Name: Ingrid Fortune

93%

NEW YORK CITY COLLEGE OF TECHNOLOGY
DEPARTMENT OF NURSING

NUR 3010

RUBRICS FOR THE HEALTH HISTORY OF AN ADULT

INITIAL INFORMATION/IDENTIFYING DATA	5%
PRESENT ILLNESS	10%
PAST MEDICAL HISTORY	5%
PAST SURGICAL HISTORY	5%
FAMILY HISTORY (GENOGRAM: Narrative & Diagram)	~~5%~~ -3 -2
PSYCHOSOCIAL HISTORY	5%
REVIEW OF SYSTEMS (Subjective Data)	15%
STAGE OF DEVELOPMENT	~~5%~~ -2 3
CULTURALLY APPROPRIATE CARE	5%
DIETARY HISTORY	5%
PROBLEM LIST	10%
SUMMARY	15%
STYLE/MECHANICS (SPELLING, GRAMMAR, PUNCTUATION, ORGANIZATION AND CORRECT USE OF APA FORMAT)	~~10%~~ -2 8
TOTAL	100%

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HEALTH HISTORY OF AN ADULT

INITIAL INFORMATION

1. Date and Time of History: February 18 2015

IDENTIFYING DATA

1. Name: G.R
2. Address: 1145 east 35th street Brooklyn, NY 11210
3. Age: 76
4. Date of birth: 2/05/1939
5. Birthplace: Haiti
6. Gender: Female
7. Marital Status: Widowed
8. Race: African American
9. Ethnic Identity/Culture: Haitian
10. Religion and Spirituality: Christian
11. Occupation: Retired home health aide
12. Health Insurance: Health First
13. Source of history: From Ms. G.R
14. Source of referral (if appropriate)

RELIABILITY:

CHIEF COMPLAINT (s) (CC): Left-sided chest pain

PRESENT ILLNESS (PI): to obtain all details related to the chief complaint.

1. Onset
   a. Date of onset: February 14 2015
   b. Manner of Onset: The onset of pain was very gradual going from little-no pain to a lot
   c. Precipitating and predisposing factors related to onset: Emotional disturbance and physical exertion such as carrying heavy objects.
2. Characteristics
   a. Character: Ms. G.R describes pain as throbbing.
   b. Location and radiation: Pain radiates to the left side of the chest
   c. Intensity or severity: Pain is at an 8 on a scale from 1-10.
   d. Timing: Intermittent. Pain is felt on and off.
3. Course since onset

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a. Incidence: Since onset, it has been a daily occurrence.
b. Progress (better, worse, unchanged): Since onset, the pain has become worse.
c. Effect of therapy: Since onset, Ms. G.R has tried not to lift heavy objects and remain calm. Despite these measures, she said that it helped little to none.

Past Medical History:

Childhood:
1. Illness: Chicken Pox
2. Immunizations: Diphtheria (Tdap), hepatitis A (Hep A), Hepatitis B (Hep B), Measles/Mumps/Rubella (MMR), Meningococcal (MCV), tetanus (Tdap)
3. Allergies: No known drug allergies (NKDA)

Adult:
1. Illness: Hypertension, Coronary artery disease, Obesity (BMI 30.5), Bell's palsy, Osteoarthritis, CVA, Hyperlipidemia, Diabetes mellitus II
2. Substance Use: No history of substance use
3. Adverse Drug Reactions: None
4. Medications: Name, dose, route, frequency, duration, and reason for administration.
   a. Amlodipine 10mg PO q day duration: 12-24hrs-Administered to lower blood pressure and widen blood vessels preventing chest pain.
   b. Carvedilol 25mg PO q12hr duration: 8-10hrs-Administered to lower blood pressure
   c. Clonidine 0.2mg PO 2x/day duration: 24hrs-Administered to lower blood pressure
   d. Lisinopril 40mg PO q day duration: 24hrs-Administered to lower blood pressure
   e. Ranolazin 500mg PO 2x/day peaks 2-5hr-Administered to treat chronic angina
   f. Clopidogrel 75mg PO q day duration: 2hrs- Administered to prevent platelet aggregation in the coronary arteries.
   g. Lantus 26 units SubQ HS duration:24hrs-Administered to lower levels of glucose in the blood
   h. Humalog SubQ 3x/day before meals duration:3-5hrs-Administered to lower levels of glucose in the blood.
   i. Docusate sodium 100mg PO 3x/day duration: 3-5days-Administered to treat constipation and straining during bowel movements
   j. Pantoprazole 40mg PO before breakfast peaks 3-5hrs-Administered to suppress gastric acid secretion
   k. Oxybutynin 5mg PO q day duration: 6-10hrs-Administered to treat symptoms of overactive bladder such as urgency
5. Herbal Supplement/Over the Counter Drugs: Motrin

Past Surgical History:
Ms. G.R. has never had any transfusions done but she did have an Angioplasty done with a stent in place. She was then hospitalized overnight after the procedure was done.

