Chapter 03: Health History and Physical Examination
Lewis: Medical-Surgical Nursing, 10th Edition

MULTIPLE CHOICE

1. A patient who is actively bleeding is admitted to the emergency department. Which approach is **best** for the nurse to use to obtain a health history?
   a. Briefly interview the patient while obtaining vital signs.
   b. Obtain subjective data about the patient from family members.
   c. Omit subjective data collection and obtain the physical examination.
   d. Use the health care provider's medical history to obtain subjective data.

   ANS: A
   In an emergency situation, the nurse may need to ask only the most pertinent questions for a specific problem and obtain more information later. A complete health history will include subjective information that is not available in the health care provider's medical history. Family members may be able to provide some subjective data, but only the patient will be able to give subjective information about the bleeding. Because the subjective data about the cause of the patient's bleeding will be essential, obtaining the physical examination alone will not provide sufficient information.

   DIF: Cognitive Level: Apply (application) REF: 40
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

2. Immediate surgery is planned for a patient with acute abdominal pain. Which question by the nurse will elicit the **most** complete information about the patient's coping-stress tolerance pattern?
   a. "Can you rate your pain on a 0 to 10 scale?"
   b. "What do you think caused this abdominal pain?"
   c. "How do you feel about yourself and your hospitalization?"
   d. "Are there other major problems that are a concern right now?"

   ANS: D
   The coping–stress tolerance pattern includes information about other major stressors confronting the patient. The health perception–health management pattern includes information about the patient's ideas about risk factors. Feelings about self and the hospitalization are assessed in the self-perception–self-concept pattern. Intensity of pain is part of the cognitive–perceptual pattern.

   DIF: Cognitive Level: Apply (application) REF: 37
   TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

3. During the health history interview, a patient tells the nurse about periodic fainting spells. Which question by the nurse will **best** elicit any associated clinical manifestations?
   a. "How frequently do you have the fainting spells?"
   b. "Where are you when you have the fainting spells?"
   c. "Do the spells tend to occur at any special time of day?"
   d. "Do you have any other symptoms along with the spells?"

   ANS: D

Asking about other associated symptoms will provide the nurse more information about all the clinical manifestations related to the fainting spells. Information about the setting is obtained by asking where the patient was and what the patient was doing when the symptom occurred. The other questions from the nurse are appropriate for obtaining information about chronology and frequency.

DIF: Cognitive Level: Apply (application) REF: 35
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

4. The nurse records the following general survey of a patient: "The patient is a 50-yr-old Asian female attended by her husband and two daughters. Alert and oriented. Does not make eye contact with the nurse and responds slowly, but appropriately, to questions. No apparent disabilities or distinguishing features." What additional information should the nurse add to this general survey?
   a. Nutritional status
   b. Intake and output
   c. Reasons for contact with the health care system
   d. Comments of family members about his condition

   ANS: A
   The general survey also describes the patient's general nutritional status. The other information will be obtained when doing the complete nursing history and examination but is not obtained through the initial scanning of a patient.

   DIF: Cognitive Level: Understand (comprehension) REF: 39
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

5. A nurse performs a health history and physical examination with a patient who has a right leg fracture. Which assessment would be a pertinent negative finding?
   a. Patient has several bruised and swollen areas on the right leg.
   b. Patient states that there have been no other recent health problems.
   c. Patient refuses to bend the right knee because of the associated pain.
   d. Patient denies having pain when the area over the fracture is palpated.

   ANS: D
   The nurse expects that a patient with a leg fracture will have pain over the fractured area. The bruising and swelling and pain with bending are positive findings. Having no other recent health problems is neither a positive nor a negative finding with regard to a leg fracture.

   DIF: Cognitive Level: Apply (application) REF: 39
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

6. The nurse who is assessing an older adult with rectal bleeding asks, "Have you ever had a colonoscopy?" The nurse is performing what type of assessment?
   a. Focused assessment
   b. Emergency assessment
   c. Detailed health assessment
   d. Comprehensive assessment

   ANS: A

A focused assessment is an abbreviated assessment used to evaluate the status of previously identified problems and monitor for signs of new problems. It can be done when a specific problem is identified. An emergency assessment is done when the nurse needs to obtain information about life-threatening problems quickly while simultaneously taking action to maintain vital function. A comprehensive assessment includes a detailed health history and physical examination of one body system or many body systems. It is typically done on admission to the hospital or onset of care in a primary care setting.

DIF: Cognitive Level: Understand (comprehension) REF: 40
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

7. The nurse is preparing to perform a focused assessment for a patient complaining of shortness of breath. Which equipment will be needed?
   a. Flashlight
   b. Stethoscope
   c. Tongue blades
   d. Percussion hammer

ANS: B
A stethoscope is used to auscultate breath sounds. The other equipment may be used for a comprehensive assessment but will not be needed for a focused respiratory assessment.

DIF: Cognitive Level: Understand (comprehension) REF: 40
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

8. The nurse plans to complete a physical examination of an alert, older patient. Which adaptations to the examination technique should the nurse include?
   a. Avoid the use of touch as much as possible.
   b. Use slightly more pressure for palpation of the liver.
   c. Speak softly and slowly when talking with the patient.
   d. Organize the sequence to minimize the position changes.

