CHAPTER 3: THE COMPLETE HEALTH HISTORY INCLUDING DOCUMENTATION

MULTIPLE CHOICE

1. The nurse taking the health history will
   a. stay with the patient as long as it takes to get a full picture of the patient's complaint.
   b. use medical jargon to reassure the patient that they are qualified health care providers.
   c. ask the patient if they have any questions about the interview before it starts.
   d. ensure that all questions are asked according to the health history document.

   ANS: C PTS 1 DIF: moderate TOP: Taking a health history

2. The patient is complaining of chest pain that started 20 minutes ago with exercise and does not stop when he rests. Which type of health history is most appropriate in this situation?
   a. emergency
   b. complete
   c. follow up
   d. episodic

   ANS: B PTS: 1 DIF: Moderate TOP: Types of health history

3. A patient is admitted to the medical surgical unit for review after a fall at home with a period of loss of consciousness. What type of health history would be most appropriate for this situation?
   a. emergency
   b. follow up
   c. episodic
   d. complete

   ANS: D PTS: 1 DIF: Easy TOP: Types of health history

4. Which question is most likely to provide the health care provider with the patient's understanding and expectations of care related to their present illness?
   a. What caused you to come to the hospital today?
   b. Can you please describe this problem from when you first experienced it to how it makes you feel now?
   c. Have you experienced this problem before?
   d. Does this condition affect your lifestyle?

   ANS: D PTS: 1 DIF: Moderate TOP: Present health and history of the present illness

5. To assess what provokes or palliates pain, you would ask the patient:
   a. 'Where are you feeling the pain?'
   b. 'What does this pain feel like?'
   c. 'What causes this pain and what makes the pain go away?'
   d. 'How disabling is this pain?'

   ANS: B PTS: 1 DIF: Easy TOP: Palliate/Provoke

6. The most effective way to assess the severity of pain is to ask the patient to:
   a. describe the pain as minor, moderate, or severe.
   b. classify the pain as small, medium, or large.
   c. rate the pain on a scale from 0 to 10 with 0 being no pain and 10 being the worst pain.

d. compare the pain with pain experienced in the past.

ANS: C PTS: 1 DIF: Moderate TOP: Quantity

7. Mr K complains of sneezing accompanied by clear nasal discharge and watering eyes, but he denies having a sore throat, body aches, cough or fever. The pertinent negative finding(s) in your assessment of Mr K include:
   a. fever.
   b. sore throat and cough.
   c. clear nasal discharge, sneezing, and tearing.
   d. sore throat, body aches, cough, and fever.

   ANS: D PTS: 1 DIF: Easy TOP: Associated signs and symptoms

8. A patient reports gastric or periumbilical pain that over the past 4 hours has localised to the right upper quadrant. The medical diagnosis is given as appendicitis. The patient states he has nausea, vomiting, anorexia, and a fever. What term characterises presence of nausea, vomiting, anorexia, and low-grade fever?
   a. chief complaint
   b. associated manifestations
   c. pertinent negatives
   d. aggravating factors

   ANS: A PTS: 1 DIF: Difficult TOP: Associated signs and symptoms

9. Mr R states that his chest pain started before lunch, when he was painting his house, and it lasted about 15 minutes. The pain was relieved when he sat down. However he has experienced the pain again today when he went for a walk and this time he felt short of breath.
   You would report the duration of Mr R's chest pain as:
   a. acute.
   b. intermittent.
   c. severe.
   d. sudden.

