

Running head: PEER HEALTH HISTORY

Peer Health History

Lucretia Shafer

Pacific Lutheran University

HEALTH HISTORY

BIOGRAPHICAL DATA

Date of assessment: 2/22/05
 Examiner's name: Lucretia Shafer
 Client's initials: N.H.
 Gender: Female
 Age: 34
 Educational Level: 2+ years of college
 Ethnic group: Caucasian
 Marital status: Married
 Religious preference: Christian

MEASURED DATA

Height: 5'6"
 Weight: 158 lbs
 Vital signs:
 Temperature: 98.6 F
 Pulse: 68
 Respirations: 12
 Blood pressure: 118/88
 Pulse oximetry: 99%

HEALTH PERCEPTIONS AND HEALTH MANAGEMENT

SUBJECT DATA:

Reason for seeking care: "I am attending PLU Nursing School and I am nervous about the semester. I am not sick."

Childhood illnesses: Client states no memory of childhood illnesses.

Surgeries and Hospitalizations: Client reports Cesarean Sections 2001, 2002

Accidents/Injuries: Client denies accidents and serious injuries.

Medications: Client reports: generic Tri-Sprintec, Advil or Tylenol prn for infrequent headaches.

Allergies: Denies any drug, food and environmental allergies.

Immunizations: Client reports:

HepatitisB 5/3/04, 6/8/04

DTaP 5/3/04
 MMR 5/3/04, 6/22/04
 Varicella 5/3/04
 HepatitisA 5/3/04, 6/8/04, 11/8/04
 TB Skin test 6/22/04, 8/3/04

Last examinations: Reported by client: Physical and Pap smear: 2/2004. Dental: 2-3 visits last year. Vision: 2000

Family History: Client is poor family historian. Maternal Grandparents, unknown; Paternal Grandparents, unknown; Mother, age 54, healthy; Maternal Uncle, unknown; Father, unknown; Sister, 5 yrs younger, born with unknown heart defect, surgery to correct defect at 6-years-old, healthy now; Sister, 10 yrs younger, healthy; Husband, healthy. Client reports both children healthy. Denies knowledge of any family history of stroke, diabetes, kidney disease, allergies, seizure disorders, mental disorders or heart disease.

Personal and Psychosocial History: Client describes herself as a Caucasian Russian, born in Pskov, who has been in the United States for 5 years. Reports 2+ years of college and is currently a full-time student and mother of 2 preschoolers, which can be “overwhelming at times”. Client lives with her American husband, 2 children, and her sister, in the same house as husband’s retired parents but have separate living quarters. Client states she is responsible for the shopping, laundry, housework and most of the childcare, shares the cooking with sister. Hobbies include reading, playing violin and piano, listening to classical music. Husband works at home. They have medical insurance but no dental. Client defines “being healthy” to be when “nothing hurts; feeling good all over, in general” and visits doctor “only when I have to”. Client reports need for regular exercise and “otosclerosis” in left ear Dx in 2001. Client denies use of ETOH, tobacco, illicit drugs, and caffeine.

OBJECTIVE DATA:

34 y/o Russian female, looks young for age, fair completion, no blemishes, clean and well-kempt; sits with erect posture; good eye contact. Communication: Fluent English with moderate accent. No obvious physical difficulties or deformities. Cooperative, not overly talkative. Scored 28/40 on the Health Perception/Health Maintenance portion of the Self Assessment test. Answers indicate inadequate regular daily exercise and monthly breast self-exam.

PROBLEMS LIST:

Unknown family history

Insufficient self-health promotion/assessment

NURSING DIAGNOSES:

Health maintenance ineffective R/T attitude about doctors, poor family history AEB statement about doctor visits and lack of knowledge of family health history.

Health seeking behaviors ineffective R/T inadequate participation AEB low score on regular exercise and monthly self breast exams.

VALUES AND BELIEFS

SUBJECTIVE:

Client reports growing up in Muslim culture, being family oriented, valuing truth and purity, with strong gender roles. Denies being “religious” but believes in “a God” and sometimes prays. “Illness has to do with who you are--anger, stress, wrong-doing impairs health. If you are happy, you will have good health.”

