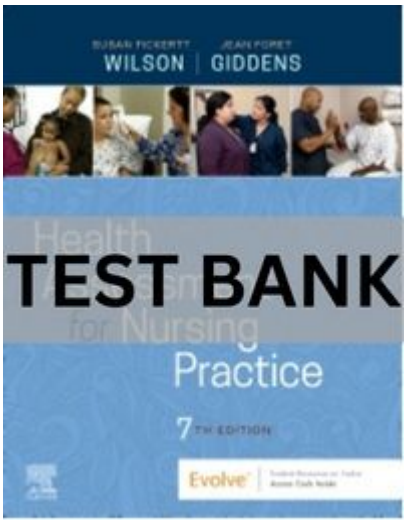
Chapter 01: Introduction to Health Assessment
Wilson: Health Assessment for Nursing Practice, 7th Edition



MULTIPLE CHOICE

1. A patient comes to the emergency department and tells the triage nurse that he is "having a heart attack." What is the nurse's top priority at this time?
   a. Determine the patient's personal data and insurance coverage.
   b. Ask the patient to take a seat in the waiting room until his name is called.
   c. Request that a nurse collect data for a comprehensive history.
   d. Ask a nurse to start a focused assessment of this patient now.

ANS: D
The nurse needs to begin an assessment as soon as possible that is focused on this patient's cardiovascular system. The type of health assessment performed by the nurse is also driven by patient need. Personal data and insurance information will be obtained, but in this situation, these data can wait until after the patient is assessed. Based also on Maslow's hierarchy of needs, physiologic needs take precedence. Rather than asking the patient to wait, the nurse needs to begin data collection, such as vital signs, immediately to determine the patient's health status. Complications can be prevented if an immediate assessment is made to analyze the patient's symptoms. A comprehensive history is not indicated in this situation at this time. Some subjective data will be collected, such as allergies and medical history related to cardiovascular disease. Eyes, ears, or a complete musculoskeletal or mental health assessment is not a priority at this time.

DIF: Cognitive Level: Apply REF: Box 1-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

2. Which situation illustrates a screening assessment?
   a. A patient visits an obstetric clinic for the first time and the nurse conducts a detailed history and physical examination.
   b. A hospital sponsors a health fair at a local mall and provides cholesterol and blood pressure checks to mall patrons.
   c. The nurse in an urgent care center checks the vital signs of a patient who is complaining of leg pain.
   d. A patient newly diagnosed with diabetes mellitus comes to test his fasting blood glucose level.

ANS: B
A health fair at a local mall that provides cholesterol and blood pressure checks is an example of a screening assessment focused on disease detection. A detailed history and physical examination conducted during a first-time visit to an obstetric clinic is an example of a comprehensive assessment. Assessing a patient complaining of leg pain in the triage area of an urgent care center is an example of a problem-based/focused assessment. A patient's return appointment 1 month after today's office visit to report fasting blood glucose levels is an example of an episodic or follow-up assessment.

DIF: Cognitive Level: Understand REF: Box 1-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Screening

3. For which person is a screening assessment indicated?
   a. The person who had abdominal surgery yesterday
   b. The person who is unaware of his high serum glucose levels
   c. The person who is being admitted to a long-term care facility
   d. The person who is beginning rehabilitation after a knee replacement

ANS: B
A screening assessment is performed for the purpose of disease detection. In this case this person may have diabetes mellitus. A shift assessment is most appropriate for the person who is recovering in the hospital from surgery. A comprehensive assessment is performed during admission to a facility to obtain a detailed history and complete physical examination. An episodic or follow-up assessment is performed after knee replacement to evaluate the outcome of the procedure.

DIF: Cognitive Level: Understand REF: Box 1-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

4. For which person is a shift assessment indicated?
   a. The person who had abdominal surgery yesterday
   b. The person who is unaware of his high serum glucose levels
   c. The person who is being admitted to a long-term care facility
   d. The person who is beginning rehabilitation after a knee replacement

ANS: A
A shift assessment is most appropriate for the person who is recovering in the hospital from surgery. A screening assessment is performed for the purpose of disease detection, in this case diabetes mellitus. A comprehensive assessment is performed during admission to a facility to obtain a detailed history and complete physical examination. An episodic or follow-up assessment is performed after knee replacement to evaluate the outcome of the procedure.

