First lecture: Health assessment / Health history

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# Introduction

Health assessment is "a dynamic and continuous process of collecting, verifying, and organizing information about a person within a particular context for the purpose of planning patient centered care."



**Component of health assessment**

**Health History**

**A** health history consist of the subjective data collected during an interview

Components of health history:

* Review of systems
* Demographic information
* Lifestyle practices/Nutrition
* Reason for seeking health care
* Current medication
* History of the present illness
* Psychological history
* Past health history
* Sociocultural history • Family medical history

**General Guidelines for Interviewing to Obtain Health**

**History**

* Greeting client, introduce self and establishing rapport. Use appropriate title Quickly review the patient's chart (to provide you with an idea of the patient and will avoid asking repetitive questions).
* Setting goals for the interview.
* Improving the environment. It should be private, quiet and uninterrupted.
* Taking Notes.
* Inviting the Patient’s Story. Begin with open-ended questions that allow full freedom of response, e.g.―What brings you to the hospital?ǁInquire how client is feeling; watch for signs of discomfort such as evidence of pain or anxiety.
* Listen actively for important symptoms, emotions, events and relationships. Be empathetic and caring
* Be professional- nonjudgmental, concerned and informed.
* Reactions as disapproval, impatience (nonverbal behaviors) block communication.
* Assure confidentiality.
* Assure clients that the information you collect will be shared only with the health care team







1- Demographic information

* Name
* Gender
* Address
* Type of health insurance
* Date of birth • Race
* Occupation

2- Reason for seeking health care/ chief complain

• It is important to get the chief complaint in the patient‘s own words.

# History of the present illness/ COLDSPA

C- Character (the quality of feeling or sensation, e.g. sharp, dull, and stabbing).

O- Onset/Timing (onset, duration, frequency, and precipitating factors of the symptoms).

L- Location (area of the body in which symptom is felt).

D- Duration

S- Severity/Intensity (the severity or quantity of the feeling). P- Pattern (Aggravating/Alleviating factors/activities or actions that make the symptom better or worse).

A- Associated factors/How it affects the client (What other symptoms occur with it? How does it affect you?)

# Past health history

* Major illnesses or previous hospitalizations and surgical procedures.
* Allergies (food, drug, and airborne allergies).
* Previous injuries/Fractures.
* Childhood diseases/Immunizations (history of polio, measles, mumps, and rubella).

## Family medical history

* Diabetes mellitus.
* Allergic disorders.
* Cardiovascular problems and race.

## Review of systems

* A brief account from the client of any recent signs or symptoms associated with any of the body systems.
	+ It reveals data related to present illness.
	+ The review of systems checklists are often used to ask about:

**General:** Usual weight, recent weight change. Weakness, fatigue, or fever.

**Skin**: Rashes, lumps, sores, itching, dryness, color change, changes in hair or nails.

**Head:** Headache, head injury, dizziness.

* **Eyes:** Vision, glasses or contact lenses, redness, excessive tearing, double vision, blurred vision, flashing lights, glaucoma, cataracts. **Ears:** Hearing, tinnitus, vertigo, earaches, infection, discharge. If hearing is decreased, use of hearing aids.
* **Nose and sinuses:** Frequent colds, nasal stuffiness, discharge, or itching, nosebleeds and sinus trouble.
* **Throat (or mouth and pharynx):** Condition of teeth, gums, bleeding gums, dentures, sore tongue, dry mouth, frequent sore throats, and hoarseness.
* **Neck: Lumps,** ―swollen glands,ǁ goiter, pain, or stiffness in the neck.
* **Breasts:** Lumps, pain or discomfort, nipple discharge
* **Respiratory system:** Cough, sputum (color, quantity), hemoptysis, dyspnea, wheezing, pleurisy, last chest x-ray.
* **Cardiovascular.** Heart trouble, high blood pressure, rheumatic fever, chest pain or discomfort, palpitations, dyspnea, orthopnea, and or edema.
* **Gastrointestinal system:** Heart burn, appetite, trouble swallowing, nausea, change in bowel habits, rectal bleeding hemorrhoids, abdominal pain, constipation, diarrhea, passing of gas, food intolerance and/or excessive belching.
* **Urinary system.** Frequency of urination, polyuria, nocturia, urgency, burning or pain on urination, hematuria, incontinence; reduced force of the urinary stream, hesitancy and/or dribbling of urine in males.
* Genital. Male: Hernias, discharge from or sores on the penis, testicular pain or masses.
* Female: Age at menarche; regularity, frequency, and duration of periods; amount of bleeding, last menstrual period; dysmenorrhea, number of deliveries, age at menopause, menopausal symptoms, postmenopausal bleeding.
* **Peripheral Vascular:** leg cramps, varicose veins, past clots in the veins.
* **Musculoskeletal system:** Muscle or joint pains, stiffness, arthritis, gout, and backache. Presence of any swelling, redness, pain, stiffness, weakness, or limitation of motion or activity; include timing of symptoms (e.g. morning or evening)
* **Neurologic system:** Fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling, tremors or other involuntary movements.
* **Hematologic:** Anemia, easy bruising or bleeding, past transfusions and/or transfusion reactions.
* **Endocrine:** Thyroid trouble, heat or cold intolerance, excessive sweating, excessive thirst or hunger, polyuria.
* **Psychiatric:** Nervousness, tension, mood, including depression, memory change.

# Lifestyle practices/Nutrition

* Hygienic practice
* Skin exposure
* Habits (the use of alcohol, drugs caffeine and tobacco use).
* Activities of daily living (ADL‘s) [bathing, toileting, transfer, eating, dressing].
* Eating pattern.

# Current medication

• Steroids, antibiotics, antihypertensive drugs, hypoglycemic drugs, vitamins, hormones or chemotherapy.

# Psychological history

* The assessment of dimensions as self-concept and self-esteem.
* Sources of patient's stress and ability to cope.
* Sources of support for clients in crisis, such as family, significant others, religion, or support groups.
* Community involvement: Church involvement, volunteer work, employment, hobbies, group memberships, social and/or recreational programs, classes.

# Sociocultural history

* Economic status: Amount and/or source of income, type of health insurance coverage, perception of adequacy of income to meet needs
* Home environment.
* Client‘s role in the family.
* The cultural aspects of the client‘s lifestyle, health beliefs, and health practice