OBJECTIVE:

Client answered questions confidently and easily. Spirituality section of Self Assessment test score 25/40 indicating comfort with personal beliefs.

PROBLEM LIST:

None

NURSING DIAGNOSES:

None

SLEEP AND REST

SUBJECTIVE:

Client reports no difficulty falling asleep or staying asleep. Reports average of 6 hours of sleep per night with no daytime naps, children wake her up 1-2X per night, husband snores.

Indicates no difficulty falling back to sleep. Reports difficulty getting up in the morning.

Denies use of caffeine (<1 cup per day), alcohol, sleep aids, narcotics, amphetamines, antidepressants and barbiturates.

OBJECTIVE:

Client appears tired, with low energy, dark circles under eyes.

PROBLEM LIST:

Insufficient amount of sleep

Interrupted sleep

Tiredness

NURSING DIAGNOSES:

Sleep deprivation R/T family responsibilities AEB reported amount of sleep per night and sleep interruptions.

ROLES AND RELATIONSHIPS

SUBJECTIVE:

Client reports “happily married” with 2 children (4 y/o and 2 y/o); client’s younger sister also included in family. States there is a “definite division of labor” where she is the children’s caregiver and the keeper of the house, husband takes care of the finances and chores (i.e. take out garbage, build fire, household repairs). Reports “As a mother, I do OK but sometimes I want to send them to school, or get rid of them.” Reports occasional communication problems caused by language difficulties. Denies any abuse, financial problems, marital concerns, discipline problems.

OBJECTIVE:

Client is in the early stage of Erikson’s “Generativity vs Stagnation” and is proceeding appropriately AEB marriage, the ability to maintain emotional and sexual intimacy, children, enrollment in Nursing school. 33/40 score in the Roles/Relationships portion of the Self Assessment indicating the same.

PROBLEM LIST:

High number of responsibilities

High emotional demands on client

NURSING DIAGNOSES:

Impaired parenting, at risk for, R/T nursing school AEB verbal complaints about children

Caregiver Role strain, at risk for, R/T time pressures AEB division of labor in home.

STRESS AND STRESS RESPONSE

SUBJECTIVE:

Client reports starting Nursing school ;“it is very stressful”. Reports no other problems cause her stress. States feeling annoyed when stressed and sometimes depressed. Indicates

shopping, getting out of the house, talking with husband and sister help relieve stress. Client states, "School stress does not go away"; states above methods relieve other stresses.

OBJECTIVE:

The client's Holmes Stress test score 124/1435 putting her well below 150 points, indicating normal, manageable amount of stress. BP 118/88; HR 68. Appears calm, patient. Client's CC is stress caused by school. Coping/Stress Tolerance Self Assessment test indicates inadequate relaxation/coping practices AEB low scores for coping behaviors.

PROBLEM LIST:

Anxiety R/T school

Inadequate relaxation techniques

Ineffective coping skills

NURSING DIAGNOSES:

Ineffective Individual Coping R/T full-time Nursing school responsibilities AEB verbal complaint of stress that does not go away, inadequate amount of sleep, irritability, lack of patience with children.

SELF CONCEPT

SUBJECTIVE:

Client describes self as quiet, not outspoken, fun to be with. Reports no need to express her views in a group, is content to listen to others. Indicates she would like to lose 10 lbs "but wouldn't we all?" Denies dissatisfaction with body image, suicidal thoughts, desire to change anything about herself. Reports school is distressing; needs more time in the day. Indicates doesn't "do enough as a student", should work harder.

OBJECTIVE:

Client's Center for Epidemiologic Studies Depression Scale score was 11/60 indicating no depression in the last week; scored 28/40 on Self-Perception/Self-Concept of Self-Assessment test which indicates a positive self-image. Self-Assessment test indicates client is reticent to express her own feelings.

PROBLEM LIST:

Lose 10 lbs

Reticence to express personal feelings and attitudes

Worries about school

NURSING DIAGNOSES:

Fear of failure R/T school pressures AEV client's verbal comments about school and reticence to voice her feelings.

ACTIVITY AND EXERCISE

ACTIVITY LEVEL:

SUBJECTIVE:

Client reports sedentary lifestyle. States "I know I should be more active, but I don't like to exercise". Reports no other physical, emotional or environmental influences that interfere with ADLs, essential or desired.

