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 MedicationsOTC |  |  |  |  |  |  |
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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 |  |  |  |
|  |  |  |  |

**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 FACTORSSPECIFIC 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 FACTORSSPECIFIC 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 FACTORSSPECIFIC 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.