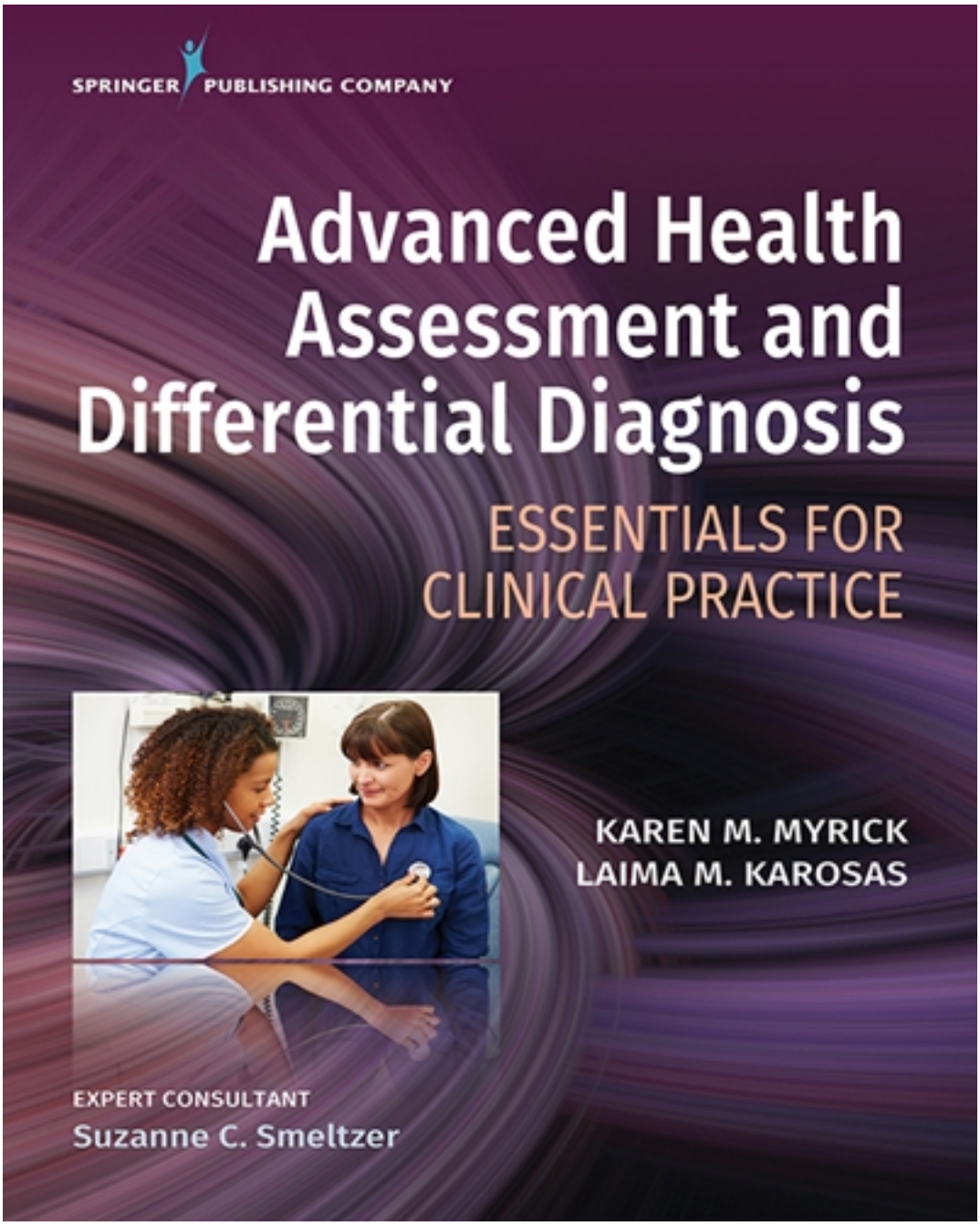
Test Bank for Advanced Health Assessment and Differential Diagnosis Essentials for Clinical Practice 1st Edition by Myrick



