Student Name: Michelle Koo

Health History Project Worksheet - NURS 2000

Biographical Data

Interviewee's Initials: KK

DOB: 07/06/1965 Age: 55

Birthplace: Hong Kong, China Occupation(s): Retired

Select One: Sex: ☐ M ☐ F Other:

- ☐ Single, never married
- ☐ Married Gender: M
- ☐ Divorced
- ☐ Separated Race: Chinese
- ☐ Widowed
- ☐ Living with partner

Source of Information: Client

Reliability of Source: Client is a reliable source

Cultural & Linguistic Assessment

Ethic Origin: Chinese

Sexual Orientation: Heterosexual

Date Entered USA: 2011

Refugee Status: N/A

Spiritual/Religion: Christianity

Primary Language: Cantonese

Secondary Language: Mandarin

Health Care Norms: Annual body check-ups at public hospitals in Hong Kong, covered by private insurance.

Chief Complaint

Chief Complaint: No c/c

History of Present Illness or Complaint: Currently no chest pain or SOB. Patient reports that he has been "monitoring blood pressure and taking medications everyday ever since his heart attack last November."

COLDSPA (if applicable):

Health History

Childhood Illnesses:

Childhood Illness	Age	Duration	Severity/Sequella
None			

History of Accidents, Injuries, Illnesses, Diseases:

Accident, Injury, Illness	Age	Duration	Severity/Sequella
LT humerus fracture	14	2 months	

Operations, Hospitalizations:

Operation/Hospitalizations	Age	Duration	Severity/Sequella
Polypectomy	48	Outpatient	
Polypectomy	51	Outpatient	
Angioplasty	55	1 Week	

Immunizations:

Immunization	Date/Year	Reactions?
Flu Shot	Oct/ 19	None
Confirmed childhood immunizations, but not in detail		

***Patient reports other immunizations are up to date**

Current Injuries, Illnesses, or Diseases:

Injuries, Illnesses, Diseases	Age	Duration	Severity/Sequella
High cholesterol	48	7 years	LDL is significantly higher than reference value
CAD	55	Heart attack 11/27/20	Blood viscosity is higher than reference value. RT coronary artery was blocked 90% prior to angioplasty.

Most Recent Exams:

Exam	Date	Significant Finding?	Location/Doctor
Complete Physical Exam	Oct/19	High cholesterol	Hong Kong/ Dr. Lee
Dental Exam	Jul/18	None	Hong Kong/ Dr. Chan
Eye Exam	None		
Hearing Test	None		
EKG	Oct/19	None	Hong Kong/ Dr. Lee
Chest X-Ray	None		
PPD	None		
Mammogram	N/A		
PAP Smear	N/A		
Stool Occult Test	None		
Prostate Exam	None		
Serum Cholesterol	Oct/19	Total cholesterol: 6.4 mmol/L HDL: 1.8 mmol/L LDL: 4.2 mmol/L	Hong Kong/ Dr. Lee

Current Medications: *(including Over-the-Counter, Vitamins, & PRN medications)*

Medication	Dose/Frequency	Date Started
Ticagrelor Tablet 90 mg	1 Tablet/ BID	11/27/2020
Bisoprolol Fumarate Tablet 2.5 mg	0.5 Tablet/ QD	11/27/2020
Pantoprazole (Sodium Sesquihydrate) Tablet 40 mg	1 Tablet/ 1 Hour Before Dinner	11/27/2020
Atorvastatin (Calcium) Tablet 40 mg	1 Tablet/ QD	11/27/2020
Aspirin Tablet 80 mg	1 Tablet/ After Dinner	11/27/2020

Allergies:

Allergies	Date/Year	Reaction/Severity/Sequella
NKDA		
No seasonal or food allergies		

Herbal/Home Remedies:

Herbs/Remedies	Dose/Frequency	Date Started
Garlic with vinegar	½ cup/ 3 times a week	July/19

