Health Assessment
Kendra L. Newland
Otterbein College
Nursing 670

Problem List

Active problems: None Identified
Inactive Problems: None Identified
Risk Factors:
- Family history
- Little exercise
- High fat and sugar diet
- History of smoking

3/1/08 12:00 pm

Mrs. King is a pleasant, 28-year-old married female practicing registered nurse residing in Mansfield, Ohio

Referral: None
Source and Reliability: Self-referred; seems reliable

Chief Complaint: "I am here for a health physical"

Present Illness: Mrs. King has no medical problems at this time. She is here for a health physical for school sports.

Medications: None
Allergies: Darvocet and Percocet both of which give her hives. No food or environmental allergies.
Tobacco: Quit 1 ½ years ago. Smoked ½ pack per day for 7 years (3.5 pack-years).
Alcohol/Drugs: Drinks occasionally while engaging in social encounters with friends. Denies illicit drugs.

Personal Medical History:

Childhood Illnesses: No measles, mumps, rubella, whooping cough, chickenpox, scarlet fever, rheumatic fever or polio.

Adult Illnesses. **Medical:** History of migraine headaches without aura; takes 800 mg of Motrin to self treat her migraine. Head CT scan done in 2002. Results were normal. **Surgical:** Umbilical hernia repair at age 3. Bladder stretched at age 3. Benign nodule removed from right breast in 2002. Pathology reported non-cancerous scar tissue. **Obstetric/Gynecology:** Two male sexual partners total, monogamous with spouse for past 14 years. Sexually active with spouse, no concerns with level of sexual desire. G3P3. No planned or spontaneous abortions. Three normal vaginal deliveries without complications. Three living children. Does not use any contraceptive measures. Menarche at age 12. Last menses 3 weeks ago. Regular menstrual periods. **Psychiatric:**

History of anxiety treated with Buspar 2.5 mg daily for 6 months. Quit taking when she started trying to conceive last child. No problems with anxiety attacks for the past year and a half.

Health Maintenance: **Immunizations:** All childhood immunizations up to date. No chicken pox vaccine. Hepatitis B vaccine X3 1997. Flu shot October 2007, no reaction. Tetanus booster February 2008. **Screening Tests:** Last Pap smear, 2006, normal results. Last mammogram 2002, normal results. TB skin test negative 2007.

Family Medical History:

Paternal grandfather, 85, alive and well, colon cancer, chronic myeloid leukemia. Paternal grandmother died at age 79 of non-Hodgkin's lymphoma. Had type II diabetes mellitus.

Maternal grandfather died at age 57 of a heart attack. Had a history of strokes. Maternal grandmother, 84, alive and well. Has hypertension, kidney disease, colon cancer, spenectomy, coronary artery bypass graft X 3 in 2005, arthritis.

Father, 64, alive and well, type II diabetes mellitus, hypertension. Mother, 59, alive and well, hypertension, chronic renal failure (stage IV), Coronary artery disease.

One Brother, 32, alive and well, no health problems.

Daughter, 9, alive and well. One son, 4, alive and well, history of asthma. One son, 8 months, alive and well.

Husband, 32, alive and well.

No family history of mental illness, suicide, epilepsy, tuberculosis, or anemia.

Personal and Social History: Born in Mansfield, Ohio. Raised in Bellville, Ohio. Finished high school and married at age 19. Mrs. King lives in a house with her husband and three children ages 9, 4 and 8 months. Mrs. King obtained her bachelors degree in nursing in 2003 from Med Central College of Nursing. She worked as a staff nurse for 2 years and is currently a clinical instructor at Med Central College of Nursing. Mrs. King is currently attending Otterbein College working on her master's degree in nursing to become a family nurse practitioner. Mrs. King does admit to feeling overwhelmed with the everyday stress of working full time, going to school and raising a family. She denies feelings of hopelessness and reports a good support system from her spouse, family and friends. She typically wakes up between 5:00 and 7:00 am and goes to bed around 10:00 or 11:00. She usually works from 7:00 am until 4:00 pm. Usually eats dinner at home with her family.

Diet and Exercise: Consumes a diet high in fat and sugar content and gets very little exercise. Reports drinking 1-2 cups of coffee per day.