DIF: Cognitive Level: Understand REF: Box 1-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

5. For which person is a comprehensive assessment indicated?
   a. The person who had abdominal surgery yesterday
   b. The person who is unaware of his high serum glucose levels

c. The person who is being admitted to a long-term care facility
d. The person who is beginning rehabilitation after a knee replacement

ANS: C
A comprehensive assessment is performed during admission to a facility to obtain a detailed history and complete physical examination. A shift assessment is most appropriate for the person who is recovering in the hospital from surgery. A screening assessment is performed for the purpose of disease detection, in this case diabetes mellitus. An episodic or follow-up assessment is performed after knee replacement to evaluate the outcome of the procedure.

DIF: Cognitive Level: Understand REF: Box 1-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

6. For which person is an episodic or follow-up assessment indicated?
a. The person who had abdominal surgery yesterday
b. The person who is unaware of his high serum glucose levels
c. The person who is being admitted to a long-term care facility
d. The person who is beginning rehabilitation after a knee replacement

ANS: D
An episodic or follow-up assessment is performed after the knee replacement to evaluate the outcome of the procedure. A shift assessment is most appropriate for the person who is recovering in the hospital from surgery. A screening assessment is performed for the purpose of disease detection, in this case diabetes mellitus. A comprehensive assessment is performed during admission to a facility to obtain a detailed history and complete physical examination.

DIF: Cognitive Level: Understand REF: Box 1-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

7. Which is an example of data a nurse collects during a physical examination?
a. The patient's lack of hair and shiny skin over both shins
b. The patient's stated concern about lack of money for prescriptions
c. The patient's complaints of tingling sensations in the feet
d. The patient's mother's statements that the patient is very nervous lately

ANS: A
The lack of hair and shiny skin over both shins are objective data or signs that are part of the physical examination. A patient's concerns about lack of money are subjective data and are part of the health history. A patient's complaints of tingling sensations in the feet are subjective data and are part of the health history. A patient's family statements are considered secondary data, are subjective data, and are part of the health history.

DIF: Cognitive Level: Apply REF: Box 1-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiological Integrity: Reduction of Risk Potential: System Specific Assessments

8. The nurse documents which information in the patient's history?
a. The patient's skin feels warm to the touch.

b. The patient is scratching his arm.
c. The patient's temperature is 100° F.
d. The patient complains of itching.

ANS: D
A patient's complaint of itching is subjective information, which means it is a symptom and is documented in the history. The patient's warm skin is objective information gathered by the nurse through palpation, is also a sign, and is documented in the physical examination. The patient's scratching is objective information gathered by the nurse through observation, is also a sign, and is documented in the physical examination. The patient's elevated temperature is objective information gathered by the nurse through measurement, is also a sign, and is documented in the physical examination.

DIF: Cognitive Level: Apply REF: Box 1-2
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

9. Which patient information does the nurse document in the patient's physical assessment?
a. Slurred speech
b. Immunizations
c. Smoking habit
d. Allergies

ANS: A
Slurred speech should be noticed by the nurse and documented as objective data in the physical assessment. Data on immunizations are collected from the patient, are subjective, and documented in the history. A smoking habit is information that comes from the patient, making it subjective data that is documented in the history. Allergies are information that come from the patient, making it subjective data that is documented in the history.

DIF: Cognitive Level: Apply REF: Box 1-2
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

10. After collecting the data, the nurse begins data analysis with which action?
a. Clustering data
b. Documenting subjective data
c. Reporting information to other health team members
d. Documenting objective information

ANS: A
After collecting data, the nurse organizes or clusters the data so that the problems appear more clearly. To cluster data, the nurse interprets the assessment data collected. Documenting subjective data is necessary for the medical record, but does not provide analysis. Before reporting data to health team members, the nurse clusters and interprets data. Documenting objective data is necessary for the medical record, but does not provide analysis.

