

## **NSC209 HEALTH AND PHYSICAL ASSESSMENT SUMMARY**

**PLEASE PATRONISE US FOR MORE SUMMARY, PAST QUESTIONS AND TMA (30/30)**

**WHATSAPP 08024665051**

\_\_\_\_\_ is an essential nursing function which provides foundation for quality nursing care and intervention.

**Health assessment**

\_\_\_\_\_ helps to identify the strengths of the clients in promoting health.

**Health assessment**

An accurate and thorough \_\_\_\_\_ reflects the knowledge and skills of a professional nurse.

**Health assessment**

An accurate and thorough health assessment reflects the \_\_\_\_\_ and skills of a professional nurse.

**Knowledge**

An accurate and thorough health assessment reflects the knowledge and skills of a\_\_\_\_\_.

**Professional nurse**

The focus of \_\_\_\_\_ care is attainment, sustenance, and recovery of health.

**Nursing**

The focus of \_\_\_\_\_ is attainment, sustenance, and recovery of health.

**Nursing care**

The focus of nursing care is attainment, sustenance, and \_\_\_\_\_of health.

**Recovery**

The \_\_\_\_\_ obtained from the nursing history and physical examination is used to determine the strengths of the client or responses that the client exhibits in response to health problem.

**Information**

The information obtained from the nursing history and physical examination is used to determine the strengths of the client or responses that the client exhibits in response to\_\_\_\_\_.

**Health problem**

The purpose of the nursing assessment is to enable you to make a clinical judgment or diagnosis about a client's health status.

**True**

\_\_\_\_\_ is identified as the first step of the nursing process

**Assessment**

An \_\_\_\_\_ describes a hand-on data collection process, while a database identifies a specific list of data to be collected.

**Assessment**

The \_\_\_\_\_ is all the health information about a client.'

**Database**

The process of obtaining a health history and performing a physical examination is an intimate experience for both you and the\_\_\_\_\_.

**Client**

During the interview and physical examination your scope of focus must be more than problems presented by the client.

**True**

Knowledge of the natural and \_\_\_\_\_ sciences is a strong foundation for you.

**Social**

Knowledge of the \_\_\_\_\_ and \_\_\_\_\_ sciences is a strong foundation for you.

### **Natural, Social**

\_\_\_\_\_ is a systematic method of collecting data about a client for the purpose of determining the client's current and ongoing health status, predicting risks to health and identifying health-promoting activities.

### **Health assessment**

A systematic method of collecting data about a client for the purpose of determining the client's current and ongoing health status, predicting risks to health and identifying health-promoting activities is referred to as \_\_\_\_\_

### **Health assessment**

The following are the principles of health assessment

1. An accurate and timely health assessment provides foundation for nursing care and intervention.
2. A comprehensive assessment incorporates information about a client's physiologic, psychosocial, spiritual health, cultural and environmental factors as well as client's developmental status.
3. The health assessment process should include data collection, documentation and evaluation of the client's health status and responses to health problems and intervention.
4. All documentation should be objective, accurate, clear, concise, specific and current.
5. Health assessment is practiced in all healthcare settings whenever there is nurse-client interaction.
6. Information gathered from health assessment should be communicated to other health care professionals in order to facilitate collaborative management of clients and for continuity of care.
7. Client's confidentiality should be kept.

\_\_\_\_\_ includes the interview, physical assessment, documentation, and interpretation of findings.

### **Health assessment**

Health assessment includes the interview, physical assessment, \_\_\_\_\_, and interpretation of findings.

### **Documentation**

Health assessment includes the interview, physical assessment, documentation, and \_\_\_\_\_ of findings.

### **Interpretation**

Health assessment includes the interview, physical assessment, documentation, and interpretation of \_\_\_\_\_.

### **Findings**

The data collected during an interview comes from \_\_\_\_\_ and secondary sources.

### **Primary**

The data collected during an interview comes from primary and \_\_\_\_\_ sources.

### **Secondary**

\_\_\_\_\_ is information that the client experiences and communicates to the nurse.

### **Subjective data**

Subjective data is information that the client experiences and communicates to the \_\_\_\_\_.

### **Nurse**

Subjective data is usually referred to as \_\_\_\_\_ or symptom

### **Covert data**

\_\_\_\_\_ is usually referred to as covert (hidden) data or as a symptom, when it is perceived by the client and cannot be observed by others.