Safety Measures: Uses seat belt regularly. Medications are kept in a locked medical cabinet. Cleaning solutions are in an unlocked cabinet below the sink in the kitchen. Spouse has guns and bullets in a locked gun cabinet in the master bedroom. Has smoke detectors and fire extinguishers on every level of the house.

Review of Systems

General: Good appetite. Sleeps well. Has been unable to lose remaining 20 pounds after the birth of her youngest son 8 months ago.

Skin: No rashes, lumps, sores, itching, dryness or other changes. No changes in hair or nails. No moles, but has freckles covering arms, legs, face and back.

HEENT: Head: History of migraine headaches without aura, no history of head injury. No dizziness or lightheadedness. *Eyes:* Vision good. No glasses or contacts. No pain, redness, blurred or double vision. Does not remember when last otoscopic exam was. *Ears:* Hearing good. No ringing, earaches, or discharge. *Nose, sinuses:* No problems with runny or stuffy nose, bleeding or sinus trouble. No hay fever. *Throat:* No fillings, toothaches. No bleeding of gums. Last dental visit 6 months ago. No dry mouth, frequent sore throats or hoarseness.

Neck: No lumps, goiter, pain. No swollen glands.

Breast: No lumps, pain, nipple discharge. No discomfort. Does breast self-exam every month.

Respiratory: No cough, wheezing, night sweats, or shortness of breath. No history of chest x-ray. No asthma, bronchitis, emphysema, pneumonia, or tuberculosis.

Cardiovascular: No known heart disease or high blood pressure. No dyspnea, orthopnea, chest pain, palpitations, varicose veins, edema. Has never had an EKG or other cardiac tests.

Gastrointestinal: Appetite good; no nausea, vomiting, indigestion. No trouble swallowing, no heartburn. Bowel movements once per day, brown and soft; no changes in bowel habits. No diarrhea or bleeding. No pain, jaundice, gallbladder or liver problems. No food intolerance, no excess belching, no excess flatus. No hepatitis, ulcer history. No history of gastrointestinal tests or hemoccult tests.

Urinary: No frequency, urgency, dysuria, hematuria, nocturia, or recent flank pain. Good force of stream, no hesitancy, no dribbling, stress incontinence. No frequent infections or history of stones.

Genital: No vaginal or pelvic infections. No dypareunia. No discharge, pain, masses. No history of STD's. Heterosexual. No sexual concerns. Last menstrual period 3 weeks ago,

regular periods every 3-4 weeks since menarche at age 12. Menses lasts 7 days with heavy to medium flow. No bleeding between periods. No exposure to DES. G3P3, no abortions, no stillborn. All babies were born vaginally without complications. Not currently using birth control.

Peripheral Vascular: No intermittent claudication, leg cramps, varicose veins, clots, edema, pain with exercise or redness.

Musculoskeletal: No muscle or joint pain, stiffness, tingling. No history of gout, arthritis, backache. No problems with range of motion or gait. No walking aids used.

Neurologic: No fainting, seizure, motor or sensory loss. Memory good. No blackouts, weakness, paralysis, numbness or decreased sensation. No tingling, tremors, involuntary movements, cognitive changes, disorientation or hallucinations.

Hematologic: No anemia, easy bruising, easy bleeding, or past transfusions.

Endocrine: No thyroid trouble, heat or cold intolerance, excess sweating. No diabetes, excess thirst or hunger. No polyuria, exopthalmia, or anorexia.

Psychiatric: No history of depression. Was treated for a 6 month period for anxiety with Buspar 2.5 mg daily. No current concerns of anxiety. No nervousness, tension. General mood is happy. No change in memory.

Physical Examination: Mrs. King is a 28 year old, healthy-appearing woman, well-groomed, fit and in good spirits. She has no obvious physical deformities. She has a steady gait, good posture, is able to get up and down from exam table without difficulty. Her speech is clear. She is able to hear normal conversational tone without difficulty. Body and breath without odor. Height is 4'11"; weight is 115 lbs, BMI 23, BP 98/60 (right arm, sitting), HR 96 (regular), RR 18 (regular), temperature 37.5 degrees C.

Skin: Color pink. Skin warm and moist. Nails without clubbing or cyanosis. No nevi. No rash, petechiae, or ecchymoses. Hair with average texture, normal distribution.