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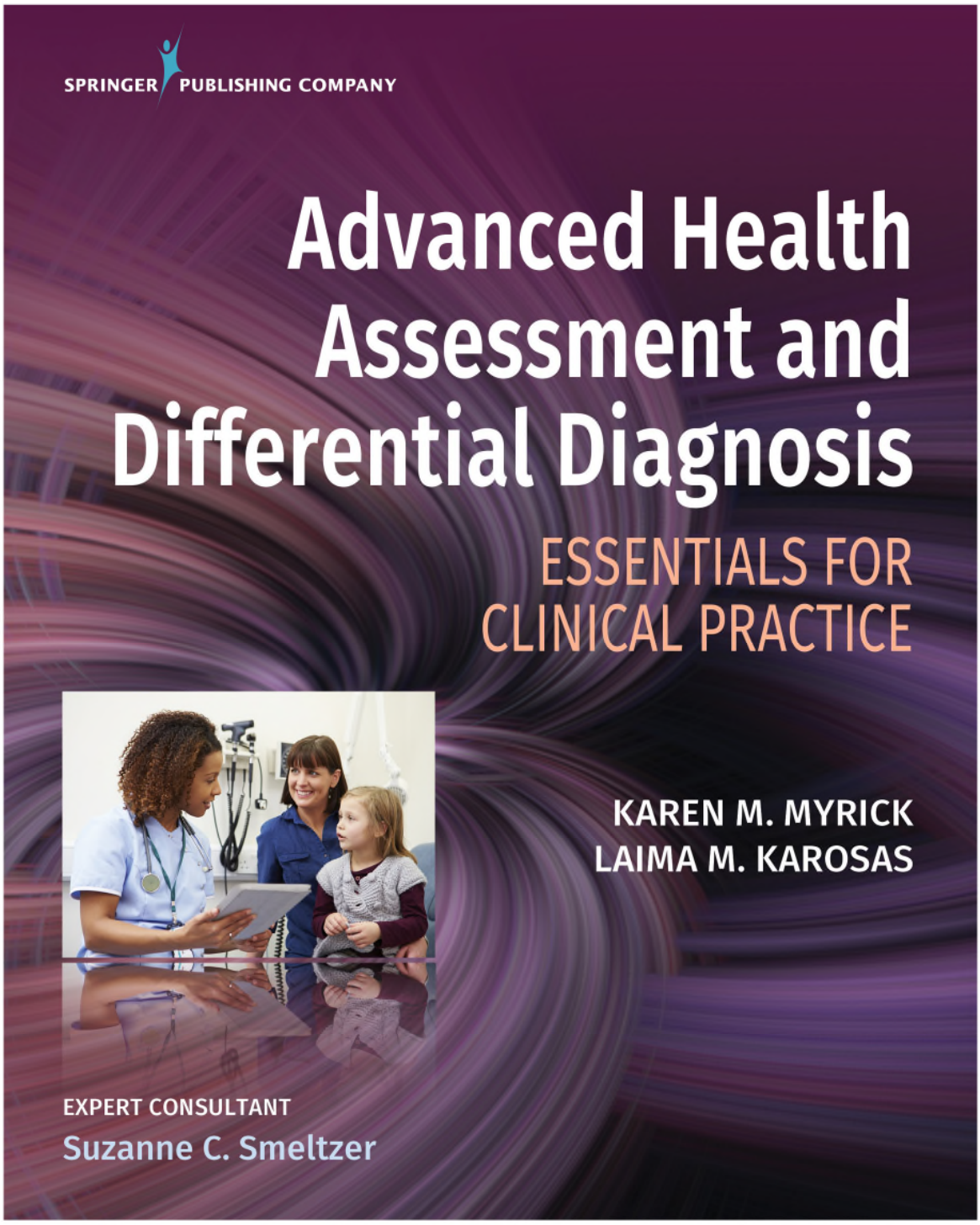

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CHAPTER 1: HEALTH HISTORY, THE PATIENT INTERVIEW, AND MOTIVATIONAL INTERVIEWING

1. Which statement, if said by the nursing student, indicates a correct understanding of the health history?
   a. "The health history is a minor part of evaluating a patient's health status."
   b. "The health history provides a snapshot of the patient and their daily life."
   c. "The health history does not reveal the patient's understanding about health."
   *d. "The health history is a holistic picture of the patient, their support systems, and habits."

Rationale: The health history is a crucial part of evaluating a patient's health status. It establishes a baseline for the patient and can reveal the patient's understanding about health and the factors that influence their health. Finally, it also provides a comprehensive, holistic picture of the patient, their support systems, habits, and daily life.

2. The clinician is getting ready to perform a health history but wants to ensure the patient can communicate before beginning. Which of the following areas should the clinician assess? Select all that apply.
   *a. Mental status
   *b. Memory
   c. Stressors
   *d. Reasoning
   e. Hygiene

Rationale: A quick assessment of whether the patient is capable of providing accurate information is crucial to the entire process. The patient must be able to communicate, although not necessarily orally, in order to convey information. Mental status plays a role in history taking. Anyone whose mental status is altered may not provide accurate information. Memory and reasoning must be intact to be able to relay past events and how they may have led to the patient's condition. Stressors and hygiene are assessed as part of the patient assessment, not their health history.

3. The clinician is performing a health history on a patient who does not speak English. In light of the language barrier, which of the following considerations are important for this patient? Select all that apply.
   *a. Address the patient, even if the interpreter is in the room.
   b. Focus on the interpreter.
   *c. Focus on the patient.
   d. Ask the patient to bring a family member to the visit to interpret.
   *e. Use an in-person interpreter when available.

