NURSING HEALTH ASSESSMENT

JRSING MNEMONICS & TIPS

HEALTH HISTORY ASSESSMENT

"SAMPLE

DESCRIPTION

QUESTIONS TO ASK

Symptoms Patient's chief complaints

"What's wrong?" "What brought you to the hospital?"

Allergies

Seeking to know what type of allergic reaction they experience.

"Are you allergic to anything?" "What happens to you when you use something that you're allergic to?"



Medications

Prescribed, OTC drugs, herbal meds, etc.

"Are you taking any medications?" "What are you taking the medications for?" "When did you last take your medications?"

Past Medical Hx

Seeking to know the previous state of health, and previous illnesses

"Have you had this problem before?" "Do you have other medical problems?"

Last Oral Intake

Seeking what are the last oral intakes of the client.

"When did you last eat or drink anything?" "What was it that you last ate?"

Events

Events leading up to the illness or injury.

Injury: "How did you get hurt?" Illness: "What led to this problem?"

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In general, do not obtain a detailed history until life-threatening injuries have been identified and therapy has been initiated. The secondary survey is essentially a head-to-toe assessment of progress, vital signs, etc. SAMPLE is often useful as a mnemonic for remembering key elements of the patient's health history.

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Health Assessment In Nursing Practice

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including older adults pregnant patients infants children and adolescents Synthesis and Application of Health Assessment unit provides guidelines for combining the body system assessments into one comprehensive examination for communicating the findings to other health care professionals and for adapting the assessment to patients in a hospital setting NEW NGN style case studies provide optimal preparation for the Next Generation NCLEX Examination NEW LGBTQ Considerations boxes summarize special assessment considerations for LGBTQ clients NEW Updated coverage of signs of abuse neglect and human trafficking equips you to become a mandatory reporter of these growing health problems NEW Updated high quality illustrations accurately represent assessment techniques and the latest examination equipment NEW Increased emphasis on normal findings is incorporated into the text along with a reduced emphasis on uncommon findings NEW emphasis in the Adapting Health Assessment chapter describes how to adjust your care for patients with a variety of conditions or limitations such as patients with IVs casts and catheters NEW Updated information on cultural and religious preferences and practices describes how these factors can have an impact on health assessment NEW UPDATED coverage addresses the latest evidence based guidelines on pain assessment NEW Enhanced Review Questions prepare you for the NCLEX exam with cognitive levels raised from remembering and understanding levels to applying and above to prepare you for clinical practice

Health Assessment for Nursing Practice ,2008 Pocket Guide for Nursing Health Assessment Sharon Jensen, 2014-11-07 The second edition of the Pocket Guide is designed to work as a clinical handbook and up to date reference for nurses when interviewing patients of all age groups and cultural backgrounds taking health histories promoting health and performing physical assessments The content derives from and has been developed in conjunction with Jensen's Nursing Health Assessment A Best Practice Approach and serves to both review the core content provided in the textbook as well as help students apply their foundational learning through reinforcement and streamlined presentation The content focuses on key questions in the area of health promotion reviewing important risk factors and outlining essential teaching points for risk assessment and intervention It includes essential questions to review common and concerning signs and symptoms for each health assessment topic The chapters review the key techniques of examination outlining normal and unexpected findings Finally tables of findings provide a quick reference by which students can compare and contrast results to assist with eventual nursing and medical diagnoses Assessment Lippincott Williams & Wilkins, 2007 This full color quick reference handbook covers all aspects of the patient history and physical examination to help nurses interpret assessment findings recognize patient needs and provide focused care Information is presented in a succinct highly bulleted format with lists tables and flowcharts to highlight key facts Recurring graphic icons include Skill Check tips for performing physical examination techniques Culture Cue and Age Alert specific variations in assessment findings and techniques related to age culture or ethnicity Alert life or limb threatening situations and Clinical Picture quick scan charts visually comparing clusters of abnormal findings and differentiating among possible causes **Health Assessment in Nursing Janet**

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