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 | p. 8-9
   TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 8
   TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 8
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: pp. 10-11
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 10

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 REF: p. 11
   TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 11
   TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 11
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 11
   TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 11
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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 REF: p. 11
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

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
    State the order of events as understood and ask patient to verify the order is correct. This **therapeutic** technique is useful when interviewing a patient who rambles or does not provide sequential data. Drawing conclusions about the order of events is interpretation. In this example, the sequence of events is more relevant than an interpretation. The nurse may have difficulty interpreting an unclear sequence of events. Asking the patient to elaborate about these events will not provide order to the sequence of events. Asking the patient to repeat what he said about these events will not necessarily provide a sequence of events.

    DIF: Cognitive Level: Understand REF: p. 11
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

13. A male patient is very talkative and shares much information that is not relevant to his history or the reason for his admission. Which action by the nurse improves data collection in this situation?
    a. Terminate the interview.
    b. Use closed-ended questions.
    c. Ask the patient to stay on the subject.

d. Ask another nurse to complete the interview.

ANS: B
Using closed-ended questions is useful to obtain specific data when open-ended questions are not obtaining the needed data. Terminating the interview is not beneficial to the patient and does not allow data collection. Asking the patient to stay on the subject is not therapeutic and may result in less data collection. Asking another nurse to complete the interview may not be practical and interrupts the nurse-patient relationship that has been established.

DIF: Cognitive Level: Understand REF: p. 11 | p. 12
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

14. A patient answers questions quietly and appears sad. While answering questions about her marriage, she begins to cry. Which response by the nurse is appropriate in this situation?
    a. "Don't cry! I'll come back when you've settled down."
    b. "I only have a few more questions to ask, and then I'll leave you alone for a while."
    c. "Everyone has ups and downs in their marriage. What problems are you having?"
    d. "I see that you are upset. Is there something you'd like to discuss?"

    ANS: D
    "I see that you are upset. Is there something you'd like to discuss?" shows that the nurse is attentive to the patient's feelings and does not make assumptions about the reason why the patient is crying. The crying may signify additional data the nurse needs to collect during this interview. "Don't cry! I'll come back when you've settled down" is not a therapeutic response. The nurse needs to support the patient rather than leave her. "I only have a few more questions to ask, and then I'll leave you alone for a while" is not a therapeutic response. The nurse is more concerned about getting the history than the patient's response. "Everyone has ups and downs in their marriage. What problems are you having?" is not a therapeutic response. The nurse is assuming there are problems in the marriage instead of collecting more data.

    DIF: Cognitive Level: Apply REF: pp. 11-12 | pp. 11-13
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

15. During an interview, a patient begins to cry and appears angry. Which response by the nurse is most therapeutic?
    a. "This topic prompted an emotional response, tell me what you are feeling."
    b. "This topic does not usually cause such an emotional response."
    c. "Calm down and tell me what is wrong."
    d. "I will leave you alone for a few minutes so you can pull yourself together."

    ANS: A

Acknowledging the patient's feelings and encouraging their expression communicates acceptance of the emotion. Crying is a natural behavior and should be permitted. "This topic does not usually cause such an emotional response" may be perceived by the patient as judgmental and it does not help the patient meet the current need. Encouraging the patient to stop crying so that the nurse can help is not supportive of the patient's current need. The therapeutic action is to postpone further questioning until the patient is ready to proceed. Leaving the room so that the patient can be alone is not supportive of the patient.

DIF: Cognitive Level: Apply REF: p. 12
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

16. In which situation is the nurse's use of closed-ended questions most appropriate?
    a. When clarifying vague or conflicting data
    b. When obtaining a history from an overly talkative patient
    c. When encouraging a patient to elaborate on details of his or her history
    d. When collecting data about the current health problem

ANS: B
When obtaining a history from an overly talkative patient, a nurse can resort to closed-ended questions to complete the data collection in a timely manner. When clarifying vague and conflicting data, the nurse needs to use open-ended questions to obtain data. When encouraging the patient to elaborate on details of his or her history, the nurse needs to use open-ended questions to obtain the details. When collecting data about the current problem, the patient needs to describe the symptoms that brought him or her to seek help. These details are not collected with closed-ended questions.

