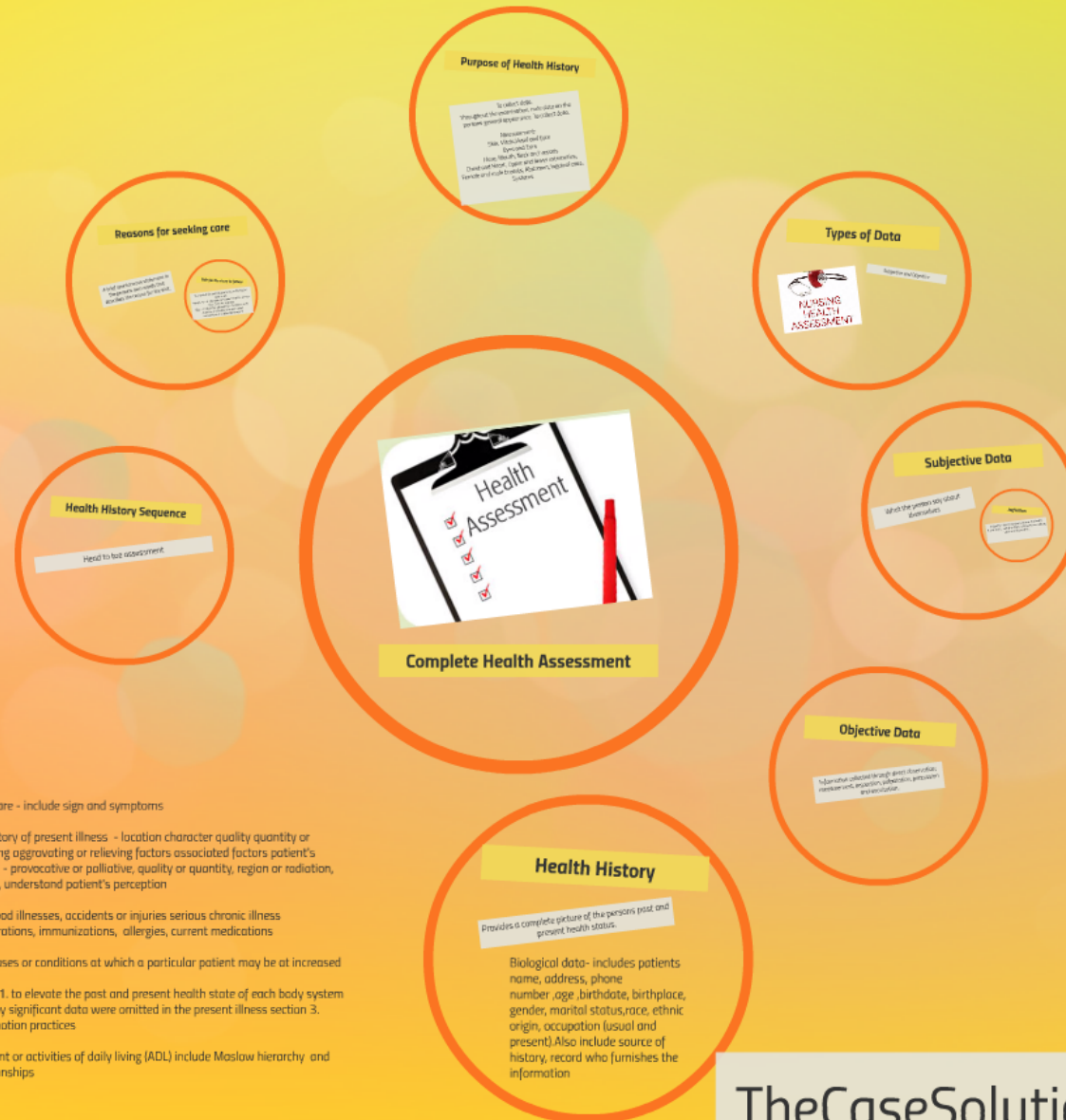


Complete Health Assessment



Reason for seeking care - include sign and symptoms

Present health or history of present illness - location character quality quantity or severity timing sending aggravating or relieving factors associated factors patient's perception. (PQRSTU - provocative or palliative, quality or quantity, region or radiation, severity scale, timing, understand patient's perception

