview. Assume that other staff may not have access to this information.

ASSIGNMENT AND DUE DATE:

One written Health History, Health Risk Assessment and Nursing Progress Note will be submitted to the student's clinical faculty within one week following this clinical experience.

HEALTH HISTORY

Use both patient interview and medical record for gathering data.

Student Name: _____ Date: _____

GENERAL INFORMATION

Patient Initials: ____ Sex: M F Age: ____ DOB: _____

Health care insurance:

Source(s) of information:

History of present condition/illness/surgery:

Patient's understanding of current condition:

Past health/medical problems:

Medications currently prescribed:

Nonprescription medications used and frequency:

Health maintenance, health promotion practices, healing modalities and home remedies:

History of family health/illness (DM, cancer, HTN, CVA, MI, communicable diseases, emotional illness):

Allergies (include foods, medications, environmental sources, latex, etc.)

SUBSTANCE	REACTION

Substance use:

Number of cigarettes/day:

Amount of caffeinated beverages/day:

Other tobacco/day:

Amount/type of alcoholic drinks/day:

Number of years smoked:

Other substances:

Oxygenation Assessment

Chest Pain/Palpitations: (frequency precipitating/alleviating factors)

Cough, Sputum or Dyspnea:

Distance patient can walk without resting: (Is patient limited by SOB, claudication, fatigue, angina)

Number of pillows patient sleeps with at night:

Nocturia:

Rest/Sleep/Comfort Assessment

Hours worked/day:

Hours of sleep/night:

Rest periods/naps: Yes No Describe:

Measures to aid sleep (include medications):

Sleep problems:

Pain, discomfort: If yes, describe (include if acute or chronic in nature):

Activity Assessment

Type and amount of activity/exercise:

Gait:

Muscle Strength:

Musculoskeletal discomfort or limitation:

Assistive Devices:

Ability to care for self:

Nutrition Assessment

24 hour recall of "typical" day.

INTAKE	BREAKFAST	LUNCH	DINNER	SNACKS
Food				
Fluid				
Usual times of meals at home				

Dietary restrictions/dislikes/difficulty:

Appetite:

Recent weight and/or appetite changes:

Ability to feed self:

Dentition:

Symptoms (nausea, vomiting, pain, emesis, bleeding):

Bowel Elimination Assessment

Typical bowel elimination pattern:

Appearance of stool:

Continence:

Symptoms (diarrhea, blood, hemorrhoids, pain):

Urinary Elimination Assessment

Typical daily voiding pattern:

Appearance of urine:

Continence:

Symptoms (dysuria, hematuria, anuria):

Safety and Security Assessment

Hearing:

Sight:

Aids:

Orientation to:

Person:

Place:

Time:

Environmental history (exposure to domestic/occupational/recreational substances; noise, chemicals, infectious agents; financial concerns)

Higher Level Needs

Educational Level:

Occupation:

Ability to speak and understand:

Type and Place of Residence:

Student: Yes No

Employed: Yes No/ Retired: Yes No

Religion:

Present emotional state:

Usual emotional state:

Symptoms (anxiety, stress, depression, grief):

Love and Belonging

Primary support:

Family composition: **(do not write down names)**

Household members= relationships

Symptoms (adequacy of relationships and social support, domestic violence):

Sexuality (partner, STD exposure and protection, contraception):

Recognition/Esteem

Hobbies:

Volunteer work:

Other pertinent data:

HEALTH RISK ASSESSMENT

Based on the data gathered in the Health History, identify:

1. Risk behavior(s): _____

2. Probable consequences of continuing this behavior for this patient: _____

3. Circle the patient=s stage of readiness for change of this risk behavior, using the information contained in the chronic illness conference guide.

1. Pre-contemplation 2. Contemplation 3. Determination/
Planning 4. Action 5. Maintenance 6. Relapse

Support this stage selection with patient information (e.g. patient statements or patient activities r/t the risk behavior): _____

4. Recommended Plan of Action: _____

EXAMPLE

1. Risk behavior(s): sedentary lifestyle, high sodium, high fat diet, cigarette smoking

2. Probable consequences of continuation of this behavior for this patient: hypertension, coronary artery disease, MI, CVA, cancer

3. Circle the patient=s stage of readiness for change of this risk behavior, using the information contained in the chronic illness conference guide.

Pre-contemplative / Contemplative / Planning / Action / Maintenance / Relapse

4. Refer to dietician; teach benefits of regular exercise; provide smoking cessation materials.

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