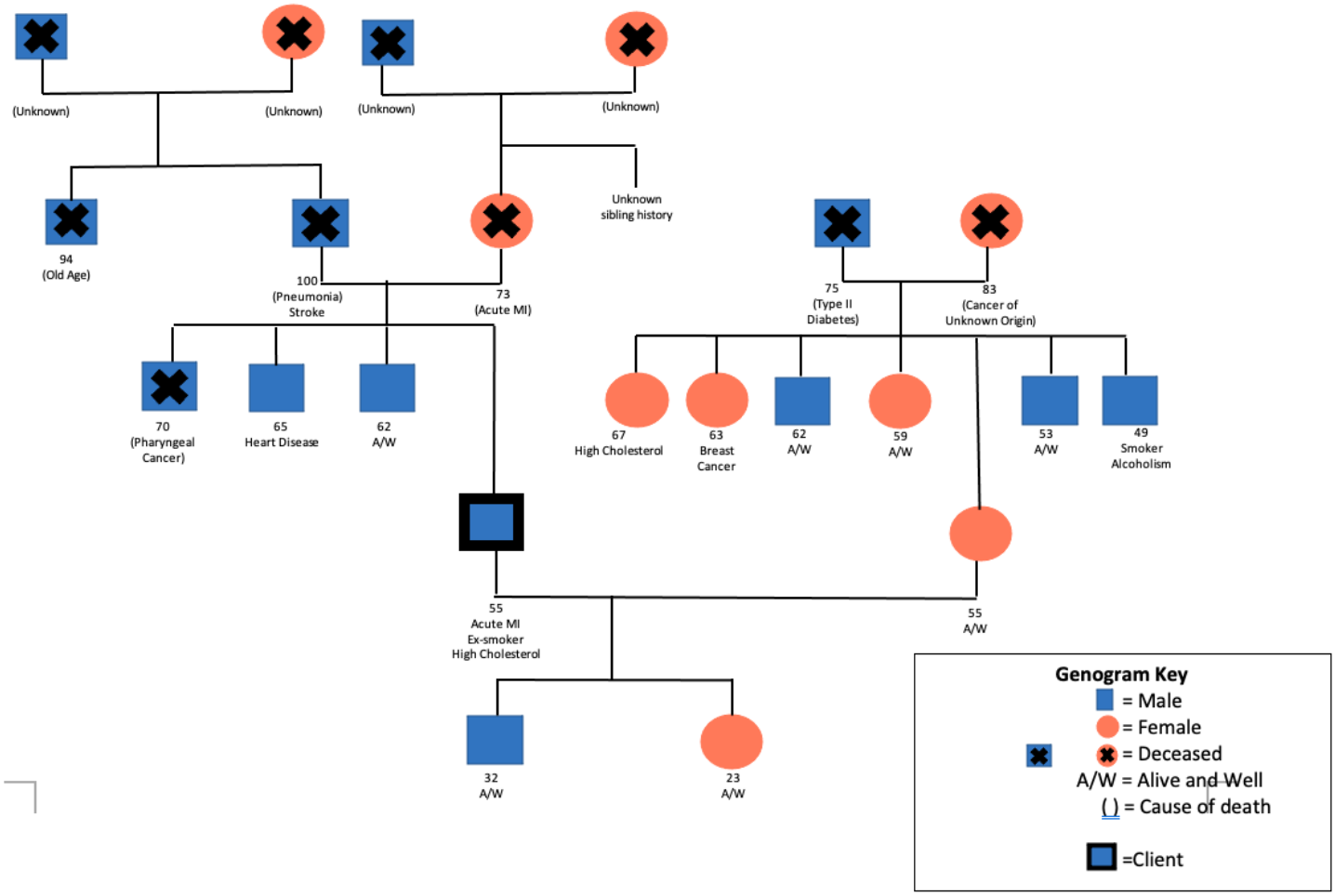
Substance Use:

Substance	Dose/Frequency	Date Started/Stopped
Alcohol *(units per day/week)*	None	
Tobacco *(# Cigarettes/day)*	1 pack/day	Start: 1983/ Stop: 1998
Recreational Drugs	None	

GYN/Obstetrical History: N/A

	# or Date	Age, Date, or Comments
LMP		
Menarche		
Menopause		
Gravida		
Para		
Abortions (Spontaneous or Therapeutic)		
Stress Incontinence		
Contraception		

Family History (Collect family history at least two levels up, i.e. siblings, parents and grandparents.)



