4- The Health History

- **1-Biographical Data: This includes**
- Full name
- Address and telephone numbers (client's permanent contact of client)
- Birth date and birth place.
- Sex
- Religion and race.
- Marital status.
- Social security number.
- Occupation (usual and present)
- Source of referral. الاحاله
- Usual source of healthcare
- Source and reliability of information.
- Date of interview.

- **2-Chief Complaint CC & Reason for seeking health care**
- Examples of chief complaints:
- Chest pain for 3 days.
- Swollen ankles for 2 weeks.
- Fever and headache for 24 hours.

3-History of Present Illness HPI

HPI is a chronologicalمرتب زمنيا story of what has been happening

Ten characteristics of each cc can be ascertained for a complete HPI:

location ,

radiation,

quality,

quantity

associated symptoms,

aggravating factors,

alleviating factors,

setting,

timing

meaning and impact

SYMPTOM ANALYSIS

P Q R S T

a. Provocative استفزازیPalliative or alleviating

First occurrence :

What were you doing when you first experienced or noticed the symptom?

What to trigger it ? stress? Position?, activity?ما يحركها

What seems to cause it or make it worse? For a psychological symptom .

What relieves the symptom : change diet? Change position ? Take medication ? Being active?

Aggravation: what makes the symptom worse?

b. Quality Or Quantity

QUALITY: How would you describe the symptom- how it feels, looks, or sounds?

QUANTITY: How much are you experiencing now?

Is it so much that it prevents you from performing any activity?

C. Region Or Radiation

Region : Where does the symptom occur?

Radiation : Does it travel down your back or arm, up your neck or down your legs?

d. Severity scale

Severity :-How bad is symptom at its worst

Course:- Does the symptom seem to be getting better, getting worse?

e-Timing

Onset : On what date did the symptom first occur

Type of onset : How did the symptom start sudden? Gradually?

Frequency : How often do you experience the symptom ; hourly ? Daily ? Weekly? monthly

Duration : How long does an episode of the symptom last

4- Past Health History PHH:

The purpose: (to identify all major past health problems of the client)

This includes: Childhood illness e.g. history of rheumatic fever

History of accidents and disabling injuries

History of hospitalization (medical H.) (time of admission, date, admitting complaint, discharge diagnosis and follow up care.

History of operations(surgical H.) "how and why this done"

History of immunizations and allergies.

History of any Communicable diseases and History of Medications.

5-Family History

Family history of communicable diseases.
Heredity factors associated with causes of some diseases.
Strong family history of certain problems.
Health of family members "maternal, parents, siblings, aunts, uncles…etc.".
Cause of death of the family members "immediate and extended family".

6-Social history

Alcohol use
Tobacco use
Drug use
Domestic and intimate partner violenceالعنف المنزلي والعنف الشريك
Sexual practice
Travel history
Work environment
Home environment
Hobbies & leisure activities
Stress

7-Health maintenance activities

Sleep
Diet
Stress management
Use of safety devices
Health check –ups

Review of Systems (ROS)

Collection of data about the past and the present of each of the client systems.

(Review of the client's physical, sociologic, and psychological health status may identify hidden problems and provides an opportunity to indicate client strength and disabilities)

General - recent wt. change, fatigue, fever

Skin - rashes, lesions, changes, dryness, itching, color change, hair loss, change in hair or nails

Eyes - change in vision, floaters, glasses, pain

Ears - pain, loss of hearing, vertigo, ringing, discharge, infections

Nose and sinuses - frequent colds, congestion, nosebleed

Mouth and throat - condition of teeth and gums, last dental visit, hoarseness, frequent sore throats

Neck - lumps, stiffness, goiter

Breasts - lumps, pain, discharge,

Respiratory - cough, sputum, wheezing, asthma, Chronic Obstructive Pulmonary Diseases, last PPD, last Chest X Rays, smoking history (can do here, or with “habits”)