DIF: Cognitive Level: Understand TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Management of Care: Establishing Priorities

11. Which activity illustrates the concept of primary prevention?
    a. Monthly breast self-examination
    b. Annual cervical (Papanicolaou test) examination
    c. Education about living with asthma
    d. Exercising three times a week

    ANS: D
    Exercising is an example of primary prevention that prevents disease from developing by maintaining a healthy lifestyle. Monthly breast self-examination is an example of secondary prevention and screening efforts to promote early detection of disease. Annual cervical (Papanicolaou test) examination is an example of secondary prevention and screening efforts to promote early detection of disease. Teaching a patient how to live with a chronic disease such as asthma is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the patient maximize his or her health.

    DIF: Cognitive Level: Understand REF: Table 1-1
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Promotion Programs

12. A nurse is teaching a patient how to manage chronic obstructive pulmonary disease (COPD). This intervention is an example of which level of health promotion?
    a. Primary prevention
    b. Secondary prevention
    c. Tertiary prevention
    d. Risk factor prevention

    ANS: C
    Teaching a patient how to live with a chronic disease is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the patient maximize his or her health. The focus of primary prevention is to prevent a disease from developing by promoting a healthy lifestyle. Secondary prevention consists of efforts to promote early detection of disease. Risk factor prevention is part of primary prevention that focuses on preventing disease by managing risk factors.

    DIF: Cognitive Level: Understand REF: Table 1-1
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Promotion Programs

13. Which activity illustrates the concept of secondary prevention?
    a. Annual mammogram
    b. Nutrition classes on low-fat cooking
    c. Education on living with diabetes mellitus
    d. Cardiac rehabilitation after coronary artery bypass surgery

    ANS: A
    A mammogram screens for breast cancer and is an example of secondary prevention to promote early detection of disease. Nutrition classes are an example of primary prevention to prevent a disease from developing by promoting a healthy lifestyle. Education about diabetes mellitus is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the patient maximize his or her health. Cardiac rehabilitation after coronary artery bypass surgery is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the patient maximize his or her health.

DIF: Cognitive Level: Understand REF: Table 1-1
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Promotion Programs

14. A community organization sponsors a health fair to increase awareness of colon cancer. At the health fair, colorectal cancer screening kits are distributed, and health care professionals answer questions, take blood pressure, and distribute literature. What level of health prevention is being implemented by this community organization?
    a. Primary
    b. Secondary
    c. Tertiary
    d. Risk factor

    ANS: B
    Secondary prevention consists of screening efforts to promote early detection of disease—in this scenario, colorectal cancer and hypertension. Primary prevention is focused on preventing disease from developing through the promotion of a healthy lifestyle. Tertiary prevention is directed toward minimizing the disability from chronic disease and helping the patient maximize his or her health. Risk factor prevention is part of primary prevention that focuses on preventing disease by managing risk factors.

    DIF: Cognitive Level: Apply REF: Table 1-1
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Promotion Programs

Chapter 02: Interviewing Patients to Obtain a Health History
Wilson: Health Assessment for Nursing Practice, 7th Edition

MULTIPLE CHOICE

1. Which statement or question does the nurse use during the introduction phase of the interview?
    a. "I'm here to learn more about the pain you're experiencing."
    b. "Can you describe the pain that you're experiencing?"
    c. "I heard you say that the pain is 'all over' your body."
    d. "What relieves the pain you are having?"

    ANS: A
    "I'm here to learn more about the pain you're experiencing" is an example of the introduction phase a nurse may use to explain the purpose of the interview to a patient. "Can you describe the pain that you're experiencing?" is an example of part of a symptom analysis that occurs in the discussion phase. "I heard you say that the pain is 'all over' your body" is an example of a summary statement by the nurse that occurs in the summary phase. "What relieves the pain you are having?" is an example of part of a symptom analysis that occurs in the discussion phase.

    DIF: Cognitive Level: Apply REF: Box 2-1
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

2. Which statement is appropriate to use when beginning an interview with a new patient?

a. "Have you ever been a patient in this clinic before?"
b. "What is your purpose for coming to the clinic today?"
c. "Tell me a little about yourself and your family."
d. "Did you have any difficulty finding the clinic?"

ANS: B
"What is your purpose for coming to the clinic today?" is an open-ended question that focuses on the patient's reason for seeking care. "Have you ever been a patient in this clinic before?" is a close-ended question that yields a "yes" or "no" response. This question may be asked on the first visit, but not as an opening question for a health interview. "Tell me a little about yourself and your family" is an open-ended question, but it is too general, and it is at least two questions: one about the patient and another about the family. "Did you have any difficulty finding the clinic?" is a social question and does not focus on the patient's purpose for the visit.

