WILLIAM PATERSON UNIVERSITY

COLLEGE OF SCIENCE AND HEALTH

DEPARTMENT OF NURSING

COMPREHENSIVE HEALTH ASSESSMENT

NUR 3270

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

AGE SPAN ASSIGNMENT

**PART I**

**Biographical Data**

Name: Initials only

Town/City of residence

Date of Birth

Age

Sex

Marital Status

Health Insurance

Primary

Supplemental

Advance Directive: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

Source of Information

Reliability of Source

**Present Health – Illness Status**

Describe your current health status

From whom do you seek health care

When was your last complete physical examination

Which of the following were performed and what were the results (Enter data into the table)

|  |  |  |
| --- | --- | --- |
| EXAM | DATE | RESULTS |
| Electrocardiogram |  |  |
| Chest X-Ray |  |  |
| Dental |  |  |
| Eye with refraction |  |  |
| Ear with audiometry |  |  |
| Rectal/colonoscopy |  |  |
| Mammogram |  |  |
| Pap Smear |  |  |
| Prostatic Specific Antigen (PSA) |  |  |
| Blood Work |  |  |
| HIV Testing |  |  |

Current Medications (Enter data into the table)

RX and OTC

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Current Medications  **R**X | Name | Dose | Purpose | Frequency | Duration | Effect |
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| Current Medications  OTC |  |  |  |  |  |  |
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Past History: Medical, Surgical, Accident/Injury, Allergies (Enter data into tables)

MEDICAL HISTORY

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| . | DATE | DIAGNOSIS | TREATMENT | OUTCOME |
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SURGICAL HISTORY

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MENTAL HEALTH HISTORY

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ACCIDENT/INJURY

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| . | DATE | TYPE | TREATMENT | OUTCOME |
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| ALLERGY | SYMPTOMS | TREATMENTS |
| Medication |  |  |
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| Food |  |  |
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| Environment |  |  |
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Blood Type and Rh factor:

Transfusion History:

**PART II CHILD**

Name of adult with child

Relationship to child

Address if not the same

Phone number

Reason for today’s visit

Age .of this child

Birth order

School

Grade

Success

Play activities

Hobbies

**Birth History of Mother with this child**

Gravida\_\_\_\_\_ Para\_\_\_\_\_\_\_\_\_ Abortions\_\_\_\_\_\_\_\_\_

Prenatal Care

Prenatal Problems

Type of Delivery

Condition of Baby

Complications

Mother

Baby

Breastfed/Formula fed

**Childhood Immunizations** (enter data into the table)

|  |  |  |  |
| --- | --- | --- | --- |
| IMMUNIZATION | YES | NO | UNKNOWN |
| DPT |  |  |  |
| Hepatitis B |  |  |  |
| MMR |  |  |  |
| Polio |  |  |  |
| Smallpox |  |  |  |
| H1N1 |  |  |  |
| Seasonal Flu |  |  |  |
| Pneumonia |  |  |  |
| Rotavirus |  |  |  |
| Gardasil |  |  |  |

**Childhood Illness** (enter data into the table)

|  |  |  |  |
| --- | --- | --- | --- |
| ILLNESS | YES | NO | OUTCOME |
| Measles |  |  |  |
| Mumps |  |  |  |
| Chicken Pox |  |  |  |
| German measles |  |  |  |
| Pertussis |  |  |  |
| Strep Throat |  |  |  |
| Rheumatic fever |  |  |  |
| Pneumonia |  |  |  |
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**Nutrition Assessment**

Height

Weight

Recent changes

Date

Reason for change

Body Mass Index

Appetite

24 hour diet recall

Breakfast

Lunch

Dinner

Snacks

Type

Amount

Fluids not included in menu

Type

Amount

Food

Likes

Dislikes

Allergies

Meals

Prepared by

Purchased by

Family together

Eating habits

Bowel habits

Religious restrictions

**Growth and Development (**Enter data in the table)

|  |  |  |
| --- | --- | --- |
| SKILLS | EXPECTED NORMS  FOR AGE (REFERENCED) | REPORTED DATA  FOR CLIENT |
| Motor |  |  |
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| Language |  |  |
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| Cognitive |  |  |
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| Psychosocial |  |  |
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**Family History and Genogram**