Rationale: Interpreters may be used in person or via an app which gives you the translation for a phrase or via phone. The provider still addresses the patient although the interpreter translates the language spoken. The provider should not be focused on the interpreter, but rather, the patient remains the focus of the conversation. Family members can be used as interpreters, although this may not be the best option because the patient may not want a family to accompany them in the room. Also, a family member may answer with their perspective versus the patient's perspective, or may not fully translate what the patient says.

4. Clinicians try to ask open-ended questions to get patients to answer more fully. Which of the following questions is an example of an open-ended question?
   a. "Do you smoke?"
   *b. "How much alcohol do you drink?"
   c. "Are you in pain?"
   d. "Do you want to eat lunch?"

Rationale: Exploring a patient's health history involves asking different types of questions. Avoid asking closed-ended questions, which will only provide a yes or no answer. Rather, ask open-ended questions to capture more detail and help the provider focus on areas to clarify.

5. What information gathered by the clinician would be classified as the history of the present illness (HPI)?
   a. Age, gender, and occupation
   b. Support system, profession, and dietary habits
   *c. Onset, location, duration, frequency, intensity, and alleviating and exacerbating factors surrounding the patient's symptom(s)
   d. The reason for the visit. It may be a direct quote or brief summary of patent's comments.

Rationale: Age, gender, and occupation relate to identification of the patient. The social history includes the patient's support system, profession, living situation, exercise, dietary and other habits, and safety at home and at work. The onset, location, duration, frequency, intensity, and alleviating and exacerbating factors surrounding the patient's symptom(s) comprise the HPI. The reason for the visit as a direct quote or brief summary of patient's comments is the chief complaint (CC).

6. What information should the clinician include in the allergy section of the health history? Select all that apply.
   *a. When the allergy occurred
   b. The use of over-the-counter medications
   *c. The type of reaction experienced
   *d. The name of the offending substance
   *e. Any reaction related to eating shellfish

Rationale: Allergies must be written in the patient's chart including, if the patient recalls, when the allergy occurred and what the reaction was. The patient should name the offending substance. Reactions to shellfish could indicate an allergy to dye. The use of over-the-counter medications is not important here unless an allergy to one of them exists.

7. Why is the social history important for the clinician to document?
   *a. The social history addresses patient's habits, such as smoking.
   b. The social history addresses only patient information.
   c. The social history should take place with family members in the room.
   d. The social history should include the habits of parents and children.

Rationale: Understanding the social history of a patient has the potential to be clinically significant. It is important to interview the patient individually, without others present, so that they can respond truthfully. In the social interview, the provider learns about the patient's family, significant others, friends, and anyone else in their support system. Some personal habits included in a patient's social history include diet, exercise, and smoking.

8. Identify the components of the Review of Systems (ROS) as done by the clinician. Select all that apply.
   *a. Skin
   *b. Neurological
   c. Allergies
   *d. Musculoskeletal
   e. Smoking

Rationale: The ROS allows the provider to gather information about each body system. Skin, neurological, and musculoskeletal are systems included in the ROS. Smoking is addressed under the social history. Allergies are addressed under the allergy section of the health history.

9. A clinician engages with a patient who presents with a chief complaint of a sore throat. Which areas should be included in the assessment of this patient?
   a. Dietary concerns
   *b. Ears, nose, and throat
   c. Respiratory and cardiac
   d. Family history

Rationale: Not all assessments need to be comprehensive. A patient with an identified problem will need an assessment that explores the symptom(s). Only areas that are related to the symptom are investigated. For a patient whose chief complaint is a sore throat, the provider must do a thorough history in the area of head, eyes, ears, nose, throat, and respiratory and review habits such as smoking. Work and home environments are explored to ensure no contributing factors are present at home or work. The cardiac system, dietary concerns, and family history have no bearing on the chief complaint of a sore throat.

10. The clinician is attempting to identify a patient's differential diagnosis. Which of the following is a component of differential diagnosis?
    a. It is not necessary to use the health history in determining the differential diagnosis.
    b. The differential diagnosis can be made during the physical examination.
    c. The provider must maintain a wide focus during the physical examination.
    *d. A differential diagnosis cannot be made until after both the health history and physical examination.

Rationale: A differential diagnosis is the process of differentiating between two or more conditions that share similar signs or symptoms. The health history is a necessary and important component in diagnostic reasoning and determining the differential diagnosis. A differential diagnosis cannot be determined until after both the history and the physical examination. The provider should not narrowly focus the examination in order to entertain all possibilities in the differential diagnosis.