Summary of Health Risks Associated with Family History:

Increased risk of heart disease as evidenced by acute MI seen in client's mother and heart disease seen in client's older brother.

Review of Systems

1. **Skin, Hair, Nails:** Pink, warm, dry skin with no lesions and edema. Balding and receding hairline noted. Clean fingernails with no clubbing. Fungal infection noted in 1st-3rd toes of LT foot.
2. **Head, Face, Neck:** No headache, stiffness of neck, difficulty swallowing or enlarged lymph nodes. No experience of LOC.

3. **Eyes:** Red-green colorblind. Far-sightedness. No loss of side-vision or black spots in visual fields bilaterally. No eye infections, redness, or pain.
4. **Ears:** No earaches, ringing, buzzing, or drainage from ears bilaterally.
5. **Nose/Sinuses:** No rhinorrhea, itching of nose or frequent colds. Reports snoring.
6. **Mouth/Throat:** No lesions, hoarseness or sore throat. No missing teeth or signs of gingivitis. Pink and moist lips, tongue and oral cavity.
7. **Breast:** No lumps or changes in breast size.
8. **Axilla:** No swollen or tender in axillary lymph nodes.
9. **Respiratory System:** No pain reported during routine activity. No cough, sputum, hemoptysis or respiratory infections.
10. **Cardiovascular:** BP is consistently from 90/60 to 100/70. Last ECG findings had no abnormal findings. No chest pain or pressure.
11. **Peripheral Vascular:** No swelling, edema, cramping or sores in all extremities.
12. **Gastrointestinal:** No indigestion, nausea, vomiting or abdominal pain. No gas, jaundice, and hernias.
13. **Urinary System:** No polyuria or dysuria. No blood reported in urine or leakage of urine.
14. **Genital System:** No history of sexually transmitted infections, lesions or penile drainage. No swelling noted in scrotum.
15. **Sexual Health:** No difficulty ejaculating or achieving an erection.
16. **Musculoskeletal System:** Full ROM with no swelling, pain, or stiffness of joints. Able to perform ADLs with full muscle strength.
17. **Neurologic System:** No signs of depression or cognitive defect. No difficulty speaking or learning. Attention span and memory intact.
18. **Hematologic System:** No history of blood disorders in family. Use of aspirin may cause bleeding. Reports no enlargement of lymph nodes.
19. **Endocrine System:** Reports no extreme weight gain or loss. No fatigue or lethargy. No changes in appetite and vision.

Functional Assessment

1. **Self-Esteem/Self-Concept:** No low self-esteem/ self-concept. Verbalizes positive thoughts about the future and self.
2. **Activity/Exercise:** Fast-paced walking for 45 minutes per day, 5 times per week.
3. **Sleep/Rest:** Sleeps before 12 am for at least 7 hours per night. Feels refreshed and well-rested from sleep. No difficulty falling or staying asleep.
4. **Nutrition/Elimination:** Maintains balanced meal by incorporating whole grains and vegetables. Reduced snacking. Reports at least 1 BM per day.
5. **Interpersonal Relationships/Resources:** Attends family gatherings every Saturday. Sometimes plays badminton and hiking with friends. Healthy relationship with peers.
6. **Spiritual Resources:** Goes to church every Sunday. Baptized in 2014.
7. **Stress Management:** Patient sometimes practices meditation and uses aromatherapy.
8. **Alcohol:** Patient reports no habit of drinking.

9. **Environmental Hazards:** Expresses no concerns of physical or chemical situations that might put him at risk.
10. **Intimate Partner Violence/Assaults:** Reports never thought that he is in danger of becoming a victim of violence.
11. **Occupational Health:** Currently retired. No exposure to chemicals or loud noise from work in the past.