Members – Nuclear (Enter data into table)

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| . | INITIALS | AGE | ROLE | RESPONSIBILITY |
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Relationship - Extended family (Enter data into the table)

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| . | INITIALS | AGE | ROLE | RESPONSIBILITY/  LOCATION |
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**Home Environment**

Describe in terms of:

Family interactions

Location (urban/suburban)

Family activities

Time spent with nuclear family and extended family

Involvement in community activities

Attendance at religious services

Responses to health or emotional problems

Describe the Child’s interactions with family/friends/others in terms of time spent, activities.

**Genogram**

Construct a 3 generation figure

Use the template and instructions at <https://www.genome.gov/pages/education/modules/yourfamilyhealthhistory.pdf>

The child should be the third generation

All family members are to be identified

Initials, Age, Health status

**Tools and Interpretation of Data**

**Risk Factors and Primary Prevention Strategies:** 1. Specific to Client, 2. Derived from the family history AND 3. Specific to this age. (Enter data into the tables)

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| --- | --- |
| RISK FACTORS  SPECIFIC TO THIS CLIENT | PRIMARY PREVENTION STRATEGIES (REFERENCED) |
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| RISK FACTORS  DERIVED FROM THE FAMILY HISTORY | PRIMARY PREVENTION STRATEGIES (REFERENCED) |
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| RISK FACTORS  SPECIFIC TO THIS AGE  (REFERENCED) | PRIMARY PREVENTION STRATEGIES  (REFERENCED) |
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**Learning Need(s):**

**1.**

**2.**

**3.**

**PART II ADOLESCENT**

Name of adult with child

Relationship to child

Address if not the same

Phone number

Reason for today’s visit

Age of this adolescent

Birth order

School

Grade

Success

Play activities

Hobbies

**Current Immunizations** (enter data into the table)

|  |  |  |  |
| --- | --- | --- | --- |
| IMMUNIZATION | YES | NO | UNKNOWN |
| DPT |  |  |  |
| Hepatitis B |  |  |  |
| MMR |  |  |  |
| Polio |  |  |  |
| Smallpox |  |  |  |
| H1N1 |  |  |  |
| Seasonal Flu |  |  |  |
| Pneumonia |  |  |  |
| Rotavirus |  |  |  |
| Gardasil |  |  |  |

**Nutrition Assessment**

Height

Weight

Recent changes

Date

Reason for change

Body Mass Index

Appetite

24 hour diet recall

Breakfast

Lunch

Dinner

Snacks

Type

Amount

Fluids not included in menu

Type

Amount

Food

Likes

Dislikes

Allergies

Meals

Prepared by

Purchased by

Family together

Eating habits

Bowel habits

Religious restrictions

**Family History and Genogram**

Members – Nuclear (Enter data into table)

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| --- | --- | --- | --- | --- |
| . | INITIALS | AGE | ROLE | RESPONSIBILITY |
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Relationship - Extended family (Enter data into the table)

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| . | INITIALS | AGE | ROLE | RESPONSIBILITY/  LOCATION |
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**Home Environment**

Describe in terms of:

Family interactions

Location (urban/suburban)

Family activities

Time spent with nuclear family and extended family

Involvement in community activities

Attendance at religious services

Responses to health or emotional problems

Describe the Child’s interactions with family/friends/others in terms of time spent, activities.

**Genogram**

Construct a 3 generation figure

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The child should be the third generation

All family members are to be identified

Initials, Age, Health Status

**Skin**

General Condition

Color

Continuity

Scars

Bruises

Lesions

Recent changes

Hygiene

Sun Exposure

Natural

Artificial

Use of sun screen

Does skin burn easily

History of “bad” sunburn (peeling, blisters) if yes - when

Tattoos

Piercing

Changes

Other

**Hair**

General Condition

Texture

Amount

Color

Care Practices

Shampoo

Use of chemicals

Use of heat

Wigs or Extensions

Changes

Other

**Nails**

General Condition

Shape

Color

Care Practices

Polish

Use of tips/wraps

Changes

Other

**Tools and Interpretation of Data**

**Risk Factors and Primary Prevention Strategies:** 1. Specific to Client., 2. Derived from the family history AND 3. Specific to this age. (Enter data into the tables)