DIF: Cognitive Level: Understand REF: p. 12
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

17. The nurse is interviewing a woman with her husband present. The husband answers the questions for the wife most of the time. What is the most appropriate therapeutic nursing action to hear the patient's viewpoint?
    a. Continue the interview.
    b. Ask the husband to step out of the room.
    c. Ask another nurse to complete the interview.
    d. Tell the woman to speak up for herself.

ANS: B
Asking the husband to step out of the room will allow the patient to answer questions in her own way. Continuing the interview is not a therapeutic action because the nurse needs to obtain the patient's answers to the questions. Asking another nurse to complete the interview does not solve the problem that the husband is answering questions for his wife. Telling the woman to speak up for herself does not solve the problem and may interfere with the therapeutic relationship between the patient and the nurse.

DIF: Cognitive Level: Remember REF: pp. 12-13
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

18. A female Korean patient accompanied by her husband and son comes to the emergency department (ED) complaining of abdominal pain. The patient speaks and understands Korean only. Which person is the appropriate choice for the nurse to use to get a history from this patient?
    a. The patient's husband who speaks Korean and English
    b. The patient's son who speaks Korean and English
    c. A male technician who works in the ED who speaks Korean and English
    d. A female interpreter who speaks Korean and English and is available by phone

    ANS: D
    A female interpreter who speaks Korean and English and is available by phone is the best choice because she can communicate with the patient and is the same gender as the patient. The patient's husband who speaks Korean and English is not the best choice because he is a family member and may alter the meaning of what is said. The patient's son who speaks Korean and English is not the best choice because he is a family member and may alter the meaning of what is said. A male technician working in the ED who speaks Korean and English is not a good choice because the patient may feel uncomfortable giving a history to a stranger who is male.

    DIF: Cognitive Level: Understand REF: p. 13
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Cultural Diversity | NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

19. Which nurse demonstrates culturally competent care for a female patient from Russia?
    a. Nurse A who asks the patient about cultural factors that influence health care
    b. Nurse B who interacts with every patient from Russia in the same manner
    c. Nurse C who learns the cultural variables of every culture, including Russia
    d. Nurse D who relies on her previous experience with patients from Russia

    ANS: A
    Asking the patient about cultural factors that influence health care is demonstrating culturally competent care, along with interacting with each patient as a unique person who is a product of past experiences, beliefs, and values. Interacting with every patient from Russia in the same manner does not allow for the uniqueness of each person within the same culture. Learning the cultural variables of every group encountered can be valuable but it is impractical to learn about all cultures because each patient is unique. A better approach is to ask patients about their beliefs. Relying on previous experience with patients from Russia does not allow for the uniqueness of each person within the same culture.

    DIF: Cognitive Level: Understand REF: p. 13
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Cultural Diversity

20. For which patient is a focused health history most appropriate?
    a. A new patient at the health clinic for an annual examination
    b. A patient admitted to the hospital with vomiting and abdominal pain
    c. A patient at the health care provider's office for a sport physical
    d. A patient discharged 11 months ago who is being readmitted today

    ANS: B

A patient admitted to the hospital with vomiting and abdominal pain benefits from a focused health history that limits data to the immediate problem. A new patient at the health clinic for an annual examination needs a comprehensive history that includes biographic data, reason for seeking care, present health status, past medical history, family history, personal and psychosocial history, and a review of all body. A patient with a specific need, such as a sport physical, needs a history for an episodic assessment. A patient discharged months ago who is being readmitted needs a history for a follow-up assessment that generally focuses on the specific problem or problems that caused the patient to be readmitted.

DIF: Cognitive Level: Understand REF: pp. 13-14
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

21. A patient tells the nurse at the clinic, "I can never seem to get warm lately and feel tired all the time." The nurse records these data under which section of the health history?
    a. Past health history
    b. Present health status
    c. Reason for seeking care (chief complaint)
    d. Subjective assessment data

    ANS: C
    The reason for seeking care (chief complaint) is the patient's reason for seeking care (also called the presenting problem). The patient's reason for seeking care is often recorded as a direct quote. The past health history includes data about immunizations, surgeries, accidents, and childhood illnesses. The present health status includes data the nurse obtains from the patient, often using a symptom analysis in which more data are collected about the patient's reason for seeking care. Subjective assessment data include information from the patient. In this example, the patient expresses the reason for seeking care, which is directly quoted and placed in quotation marks in the chief complaint section of the data sheet so that the patient's reason for seeking care can be easily identified.

    DIF: Cognitive Level: Apply REF: p. 14
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

22. A patient comes to the ambulatory surgery center for an elective procedure this morning. While giving the admission history, the patient states she is allergic to latex. What is the most appropriate response by the nurse at this time?
    a. Removing all latex products from the patient's room
    b. Using powdered gloves when providing care to this patient
    c. Informing the surgeon that the patient has type I hypersensitivity to latex
    d. Questioning the patient about symptoms experienced in the past with latex

    ANS: D

Questioning the patient about symptoms experienced in the past with latex is the appropriate response. When patients indicate an allergy to a medication or substance, ask them to describe what happens with exposure to determine whether the reaction is a side effect or an allergic reaction. Removing all latex products from the patient's room is unnecessary at this time because the latex allergy has not been confirmed. Using powdered gloves when providing care to this patient is unnecessary at this time because the latex allergy has not been confirmed. Informing the surgeon that the patient has type I hypersensitivity to latex is unnecessary at this time because the latex allergy has not been confirmed.

DIF: Cognitive Level: Understand REF: p. 15
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Safety and Infection Control: Injury Prevention

23. A nurse is interviewing a male patient who reports he has not had a tetanus immunization in about 15 years because he had a "bad reaction" to the last tetanus immunization. What is the most appropriate response by the nurse in this case?
    a. Notify the health care provider that this immunization cannot be given.
    b. Document that the patient is allergic to the tetanus vaccine.
    c. Give the vaccine after explaining that adverse reactions are rare.
    d. Ask the patient to describe the "bad reaction" to the vaccine in more detail.

    ANS: D
    The nurse needs to collect more data about the reaction from the patient to determine the type of reaction experienced. The nurse is trying to assess the relationship between the "reaction" reported by the patient and an allergic reaction. The immunization should not be eliminated at this time. Additional facts are needed to determine the type of reaction the patient experienced. Documenting an allergy to the tetanus vaccine may be an error because there are insufficient data to make that determination at this time. Giving the vaccine may be an error if the patient is allergic to the vaccine and additional data indicates that may be the case.

    DIF: Cognitive Level: Apply REF: p. 15
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Health Promotion and Maintenance: Health Promotion and Disease Prevention

24. A patient admitted with pneumonia reports that she takes insulin for diabetes mellitus. In which section of the history does the nurse document the insulin and diabetes?
    a. Past health history
    b. Present health status
    c. Reason for seeking care (chief complaint)
    d. History of present illness

    ANS: B

The present health status documents the current health conditions, which include chronic diseases and medications taken. In this case, diabetes and taking insulin are not the reason for seeking care, but need to be managed while the patient's pneumonia is being treated because they may affect the patient's recovery from pneumonia. The past health history includes categories of childhood illness, surgeries, hospitalizations, accidents or injuries, immunizations, and obstetric history. The reason for seeking care (chief complaint) is a brief statement of the patient's purpose for requesting the services of a health care provider. History of present illness further investigates the history of the present problem; best accomplished by conducting a symptom analysis.

DIF: Cognitive Level: Understand REF: p. 15
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Safe and Effective Care Environment: Collaboration with Interdisciplinary Team

25. A nurse is getting a history from a patient who is disabled from rheumatoid arthritis. Which question will provide data about this patient's functional ability?
    a. "When did your arthritis symptoms begin?"
    b. "How has your arthritis affected your daily life?"
    c. "Why did you come to the clinic today?"
    d. "How do you feel about your diagnosis of rheumatoid arthritis?"

    ANS: B
    "How has your arthritis affected your daily life?" is a question that leads to data about the patient's ability to perform self-care activities or functional abilities. "When did your arthritis symptoms begin?" is a question asked as part of the history, but does not collect data about functional ability. "Why did you come to the clinic today?" is a question asked to obtain the chief complaint about a current problem, but does not focus directly on the functional assessment. "How do you feel about your diagnosis of rheumatoid arthritis?" is a question to ask in the psychosocial history, but does not focus directly on the functional assessment.

    DIF: Cognitive Level: Apply REF: p. 17
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

26. An example of a health promotion question included in the health history is:
    a. "Do you have any allergies?"
    b. "How often are you exercising?"
    c. "What are you doing to relieve your leg pain?"
    d. "What kind of herbs are you using?"

    ANS: B
    "How often are you exercising?" is a question about activities patients regularly perform to maintain health. "Do you have any allergies?" is a question for the present health status rather than health promotion. "What are you doing to relieve your leg pain?" is a question that is part of the symptom analysis. "What kind of herbs are you using?" is a question for the present health status rather than health promotion.

    DIF: Cognitive Level: Remember REF: p. 17
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

27. The patient reports having a persistent cough for the past 2 weeks and that the cough disrupts sleep and has not been helped by over-the-counter cough medicines. Which question is most appropriate for the nurse to ask next?
    a. "So what do you think is causing this persistent cough?"
    b. "Have you tried taking sleeping pills to help you sleep?"
    c. "Did you think this will just go away on its own?"
    d. "What other symptoms have you noticed related to this cough?"

    ANS: D
    "What other symptoms have you noticed related to this cough?" is part of a symptom analysis to provide more data. The answer to the question "So what do you think is causing this persistent cough?" is a guess by the patient and does not provide useful data. "Have you tried taking sleeping pills to help you sleep?" does not focus on the cough, which is what is disturbing the patient's sleep. "Did you think this will just go away on its own?" does not provide useful data and criticizes the patient's lack of action.

    DIF: Cognitive Level: Apply REF: p. 18 | Box 2-3
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

MULTIPLE RESPONSE

1. Which data do nurses document under the heading of Past Health History? (*Select all that apply.*)
    a. Father has Alzheimer disease.
    b. Last tetanus in 2009
    c. Had chicken pox as a child
    d. Drinks three to four beers each day
    e. Had a dental examination 6 months ago

    ANS: B, C, E
    Last tetanus is an immunization, chicken pox as a child is a childhood illness, and last examinations, including dental, are documented under the heading of Past Health History. Family History documents father's Alzheimer disease; patient drinking three to four beers each day refers to alcohol use, which is documented under the heading Personal and Psychosocial History.

    DIF: Cognitive Level: Understand REF: pp. 15-16
    TOP: Nursing Process: Assessment
    MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

2. Which data do nurses document under the heading of Personal and Psychosocial History? (*Select all that apply.*)
    a. Walks for 45 minutes each day
    b. Eats meats, vegetables, and fruit at two meals daily
    c. Is allergic to milk and milk products
    d. Is married and has two daughters whom he is close to
    e. Smokes marijuana once a week
    f. Grandfather died from prostate cancer

ANS: A, B, D, E

Walks for 45 minutes each day is documented under health promotion activity in Personal and Psychosocial History; eats meats, vegetables, and fruit at two meals daily is documented about diet activity in Personal and Psychosocial History; is married and has two daughters whom he is close to is documented under family and social relationship activity in Personal and Psychosocial History; smokes marijuana once a week is documented under personal habits activity in Personal and Psychosocial History. Allergic to milk and milk products is an allergy, which is documented under the heading Present Health Status; Grandfather died from prostate cancer is documented under the heading Family History.

DIF: Cognitive Level: Understand REF: p. 16
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Psychosocial Integrity: Therapeutic Communications

3. Which questions are pertinent to ask when obtaining a symptom analysis from a patient who reports breathing problems? (*Select all that apply.*)
   a. How long have you had this problem with your breathing?
   b. Do you have a family history of breathing problems?
   c. Does this breathing problem come and go or is it constant?
   d. What do you do to make your breathing better?
   e. How does this breathing problem affect your work or daily activities?
   f. How many packs of cigarettes do you smoke a day?

   ANS: A, C, D, E

   How long have you had this problem with your breathing?, Does this breathing problem come and go or is it constant?, What do you do to make your breathing better?, and How does this breathing problem affect your work or daily activities? are questions asked in a symptom analysis. Use the mnemonic of OLD CARTS (e.g., onset of symptoms, location and duration of symptoms, characteristics, aggravating factors, related symptoms, treatment used, and severity of symptoms). Do you have a family history of breathing problems? This question relates to the patient's history; How many packs of cigarettes do you smoke a day? This question relates to the patient's history.

   DIF: Cognitive Level: Apply REF: p. 17 | Box 2-3
   TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

4. Which questions are pertinent to ask when obtaining a symptom analysis from a patient who reports a headache? (*Select all that apply.*)
   a. Describe what the headache feels like.
   b. When was your last eye examination?
   c. What makes the headaches worse?
   d. How do you rate the headaches on a scale of 0 (meaning no pain) to 10 (meaning the worse pain ever)?
   e. Do you have any symptoms with the headaches, such as nausea?
   f. When did you first notice the headaches?

   ANS: A, C, D, E, F

Describe what the headache feels like?, What makes the headaches worse?, How do you rate the headaches on a scale of 0 (meaning no pain) to 10 (meaning the worse pain ever)?, Do you have any symptoms with the headaches, such as nausea?, and When did you first notice the headaches? are questions asked in a symptom analysis. Use the mnemonic of OLD CARTS (e.g., onset of symptoms, location and duration of symptoms, characteristics, aggravating factors, related symptoms, treatment used, and severity of symptoms). When was your last eye examination? assumes that the headaches are related to a vision problem. Last eye examination is documented in the history under the heading of Past Health History.

DIF: Cognitive Level: Apply REF: p. 15 | Box 2-3
TOP: Nursing Process: Assessment
MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments

5. Which questions are pertinent for a nurse to ask a patient while performing a review of the cardiovascular system? (*Select all that apply*.)
   a. Do you remember what your last cholesterol value was?
   b. Have you had chest pain or shortness of breath?
   c. Do you have trouble breathing when you lie down?
   d. Are your feet cold, numb, or do they change color?
   e. How much do you weigh?
   f. Have you noticed edema in your ankles at the end of the day?

   ANS: B, C, D, F
   Have you had chest pain or shortness of breath?, Do you have trouble breathing when you lie down?, Are your feet cold, numb, or do they change color?, and Have you noticed edema in your ankles at the end of the day? are questions asked to give the patient an opportunity to report symptoms of the cardiovascular system. Do you remember what your last cholesterol value was? relates to a lab value, which is objective data not documented in the history; How much do you weigh? is objective data not documented in the history.

   DIF: Cognitive Level: Remember REF: p. 18
   TOP: Nursing Process: Assessment
   MSC: NCLEX Patient Needs: Physiologic Integrity: Reduction of Risk Potential: System Specific Assessments