Cardiac - heart trouble, chest pain, Shortness of Breath, murmur, history of rheumatic fever, past ECG, Family History of heart disease <50 yrs. of age

GI - problems swallowing, heartburn, vomiting, bowel habits, pain, jaundice

Urinary - frequency, incontinence, pain, burning, hesitancy, nocturia, polyuria

Genitalia - lesions, discharge, sexual orientation, sexual function, menstrual history, contraception, pregnancy history,

Peripheral vascular - intermittent claudication, varicose veins, blood clots

Musculo-Skeletal - muscle or joint pain, redness, stiffness, warmth, swelling, family history

Neuro - fainting, blackouts, seizures, weakness

Endocrine - sweats, skin change, heat or cold intolerance, excessive thirst (polydipsia), excessive urination (polyuria), weight change, menstrual changes

Psychiatric - mental illness, thoughts of harming self or others

Vital signs

A. Temperature

Body temperature is difference between heat produced and heat lost. The hypothalamus acts as the body's thermostat to maintain between the body's heat-producing function (metabolism, shivering, muscle contraction, exercise and thyroid activity) and heat losing methods (radiation, convection)

Method of measurement

a. Oral b. Rectal c. Axillary d. Electronic e. Tympanic

5/9*(F-23)=C (9/5*C)+32=F

B. Pulse

The pulse reflects the force of the heart contracting. Also reflects stroke volume, the mount of blood ejected with each contraction.

A pulse deficit (a difference between the apical and radial pulse rate)

Factors influencing of pulse

1. Pain 2. Emotion 3. Exercise
4. Prolong heat application
5. Decrease BP, and increase temperature.
6. Poor oxygen in the blood.

Remember

Palpate the radial pulse and count for at least "30" second.

If the pulse is irregular, count for full minute and note the number of irregular beats per minute.

Note is the pulse against your finger strong or weak (Amplitude of rhythm)

Rate:60-100 time per min.

Age Group	Heart Rate
Preterm	120-180
Newborn (0 to 1 month)	100-160
Infant (1 to 12 months)	80-140
Toddler (1 to 3 years)	80-130
Preschool (3 to 5 years)	80-110
School Age (6 to 12 years)	70-100
Adolescents (13 to 18 years)	60-90

Rhythm: regular or irregular
Amplitude (volume): Scale

Absent	0
Thready /weak	1
Normal	2
Bounding	3

Site of pulse
Temporal, Carotid, Brachial, Radial, Femoral, Dorsalis Pedis , Popliteal, Posterior Tibia and Apical

. C. Respiration:
Count the number of respiration (rate), in full minute Respiration: normally "12-20 breath/minute" (for healthy adult person).
Note rhythm (regular or irregular) and depth of breathing (reflects the tidal volume, described as shallow or deep breathing).
Factors influencing of reparation

1. Age
   Newborn 40 breath / minute ,
   1 year 30 breath / minute ,
   6 year 19 breath / minute,
   10 year 18 breath / minute ,
   18 year 18 breath / minute
2. Any disease 3. Exercise 4. Emotion

D. Blood pressure:

Measure Blood Pressure in both arms.

Pulse pressure: the difference between the systolic and the diastolic pressures (normally is 30 to 40 mm Hg)

Note position of client when measuring blood pressure.

Monitor blood pressure after client is seated or supine quietly for "10" minute.

Repeat after two minutes. Then repeat with client standing.

Factors influencing the BP

1. Age

    Newborn 40 mmHg/systolic / 20 diastole

    1 month 84/54 mmHg

    1 year 95 /65 mmHg

    6 year 105 / 65 mmHg

    10 – 13 year 120 / 80 mmHg

    14- 17 year 120/80 mmHg

    18 year 120/80 mmHg

Normal range 100 – 140mmHg (systolic) and from 60-90 mmHg/(diastolic)

2. Sex 3. Emotion 4. Position: Laying down

4. After meal 5. Exercise