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| --- | --- |
| RISK FACTORS  SPECIFIC TO THIS CLIENT | PRIMARY PREVENTION STRATEGIES (REFERENCED) |
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| RISK FACTORS  .DERIVED FROM THE FAMILY HISTORY | PRIMARY PREVENTION STRATEGIES (REFERENCED) |
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| --- | --- |
| RISK FACTORS  SPECIFIC TO THIS AGE  (REFERENCED) | PRIMARY PREVENTION STRATEGIES  (REFERENCED) |
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**Learning Need(s):**

**1.**

**2.**

**3.**

**PART II OLDER ADULT**

**Eyes**

General Condition

Examination with Refraction

Acuity

Changes

Appliances

Corrected Vision

Night Vision

Problems

Diplopia

Floaters

Blind Spot

Infection

Surgery

Other

**Ears**

General Condition

Examination

Acuity

Changes

Appliances

Infections

Surgery

Other

**Nose and Sinuses**

General Condition

Sense of Smell

Patency

Pain

Pressure

Drainage

Use of

Drugs

Rx

OTC

Other

**Mouth and Throat**

General Condition

Sense of Taste

Teeth

General Condition

Caps/Crowns/Dentures

Gums

Oral Hygiene

Dental Examination

Tongue

Swallowing

Throat Infections

Change in Voice

Use of tobacco

Surgery

Other

**Respiratory System**

General Condition

Breathing Pattern

Color of

Lips

Nailbeds

Cough

Sputum

Shortness of Breath

At rest

With Activity

Appliances/Devices

Infections

Surgery

Tobacco Use

Immunizations

Other

**Abdomen**

Appetite

24 hour food recall

Food intolerance

Swallowing

Recent weight changes

Bowel Habits

Frequency

Consistency

Color

Constipation

Diarrhea

Changes

Use of laxatives

Use of enemas

Nausea/Vomiting

Surgery

Other

**Urinary System**

General Condition

Urine

Pattern of Voiding

Change in Pattern

Color

Stream

Pain

Appliances

Continence

Nocturia

Infections

Kidney Stones

Surgery

Other

**Musculoskeletal System**

Activities of Daily Living

Muscles

Size

Shape

Strength

Changes

Pain

Skeleton

Posture

Bones

Pain

Fractures

Deformities

Ability to Ambulate

Joints

Range of Motion

Pain

Gait

Stiffness

Swelling

Appliances

Surgery

Other

**Neurologic System**

Handedness:

Right

Left

Both

Sensitivity

Touch

Temperature

ADL

Ability

Changes

Headaches

Frequency

Treatment

Mental function

Reason for visit

Fainting spells

Seizures

Motor Function

Gait

Coordination

Weakness

Numbness

Tingling

Tremors

Tics

Paralysis

Pain

Location

Characteristics

Frequency

Rating (1 – 10)

Actions taken

Injuries

Dizziness

Mood changes

Other

**Tool and Interpretation**

**Risk Factors and Primary Prevention Strategies:** 1. Specific to Client AND 2. Specific to this age. (Enter data into the tables)

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| RISK FACTORS  SPECIFIC TO THIS CLIENT | PRIMARY PREVENTION STRATEGIES (REFERENCED) |
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| RISK FACTORS  SPECIFIC TO THIS AGE  (REFERENCED) | PRIMARY PREVENTION STRATEGIES  (REFERENCED) |
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**Learning Need(s):**