Mental Assessment

1. **Posture:** Client is relaxed, with shoulders and back erect when standing or sitting. No tripoding or hunched back.
2. **Dress:** Dress is appropriate for occasion and weather.
3. **Hygiene:** Clean and well-groomed. No stains on hands or dirt in nails.
4. **Behavior:** Cooperative and shows appropriate affect. Expresses feelings appropriate to the situation.
5. **Orientation:** Alert and oriented to person, place, time and event.
6. **Attention Span:** No difficulty staying focused and attentive. Maintains eye contact.
7. **Memory:** Recalls past and recent events with no difficulty.
8. **Thought Process:** Expresses full, free-flowing thoughts. Follows directions accurately, expresses realistic perceptions and is easy to understand.
9. **Anxiety/Depression/Suicidal Thoughts:** Does not voice suicidal thoughts. No signs of anxiety and depression.
10. **Summary of Mental Status:** Patient is alert, oriented, and friendly. Patient is free of cognitive deficit like limited attention span and degenerative memory.

Anything Else?

Is there anything else about your history that I should know? No.

Perception of Health

1. **How do you define Health?** Health is being able to perform daily activities without difficulties. Physiological and mental health are both important.
2. **How do you view your health now?** Client believes that acute MI that happened last November was an alarming sign of deteriorating health. He wants to do his best to stay healthier.
3. **What are your health goals?** Lower LDL to 1.3 mmol/L. Exercise regularly and maintaining a balanced diet.
4. **What do you expect from your health care providers?** He expects health care providers to closely monitor his heart condition and give guidance on how to maintain a healthier lifestyle.

Nursing Diagnoses

Nursing Diagnosis #1: Risk for bleeding disorders or ulcers due to daily use of Aspirin.

Nursing Diagnosis #2: Readiness for Enhanced Health Management: Desired information on exercise and low-fat diet.

What did you learn?

List and discuss the three most important things you learned from this assignment?

1. I learned that interviewing skills are very important. It is crucial to know when to use open and close-ended questions as it helps with the flow of the interview.
2. It was difficult at first to document the pertinent findings and negatives while listening attentively. I realized the ability to listen and document only the key findings is an important skill.
3. Patients don't always remember all the details and sometimes may go off-topic. I learned to bring the discussion back on track so that the interview could be finished in a timely manner.

What would you do differently next time?

Next time, I will try to incorporate some teachings and empathetic statements like I did in Shadow Health assignments. It is my first time doing a detailed health history interview, so I mainly focused on asking questions and documentation.

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Health History Project – Grading Rubric

Student's *Na*me: _____

Standard	***COMMENTS***	***Points***
Appropriate Client that meets assignment guidelines		/4
Biographic Data (protecting privacy)		/2
Cultural & Linguistic Assessment • Adequately covers relevant cultural phenomena • Adequately describes linguistic needs of the client • Addresses "reliable source"		/2
Chief Complaint • Adequately describes the Chief Complaint • Use of PQRSTU		/2
Health History • Childhood Illnesses • Accidents, Illnesses, Injuries, etc. • Operations, Hospitalizations • Immunizations • Medications, Allergies • Last Exams • Obstetrical History		/20
Family History • Thorough Genogram (at least 3 generations) • Summarizes risks associated with family history		/15
Review of Systems • Adequately covers all topics on worksheet (ref. Weber Ch. 7) • **Note:** Do NOT conduct a physical assessment, only gather history as it relates to the review of systems •		/20
Functional Assessment • Adequately covers ADLs • Adequately cover all areas (pgs. 57-59 of Jarvis) • Appropriate to age of client		/10

Mental Assessment • Adequately documents Mental State		/5
Perception of Health • Defines client's perception of health • Summarizes client's health goals		/2
Nursing Diagnoses • 2 Appropriate Nursing Diagnoses based solely on health history		/8
What did you learn?		/5
Spelling, Grammar, Punctuation		/5
TOTAL POINTS EARNED:		/100