11. Which information gathered by the clinician would be classified as the chief complaint (CC)?
    a. Age, gender, and occupation
    b. Support system, profession, and dietary habits
    c. The onset, location, duration, frequency, intensity, and alleviating and exacerbating factors surrounding the patient's symptom(s)
    *d. The reason for the visit. It may be a direct quote or brief summary of the patient's comments.

Rationale: Age, gender, and occupation relate to identification of the patient. The social history includes the patient's support system, profession, living situation, exercise, dietary and other habits, and safety at home and at work. The onset, location, duration, frequency, intensity, and alleviating and exacerbating factors surrounding the patient's symptom(s) comprise the history of the present illness (HPI). The reason for the visit as a direct quote or brief summary of patient's comments is the CC.

12. A patient with a diagnosis of congestive heart failure (CHF) is seen in the medical office by the clinician. Which question should be included in the review of systems (ROS) for this patient?
    a. "Do you have any difficulty swallowing?"
    *b. "Are you experiencing any trouble speaking words?"
    c. "Are you short of breath when walking short distances?"
    d. "Do you have any double vision?"

Rationale: Questions to include in the ROS for cardiac concerns include chest pain, swelling of the legs, and shortness of breath when walking short distances or up a flight of stairs. Difficulty swallowing would be a concern for the throat. Double vision would be a concern for those with vision or concerns with their eyes. Difficulty speaking would be included under the neurological ROS.

13. Name the seven attributes of a symptom, which may be recalled with the mnemonic OLD CART.

Answer:
OL: **O**nset **L**ocation

D: **D**uration

C: **C**haracteristics

A: **A**ggravating factors

R: **R**elieving factors

T: **T**reatment

Rationale: If there is a specific complaint, it must be fully explored. The onset, location, and duration of the symptoms as well as any accompanying symptoms, aggravating or relieving activities, and what the patient has tried for treatment must be discussed. These areas are known as the seven attributes of a symptom, which may be recalled with the mnemonic OLD CART.

14. Describe how to document a patient's family history.

Answer: Family history may be documented in a narrative format or a genogram may be constructed.

Rationale: The family history should include relatives in a direct line to the patient such as parents, grandparents, and children of the patient. Patterns may indicate genetic predisposition to certain illnesses, but environmental influences should not be overlooked.

15. Describe the purpose of doing a motivational interview.

Answer: Motivational interviewing is a skill that can help a provider move more to a patient-centered approach during the health history interview.

Rationale: Motivational interviewing helps the patient explore the pros and cons of change and the implications of change. The health history interview becomes less provider-driven and more patient-centered. The patient considers the reasons for or against changes in health behaviors. The provider guides the patient in the process of thinking about a behavior. The behavioral change will come from a desire within the patient rather than the provider telling the patient what to do.

16. Discuss the role of the focused health history.

Answer: A focused health history is the detailed assessment of specific body system(s) relating to the presenting problem or current concern(s) of the patient.

Rationale: The components of the focused health history must be recorded for documentation of the complaint as well as billing and reimbursement. For a focused history, anything pertinent to the patient problem must be explored and documented in the history.

17. Identify some considerations a clinician should consider caring for special populations of patients.

Answer: Physical disabilities, mental disabilities, and communication difficulties due to culture and language.

Rationale: The provider must be sensitive to patients and their abilities. Some patients may have physical or mental disabilities. In a health history, the provider must remain nonjudgmental and supportive of the patient. The provider must ensure that the patient understands the information presented and that they answer the patient's questions clearly. This is especially important if culture and language differences exist. An open patient–provider relationship serves to maintain communication and create an environment of wellness and healing for the patient.

18. Why is it important to differentiate between subjective and objective information obtained during the taking of health history of a patient?

Answer: What the patient tells the provider may be confirmed or opposed to the findings of the provider.

Rationale: The entire health history is subjective information as it is what the patient tells the provider. The physical examination is the objective information gathered by the provider. It is important to distinguish between these two types of information in a history and physical examination. Incongruent findings may lead to more questions to determine the reason for the discrepancies. Often providers can uncover a misunderstanding about wellness or illness and educate the patient about physiology and disease process.

19. What information should be included under the allergies section of the health history?

Answer: When the allergy occurred and what the reaction was.

Rationale: Allergies must be written in the patient's chart including, if the patient recalls, when the allergy occurred and what the reaction was. At times, patients may list an allergy to a substance when the actual offending agent may be different.

20. State why the social history is such an important part of the health history.

Answer: The social history fills in the gaps regarding the living situation and support system for the patient.

Rationale: The social history is extremely important and is often overlooked or not explored in detail. The provider learns about the patient's family, significant others, friends, coworkers, and anyone else who the patient considers part of the support system. In addition, the provider must ask about habits including dietary, exercise, smoking, use of other substances, sleeping habits, safety in and outside the home, and anything else the patient may reveal. Healthcare providers are uniquely positioned to uncover difficult situations that patients may find themselves in.