   ANS: B PTS: 1 DIF: Easy TOP: Timing

10. The patient tells you that he has episodes of chest pain with exertion however the pain is relieved when he rests. Today he experienced the pain again and resting did not make it go away. He also experienced pain in his left arm. Using PQRST to make a focused assessment the pain in his left arm would belong to which category?

    a. P, for palliation
    b. R, for region or radiation
    c. S, for severity
    d. T, for time

    ANS: B PTS: 1 DIF: Difficult TOP: Quality: Clinical reasoning

11. The patient's past health history includes which of the following?
    a. childhood illnesses, allergies, alcohol use
    b. religion, sexual practice and surgeries
    c. work environment, injuries and accidents and tobacco use

d. medications, immunisations and communicable diseases

ANS: D PTS: 1 DIF: Easy TOP: Past health history

12. A patient tells you that she only takes her prescribed medication for blood pressure when she feels dizzy because it is expensive and she cannot afford to take it every day as prescribed. What is the nurse's most appropriate response?
    a. 'You have to take the medication as the doctor prescribed it and do without something so you can afford it'
    b. 'You need to ask your health care provider if you should be taking this medication as you don't take it all the time.'
    c. 'Please discuss this with your health care provider and explain the situation. They may be able to find a less expensive medication that is appropriate to your needs.
    d. 'Have you tried any herbal products for high blood pressure. They are cheaper?'

    ANS: C PTS: 1 DIF: Difficult TOP: Clinical reasoning: Expired medications

13. Jane, 14 years old, has received treatment for a sexually transmitted disease and has been suspended from school for drug use. You follow the suggested guidelines for addressing sensitive topics in your interview with Jane. The guidelines include:
    a. using a firm tone of voice to emphasise the importance of these issues.
    b. avoiding constant direct eye contact to minimise her embarrassment.
    c. approaching her with a nonjudgemental demeanour.
    d. addressing these topics early in the interview to lessen her anxiety.

    ANS: C PTS: 1 DIF: Easy TOP: Reflection in practice dealing with sensitive topics

14. A patient answers 'yes' to the nurse's question, 'In the past year, have you been hit, kicked, punched or hurt in other ways by someone close to you?' What next nursing intervention is most important?
    a. Conduct a physical exam to assess for signs/symptoms of suspected violence and abuse.
    b. Report the suspected violence and abuse to the appropriate state agency.
    c. Ask the patient if she feels safe in her current environment or situation.
    d. Document physical findings concisely and accurately.

    ANS: C PTS: 1 DIF: Difficult TOP: Domestic and intimate partner violence

15. When interviewing a patient whose health problems are most likely related to exposure to a potentially dangerous substance, which areas should you explore?
    a. military service and sexual practices
    b. hobbies and economic status
    c. work and home environment
    d. religion and stress

    ANS: C PTS: 1 DIF: Easy TOP: Work Environment

16. It is important to assess the educational level of patients primarily to:
    a. have a complete profile of the patient for your records.
    b. ascertain the patient's level of understanding of science and health-related concepts.
    c. determine the patient's ability to comprehend verbal or written instructions about health care.

d. decide how much information you should provide.

ANS: C PTS: 1 DIF: Moderate TOP: Education

17. While conducting the review of systems (ROS), the nurse asks the patient if he has experienced headaches, loss of memory, lack of coordination, or weakness. In which section of the ROS would this information be recorded?
    a. psychological
    b. endocrine
    c. cardiovascular
    d. neurological

    ANS: D PTS: 1 DIF: Easy TOP: Review of systems

18. The patient reports that he has had surgery for testicular cancer. You should record this information in which section of the health history?
    a. past health history
    b. medical history
    c. social history
    d. health checkups

    ANS: A PTS: 1 DIF: Easy TOP: Health check-ups

19. A patient fell while exercising and put out her arms to break her fall yesterday. Her right wrist is swollen and painful. Which of the following chart entries is documented correctly?
    a. right wrist is still sore
    b. pain in right wrist appears to be worse today after fall yesterday
    c. takes ibuprofen for pain 7/10
    d. right wrist with 1+ nonpitting edema and pain score of 7/10

    ANS: D PTS: 1 DIF: Difficult TOP: Table 3.3 Assessment-specific documentation guidelines

20. After interviewing your patient, you document ‘patient denies nausea, vomiting or diarrhea’. In which sections of the review of systems is this information recorded?
    a. nose and sinuses
    b. mouth
    c. throat and neck
    d. gastrointestinal

    ANS: D PTS: 1 DIF: Easy TOP: Table 3.1 Review of systems

21. The nurse makes a mistake when charting in the patient’s record. To correct this mistake the nurse should:
    a. use correction fluid to cover the mistake and make the correct entry.
    b. blot out the error with black ink and make the correct entry.
    c. erase the error and write over it.
    d. cross out the error with a single line, then date, time and sign the correction.

