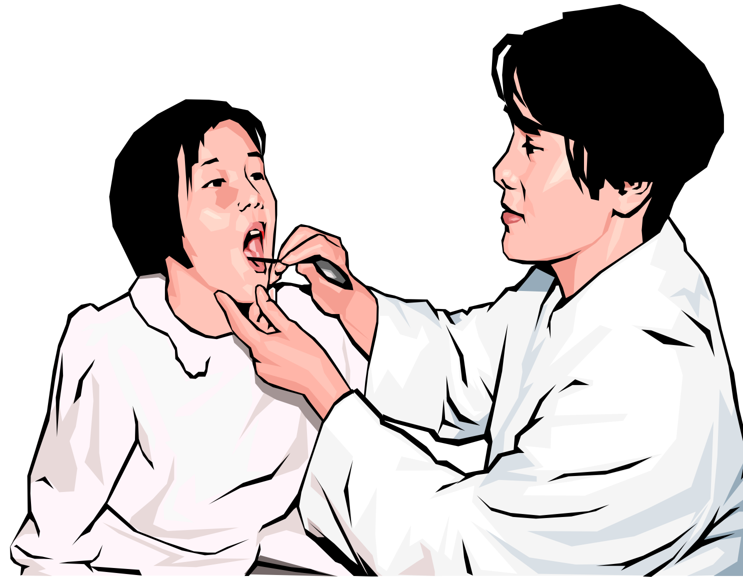
English for Public Health

Unit 4: Health Assessment



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Unit 4
Contents:

1. Checking patient details
2. Assessing common disease for adult
3. Describing symptoms
4. Health assessment information for patient

I. Checking patient details

Biographical Data: This includes

- Full name
- Address and telephone numbers (client's permanent contact of client)
- Birth date and birth place.
- Sex
- Religion and race.
- Marital status.
- Social security number.
- Occupation (usual and present)
- Source of referral.
- Usual source of healthcare.
- Source and reliability of information.
- Date of interview.

II. Assessing common disease for adult

According to physical systems :

- General review of skin, hair, head, face, eyes, ears, nose, sinuses, mouth, throat, neck nodes and breasts.
  (General Appearance and HEENT)
- Respiratory and cardiovascular system.
- Gastrointestinal system.
- Urinary system.
- Genital system.
- Extremities and musculoskeletal system.
- Endocrine system.
- Heamatoboitic system.
- Social system.
- Psychological system.

III. Describing symptoms

By definition of Health History

Systematic collection of subjective data which stated with client, and objective data which observed by the health officer (or nurse).

III. Describing symptoms (cont'd)

Chief Complaint: "Reason For Hospitalization".

Examples of chief complaints:

- Chest pain for 3 days.
- Swollen ankles for 2 weeks.
- Fever and headache for 24 hours.
- Pap smear needed.
- Physical examination needed for camp.

IV. Health assessment information for patient (cont'd)

Phases of taking health history

Two phases:-

- The interview phase
- The recording phase

IV. Health assessment information for patient (cont'd)

Guidline for taking health history

- Private, comfortable, and quiet environment.
- Allow the client to state problems and expectations for the interview.
- orient the client the structure, purposes, and expectations of the history.

IV. Health assessment information for patient (cont'd)

Guidline for taking health history

- Communicate and negotiate priorities with the client
- Listen more than talk.
- Observe non verbal communications e.g. "body language, voice tone, and appearance".

IV. Health assessment information for patient (cont'd)

Guidline for taking health history

- Review information about past health history before starting interview.
- Balance between allowing a client to talk in an unstructured manner and the need to structure requested information.
- Clarify the client's definitions (terms & descriptors)

IV. Health assessment information for patient (cont'd)

Guidline for taking health history

- Avoid yes or no question (when detailed information is desired).
- Write adequate notes for recording?
- Record nursing health history soon after interview.

IV. Health assessment information for patient (cont'd)

Types of health history

- Complete health history: taken on initial visits to health care facilities.
- Interval health history: collect information in visits following the initial data base is collected.
- Problem- focused health history: collect data about a specific problem

IV. Health assessment information for patient (cont'd)

History of present illness.

Gathering information relevant to the chief complaint, and the client's problem, including essential and relevant data, and self medical treatment

IV. Health assessment information for patient (cont'd)

Component of present illness

- Introduction: "client's summary and usual health".
- Investigation of symptoms: "onset, date, gradual or sudden, duration, frequency, location, quality, and alleviating or aggravating factors".
- Negative information.
- Relevant family information.
- Disability "affected the client's total life".

IV. Health assessment information for patient (cont'd)

Past Health History:

The purpose: (to identify all major past health problems of the client)

This includes:

- Childhood illness e.g. history of rheumatic fever.
- History of accidents and disabling injuries

IV. Health assessment information for patient (cont'd)

Past Health History:

- History of hospitalization (time of admission, date, admitting complaint, discharge diagnosis and follow up care.
- History of operations "how and why this done"
- History of immunizations and allergies.
- Physical examinations and diagnostic tests.

IV. Health assessment information for patient (cont'd)

Family History:

The purpose: to learn about the general health of the client's blood relatives, spouse, and children and to identify any illness of environmental genetic, or familiar nature that might have implications for the client's health problems.

IV. Health assessment information for patient (cont'd)

Family History:

- Family history of communicable diseases.
- Heredity factors associated with causes of some diseases.
- Strong family history of certain problems.
- Health of family members "maternal, parents, siblings, aunts, uncles…etc.".
- Cause of death of the family members "immediate and extended family".

IV. Health assessment information for patient (cont'd)

Environment History:

purpose

"to gather information about surroundings of the client", including physical, psychological, social environment, and presence of hazards, pollutants and safety measures."

IV. Health assessment information for patient (cont'd)

Current Health Information:

The purpose is to record major, current, health related information.

- Allergies: environmental, ingestion, drug, other.
- Habits "alcohol, tobacco, drug, caffeine"
- Medications taken regularly "by doctor or self prescription
- Exercise patterns.
- Sleep patterns (daily routine).
- The pattern life (sedentary or active)

IV. Health assessment information for patient (cont'd)

Psychosocial History:

Includes :

- How client and his family cope with disease or stress, and how they responses to illness and health.
- You can assess if there is psychological or social problem and if it affects general health of the client.

IV. Health assessment information for patient (cont'd)

Review of Systems (ROS) :

Collection of data about the past and the present of each of the client systems.

(Review of the client's physical, sociologic, and psychological health status may identify hidden problems and provides an opportunity to indicate client strength and liabilities

IV. Health assessment information for patient (cont'd)

Nutritional Health History :

"Pattern of Food and Drinks of their lifestyle"

IV. Health assessment information for patient (cont'd)

Assessment of Interpersonal Factors :

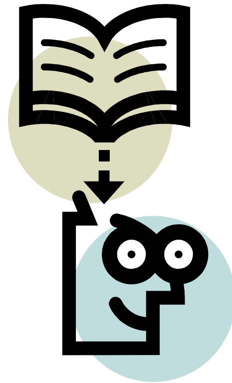
This includes :-

- Ethnic and cultural background, spoken language, values, health habits, and family relationship.
- Life style e.g. rest and sleep pattern
- Self concept perception of strength, desired changes
- Sexuality developmental level and concerns
- Stress response coping pattern, support system, perceptions of current anticipated stressors.

Nursing Diagnosis :

The North American Nursing Diagnosis Association (NANDA,1994) defines a nursing diagnosis as “A clinical judgments about individual, family or community response to actual and potential health problems and life responses”

Summary



Any questions?

Thank You
For your Attention

See you later next week