ANS: D
Older patients may have age-related changes in mobility that make it more difficult to change position. There is no need to avoid the use of touch when examining older patients. Less pressure should be used over the liver. Because the patient is alert, there is no indication that there is any age-related difficulty in understanding directions from the nurse.

DIF: Cognitive Level: Apply (application) REF: 40
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

9. While the nurse is taking the health history, a patient states, “My mother and sister both had double mastectomies and were unable to be very active for weeks.” Which functional health pattern is represented by this patient’s statement?
   a. Activity–exercise
   b. Cognitive–perceptual
   c. Coping–stress tolerance
   d. Health perception–health management

ANS: D
The information in the patient statement relates to risk factors and important information about the family history. Identification of risk factors falls into the health perception–health maintenance pattern.

DIF: Cognitive Level: Understand (comprehension) REF: 37
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

10. A patient is seen in the emergency department with severe abdominal pain and hypotension. Which type of assessment should the nurse do at this time?
    a. Focused assessment
    b. Subjective assessment
    c. Emergency assessment
    d. Comprehensive assessment

    ANS: C
    Because the patient is hemodynamically unstable, an emergency assessment is needed. Comprehensive and focused assessments may be needed after the patient is stabilized. Subjective information is needed, but objective data such as vital signs are essential for the unstable patient.

    DIF: Cognitive Level: Understand (comprehension) REF: 40
    TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

11. The registered nurse (RN) cares for a patient who was admitted a few hours previously with back pain after falling. Which action can the RN delegate to unlicensed assistive personnel (UAP)?
    a. Finish documenting the admission assessment.
    b. Determine the patient's priority nursing diagnoses.
    c. Obtain the health history from the patient's caregiver.
    d. Take the patient's temperature, pulse, and blood pressure.

    ANS: D
    The RN may delegate vital signs to the UAP. Obtaining the health history, documentation of the admission assessment, and determining nursing diagnoses require the education and scope of practice of the RN.

    DIF: Cognitive Level: Apply (application) REF: 36
    OBJ: Special Questions: Delegation TOP: Nursing Process: Planning
    MSC: NCLEX: Safe and Effective Care Environment

12. When assessing for formation of a possible blood clot in the lower leg of a patient, which action should the nurse take **first**?
    a. Visually inspect the leg.
    b. Feel for the temperature of the leg.
    c. Check the patient's pedal pulses using the fingertips.
    d. Compress the nail beds to determine capillary refill time.

    ANS: A
    Inspection is the first of the major techniques used in the physical examination. Palpation and auscultation are then used later in the examination.

    DIF: Cognitive Level: Apply (application) REF: 39
    OBJ: Special Questions: Prioritization TOP: Nursing Process: Assessment
    MSC: NCLEX: Health Promotion and Maintenance

13. When assessing a patient's abdomen during the admission assessment, which action should the nurse take **first**?
    a. Feel for any masses.
    c. Listen for bowel sounds.

b. Palpate the abdomen.
d. Percuss the liver borders.

ANS: C
When assessing the abdomen, auscultation is done before palpation or percussion because palpation and percussion can cause changes in bowel sounds and alter the findings. All of the techniques are appropriate, but auscultation should be done first.

DIF: Cognitive Level: Understand (comprehension) REF: 39
OBJ: Special Questions: Prioritization TOP: Nursing Process: Assessment
MSC: NCLEX: Health Promotion and Maintenance

14. When admitting a patient who has just arrived on the unit with a severe headache, what should the nurse do **first**?
    a. Complete only basic demographic data before addressing the patient's pain.
    b. Inform the patient that the headache will be treated as soon as the health history is completed.
    c. Medicate the patient for the headache before doing the health history and examination.
    d. Take the initial vital signs and then address the headache before completing the health history.

ANS: C
The patient priority in this situation will be to decrease the pain level because the patient will be unlikely to cooperate in providing demographic data or the health history until the nurse addresses the pain. However, obtaining information about vital signs is essential before using either pharmacologic or nonpharmacologic therapies for pain control. The vital signs may indicate hemodynamic instability that would need to be addressed immediately.

DIF: Cognitive Level: Apply (application) REF: 35
OBJ: Special Questions: Prioritization TOP: Nursing Process: Assessment
MSC: NCLEX: Physiological Integrity

OTHER

1. In what order will the nurse perform these actions when doing a physical assessment for a patient admitted with abdominal pain? *(Put a comma and a space between each answer choice [A, B, C, D].)*
    a. Percuss the abdomen to locate any areas of dullness.
    b. Palpate the abdomen to check for tenderness or masses.
    c. Inspect the abdomen for distention or other abnormalities.
    d. Auscultate the abdomen for the presence of bowel sounds.

ANS:
C, D, A, B

When assessing the abdomen, the initial action is to inspect the abdomen. Auscultation is done next because percussion and palpation can alter bowel sounds and produce misleading findings.

DIF: Cognitive Level: Understand (comprehension) REF: 39
TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity