Chapter 2, The Health History and Interview

MULTIPLE CHOICE

1. A nursing instructor is talking about nonverbal communication with the nursing class. The instructor explains that facial expressions should be as what?
   A) Happy
   B) Inquisitive
   C) Relaxed
   D) Detached

   ANS: C
   Feedback: Facial expressions should be relaxed, caring, and interested. Facial expressions that are happy, inquisitive, or detached can interfere with the therapeutic communication process.

   PTS: 1 REF: Page: 20 | Header: Nonverbal Communication Skills
   OBJ: 1 NAT: Client Needs: Psychosocial Integrity
   TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
   BLM: Cognitive Level: Apply

2. A nurse is admitting a new client. The client is lying in bed. Where should the nurse be positioned?
   A) Seated in a chair at eye level with the client
   B) Sitting on the side of the bed, looking down at the client
   C) Leaning on the nightstand at eye level with the client
   D) Standing beside the bed, looking down at the client

   ANS: A
   Feedback: To facilitate optimal eye contact, the nurse needs to be at eye level with the client. Those who stand while clients are in bed will be taller than clients, assuming a position of power. Thus, the nurse should be seated in a chair at eye level with clients who are in bed during interviews. Leaning on the nightstand and sitting on the bed do not promote therapeutic communication or professionalism.

   PTS: 1 REF: Page: 20 | Header: Nonverbal Communication Skills
   OBJ: 1 NAT: Client Needs: Psychosocial Integrity
   TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
   BLM: Cognitive Level: Apply

3. A way to use nonverbal communication is through silence. The purposeful use of silence during the interview allows clients to what?
   A) Rest and improve health
   B) Provide accurate answers
   C) Talk about their feelings
   D) Communicate verbal concern

   ANS: B

Feedback: The nurse uses silence purposefully during the interview to allow clients time to gather their thoughts and provide accurate answers. The nurse also uses silence therapeutically to communicate nonverbal concern. Silence also gives clients a chance to decide how much information to disclose. Silence is not used to rest and improve the client's health, have the client talk about their feelings, or communicate verbal concern.

PTS: 1 REF: Page: 21 | Header: Silence OBJ: 1
NAT: Client Needs: Psychosocial Integrity TOP: Chapter: 2
KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

4. A nurse is interviewing a client who uses an expression with which the nurse is unfamiliar. What is the **most** appropriate expression for the nurse to use to clarify the expression's meaning from the client?
   A) Tell me what you mean by _____?
   B) I think that expression means _____
   C) That expression is unclear to me
   D) Where did you hear that expression?

   ANS: A
   Feedback: Clarification is important when the client's word choice or ideas are unclear. For example, the nurse states, “Tell me what you mean by _____.” Another way to clarify is to ask, “What happens when you _____?” Such questions prompt clients to identify other symptoms or give more information so that the nurse better understands. The nurse also can use clarification when the client's history of illness is confusing. Where the client heard the expression is not an appropriate response to help clarify the expression. The nurse's thinking or believing the expression means something does not clarify the true meaning of the expression with the client. The nurse stating that the expression is unclear does not clarify the meaning with the client.

   PTS: 1 REF: Page: 22 | Header: Clarification OBJ: 1
   NAT: Client Needs: Psychosocial Integrity TOP: Chapter: 2
   KEY: Integrated Process: Communication and Documentation
   BLM: Cognitive Level: Analyze

5. The client tells the nurse that he is sorry he fell off the roof and broke his leg. The nurse responds by saying, “Oh, you poor thing! I am sorry you fell off the roof and broke your leg, too.” What type of response is this?
   A) Empathetic
   B) Therapeutic
   C) Sympathetic
   D) Supportive

   ANS: C
   Feedback: Sympathy is the feeling what a client feels from the viewpoint of the nurse. When the nurse is being sympathetic, the nurse is interpreting the situation as the nurse perceives it. The nurse's response is incorrect to the situation. The nurse should be supportive, therapeutic, and empathetic in response to the client's situation.

   PTS: 1 REF: Page: 22 | Header: Sympathy OBJ: 1

NAT: Client Needs: Psychosocial Integrity TOP: Chapter: 2
KEY: Integrated Process: Caring BLM: Cognitive Level: Apply

6. A nursing instructor is discussing therapeutic versus nontherapeutic responses with nursing students. Which of the following would the nurse identify as nontherapeutic?
   A) Clarification
   B) Distraction
   C) Summarizing
   D) Focusing

   ANS: B
   Feedback: Distractions in the environment contribute to nontherapeutic communication. Clarification, summarizing, and focusing are all important aspects of therapeutic communication since they all support effective communication.

   PTS: 1 REF: Page: 24 | Header: Distraction OBJ: 1
   NAT: Client Needs: Psychosocial Integrity TOP: Chapter: 2
   KEY: Integrated Process: Communication and Documentation
   BLM: Cognitive Level: Understand

7. A nurse is preparing to admit a new client to the unit and is reviewing the client record chronologically. In what phase of the interview process are the nurse and the client?
   A) Preinteraction
   B) Beginning
   C) Working
   D) Closing

   ANS: A
   Feedback: In the preinteraction phase, the nurse reviews the record chronologically to detect patterns of illness, such as declining functional status, and to identify how things fit together. Beginning, working, and closing are all phases in the interview process. The beginning phase starts when introductions are exchanged, creating a safe and relaxed environment for the interview to occur. The working phase is the phase where data, both subjective and objective, are collected. The closing phase is when a summary of the interview session occurs, allowing the client to ask any questions or verbalize any concerns.

   PTS: 1 REF: Page: 27 | Header: Preinteraction Phase
   OBJ: 2 NAT: Client Needs: Health Promotion and Maintenance
   TOP: Chapter: 2 KEY: Integrated Process: Nursing Process
   BLM: Cognitive Level: Apply

8. During the interview process, the nurse uses both open-ended and closed-ended questions. During what phase of the interview process does the nurse use these specific types of questions?
   A) Preinteraction
   B) Beginning
   C) Working
   D) Closing

ANS: C
Feedback: During the working phase, the nurse collects data by asking specific questions. Two types of questions are closed-ended and open-ended questions. Each type has a purpose; the nurse chooses which type will help solicit the appropriate information. Preinteraction, beginning, and closing are all phases in the interview process. The preinteraction phase is prior to meeting the client, when the nurse collects data from the medical record. The information gathered from the medical record is used to conduct the client interview. The beginning phase is when introductions are exchanged, privacy is ensured, and actions are made by the nurse to relax the client. The closing phase is when a review of the interview is conducting, summarizing areas of concerns or importance, allowing the client to ask any closing questions.

PTS: 1 REF: Page: 27 | Header: Working Phase OBJ: 2
NAT: Client Needs: Health Promotion and Maintenance TOP: Chapter: 2
KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Remember

9. The nurse is interviewing a client from a culture different from that of the nurse. The nurse works to preserve the code of conduct that shows respect for others. What is this code of conduct called?
A) Good manners
B) Direct communication
C) Nonverbal communication
D) Communication etiquette

ANS: D
Feedback: Communication etiquette refers to the code of conduct and good manners that show respect for others. Such etiquette varies between and within cultures. Good manners are subjective and differ from culture to culture. Direct communication may not be culturally acceptable to the client. Acceptable and unacceptable nonverbal communication differs from culture to culture.

PTS: 1 REF: Page: 25 | Header: Intercultural Communication
OBJ: 3 NAT: Client Needs: Health Promotion and Maintenance
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

10. A client who only speaks Spanish is admitted to the unit. The client's sister, who speaks English, is in the room when the English-speaking nurse starts the admission assessment. Why would it be inappropriate to use the sister as an interpreter for this client?
A) The sister may not tell the client exactly what the nurse says.
B) The client's sister may not understand medical terminology.
C) The sister may not be there every time the nurse needs to talk to the client.
D) The client may not want the sister to know their private information.

ANS: D

Feedback: Using children in the family, other relatives, or close friends as interpreters violates privacy laws, because clients may not want to share personal information with others. HIPAA guidelines address privacy issues such as this scenario. Even when the client gives permission for the family member to be present, an official interpreter should be present per facility policy. The other options could be true in some situations, but the priority answer addresses privacy, both the client's right to privacy, and the facility's handling of private information.

PTS: 1 REF: Page: 25 | Header: Working With an Interpreter
OBJ: 3
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Analyze

11. A nurse is performing an admission assessment on a new client to the unit. What would be the **best** way to phrase a question about the client's marital status?
A) "Is your spouse living with you?"
B) "Are you living with your spouse?"
C) "Do you live alone or with someone?"
D) "Are you married, divorced, or widowed?"

ANS: C
Feedback: An inclusive, sensitive, and ultimately better question by which to determine the client's marital status is, "Do you live alone or with someone?" This phrasing provides a more direct avenue for finding out about support at home. The other options list questions that would not be the most appropriate question to ask the client about their marital status since they make assumptions or limit possible answers.

PTS: 1 REF: Page: 26 | Header: Gender and Sexual Orientation Issues
OBJ: 3 NAT: Client Needs: Psychosocial Integrity
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Analyze

12. A pediatric nurse, working in a community health clinic, is about to start an interview with a school-aged child. What is the **most** appropriate way to address this child and the accompanying adults?
A) Call the child by their legal name and refer to the parents as Mr. and Mrs.
B) Call the child by their first name and ask the parents how they prefer to be addressed.
C) Call the child by their first name and refer to the parents as Mr. and Mrs.
D) Call the child by their full name and refer to the parents as "mom" and "dad."

ANS: B
Feedback: The nurse should refer to children by their first names and ask the adults what name they prefer for address. The nurse avoids calling parents "mom" or "dad" to maintain professional communication. Referring to the adults as Mr. and Mrs. is making an assumption that may not be correct.

PTS: 1 REF: Page: 36 | Header: Life Span Considerations
OBJ: 3 NAT: Client Needs: Psychosocial Integrity

TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Analyze

13. The nurse is interviewing a 6-year-old who has been accompanied to the clinic by a parent. The child has a laceration on the leg from a sports related accident. Which assessment method is directed at securing primary data?
A) Asking the child, “Does your leg hurt?”
B) Asking the parent, “When did the accident occur?”
C) Reviewing the child's medical records for current vaccinations
D) Reviewing the child's medical records for known allergies to antibiotics

ANS: A
Feedback: The individual patient is considered the primary data source. Charts and information from family members are considered secondary data sources.

PTS: 1 REF: Page: 28 | Header: Primary and Secondary Data Sources
OBJ: 4 NAT: Client Needs: Health Promotion and Maintenance
TOP: Chapter: 2 KEY: Integrated Process: Caring
BLM: Cognitive Level: Analyze

14. What intervention would be **most** helpful when conducting an interview with a client who has stated, “I'm a little hard of hearing”?
A) Asking the client if they are wearing a hearing aide
B) Using prewritten cards that state the interview questions
C) Closing the door may help to limit background noise
D) Introducing hand gestures whenever it is appropriate

ANS: D
Feedback: Closing the door may help to limit background noise, making it easier for the client to hear. Not all clients with minimal hearing loss wear hearing aids. Pre-written questions and hand gestures are interventions reserved for those diagnosed with severe hearing limitations.

PTS: 1 REF: Page: 36 | Header: Hearing Impairment
OBJ: 3 NAT: Client Needs: Health Promotion and Maintenance
TOP: Chapter: 2 KEY: Integrated Process: Caring
BLM: Cognitive Level: Apply

15. When dealing with a client who has impaired hearing, what interventions should the nurse implement to facilitate lip reading?
A) Speak louder than usual
B) Exaggerate your lip movement
C) Sit closer than normally to the client
D) Speak much more slowly than usual

ANS: C
Feedback: The nurse sits closer to the client with hearing impairment to facilitate a setting for lip reading. The nurse uses regular speech volume and lip movement but may speak slightly more slowly.

PTS: 1 REF: Page: 37 | Header: Hearing Impairment
OBJ: 3
NAT: Client Needs: Physiological Integrity: Physiological Adaptation
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Apply

16. Nurses weave the individualization of the client interview through all aspects of the encounter. The nurse should avoid assuming that clients follow cultural beliefs. In place of making this assumption, what should a nurse do?
A) Assess the degree to which the client perceives the cultural beliefs
B) Assess how acculturated the client is
C) Know the mores of the culture
D) Know his or her own cultural beliefs

ANS: A
Feedback: The nurse should avoid assuming clients follow cultural beliefs and assess the degree to which each individual perceives those beliefs. Knowing the mores of the culture and the nurse's own cultural beliefs are important, but do not answer the question at hand. The nurse would have difficulty assessing how acculturated the client is within the client's cultural beliefs.

PTS: 1 REF: Page: 35 | Header: Social, Cultural, and Spiritual Assessment
OBJ: 3 NAT: Client Needs: Psychosocial Integrity
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Apply

17. When a nurse conducts a health history with a client, what is the purpose of the conversation?
A) To provide therapeutic communication
B) To gather subjective information
C) To assess the client's physical status
D) To identify the client's diagnoses

ANS: A
Feedback: The purpose of taking the health history is to collect subjective data from patients. The nurse's role related to interviewing is to gather information to assess the client's health status and to provide therapeutic communication when indicated. Identifying the client's diagnoses, either nursing or medical, is not the purpose of the health history.

PTS: 1 REF: Page: 18 | Header: The Communication Process
OBJ: 1 NAT: Client Needs: Health Promotion and Maintenance
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Analyze

18. How does a nurse indicate to a client that their concerns are not worth discussing?
A) By being empathetic
B) By providing false reassurance
C) By being sympathetic

D) By giving unwanted advice

ANS: B
Feedback: By providing false reassurance, the nurse unconsciously indicates to clients that their concerns are not worth discussing. Empathy is a therapeutic response to a client and is a positive interaction. Being sympathetic and giving unwanted advice are nontherapeutic responses, but they do not tend to imply that the client's concerns are not worth discussing.

PTS: 1 REF: Page: 22 | Header: False Reassurance
OBJ: 1 NAT: Client Needs: Psychosocial Integrity
TOP: Chapter: 2 KEY: Integrated Process: Caring
BLM: Cognitive Level: Analyze

19. During the interview process, the nurse obtains what type of data from the client?
A) Primary
B) Secondary
C) Objective
D) Oral

ANS: A
Feedback: Nurses collect primary data from clients themselves. Secondary data come from family and medical records. Objective data are data observed. Oral data is a form of data obtained through conversation.

PTS: 1 REF: Page: 28 | Header: Primary and Secondary Data Sources
OBJ: 4
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

20. The nurse is admitting a new client to the unit. While reviewing old records of the client, the nurse knows that the data being gathered are what kind of data?
A) Primary
B) Secondary
C) Subjective
D) Objective

ANS: B
Feedback: Charts and family members are considered secondary data sources. The client is the source of primary data. Subjective data are data provided to the nurse by the client; objective data are data that the nurse observes.

PTS: 1 REF: Page: 28 | Header: Primary and Secondary Data Sources
OBJ: 4
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

21. The nurse is gathering a complete history of the client's present illness. The nurse knows that the **most** appropriate way to begin to gather this information is what?
    A) Assessing the client's vital signs
    B) Gathering a complete list of the client's medications
    C) Asking open-ended questions
    D) Asking focused questions

    ANS: C
    Feedback: The nurse collects information about the present illness by beginning with open-ended questions and having the client explain symptoms. The most appropriate way to collect data about the present illness is not to assess the client's vital signs, gather a complete list of the client's medications, or ask focused questions.

    PTS: 1 REF: Page: 29 | Header: History of Present Illness
    OBJ: 6
    NAT: Client Needs: Safe, Effective Care Environment: Management of Care
    TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
    BLM: Cognitive Level: Analyze

22. A clinical instructor is discussing with a clinical group how to take a history of the client's present illness. A student asks how to best guide the interview. What would be the instructor's **most** appropriate answer?
    A) Follow the cues of the client during the interview
    B) Use a written checklist to make sure you cover all necessary areas
    C) Use a head-to-toe approach to make sure you do not miss anything
    D) Use a focused approach, asking only about symptoms of the present illness

    ANS: A
    Feedback: Regardless of the order of data, the nurse guides the conversation following the cues of the client and uses a mental checklist to ensure that he or she has assessed all categories before the end of history taking. The nurse would not use a written checklist during the interview, and the nurse would not use a head-to-toe approach when eliciting information about the present illness. The nurse also would not focus only on the symptoms of the present illness.

    PTS: 1 REF: Page: 29 | Header: History of Present Illness
    OBJ: 6
    NAT: Client Needs: Safe, Effective Care Environment: Management of Care
    TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
    BLM: Cognitive Level: Apply

23. A genogram is developed to visually show what?
    A) Family tree
    B) Family health patterns
    C) Family relationships
    D) Nationalities of family members

    ANS: B

Feedback: A common tool used to understand family health patterns is the genogram. This graphic representation allows the nurse to map family structures and compile a large amount of information visually. Genograms make it easier for the nurse to identify the complexity of families and validate patterns pertinent to clients. A genogram is much more than a family tree showing family relationships or nationalities of family members.

PTS: 1 REF: Page: 31 | Header: Family History OBJ: 7
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

24. A group of student nurses is presenting information on Gordon's framework for assessing a client. What type of assessment would they be talking about?
A) Comprehensive
B) Focused
C) Functional
D) Emergency

ANS: C
Feedback: Functional health patterns are especially important to nursing, because they focus on the effects of health or illness on a client's quality of life. By using this approach, the nurse can assess the strengths of a client as well as areas needing improvement. Comprehensive, focused, or emergency assessments are not based on Gordon's framework.

PTS: 1 REF: Page: 32 | Header: Functional Health Assessment
OBJ: 8
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Remember

25. When using Gordon's framework for a functional health assessment, the nurse asks a client, “Have you made any changes in your environment because of vision, hearing, or memory decrease?” What functional health pattern is the nurse assessing?
A) Vision
B) Hearing
C) Coping
D) Cognition

ANS: D
Feedback: A question to include in review of cognition and perception is whether the client has made any environmental changes because of vision, hearing, or memory decrease. The options of vision or hearing individually would not be complete as a response. The option of coping is not addressed in the question posed by the nurse.

PTS: 1
REF: Page: 33 | Header: Table 2.2 Gordon's Functional Health Patterns
OBJ: 8 NAT: Client Needs: Health Promotion and Maintenance
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Analyze

26. The nurse is caring for an older adult client who has been admitted with a fractured hip. While doing the admission assessment, the client states, “I tripped over the small rug we have in front of the sink.” What subject would this report indicate that needs teaching during this client's hospital stay?
    A) The need to eliminate rugs on the client's floors
    B) The need to have wall-to-wall carpeting throughout the client's house
    C) The need for the client to use a walker when she goes into the kitchen
    D) The need for the client to be in a wheelchair

    ANS: A
    Feedback: The nurse performs health teaching, based on each client's needs and priorities, and weaves health promotion and disease prevention into care. Client teaching about wall-to-wall carpeting or use of a walker or wheelchair is not indicated for this client. The nurse would teach this client about the need to eliminate small rugs from the floors of her house.

    PTS: 1 REF: Page: 17 | Header: Introduction OBJ: 6
    NAT: Client Needs: Safe, Effective Care Environment: Safety and Infection Control
    TOP: Chapter: 2 KEY: Integrated Process: Teaching/Learning
    BLM: Cognitive Level: Apply

27. In the closing phase of the interview process, the nurse analyzes the data collected for what **priority** reason?
    A) Establish a baseline from which to start interviewing the family
    B) Identifying the primary problems or patterns of concern
    C) Communicate information to the physician
    D) Communicate information to other staff members

    ANS: B
    Feedback: The nurse prioritizes, collects, and analyzes subjective and objective data and summarizes and states the two to three most important patterns or problems might be. The nurse's priority is not to use the data gathered in the client interview as a baseline for interviewing the family or for communicating to the physician or other staff members.

    PTS: 1 REF: Page: 28 | Header: Closing Phase OBJ: 2
    NAT: Client Needs: Health Promotion and Maintenance TOP: Chapter: 2
    KEY: Integrated Process: Nursing Process
    BLM: Cognitive Level: Remember

28. What statement made by a student nurse reflects an understanding of the role of medical terminology when communicating with the client?
    A) “Medical terminology is used only when communicating with other health care professionals.”
    B) “I always try to use really simple language when talking to my clients.”
    C) “Clients are more sophisticated today; they understand medical terminology so much better.”
    D) “I try to use language that my client is able to best understand.”

    ANS: D

Feedback: The nurse demonstrates an understanding the effective use of medical terminology when stating the need to use language that the client will best understand. Medical terminology is not exclusively used for interprofessional conversations but it is important to assess the client's ability to understand the terms and the information they are providing; the client may be able to understand some medical terms. While it is true that the public is more familiar with medical terminology, it is not appropriate to assume that ability of all clients.

PTS: 1 REF: Page: 33-35 | Header: Review of Systems
OBJ: 2
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Analyze

29. The nurse is caring for an older adult client and is reviewing information obtained in the health history assessment. The nurse knows that it is important to identify the pattern of illnesses and recognize how they might be related because of what factor?
A) Client is hospitalized
B) Client presents as being stoic
C) Client is of advanced age
D) Client is chronically ill

ANS: C
Feedback: It is important to identify the pattern of the illnesses and recognize how they might be related as the client is an older adult. The question does not state that the client is in the hospital, stoic, or chronically ill.

PTS: 1 REF: Page: 38 | Header: Older Adults OBJ: 6
NAT: Client Needs: Health Promotion and Maintenance TOP: Chapter: 2
KEY: Integrated Process: Caring BLM: Cognitive Level: Apply

30. Through what process do the client and the nurse work together to develop a plan of care?
A) Functional health assessment
B) Use of subjective and objective data
C) Therapeutic communication
D) Use of Gordon's framework

ANS: C
Feedback: Through therapeutic communication, the client and the nurse work together to resolve problems by developing collaborative strategies and solutions. The use of Gordon's framework organizes collected data into functional groups. Subjective and objective data is collected in the assessment phase, but data collection is not how the client and nurse work together. A functional health assessment looks at the impact of illness or disease on a client's way of life.

PTS: 1 REF: Page: 18 | Header: Therapeutic Communication
OBJ: 1 NAT: Client Needs: Psychosocial Integrity
TOP: Chapter: 2 KEY: Integrated Process: Caring
BLM: Cognitive Level: Analyze

31. A nurse is assessing a client and collecting only the most important information. What type of assessment is the nurse doing?
    A) Functional
    B) Emergency
    C) Comprehensive
    D) Focused

    ANS: B
    Feedback: In an emergency assessment, nurses collect the most important information and defer obtaining details until clients are stable. They elicit the reason for seeking care along with current health problems, medications, and allergies. A functional assessment focuses on a client's ability to perform activities of daily living and other patterns in specific areas. A comprehensive assessment involves review of the client's overall health. A focused assessment emphasizes a specific area but may go into great detail in that area of concern.

    PTS: 1 REF: Page: 29 | Header: Table 2.1 Types of Health Histories
    OBJ: 5
    NAT: Client Needs: Safe, Effective Care Environment: Management of Care
    TOP: Chapter: 2 KEY: Integrated Process: Nursing Process
    BLM: Cognitive Level: Remember

32. What kind of information is the nurse's **priority** when conducting a review of systems?
    A) Primary
    B) Objective
    C) Subjective
    D) Secondary

    ANS: C
    Feedback: In the review of systems, data collected is subjective information. Objective data, or that completed in the physical assessment, is documented separately. If the information is secured from the client, it is considered a primary source, while secondary, if secured from other sources.

    PTS: 1 REF: Page: 33 | Header: Review of Systems
    OBJ: 6
    NAT: Client Needs: Safe, Effective Care Environment: Management of Care
    TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
    BLM: Cognitive Level: Understand

33. Why is it important for the nurse to reconcile all the hospitalized client's medication lists with the medication that the client regularly takes at home?
    A) So the physician can order the correct drugs for the hospitalized client
    B) So the client's medication record correlates with the client's medication history
    C) So the client continues taking the correct drugs
    D) So the physician can make sure to change the client's drugs

    ANS: C

Feedback: For hospitalized clients, the nurse must reconcile all medication lists with the medications taken regularly at home so that clients continue using the correct drugs. Reconciling the client's medication lists with the medications the client takes at home is not done so that the physician can order the correct drugs, to correlate the medication record with the medication history, or to change the client's drugs.

PTS: 1 REF: Page: 31 | Header: Current Medications With Indications
OBJ: 6
NAT: Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

34. The nursing instructor explains that sometimes a nurse uses a mnemonic, such as OLDCARTS, as the nurse completes the assessment. What is the purpose of the mnemonic?
A) To remember the elements that are important to assess with a symptom
B) To remember the parts of a focused assessment
C) To remember the order of the assessment
D) To remember how to document assessment findings

ANS: A
Feedback: Some providers use a mnemonic to remember the elements that are important to assess for the presenting symptom. OLDCARTS is one example and stands for onset, location, duration, character, associated/aggravating factors, relieving factors, timing, and severity. OLDCARTS does not help a nurse remember the parts of a focused assessment, order of assessment, or how to document findings.

PTS: 1 REF: Page: 29 | Header: History of Present Illness
OBJ: 6 NAT: Client Needs: Health Promotion and Maintenance
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Apply

35. During the admission process, the client states, “I am allergic to sulfa drugs.” How would the nurse verify this information?
A) Ask family members
B) Ask the physician
C) Ask the client about the response to the allergen
D) Compare against the client's medical records

ANS: D
Feedback: Allergies are verified with clients and compared against their medical records. When asking about allergies, the nurse notes the type of response such as rash, throat swelling, difficulty breathing, or anaphylactic shock. It is not appropriate to ask either family members or the physician about allergies that the client may have. Asking the client about reactions to an allergen is part of the assessment; it is not to verify the allergy information.

PTS: 1 REF: Page: 31 | Header: Allergies OBJ: 6
NAT: Client Needs: Safe, Effective Care Environment: Safety and Infection Control
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation

BLM: Cognitive Level: Apply

36. A new client is admitted to the clinic. The nurse assesses how the effects of health or illness affect the client's quality of life. What type of assessment is this nurse performing?
A) Comprehensive
B) Functional
C) Emergency
D) Focused

ANS: B
Feedback: Functional health patterns are especially important to nursing because they focus on the effects of health or illness on a patient's quality of life. The emergency assessment is urgent in nature, addressing an emergent issue at hand. The comprehensive assessment is detailed in nature, not focusing specifically on the impact of the illness on the client's quality of life. The focused assessment addresses a particular issue or concern, not looking at the impact of the issue or concern on the client's quality of life.

PTS: 1 REF: Page: 32 | Header: Functional Health Assessment
OBJ: 6
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Analyze

MULTIPLE RESPONSE

37. Clients in health care settings often are anxious. What behaviors would lead a nurse to believe that a client is anxious? (Select all that apply.)
A) Rapid speech
B) Nail-biting
C) Defensive tone
D) Vacant stare
E) Sweating

ANS: A, B, C, E
Feedback: Behaviors that indicate anxiety are nail-biting, foot-tapping, sweating, and pacing. Voice may quiver, speech may be rapid, and language or tone may be defensive. These behaviors are an attempt to relieve anxious feelings. A vacant stare is not an indication of anxiety but rather boredom or confusion.

PTS: 1 REF: Page: 37 | Header: Anxiety OBJ: 1
NAT: Client Needs: Psychosocial Integrity TOP: Chapter: 2
KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

38. When a client responds to a question with a “yes” or “no” answer, what appropriate responses by the nurse encourage the client to elaborate? (Select all that apply.)
A) Yes
B) I see

C) Um hum
D) Go on
E) Okay

ANS: A, B, D
Feedback: These responses encourage clients to say more and continue the conversation. They show clients that the nurse is interested. The nurse may nod the head or say "Um hum," "Yes," or "Go on" to cue clients to keep talking. Responses of "I see" and "Okay" do not encourage elaboration by the client and are therefore incorrect.

PTS: 1 REF: Page: 21 | Header: Elaboration (Facilitation)
OBJ: 1 NAT: Client Needs: Psychosocial Integrity
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

39. A student asks when it would be appropriate to take a comprehensive health history. What would be the instructor's **best** answer? (Select all that apply.)
A) During a hospital admission
B) At a clinic visit for a fall
C) In the emergency department after a car accident
D) During an annual physical examination
E) At a screening for sports participation

ANS: A, D, E
Feedback: The comprehensive health history takes place during an annual physical examination, for sports-participation screenings, and during a hospital admission. An emergency history would be done after a car accident. A focused history would be done in the clinic after a fall.

PTS: 1 REF: Page: 28, 29 | Header: Components of the Health History
OBJ: 5
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand

40. Student nurses are practicing taking comprehensive health histories from one another. What components should be included in a comprehensive health history? (Select all that apply.)
A) When coughing began
B) Pain location
C) Pain duration
D) Pain intensity
E) Diet over last three meals

ANS: A, B, C, D
Feedback: Location, duration, intensity, description, aggravating factors, alleviating factors, and functional impairment are components of a comprehensive health history. Asking the client what was eaten for the last three meals does not fall into the definition of a comprehensive health history.

PTS: 1 REF: Page: 28, 29 | Header: Components of the Health History
OBJ: 6
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 2 KEY: Integrated Process: Communication and Documentation
BLM: Cognitive Level: Understand