### **Subjective data**

The purpose of client interview is to \_\_\_\_\_

## **Obtain a health history about the client's past and present health state**

An effective \_\_\_\_\_ is a key factor in interview process

### **Communication**

Effective communication is a key factor in \_\_\_\_\_ process.

### **Interview**

Creating a climate of trust and respect is critical to establishing a \_\_\_\_\_ relationship.

### **Therapeutic**

The purpose of \_\_\_\_\_ is to obtain information about the client's health in his or her own words and based on the client's own perceptions.

### **Health history**

The \_\_\_\_\_ provides cues regarding the client's health and guides further data collection.

### **Health history**

The most important aspect of the assessment process is \_\_\_\_\_

### **Health history**

The amount of time you need to complete a nursing history may vary with the format used and your \_\_\_\_\_.

### **Experience**

The \_\_\_\_\_ interview enables you to clarify points, to obtain missing information, and to follow up on verbal and nonverbal cues identified in the health history.

### **Focused**

\_\_\_\_\_ is hand-on examination of the client.

### **Physical assessment**

\_\_\_\_\_ is observed or measured by the professional nurse.

## **Objective data**

Objective data is observed or measured by the\_\_\_\_\_.

### **Professional nurse**

\_\_\_\_\_ is also known as overt data or a sign once it is detected by the nurse.

## **Objective data**

\_\_\_\_\_ data can be seen, felt, heard, or measured by the professional nurse.

## **Objective data**

Data that can be observed by one person and verified by another person observing the same patient are known as\_\_\_\_\_

## **Objective data**

\_\_\_\_\_ of data from health assessment creates a client record or becomes an addition to an existing health record.

## **Documentation**

Documentation must be accurate, confidential, appropriate, complete, and\_\_\_\_\_.

## **Detailed**

\_\_\_\_\_ means that documentation is limited to facts or factual accounts of observations.

## **Accuracy**

\_\_\_\_\_ can be defined as making determination about all of the data collected in the health assessment process.

## **Interpretation of findings**

\_\_\_\_\_ are used by nurses to gather information about a patient's condition.

## **Health assessments**

The role of nurses in health assessment include the following

- Nursing Diagnoses and Care Planning
- Managing Problems
- Evaluation
- Discharge Teaching
- Advocate

A \_\_\_\_\_ takes note of actual or potential problems her patient may have during a health assessment.

**Nurse**

\_\_\_\_\_ of a patient's health status is done through health assessments.

**Evaluation**

\_\_\_\_\_ determine if a patient has responded to nursing care sufficiently enough to be recommended for discharge.

**Evaluations**

\_\_\_\_\_ is the first step of the nursing process

**Assessment**

The first step of the nursing process is known as \_\_\_\_\_

**Assessment**

An \_\_\_\_\_ describes a hands-on data collection process.

**Assessment**

A \_\_\_\_\_ includes a detailed health history and physical examination of one body system or many body systems

**comprehensive assessment**

A comprehensive or complete health assessment usually begins with obtaining a thorough health history and \_\_\_\_\_ exam.

**Physical**

A \_\_\_\_\_ is a more abbreviated assessment used to evaluate the status of previously identified problems and monitor for signs of new problems.

**Focused assessment**

The advantage of an abbreviated assessment is that\_\_\_\_\_

**It allows you to thoroughly assess your patient in a shorter period of time**

The report of pain is a \_\_\_\_\_

**Social transaction**

The report of \_\_\_\_\_is a social transaction

**Pain**

Pain is essential in comprehensive health assessment.

**True**

Pain can be acute and chronic, severe or mild

\_\_\_\_\_ is a complex multidimensional experience.

**Pain**

Pain is a complex multidimensional\_\_\_\_\_.

**Experience**

Pain is one of the major reasons that people seek health care.

**True**

The International Association for the Study of Pain (IASP) defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”.

IASP means\_\_\_\_\_

**International Association for the Study of Pain**

\_\_\_\_\_ is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage

### **Pain**

The intensity of pain is most accurately assessed with\_\_\_\_\_.

### **pain rating scales**

Quality of pain is assessed by \_\_\_\_\_

### **Asking the client to apply an adjective to the pain**

The \_\_\_\_\_ of pain refers to the onset and duration of the pain experience.

### **Pattern**

The following are factors which precipitate pain

- Activity
- Exercise
- Temperature
- Climatic Changes

The \_\_\_\_\_ provides information about the patient's prior state of health.

### **Past health history**

\_\_\_\_\_ is the systematic assessment of the physical and mental status of a patient, and findings are considered objective data.