    ANS: D PTS: 1 DIF: Easy TOP: Table 3.2 General documentation guidelines

22. Which of the following entries is documented correctly?

a. At 0900 hours, Dr. Green inserted a urinary catheter.
b. The catheter is draining well.
c. The patient is more comfortable now that the urinary has been inserted.
d. At 0900 hours, a urinary catheter was inserted.

ANS: A PTS: 1 DIF: Moderate TOP: Table 3.3 Assessment-specific documentation guidelines

23. To obtain demographic data information about a patient, the nurse would ask:
a. 'Please can you tell me what the reason is for your visit today?'
b. 'Do you have an allergies to medications or food?'
c. 'On a scale from 1 to 10 with 1 being "poor" and 10 being "ideal," how would you rate your health?'
d. 'Please could you tell me your name, address, phone number, date of birth

ANS: D PTS: 1 DIF: Easy TOP: Demographic data

COMPLETION

1. The genogram and a list of familial diseases would be documented in the _____ section of the health history.

ANS:
family health history

PTS: 1 DIF: Easy TOP: Family health history

2. The term that describes negative, harmful stress is _____.

ANS:
distress

PTS: 1 DIF: Easy TOP: Stress

3. Mr M incorporates specific stress-management techniques into his lifestyle. This is documented in the _____ section of the health history.

ANS:
health maintenance / promotion activities
PTS: 1 DIF: Moderate TOP: Health maintenance/Promotion activities

4. Mr J is complaining of chest pain that started with exertion1 hour ago. The type of health history most appropriate in this situation is the _____ health history.

ANS:
emergency
PTS: 1 DIF: Moderate TOP: Types of health history

5. By asking Mr K the question, 'Can you tell me if there is anything that causes your nausea?' you are determining if there are any _____ factors.

ANS:
aggravating

PTS: 1 DIF: Difficult TOP: Aggravating factors

6. The type of health history that documents the patient's progress or recovery from illness is _____ or _____.

ANS:
interval, follow-up

PTS: 1 DIF: Difficult TOP: Types of health history

SHORT ANSWER

1. The use of the mnemoic PQRST helps the nurse to accurately report on a chief complaint. Briefly explain the meaning of each of the elements of PQRST.

ANS:
P what makes the symptom/complaint worse or better (palliates or provokes)?
Q what is the quality of the symptom – what is it like
R does it radiate to any other area
S How severe is it – rate it on a scale of 0 to 10 with 0 being the least to 10 being the most severe
T how long does it last for?

PTS: 5 DIF: Moderate TOP: Remembering what information you need to collect

2. SBAR communication allows the nurse to effectively communicate issues or problems to other co-workers. List the steps used in SBAR and briefly explain each step.

ANS:
Situation State reason that has warranted this communication; Background: Circumstances leading up to this situation; Assessment: what is the problem?; and Recommendation: solutions to the problem.

PTS: 8 DIF: Moderate TOP: SBAR communication

3. As people travel to other countries, they sometimes present with symptoms that may not attribute to routine illness. State four questions you would ask your patient in regards to travel history.

ANS: Any of the below
Where did he travel? Rural or urban? Was he immunised prior if so, what were they? Was the patient ill whilst overseas? Was medical treatment sought? What was the diagnosis? What was the treatment?

PTS: 4 DIF: Moderate TOP: SBAR communication