DIF: Cognitive Level: Understand TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

3. Which statement by the nurse demonstrates a patient-centered interview?
a. "I need to complete this questionnaire about your medical and family history."
b. "The hospital requires me to complete this assessment as soon as possible."
c. "Tell me about the symptoms you've been having."
d. "I've had the same symptoms that you've described."

ANS: C
"Tell me about the symptoms you've been having" focuses on the needs of the patient so that the patient is free to share concerns, beliefs, and values in his or her own words. "I need to complete this questionnaire about your medical and family history" focuses on the nurse's need to complete the assessment rather than the needs of the patient. "The hospital requires me to complete this assessment as soon as possible" focuses on the nurse's need to meet hospital requirements rather than the needs of the patient. "I've had the same symptoms that you've described" focuses on the nurse rather than on the patient.

DIF: Cognitive Level: Apply TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

4. Which question is an example of an open-ended question?
a. "Have you experienced this pain before?"
b. "Do you have someone to help you at home?"
c. "How many times a day do you use your inhaler?"
d. "What were you doing when you felt the pain?"

ANS: D
"What were you doing when you felt the pain?" is a broadly stated question that encourages a free-flowing, open response. "Have you experienced this pain before?" is closed-ended, which can obtain a "yes" or "no" answer to the question without any additional data. "Do you have someone to help you at home?" is closed-ended, which can obtain a "yes" or "no" answer to the question without any additional data. "How many times a day do you use your inhaler?" is closed-ended, which can obtain an answer of a specific number without any additional data.

DIF: Cognitive Level: Understand TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

5. A nurse suspects a female patient is a victim of physical abuse. Which response is most likely to encourage the patient to confide in the nurse?
   a. "You've got a huge bruise on your face. Did your husband hit you?"
   b. "That bruise looks tender. I don't know how people can do that to one another."
   c. "If your boyfriend hit you, you can get a restraining order against him."
   d. "I've seen women who have been hurt by boyfriends or husbands. Does anyone hit you?"

   ANS: D
   "I've seen women who have been hurt by boyfriends or husbands" is an example of a technique referred to as "permission giving" in which the nurse communicates that it is safe to discuss uncomfortable topics. "You've got a huge bruise on your face. Did your husband hit you?" assumes that domestic violence did occur, and the comment does not encourage the patient to divulge additional information. "That bruise looks tender. I don't know how people can do that to one another" assumes that domestic violence did occur, and the comment does not encourage the patient to divulge additional information. "If your boyfriend has hit you, you can get a restraining order against him" assumes that domestic violence did occur, and the comment does not encourage the patient to divulge additional information.

   DIF: Cognitive Level: Apply TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Abuse/Neglect

6. Which technique used by the nurse encourages a patient to continue talking during an interview?
   a. Laughing and smiling during conversation
   b. Using phrases such as "Go on," and "Then?"
   c. Repeating what the patient said, but using different words
   d. Asking the patient to clarify a point

   ANS: B
   Using phrases such as "Go on" and "Then?" encourages the patient to continue talking. Laughing and smiling during conversation may show attentiveness during the interview, but does not encourage more talking. Rephrasing what the patient has said is restatement. It confirms your interpretation of what they said, but does not encourage additional talking. Asking the patient to clarify a point is done when the information is conflicting, vague, or ambiguous.

   DIF: Cognitive Level: Remember TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

7. During the history, the patient states that she does not use many drugs. What is the nurse's appropriate response to this statement?
   a. "Tell me about the drugs you are using currently."
   b. "To some people six or seven is not many."
   c. "Do you mean prescription drugs or illicit drugs?"
   d. "How often are you using these drugs?"

   ANS: A

"Tell me about the drugs you are using currently" is an open-ended question that allows patients to provide further data. "To some people six or seven is not many" is a comment that does not ask a question or obtain useful data. "Do you mean prescription drugs or illicit street drugs?" is a closed-ended question that yields data about the type of drugs used only. "How often are you using these drugs?" asks about frequency of drug use, which is not useful until the drugs are known.