### **Physical examination**

\_\_\_\_\_ is the process of obtaining information about patient's health status through communication.

### **Nursing history**

The four major techniques used in performing the physical examination are

- Inspection
- Palpation
- Percussion
- Auscultation

\_\_\_\_\_ is the visual examination of a part or region of the body to assess normal conditions and deviations from normal.

### **Inspection**

\_\_\_\_\_ is the examination of the body through the use of touch.

### **Palpation**

Palpation is the examination of the \_\_\_\_\_ through the use of touch.

### **Body**

Palpation is the examination of the body through the use of\_\_\_\_\_.

### **Touch**

\_\_\_\_\_ is an assessment technique involving the production of sound to obtain formation about the underlying area.

### **Percussion**

Percussion is an assessment technique involving the production of \_\_\_\_\_ to obtain formation about the underlying area.

### **Sound**

\_\_\_\_\_ is listening to sounds produced by the body to assess normal conditions and deviations from normal.

### **Auscultation**

The process used for the assessment of hyperresonance over inflated lung tissue in a patient with emphysema is\_\_\_\_\_

### **Auscultation**

\_\_\_\_\_ is usually performed with a stethoscope.

### **Auscultation**

Auscultation is usually performed with a\_\_\_\_\_.

### **Stethoscope**

\_\_\_\_\_ is particularly useful in evaluating sounds from the heart, lungs, abdomen and vascular system.

### **Auscultation**

Auscultation is particularly useful in evaluating sounds from the heart, lungs, abdomen and\_\_\_\_\_.

### **Vascular system**

The \_\_\_\_\_ of the stethoscope is more sensitive to low-pitched sounds

### **Bell**

The bell of the \_\_\_\_\_ is more sensitive to low-pitched sounds

### **Stethoscope**

The \_\_\_\_\_ of the stethoscope is more sensitive to high-pitched sounds.

### **Diaphragm**

The diaphragm of the stethoscope is more sensitive to \_\_\_\_\_ sounds.

### **high-pitched**

The bell of the stethoscope is more sensitive to \_\_\_\_\_ sounds

### **low-pitched**

The integumentary system comprises of the skin, hair, and \_\_\_\_\_

### **nails**

The \_\_\_\_\_ for the integumentary system concerns data related to the structures and functions of that system.

## **Focused interview**

Physical assessment of the ear consists of \_\_\_\_\_ parts

### **Three**

Physical assessment of the ear consists of three parts

- Auditory screening
- Inspection and palpation of the external ear
- Otoscopic assessment

The general approach to heart assessment

- Explain to the patient what you are going to do
- Ensure that the room is warm, quite, well lit
- Expose the patient's chest only as much as is needed for the assessment
- Position the patient in supine or sitting position
- Stand to the patient's right side

The cardiovascular physical assessment has two major components

- Assessment of the pericardium
- Assessment of the periphery

Behaviors indicative of \_\_\_\_\_ include facial grimace, moaning, crying or screaming, guarding or immobilization of a body part, tossing and turning, and rhythmic movements.

### **Pain**

The nails should have a \_\_\_\_\_undertone and lie flat or form a convex curve on the nail bed

### **Pink**

When viewed laterally, the angle between the skin and the nail base should be approximately\_\_\_\_\_degrees.

### **160**

The process used for the assessment of hyperresonance over inflated lung tissue in a patient with emphysema is\_\_\_\_\_

## **Auscultation**

Using eleven functional health patterns, the processes of ingestion, digestion, absorption, and metabolism are assessed in\_\_\_\_\_

## **NutritionalMetabolic Pattern**

Types of assessment that are used to obtain information about a client are comprehensive, focused, and\_\_\_\_\_

## **Emergency**

The purpose of the nursing assessment is to make a \_\_\_\_\_about a client's health status.

