Nurse and Client Assessment.

Nursing assessment and it component.

Nursing assessment is a systematic process of collecting data about a patient's health status. It forms the foundation for developing a nursing diagnosis, planning interventions, and evaluating outcomes. **It is composed of nursing history taking and physical examination**.

1. Biographical Data

- **Name: Full name and preferred name.**

Example: what is your name? My names is john Daniel.

- **Date of birth: Age.**

Example: how are old are? I am 25 year old.

- **Gender: Identity**.

Example : are you male or female? Yes am male.

- **Marital status: Relationship status.**

Example are you married or single, divorced? Yes am single.

- **Occupation: Job or profession.**

Example: what is did you do in every day life? Shop keeper .

- **Religion: Religious beliefs.**

Example : what is you religious? Am catholic christian.

- **Ethnicity: Ethnic identity.**
- **Address: Home address.**

example: Where do you live?

By now am in Rwanda, Provence of Kigali city, kicukiro ditrict, kanombe sector , and busanza village.

- **Contact information: Phone number and email address**
- **Emergency contact information: Name, relationship, and contact information**

2. Chief Complaint.

Reason for seeking care: The main problem or symptom that brought the patient to the healthcare facility.

Example : why do you come to the hospital?

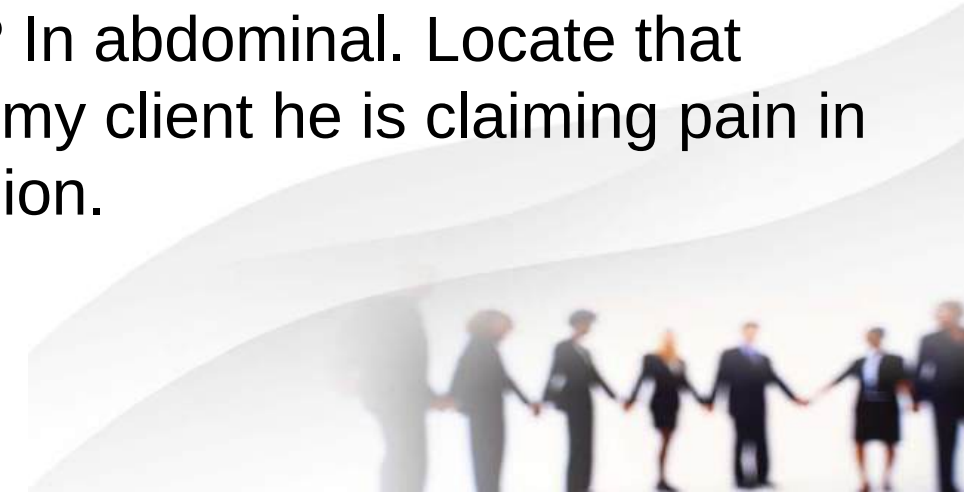
Am here because I have diarrhea and vomiting last two day and also I have fever , nausea, general body weakness,and dizziness and abdominal pain that why I was here.

3. History of Present Illness.

1.Onset: When did the problem start?

Example: when did it start? 2 day ago.

2.Location: example: Where is the problem located? In abdominal. Locate that part? And you observe which region of abdomen, on my client he is claiming pain in hypo-gastric located between two inguinal or iliac region.



3.Duration: How long has the problem lasted? 40 minutes and also come 5 times per day.

4.Character: Describe the quality or nature of the symptom example: your pain is sharp, dull, throbbing? My pain is dull.

5.Severity: How intense is the symptom mark you pain is it mild, moderate, severe? My pain is moderate.

6.Aggravating factors: example: What makes the symptom worse? When I drink water my pain be come severe.

7.Relieving factors: example: What makes the symptom better? When I was lie in prone position.

8.Associated symptoms: example: Are there any other symptoms related to the main complaint? Yes as I told you, I have diarrhea and vomiting last two day and also I have fever , nausea, general body weakness,and dizziness and abdominal pain.

4. Past Medical History

A.Allergies: Medications, food, or environmental substances

Example: do you have an allergies? No.

B.Illnesses: Previous illnesses or conditions.

Example: what are other disease do you have previously?

I don’t have other disease.

C.Surgeries: History of surgical procedures.

D.Hospitalizations: Previous hospital stays.

E.Immunizations: Vaccination history.

F.Medications: Current medications, including dosage, frequency, and reason for use.

G.Health maintenance: Regular check-ups, screenings, and preventive care.

5. Family History.

I.Health status of immediate family members: Parents, siblings, children.

II.History of genetic disorders: Known genetic conditions in the family.

6. Review of Systems.

Generally when we are focusing on the review system we focus on the following:

1.General: Weight loss, fever, fatigue, night sweats.

2.Head and neck: Headaches, dizziness, vision changes, hearing loss, sore throat, neck pain.

3.Respiratory: Cough, shortness of breath, chest pain.

4.Cardiovascular: Chest pain, palpitations, heart rate.

5.Gastrointestinal: Appetite changes, nausea, vomiting, diarrhea, constipation, abdominal pain.

6.Genitourinary: Urinary frequency, urgency, incontinence, dysuria, hematuria, menstrual history, sexual history.

7.Musculoskeletal: Joint pain, swelling, stiffness, muscle weakness.

8.Neurological: Seizures, numbness, tingling, weakness, coordination problems.

9.Skin: Rashes, itching, changes in skin color or texture

10.Endocrine: Thyroid problems, diabetes, excessive thirst or urination.

8. Physical Examination

a.General appearance: Overall health status, level of consciousness, posture, gait.

b.Vital signs: Temperature, pulse, respiration, blood pressure, pain level.

c.Head and neck: Inspection of the head, face, and neck; palpation of lymph nodes and thyroid gland.

d.Respiratory: Inspection of the chest, auscultation of breath sounds.

e.Cardiovascular: Inspection of the precordium, palpation of apical impulse, auscultation of heart sounds.

f.Gastrointestinal: Inspection of the abdomen, auscultation of bowel sounds, palpation of organs.

g.Genitourinary: Inspection of external genitalia, assessment of urinary and menstrual history.

h.Musculoskeletal: Inspection of joints, assessment of range of motion, muscle strength.

i.Neurological: Assessment of mental status, cranial nerves, motor function, sensory function, reflexes.

j.Skin: Inspection of skin color, texture, lesions, and integrity.