Family History:
1. Immediate Family (Narrative)
2. Extended Family (Narrative)

? -3 you need a narrative of the information contained on the genogram.

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3. Genogram

Psychosocial History:
1. Occupational History: Ms. G.R. worked as a homemaker for 17 years, and then decided to pursue a career as a Home health aide
2. Education: High school Diploma
3. Financial Background: lower-middle class
4. Roles and Relationships: Mother
5. Children and ages: Ms. G.R has 7 sons. Their ages are 54, 52, 48 40, 38, 37 and 35.
6. Sexual History: Ms. G.R admitted to having relations with a total of 5 people.
7. Exercise: Walks 2 blocks per day
8. Pets: 2 cats and 1 dog
9. Exposures (Asbestos, 9/11): None

REVIEW OF SYSTEMS (ROS): to elicit information concerning any potential health problem.

1. General – recently (a month ago) felt fatigue, was constantly tired. She needs assistance with carrying out activities of daily living due to CVA that affected her left side of the body. She said that she has activity intolerance due to her weight. She has trouble walking or exercising for an adequate period of time without feeling tired and worn out.

2. Skin – rash on right foot, left hand and arm. She has hard brittle nails, hair loss and uses black colored dye to make her hair black.

3. Head, Eyes, Ears, Nose, Throat (HEENT)– headaches (once in a while in the morning or evening).
Eyes: She said that she holds books close to face when reading and always squints. She wears glasses and date of last optic exam was March of 2000.
Ears: She said that she is hard of hearing. She constantly asks her children to repeat what their saying and to speak loudly.
Nose and sinuses: Client said that she has stuffy nose, difficulty breathing.
Throat: Client said that she has gum bleeding when brushing her teeth. She brushes her teeth once a day and uses fluoride. Last visit to dentist was February 2012.

4. Neck & Lymphatics – Client said that she has no complaints in this area.

5. Chest – Client said that she has no complaints in this area.

6. Respiratory –Client said that she has frequent colds (3 per year). She has shortness of breath on exertion and frequent sputum production. Her date of last chest x-ray was September 2012 and date of last tuberculin test was November 2014.

7. Cardiovascular– Client said that she has fatigue on exertion and history of coronary artery disease.

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8. Gastrointestinal – Client said that she has an appetite, a bowel movement 3x/week, tolerates food well, constipated and has nausea from time to time.

9. Urinary – Client said that she has urinary urgency, nocturia and polyuria

10. Genital- Female: Client said that her last menstrual cycle was 28 years ago, has white vaginal discharge, last pap was 2012 and the results were normal, last mammogram was in 2012 and results for that were also normal.

11. Peripheral Vascular- Client said that she often gets leg cramps when walking and has a little bit of varicose veins.

12. Musculoskeletal- Client said that she has full range of motion capability on right side of body but range of motion on left side of body is limited (legs, arms, hands)

13. Neurologic- Client said that she once had a loss of consciousness which occurred 7 years ago while walking her dog outside her home one day.

14. Hematologic- Client said that she does not have any complaints in this area.

15. Endocrine- Client said that she occasionally has excessive thirst, hunger and shoe size has gotten bigger.

16. Psychiatric- Client said that she can be very moody, often going from being happy one moment to being sad and depressed the next.

STAGE OF DEVELOPMENT

Integrity vs. Despair

Describe the developmental task and the core problem

ACTUAL FINDINGS

Ms. G.R has Ego Integrity. She expressed to me that she is very well satisfied with the life that she lived and that she has accepted the idea of death and is prepared.

Enhancing Culturally Appropriate Care

Describe how you made your client feel more comfortable during the interview/health history.
I am familiar with the Haitian culture, so I came into the interview prepared knowing what to expect and how to conduct myself. During the interview, I made my client feel more comfortable by allowing her to have some control of the interview. I spoke slowly and allowed enough time for her to respond after each question. I provided her with respect by not being rude and by calling her by her last name. I was also not judgmental towards her and made sure to limit eye contact as I know that her culture forbids that when it comes to an older adult verses a younger adult.

DIETARY HISTORY

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A nutritional assessment is an essential part of a complete health appraisal. Its purpose is to evaluate the client's nutritional status – the state of balance between nutrient expenditure and need.