**1.**

**2.**

**3.**

**PART II ADULT**

**Biographical Data**

Name: Initials only

Town/City of residence

Date of Birth

Age

Sex

Marital Status

Health Insurance

Primary

Supplemental

Advance Directive: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

Source of Information

Reliability of Source

**Breast and Axilla Female**

Size

Shape

Symmetry

Nipple and areolar

Examination

Self

MD

Mammogram

History of Breast Feeding

Problems

Other

**Breast and Axilla Male**

Size

Shape

Nipples

Problems

Other

**Sexuality (all clients)**

Orientation

Comfort with sexual preference

Activity

Satisfaction

Performance

Protection

Aids/Appliance/Devices

Infertility

Sterility

Sexually Transmitted Disease

Other

**Female Reproductive System**

Menses

Onset

Frequency

Duration

Last Menstrual Period

Problems

Pregnancy

Gravida

Para

Abortions

Delivery

Complications

Mother

Baby

Other

**Male Reproductive System**

Scrotum

Size

Shape

Changes

Testes

Size

Shape

Location

Changes

Penis

Size

Shape

Meatus

Foreskin

Self Examination

Other

**Cardiac System**

General Condition

Palpitations

Chest Pain

Breathing Problems

Dyspnea

Orthopnea

Color

Fatigue

Surgery

**Peripheral Vascular System**

General Condition

Pulsations

Blood Pressure

Bruises

Extremities

Edema

Varicose Veins

Pain with Exercise

Change in Temperature

Other

**Tools and Interpretations**

**SPIRITUAL, CULTURAL, PYSCHOSOCIAL ASSESSMENT**

**Spiritual**

HOPE Assessment (enter data in table – following questions)

|  |  |
| --- | --- |
| H  Spiritual Resources | What are your sources of hope or comfort?  What helps you during difficult times? |
| O  Organized Religion | Are you a member of an organized religion?  What religious practices are important to you? |
| P  Personal Spirituality | Do you have spiritual beliefs, separate from organized religion?  What spiritual practices are most helpful to you? |
| E  Effects on Care | Is there any conflict between your beliefs and any health care you may receive or be receiving?  Do you hold beliefs or follow practices that you believe may affect your health care?  Do you wish to consult with a religious or spiritual leader when you are ill or making decisions about your healthcare? |

**Cultural**

What racial group do you identify with?

What is your ethnic group?

How closely do you identify with that ethnic group?

What cultural group does your family identify with?

What language(s) do you speak?

What language is spoken in your home?

Do you need an interpreter to participate in this interview?

Would you like an interpreter when you discuss health issues?

Are there customs in your culture about talking and listening, such as the amount of distance one should maintain between individuals, or making eye contact?

How much touching is allowed during communication between you and members of other cultures?

How do members of your culture demonstrate respect for one another/

What are the most important beliefs in your culture?

What does your culture believe about health?

What does your culture believe about illness or the causes of illness?

What are the attitudes about healthcare in your culture?

How do members of your culture relate to healthcare professionals?

What are the rules about the sex of the person who conducts a health assessment in your culture?

What are the rules about exposure of body parts in your culture?

What are the restrictions about discussing sexual relationships or family relationships in your culture?

Do you have a preference for your health care provider to be a member of your culture?

What do members of your culture believe about mental illness?

Does your culture prefer certain ways to discuss certain topics such as birth, dying, and death?

Are there topics that members of your culture would not discuss with a nurse or doctor?

Are there rituals or practices that are performed by members of your culture when someone is ill or dying or when they die?

Who is the head of the family in your culture?

Who makes decisions about health care?

Do you or members of your culture use cultural healers or remedies?

What are the common remedies in your culture?

What religion do you belong to?

Do most members of that culture belong to that religion?

Does your culture or religion influence your diet?

Are there common spiritual beliefs in your culture?

How do those spiritual beliefs influence your health care?

Are there cultural groups in your community that provide support for you and your family?

What supports do those groups provide?

**Psychosocial Assessment**

Who is your significant other? (initials and relationship/role title)

Who is included in your support systems? (initials and role/relationship title(s))

Self Concept

Describe your Mirror Image (what do you see when you look in the mirror?)

How would your significant other describe you?

Describe what you like about yourself.

Describe what you dislike about yourself

What changes would you make in yourself?

What are your strengths?

What are your weaknesses?

Education

What is your educational background (highest level first)?

Occupation

Employment/Occupation(s) (title, date, starting with the most recent)

Finances

How would you describe your financial situation?

Have you experienced changes in your situation?

Interests

Describe/Identify your interests and/or hobbies.