OBJECTIVE:

Client's Three Day Activity Log indicates a pattern of no regular exercise except what is achieved through daily activities. Client scored 16/40 in the Activity/Exercise portion of the Self-Assessment of State of Health.

CARDIOVASCULAR SYSTEM

SUBJECTIVE:

Client reports no chest pain, palpitations, rhythm irregularities, edema, indigestion, N & V, or nocturia; no changes in sensation or appearance of extremities; no episodes of SOB, paroxysmal nocturnal dyspnea; no visual disturbances, syncope or fatigue; no unusual weight gain or loss. Client reports no smoking, “good, healthy diet”, no knowledge of family Hx of heart disease, HTN, DM. Client states “not concerned about cholesterol”.

OBJECTIVE:

Client is sitting, erect, at ease. Breathing regular, even, unlabored. Chest anterior wall noted. S1, S2 noted. No S3, S4, murmurs or rubs. No lifts, heaves or thrills. Regular heart rate and rhythm. Jugular noted. No undulation, distention. Carotid noted. No bruits. Upper extremities warm, pink, skin intact. Capillary refill +1, skin turgor, elastic, no tenting. Bilateral radial pulses equal, +2. Lower extremities: toes cold, pale, feet warm. Skin dry, intact. Capillary refill +2. No edema; skin turgor elastic, no tenting. Bilateral dorsal pedis pulses equal, +2.

RESPIRATORY SYSTEM

SUBJECTIVE:

Client reports no Hx of dyspnea, cough, sputum production, seasonal or environmental allergies, smoking or second hand smoking.

OBJECTIVE:

Client is sitting erect; skin pink, warm, dry and intact. AAOx4. Nails and MM pink, capillary refill brisk, toes and hands cool. Thorax symmetrical; AP, musculature and bone structures, and trachea noted. Breathing regular, even, unlabored. Palpation: no tenderness, buldges, thoracic expansion and symmetry noted. Vocal fremitus present and symmetrical.

Both lungs equal and resonant posterior, lateral and anterior. Breath sounds WNL for inspiration and expiration.

MUSCULOSKELETAL SYSTEM

SUBJECTIVE:

Client reports no pain, swelling, weakness, limitation of movement, stiffness, numbness or tingling in any muscle or joint. States, "I am fine, I have no problems".

OBJECTIVE:

Posture erect, symmetrical, aligned. Bilateral muscle symmetry noted. No tenderness, redness, heat, inflammation noted on examination of joints and muscles. Muscle strength and ROM noted, no abnormal rotation, flexion or extension weakness or limitations. Joints stable. Gait noted for conformity, symmetry and rhythm. No abnormalities.

HEMATOLOGICAL SYSTEM

SUBJECTIVE:

Client reports no symptoms of fatigue, weakness, chills, fever, weight loss, heat intolerance, night sweats, slow healing, apathy, lethargy, malaise, bleeding, excessive bruising, jaundice, pruritus, pallor, epistaxis (nose bleeds), bleeding gums, mouth sores, dysphagia, persistent hoarseness, emboli, hemoptysis (coughing up blood), bloody stools or urine, liver disease, ulcers, change in bowel habits, vit K deficiency, Etoh abuse, problems with menses, bladder dysfunction, or UTIs.

OBJECTIVE:

Based on observable data, no evidence of hematologic abnormalities.

PROBLEM LIST:

Lack of weight bearing exercise

Lack of flexibility and stretching exercise.

NURSING DIAGNOSIS:

Risk for activity intolerance r/t low level of daily exercise AEB client's negative attitude regarding exercise, BMI=25 (25-29.9: overweight), lack of regular physical exercise as shown by 3-day activity log.

NUTRITION AND METABOLISM

ELIMINATION

ACTIVITY AND EXERCISE

COGNITION AND PERCEPTION

SEXUALITY AND REPRODUCTIVE FUNCTION

Obstetric History: Client reports: G2, T2, P0, L2. 2001 cesarean section, baby breech, 8 lb 3 oz healthy girl, no complications; 2002 cesarean section, 11 lb 4 oz healthy boy, no complications.