What is the family's usual mealtime? 10:00am, 5:00pm 8:00pm
Do family members eat together or at separate times? Separate times
Who does the family grocery shopping and meal preparation? Ms. G.R's son
How much money is spent to buy goods each week? $100.00
How is most food prepared – baked, broiled, fried, and other? Fried
How often does the family or the client eat out? Four times a month
What kind of restaurants do you go to? Haitian restaurants
What kind of foods do you typically eat at restaurants? Fried pork, chicken, rice and beans, fish
Do you eat breakfast? Yes
Where do you eat lunch? At home
What are your favorite foods, beverages, and snacks? Fried pork, fried plantains, barbecue chicken, soda, potato chips
What is the average amount eaten each day? 3400 calories
What foods are artificially sweetened? Coffee, soda
What are your snacking habits? After each meal or when hungry
When are sweet foods usually eaten? Whenever I'm sick (e.g. honey) or blood pressure drops (candy).
What are your tooth brushing habits? I brush my teeth once a day; in the morning when I wake up.
What special cultural practices are followed? Home remedies such as making our own medicine and treatments.
What ethnic foods are eaten? Rice, Plantain, Cassava, Potato, Cornmeal, Oatmeal, Pasta and Bread
What foods and beverages do you dislike? I dislike all types of vegetables, orange juice, grape juice and peanuts.
Do you use bottled water for drinking? No, I use tap water.
Do you use a microwave for cooking and reheating foods? Yes, sometimes
How would you describe your usual appetite (hearty eater, picky eater)? A little bit of both. I eat foods that taste good.
What are your feeding habits (eats by self, needs assistance, and special devices)? I eat by myself and do not need any assistance.
Do you take vitamins or other supplements; do they contain iron or fluoride? I do not take and vitamins or other supplements
Are there any known or suspected food allergies? No
Are you on a special diet? Low carb diet
Have you lost or gained weight recently? Gained weight recently, around 8lbs.
Do you have any feeding problems (difficulty swallowing), any dental problems or appliances, such as dentures, that affect eating? No problems with difficulty swallowing or any dental problems. I do wear dentures but it does not affect my eating.

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PROBLEM LIST

1. Client complains of left sided chest pain on exertion.
2. Client reports headaches once in a while in the morning and evening.
3. Client has activity intolerance due to her weight (BMI 30.5).
4. Client complains of knee pain due to osteoarthritis.
5. Client has trouble performing her activities of daily living due to her left-sided CVA.
6. Ms. G.R said that she holds books close to her face when reading and likes to squint.
7. Ms. G.R brushes her teeth once per day and her last visit to the dentist was Feb of 2012
8. Constipation
9. Urinary urgency
10. Ms. G.R says her gait is not steady and is afraid she might fall one day on the way to the bathroom for example.

Excellent summary of health history & judgment of problems

SUMMARY OF RECOMMENDATIONS

Ms. G.R. complains of chest pain on exertion so I recommended that she not lift anything above 10lbs. I also recommended that she should try to behave in a calm manner whenever

possible and to go to the hospital as soon as she can to assess the matter. Since she has CAD, one of her coronary arteries may have become occluded or narrowed extensively. For Ms. G.R's headaches that she reports to be experiencing from time to time, I advised her that it is important for her to take her medication on time. She needs to take the exact dose that's prescribed and at the same time every day to avoid the spikes in blood pressure. Ms. G.R's weight is related to her not being able to be as active as she wants to be. I recommended that she increases her activity level little by little each day to build up some tolerance. I informed her also that this will make her lose weight, making it easier to perform various activities. In addition to losing the weight, this will help Ms. G.R with her osteoarthritis. I explained to her that there is a lot of weight bearing down on the knees making it even more painful. I told her that in order for her to alleviate the pain, its best to lose the weight not only by exercising but by eating the right healthy foods in correct portions. Due to Ms. G.R's left side of the body not being as strong as the right, poses an issue for her. I recommended that her son that she lives with her help her out with her ADLs such as cooking, cleaning and grocery shopping.

