Complete Health History

Kristie Bruesch

Ferris State University

Complete Medical History

Date: 9-17-16

Patient name: Mr. Chad.E.B DOB: 4-7-72 Age: 44 Marital: Single Sex: Male Informant: Patient, who is reliable, name and DOB confirmed. Occupation: Carpenter

Height: 6 foot 2 inches Weight: 255 pounds BMI: 32.7

Address: 1015 S. Livingston St, Whitehall, MI 49461 Cell Phone: 231.206.7106

Location: Private home Insurance: Self pay Religion: none

Emergency contact: Kristie Bruesch (fiancé) - 231.893.2065 .

**Vital Signs:** 98.4 temperature, 82 heart rate, 20 respiration, 132/76 blood pressure, 98% pulse ox

**Reason for Seeking Care:** Left knee pain when walking and bending. Intermittent pain, sharp and stabbing feeling. 6/10 pain scale when pain arises. Able to perform tasks at slower rate than average, often feels like the knee may “give out”. Pain initiated after playing baseball and hitting ball one year ago and has progressed in pain and intermittence in the last three months. Patient acknowledges the possibility of needing treatment for knee based on diagnosis. Resting alleviates the pain, no other treatment initiated. Running exacerbates the pain, patient avoids running. Educated patient on need to perform complete health history and will acknowledge complaint.

**History of present illness/condition/surgery:** Right arm surgery from car accident 20 years ago, patient states has one plate and six pins in arm.

**Past Medical History:** Epilepsy as a child, patient has little knowledge of episode. States “just went away” with no treatment. Car accident 20 years ago, right arm break and 250 stitches in mouth. Patient states “fell asleep at the wheel and hit a tree going 70mph”, face hit the steering wheel, wearing seatbelt.

**Allergies (food, medicines, environmental):** none

**Medications, Supplements, Treatments:** none.

**Chemical Use:** Patient denies cigarette use. Patient admits to chewing tobacco on daily occurrencefor 15 years, patient states chewing is a habit. Educated patient on risks of chewing and patient prefers no further education needed and does not plan to quit. Patient drinks four cups of coffee daily in the morning and follows with one energy drink in the afternoon, three to four times per week. Educated patient on the risk of energy drinks. Patient admits to drinking alcoholic beverages, beer, on a weekly basis, estimates 12 beers per week, patient states “I like the taste of beer”. Patient educated on the risks of drinking and informed of normal drinking habits. Patient states “I am fine with how much I drink”.

**Rest and Sleep Patterns:** Patient works eight hours per day with zero rests/nap periods. Patient sleeps approximately six hours per night, and needs no sleep aid, patient states there is not a sleep problem.

**Mobility/Exercise:** No daily exercise pattern, patient states job “keeps me busy”. Patient states job is building homes, lifting heavy wood, and a fast paced environment. Patient is able to care for himself with daily activities and needs no assistance.

**Diet:** General diet, patient unable to recall caloric intake. 24 hour recall inquired. Usual time of meals at home is 0800, 1200, and 1700 with occasional snack around 2100. Patient has no difficulty in feeding self, no dentures. Rare dental exams stated due to no insurance. Fluid intake per day: four cups of coffee, an occasional 12 ounce energy drink and approximately 24 ounces of water.

Breakfast: French toast. Lunch: Pizza. Dinner: Buffet at Ponderosa. Snack: Ice cream.

Educated patient on health risks of excessive caloric intake with unhealthy foods. Educated patient on BMI status and referred patient to dietician to improve diet intake.

**Elimination:** Patient states having bowel movements two times per day, formed to soft and brown in color. Urinary habits states no less than four times per day, with no burning, frequency, or small amounts.

**Communication:** Patient speaks fluent English. Hearing and eye test performed, passed, and patient has no concerns with hearing or visual. Patient has a 12th grade high school education with diploma. Orientated to person place and time. Patient appears calm and relaxed during exam.

**Activities:** Patient partakes in golfing, hiking on vacation, fishing, hunting and camping. Patient denies other employment, or volunteer work.

**Family History:** See table.Paternal and Maternal Grandparents deceased, unknown reason. Mother has history of breast cancer, father has early onset dementia and Parkinson disease. Sister has history of shoulder repair with unknown diagnosis. All siblings are on anti-depressant medications. Niece, Paris has history of lump on neck which was removed, benign. Nephew, miles has speech impediment. Daughter, Sydney age 19 was born missing hand. Son, Colton age 14 has right eye stigmatism. Patient lives in owned home in the city with city water. Living with fiancé for seven years, who has two boys age 10 and 21, son lives one week on, one week off. Sydney and Madison, age 17 does not live in house. Household pets include one dog and two cats. Financial means stable with support from self and fiancé. No further needs for community support.

