Lewis: Medical-Surgical Nursing, 8th Edition

Chapter 3: Health History and Physical Examination

Test Bank

MULTIPLE CHOICE

1. A patient who is having difficulty breathing is admitted to the hospital. The best approach for the nurse to use to obtain a complete health history is to
   a. obtain subjective data about the patient from family members.
   b. omit subjective data collection and obtain the physical examination.
   c. use the health care provider's medical history to obtain subjective data.
   d. schedule several short sessions with the patient to gather subjective data.

   ANS: D
   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 shortness of breath. Since the subjective data about the patient's respiratory status will be essential, obtaining the physical examination alone will not provide sufficient information.

   DIF: Cognitive Level: Application REF: 38
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

2. Immediate surgery is planned for a patient with acute abdominal pain. The question used by the nurse that will elicit the most complete information about the patient's coping-stress tolerance pattern is
   a. "Can you tell me how intense your pain is now?"
   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: Comprehension REF: 41-42
   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 be most helpful in determining the setting in which the fainting spells occur?

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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: B
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, frequency, and associated clinical manifestations.

DIF: Cognitive Level: Comprehension REF: 39
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 68-year-old male Asian attended by his wife 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." Additional information that should be added to this general survey includes
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: Application REF: 44
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

5. A nurse is performing a health history and physical examination for a patient with right-sided rib fractures. The pertinent negative finding is that the patient
a. states that there have been no other health problems recently.
b. denies having pain when the area over the fractures is palpated.
c. has several bruised and swollen areas on the right anterior chest.
d. refuses to take a deep breath because of the associated chest pain.

ANS: B
The nurse expects that a patient with rib fractures will have pain over the fractured area. The first statement is neither a positive nor a negative finding with regard to the rib fractures. The bruising and swelling and pain with breathing are positive findings.

DIF: Cognitive Level: Application REF: 42
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

6. As the nurse assesses the patient's neck, the patient says, "My neck is so stiff I can hardly move it." This finding indicates the nurse should perform a(n)

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a. focused assessment.
b. screening assessment.
c. emergency assessment.
d. comprehensive assessment.

ANS: A
The focused assessment is needed when a patient has clinical manifestations that indicate a problem. 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. The screening examination or assessment is used to assess for possible problems such as colorectal cancer in patients who are age 50 or older. A comprehensive assessment is a detailed health history and physical examination.

DIF: Cognitive Level: Application REF: 45-46
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

7. The nurse is preparing to perform a focused abdominal assessment for a patient who has high-pitched bowel sounds. Which equipment will be needed?
a. Flashlight
b. Stethoscope
c. Tongue blades
d. Percussion hammer

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

DIF: Cognitive Level: Comprehension REF: 43 | 45
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

8. When the nurse is planning for the physical examination of an alert 86-year-old patient, adaptations to the examination technique should include
a. speaking slowly when directing the patient.
b. avoiding the use of touch as much as possible.
c. using slightly more pressure for palpation of the liver.
d. organizing the sequence to minimize 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. Since the patient is alert, there is no indication that there is any age-related difficulty in understanding directions from the nurse.

DIF: Cognitive Level: Application REF: 45
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

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9. While the nurse is taking the health history, a patient states, “My father and grandfather both had heart attacks and were unable to be very active afterwards.” This statement is related to the functional health pattern of
   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 that may cause cardiovascular problems in the future. Identification of risk factors falls into the health perception–health maintenance pattern.

   DIF: Cognitive Level: Comprehension REF: 40-41
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

10. A patient is seen in the emergency department with chest 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
   Since 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 also are essential for the unstable patient.

   DIF: Cognitive Level: Comprehension REF: 46
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

11. When caring for a patient who was admitted a few hours previously with nausea and vomiting, which nursing action can the RN delegate to an LPN/LVN?
   a. Ask the patient about any current nausea.
   b. Finish documenting the admission assessment.
   c. Determine the patient’s priority nursing diagnoses.
   d. Obtain the health history from the patient’s caregiver.

   ANS: A
   The RN may delegate parts of the focused assessment to an LPN/LVN. Obtaining the health history, documentation of the admission assessment, and determining nursing diagnoses require RN education and scope of practice.

   DIF: Cognitive Level: Application REF: 46
   OBJ: Special Questions: Delegation TOP: Nursing Process: Planning
   MSC: NCLEX: Safe and Effective Care Environment

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12. When assessing the circulation to the lower leg of a patient who has had knee surgery, which action should the nurse take first?
    a. Feel for the temperature of the foot.
    b. Visually inspect the color of the foot.
    c. Check the patient's pedal pulses using the fingertips.
    d. Compress the nail beds to determine capillary refill time.

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

    DIF: Cognitive Level: Application REF: 43
    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 of these actions should the nurse take first?
    a. Feel for any masses.
    b. Palpate the abdomen.
    c. Percuss the liver borders.
    d. Listen to the bowel sounds.

    ANS: D
    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: Comprehension REF: 43
    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 medical unit with severe abdominal pain, what should the nurse do first?
    a. Complete only basic demographic data before addressing the patient's abdominal pain.
    b. Medicate the patient for the abdominal pain before attending to the health history and examination.
    c. Inform the patient that the abdominal pain will be treated as soon as the health history is completed.
    d. Take the initial vital signs and then deal with the abdominal pain before completing the health history.

    ANS: D
    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.

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DIF: Cognitive Level: Application REF: 39
OBJ: Special Questions: Prioritization TOP: Nursing Process: Assessment
MSC: NCLEX: Physiological Integrity

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