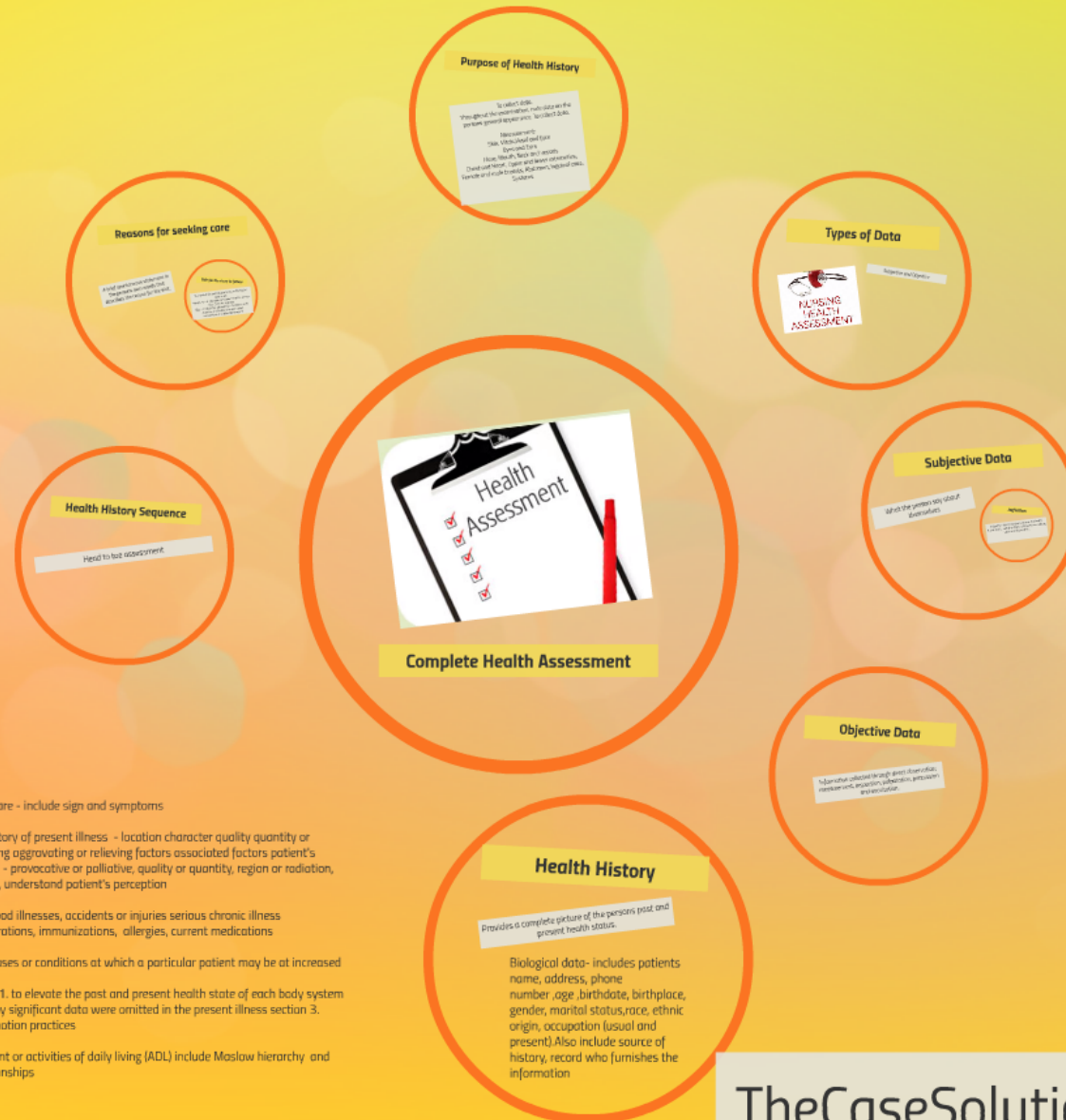
Past history - childhood illnesses, accidents or injuries serious chronic illness hospitalizations, operations, immunizations, allergies, current medications

Family history - diseases or conditions at which a particular patient may be at increased risk

Review of systems - 1. to elevate the past and present health state of each body system 2. to double check any significant data were omitted in the present illness section 3. evaluate health promotion practices

Functional assessment or activities of daily living (ADL) include Maslow hierarchy and enter personal relationships

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Complete Health Assessment

Purpose of Health History

To collect data.
Throughout the examination, note data on the persons general appearance. To collect data.

Measurement:
Skin, Vitals, Head and face
Eyes and Ears
Nose, Mouth, Neck and vessels
Chest and Heart, Upper and lower extremities,
Female and male breasts, Abdomen, Inguinal area,
Systems.

Types of Data



Subjective and Objective

Subjective Data

What the person say about themselves

Definition

Subjective data in nursing is part of the health assessment. includes effective listening and asking open ended questions.

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Objective Data

Information collected through direct observation; measurement, inspection, palpation, percussion and auscultation.