Although Ms. G.R does wear glasses, I recommended that she go and see the eye doctor again since her last appointment was March of 2000. I informed her that her eyes may have gotten worse or they may have given her the wrong prescription. I also suggested to Ms. G.R that she goes to see the dentist twice a year and that she brushes her teeth twice a day and that once a day is not enough. I explained to her all the consequences that could result if she does not do so. Since my client says that she gets constipated very often, I recommended that she drinks at least 6-8 cups of water per day and that she moves around frequently. I stressed the importance of taking the Colace with fluids to help her stools pass without straining. As far as Ms. G.R's

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urinary urgency problems, I suggested that she goes to the doctor. While there, they may prescribe her some anticholinergics to relax the bladder. This will help the bladder to stop contracting as much and possibly eliminate her problem. Also, due to my client's gait not being steady, I recommended that Ms. G.R start thinking about the possibility of having an assistive device such as a walker. I informed her that this will help her tremendously when walking and will allow her to achieve a steadier gait, decreasing her chances of falling in the future.

Use APA style inclusive of cover page, page number and references

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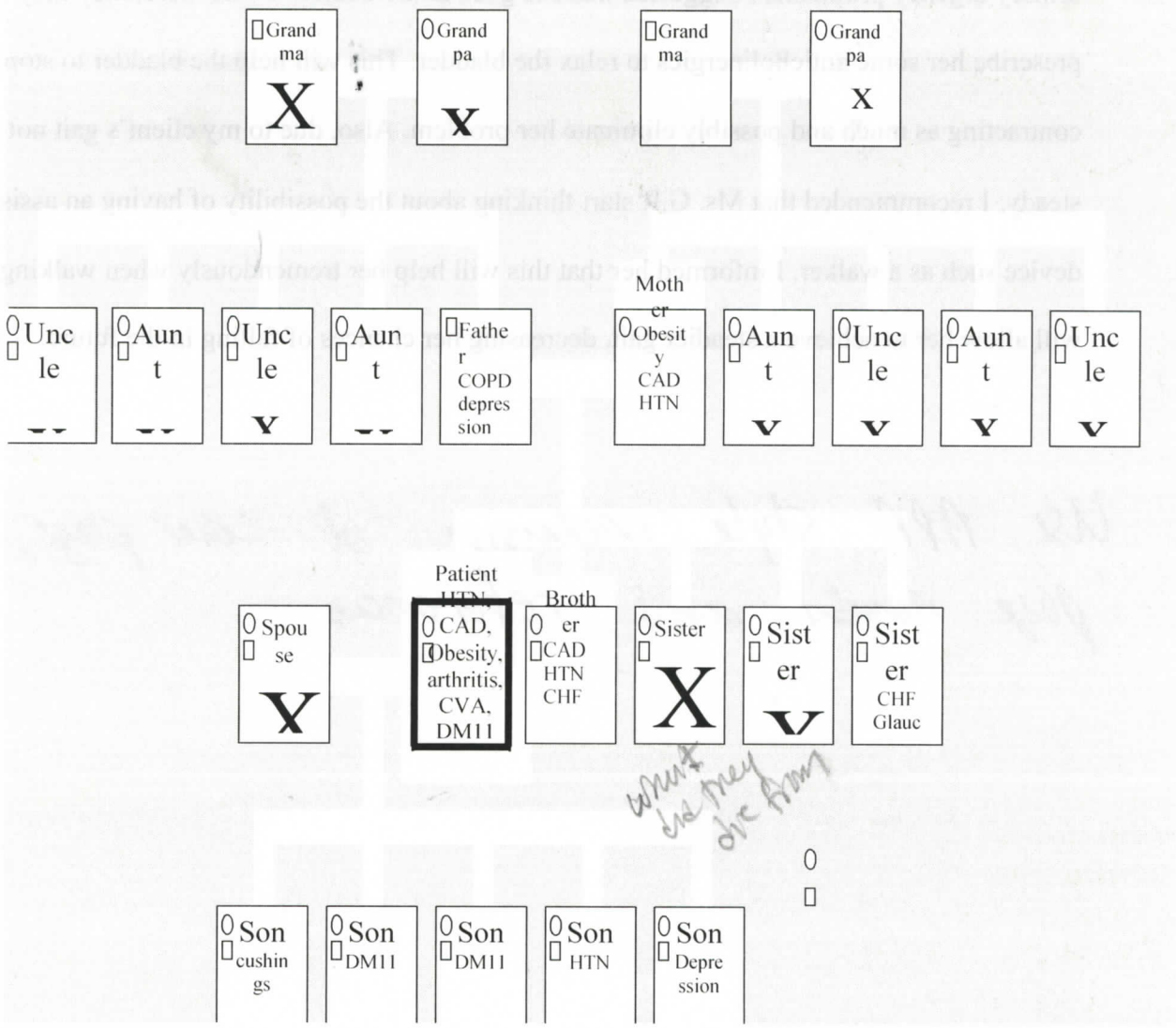

Genogram:
X deceased cause of death or any health problems