DIF: Cognitive Level: Apply TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

8. A nurse is interviewing a patient who was diagnosed with type 2 diabetes mellitus 6 months ago. Since that time, the patient has gained weight and her blood glucose levels remain high. The nurse suspects that the patient is noncompliant with her diet. Which response by the nurse enhances data collection in this situation?
   a. "Tell me about what foods you eat and the frequency of your meals."
   b. "What symptoms do you notice when your blood sugar levels are high?"
   c. "You need to follow what the doctor has prescribed to manage your disease."
   d. "Tell me what you know about the cause of type 2 diabetes."

   ANS: A
   "Tell me about what foods you eat and the frequency of your meals" gathers more data from the patient to help the nurse confirm if noncompliance is the reason for the weight gain and high glucose levels. "What symptoms do you notice when your blood sugar levels are high?" does not help the nurse determine if the patient is noncompliant. It may be useful later when teaching the patient about her disease. "You need to follow what the doctor has prescribed to manage your disease" does not provide additional data for the nurse and may be viewed as authoritarian and paternalistic. "Tell me what you know about the cause of type 2 diabetes" assumes that the reason for the weight gain and high glucose levels is a lack of knowledge. A more therapeutic approach is to gather more data from the patient about how the diabetes has been managed.

   DIF: Cognitive Level: Apply TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

9. A male patient tells the nurse that he rarely sleeps more than 4 hours a night and has not experienced any problems because of the lack of sleep. Which response by the nurse is most appropriate?
   a. "That is interesting."
   b. "Only 4 hours of sleep? How do you stay awake during the day?"
   c. "Really? Everyone needs more sleep than that."
   d. "Did I understand that you sleep 4 hours every night?"

   ANS: D
   "Did I understand that you sleep 4 hours every night?" is a reflection technique that allows the nurse to confirm and obtain additional information. "That is interesting" does not provide an opportunity for the patient to explain any reason for the number of hours of sleep. "Only 4 hours of sleep? How do you stay awake during the day?" questions the accuracy of the patient's data and may not encourage the patient to give further details. "Really? Everyone needs more sleep than that" can be perceived as argumentative, but does not encourage further data from the patient.

   DIF: Cognitive Level: Apply TOP: Nursing Process: Assessment

MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

10. Which technique should the nurse use to obtain more data about a patient's vague or ambiguous statement?
    a. Laughing and smiling during conversation
    b. Using phrases such as "Go on," and "Then?"
    c. Repeating what the patient has said, but using different words
    d. Asking the patient to explain a point

    ANS: D
    Asking the patient to explain a point is clarification, which is used to obtain more information about conflicting, vague, or ambiguous statements. Laughing and smiling during conversation may show attentiveness during the interview, but does not help to clarify vague information. Using phrases such as "Go on" and "Then?" encourages patients to continue talking, but does not help clarify. Rephrasing what the patient has said is restatement. It confirms your interpretation of what they said, but does not encourage additional talking.

    DIF: Cognitive Level: Understand TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

11. What does the nurse say to obtain more data about a patient's vague statement about diet such as, "My diet's okay"?
    a. "Eating a variety of meats, fruits, and vegetables each day is important."
    b. "Give me an example of the foods you eat in a typical day."
    c. "Go on."
    d. "Does your diet meet your needs or does it need improvement?"

    ANS: B
    "Give me an example of the foods you eat in a typical day." This statement asks the patient to clarify the vague statement, "My diet is okay." "Eating a variety of meats, fruits, and vegetables each day is important." While this statement is true, it does not obtain data about what foods the patient consumes. "Go on" encourages patients to continue talking, but does not help clarify what foods are consumed. "Does your diet meet your needs or does it need improvement?" This response does not help clarify what foods the patient eats. Also it contains two questions rather than asking one question at a time.

    DIF: Cognitive Level: Apply TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communication

12. While giving a history, a male patient describes several events out of order that occurred in different decades in his life. What technique does the nurse use to understand the timeline of these events?
    a. State the order of events as understood and ask the patient to verify the order.
    b. Draw conclusions about the order of events from data given.
    c. Ask the patient to elaborate about these events.
    d. Ask the patient to repeat what he said about these events.

    ANS: A