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| **REVIEW OF SYSTEM** | **HISTORY** | **ASSESSMENT** |
| **General Overview** |  | **Pt appears to be a clean well-kept male. Appears to be obese in size, tall. Appropriate and relaxed for examination.** |
| **Skin/Hair/Nails** | **Pt states having sunburn frequently due to complexion** | **Moderate freckles entire body, fair skin tone, no pigmentation, no rash noted. Hair is thick, non-brittle, fair amount of greying. Beard is red toned and thick. Nail beds-formed, pink, cap refill <3 secs** |
| **Head/Neck** | **No complaints of pain, headaches, dizziness, lumps.** | **Symmetrical, lymph nodes palpated normal, ROM within normal limits (WNL), facial scarring on chin noted from car accident. Thyroid WNL, trachea midline,** |
| **Eyes** | **No complaints of blurred vision, visual disturbances, redness, swelling, discharge or watering.** | **Eye exam passed, Eyes symmetrical, schlera white, moist and glossy, cornea smooth and clear, accommodation WNL.** |
| **Nose/Sinus** | **No complaints on discharge, or smelling.** | **Patient nose symmetrical, no drainage noted. Sinus percussion WNL, no tenderness.** |
| **Ears** | **Patient complains ears are sunburned in the summer due to exposure of environment. No complaints of earaches, discharge, vertigo, hearing loss.** | **External visual appears to be peeling on bilateral ears. Tenderness noted on physical touch. Internal exam not performed. Symmetrical and equal size. Hearing test passed.** |
| **Mouth/Throat** | **Patient has no complaints of mouth or throat pain, tenderness, tasting. Patient states having history of dental pain in past with cracked tooth.** | **No lesions noted in mouth or throat, moist and pale membranes noted, dental noted with missing/cracked yellow teeth. Saliva WNL. Tonsils appeared pink and non-enlarged.** |
| **Respiratory** | **Patient (pt) has no complaints of difficulty breathing, cough, chest pain, or respiratory infections.** | **Anterior/posterior lung sounds clear to auscultate in all fields. Chest symmetrical with breathing. Percussion WNL. No lumps noted. Tactile fremitus normal. Diaphragmatic excursion WNL. Voice sounds WNL. Pt had no difficulties in performing tasks.** |
| **Cardiovascular** | **Pt has no complaints of chest pain, dyspnea, fatigue, edema, cough, dyspnea, or past cardiac history.** | **Heart rate WNL all 4 valves, s1/s2, regular rate and rhythm. Carotid artery palpated, WNL. No bruit. Jugular pulse palpated, WNL. Apical pulse palpated, WNL. Radial, brachial, popliteal, pedal pulse palpated, WNL. Extremity color noted pink and WNL.** |
| **Gastrointestinal** | **Pt has no complaints of abdomen pain, nausea/vomiting, or food intolerance.** | **Bowel sounds are active in all four quadrants, no bruits noted, Appearance is protuberant, soft to palpate, non-tender, umbilicus is midline and inverted. No presence of lumps on palpation.** |
| **Breasts/axillae** | **Patient has no complaints of pain on chest wall.** | **Symmetrical, no lumps noted. Nipples erect and symmetrical, WNL.** |
| **Genitourinary** | **Pt has no complaints of pain, dysuria, hesitancy, frequency, lesions, or discharge.** | **Pt declined exam.** |
| **Musculoskeletal** | **Pt complains of left knee pain. No other complaints of joint/muscle/bone pain, stiffness, or swelling.** | **ROM completed on bilateral arms, hands, neck feet, right leg, WNL. Left knee extension/retraction tender and a “click” sound can be heard. No warmth or redness noted, ROM WNL with tenderness. Left foot ROM WNL. Extension and flexion of torso WNL.** |
| **Neurologic** | **Pt denies headache, head injury, tremors, weakness, numbness or tingling, difficulty speaking, or swallowing. Pt states having epilepsy as a child, unable to remember incident or treatment. Has not had episodes since age 5 or less.** | **Cranial Nerve**  **I-WNL, II-WNL, III-IV-VI-WNL, IV- WNL, V- WNL, VII- WNL, VIII- WNL, IX-X- WNL, XI- WNL, XII- WNL.**  **Muscles of the hands, arms, legs and feet- strength, tone, balance, WNL. DTR 2+ in all fields.** |
| **Other Pertinent Data** |  |  |

Reflection

In performing the complete health history, I reflected back to my earlier years as a nurse. The information to perform as a naïve nurse brings the nurse back to nursing school and what is taught step by step. I am employed at a community college where I help with lab test outs of nursing students and see these assessment skills performed through memorization. I found Jarvis to have solidarity in each chapter to perform the complete health history in a systematic order (Jarvis, 2016). As an experienced nurse, these steps are not always followed in routine admission of a labor patient in which my career is in. Trends are created to ask pertinent information when patients present in labor and if there seems to be an issue then the issue is further assessed. I cannot remember the last time I performed a full neurologic exam on a patient including all the cranial nerves. However, if a patient presents with signs of distress, those would be assessed. This assignment was a great way to show how some assessments are lost over time and how trends are created.

Nothing new was found in the complete health history which was not already known prior to the exam. The exam was a great way to re-educate a family member on nutrition and substance use criteria. The risks which come with the substance use and not partaking in a healthy nutritious diet are great way to open the mind of patients.

Reference

Jarvis, C. (2016). *Physical examination & health assessment.* (7th ed.). St. Loius: Elsevier.