HEENT: Head-The head is normocephalic/atraumatic. Face is symmetric with appropriate expression. Temporal arteries palpable, no thrills or heaves bilaterally. Temporomandibular joint without edema or erythema, with smooth range of motion, no snapping or clicking bilaterally. *Eyes*- Symmetric, no erythema or exudate. Eyebrows symmetric with equal distribution. No ptosis, ectropion, chalazion, or xantehlasma noted. Visual acuity 20/20 OU. Peripheral vision normal. Corneas clear bilaterally. Irises blue, markings clearly defined bilaterally. Sclera white, conjunctiva pink. Pupils are 4 mm constricting to 2 mm, equally round and reactive to light and accommodation. Corneal light reflex symmetric. Extraoccular movements conjugate. Disc margins sharp; no hemorrhages or exudates. Red reflex present bilaterally. *Ears:* Acuity good to whispered voice. External ears symmetric without erythema, masses or edema. External ear canal without erythema. No erythema, edema or exudates appreciated. Tympanic membranes

with good cone of light, pearly grey, bony structures visible bilaterally. *Nose:* External nose symmetric, without erythema, edema. Nasal mucosa pink, septum midline; no maxillary or frontal sinus tenderness. *Mouth and throat:* Oral mucosa pink, dentition good, pharynx without exudates. Gums pink. Tongue midline and pink. Pharynx without exudates. Soft palate and uvula mobile. Uvula midline.

Neck: Trachea midline. Neck symmetric, supple, thyroid isthmus palpable, lobes not felt. No visible lumps or pulsations. Carotid pulses strong, regular rate and rhythm, equal bilaterally. No bruits. Full range of motion, strong muscle strength.

Lymph nodes: Tonsillar, submandibular, submental, anterior and posterior cervical, preauricular, posterior auricular, occipital, inguinal, axillary, and inguinal nodes without noted lymphadenopathy or tenderness.

Chest: Thorax is symmetric with good expansion. Respirations even and unlabored. Lungs resonant bilaterally anterior and posterior. Breath sounds vesicular bilaterally, anterior and posterior; no rales, wheezes or rhonchi. Diaphragm descends 4 cm bilaterally. No costovertebral angle tenderness. Tactile fremitus equal bilaterally throughout lung fields. No retractions noted. No visible signs of distress.

Breasts: Breasts symmetric and without masses, dimpling. Nipples without discharge.

Cardiovascular: Jugular venous pressure 1 cm above sternal angle, with head of examining table raised to 30 degrees. Carotid upstrokes brisk, without bruits. Apical pulse with regular rate and rhythm. Apical impulse discrete and tapping, barely palpable in the 5th left interspace. Good S1, S2; no S3 or S4. No murmurs appreciated. Radial and brachial pulses palpable, strong and regular bilaterally.

Peripheral Vascular System: Extremities are warm and without edema. No varicosities or stasis changes. Calves are supple and nontender. No femoral or abdominal bruits. Brachial, radial, femoral, popliteal, dorsalis pedis, and posterior tibial pulses are 2+ and symmetric.

Gastrointestinal: Abdomen is flat, soft, non-distended and non-tender. Active bowel sounds in all 4 quadrants. No masses or hepatosplenomegaly. Liver span is 6 cm in the right midclavicular line, edge is smooth. Spleen and kidneys not felt. No costovertebral angle tenderness. No pulsations appreciated. No aortic, renal, iliac or femoral bruits noted. Femoral pulses palpable, strong, equal and regular bilaterally. No inguinal lymphadenopathy or tenderness.

Musculoskeletal: No joint deformities. Good range of motion and strong muscle strength in hands, wrists, elbows, shoulders, spine, hips, knees, ankles.

Neurologic: Mental Status: Alert and cooperative. Thought coherent. Oriented to person, place and time. *Cranial Nerves:* II-XII intact. *Motor:* Good muscle bulk and tone. Strength 5/5 throughout. *Cerebellar:* Rapid alternating movements, point-to-point

movements intact. Negative Babinski. Gait stable, fluid. *Sensory:* Pinprick, light touch, position sense intact. Romberg negative. *Reflexes:*

	Biceps	Triceps	Brachioradialis	Patellar	Achilles
RT	2+	2+	2+	2+	2+
LT	2+	2+	2+	2+	2+