## **clinical judgment**

Data that can be observed by one person and verified by another person observing the same patient are known as\_\_\_\_\_

## **objective data**

The bell of the stethoscope is used for \_\_\_\_\_sounds

## **low-pitched**

The pulmonic area is the second intercostals space (ICS) to the\_\_\_\_\_

## **right of the sternum**

Percussion has limited usefulness in the\_\_\_\_\_ because X rays and other diagnostic tests provide the same information in a much more accurate manner

## **cardiovascular assessment**

In Asian cultures, breast selfexamination may be considered a form of\_\_\_\_\_

## **Masturbation**

Physical assessment of the ear consists of auditory screening, inspection and palpation of the external ear and\_\_\_\_\_

## **otoscopic assessment**

Assessment of the eyes should be carried out in an orderly fashion, moving from the extraocular structures to the\_\_\_\_\_

**intraocular structures**

\_\_\_\_\_ is used to determine exact ROM in joints with limited ROM

**Goniometer**

Physical assessment of the neurologic system proceeds in a\_\_\_\_\_ and distal to proximal pattern

**Cephalocaudal**

Physical assessment of the neurologic system begins with assessment of the client's\_\_\_\_\_

**mental status**

Schamroth techniques are used to assess\_\_\_\_\_

**Clubbing**

Localized hot, red, swollen painful areas indicate the presence of\_\_\_\_\_ and possible infection.

**Inflammation**

\_\_\_\_\_ is produced when bacterial waste products mix with perspiration on the skin surface.

**Body odor**

Gray hair can occur as a result of decreased melanin,\_\_\_\_\_ or aging.

**Genetics**

Hair color is determined by the amount of\_\_\_\_\_

**Melanin**

The\_\_\_\_\_ is sensitive to touch and temperature  
**skin**

In physical assessment of the integumentary system, the techniques of inspection and \_\_\_\_\_ will be used

### **Palpation**

Listening to sounds produced by the body to assess normal conditions and deviations from normal is done through \_\_\_\_\_

### **Auscultation**

\_\_\_\_\_ of the stethoscope is more sensitive to high-pitched sounds.

### **The diaphragm**

Auscultation is usually performed with a \_\_\_\_\_

### **Stethoscope**

The usual percussion sound in the right lower quadrant of the abdomen is \_\_\_\_\_

### **Tympany**

\_\_\_\_\_ is an assessment technique involving the production of sound to obtain formation about the underlying area

### **Percussion**

The tips of the fingers can be used to palpate \_\_\_\_\_

### **lymph nodes**

The dorsa (back) of the hands and fingers can be used to assess \_\_\_\_\_

### **Temperatures**

\_\_\_\_\_ is the visual examination of a part or region of the body to assess normal conditions and deviations from normal

### **Inspection**

\_\_\_\_\_ is observed or measured by the professional nurse

### **Objective data**

\_\_\_\_\_ is hand-on examination of the client

### **Physical assessment**

Perception of pain, nausea, dizziness, itching sensations, or feeling nervous are examples of\_\_\_\_\_

### **Subjective data**

\_\_\_\_\_ is information that the client experiences and communicates to the nurse

### **Subjective data**

The primary source from which data is collected is\_\_\_\_\_

### **The client**

Assessment is\_\_\_\_\_ step of nursing process

### **First**

Objective data is obtained through\_\_\_\_\_ to determine the patient's physical status, limitations, and assets.

### **physical examination**

Functional health patterns format includes an initial collection of important health information followed by assessment of\_\_\_\_\_ areas of health status or function

### **Eleven**

Functional health patterns format for taking Nursing history was developed by\_\_\_\_\_

### **Gordon**

Subjective data is gathered during\_\_\_\_\_

### **Interview**

The nursing health assessment is used to support the identification of a\_\_\_\_\_

### **Nursing diagnosis**

\_\_\_\_\_ is a systematic data collection

## **Health assessment**

This part of the body is more sensitive to vibrations\_\_\_\_\_

### **Palmar surface**

The 'gold standard' for assessing the existence of pain is\_\_\_\_\_

### **Client selfreport**

The part of the body that is more sensitive to vibrations is\_\_\_\_\_

### **Palmar surface**

The 'gold standard' for assessing the existence of pain is\_\_\_\_\_

### **Client selfreport**

The step of the nursing process that includes data collection by health history, physical examination, and interview is\_\_\_\_\_

### **Assessment**

\_\_\_\_\_ is used for head-to-toe assessment.

### **Comprehensive Assessment**

\_\_\_\_\_ includes an assessment related to a specific problem

### **Focused Assessment**

Detailed assessment that focuses on one or more body systems, including those not directly involved in presenting problem or admission diagnosis is\_\_\_\_\_

### **Comprehensive Assessment**

\_\_\_\_\_ determine if a patient has responded to nursing care sufficiently enough to be recommended for discharge

### **Evaluations**

Blood pressure, pulse rate, blood counts, and age are examples of\_\_\_\_\_

**Variable data**

\_\_\_\_\_ is information that does not change over time such as race, sex, or blood type

**Constant data**