Health Assessment in Nursing 7th edition Weber Test Bank

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Chapter 02

1. When beginning the collection of the client data base, which of the following would be most important for the nurse to do?
A. Establish a trusting relationship
B. Determine the client's strengths
C. Identify health problems
D. Make inferences

Answer: A

Rationale: It is essential for the nurse to develop trust and rapport with the client to elicit accurate and meaningful information. This trust is the focus of the interview and must be developed in the initial phase of the interview. Determining the client's strengths, identifying health problems, and making inferences occur during the working phase of the interview.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 10, Phases of the Interview

2. During which of the following phases of the interview process will the nurse assure the client that all personal data the client discusses with the nurse will be kept confidential?
A. Preintroductory
B. Introductory
C. Working
D. Summary and closing

Answer: B

Rationale: The introductory phase includes the nurse's introduction to the client, explaining to the client about the type of questions that will be asked, and assuring the client of confidentiality in all areas that are discussed during the interview. The preintroductory phase occurs before the nurse meets the client. During the working phase the nurse obtains biographical data, reasons for seeking care, history of the present concern, past medical history, family history, and review of body systems (ROS). During the summary and closing phase, the nurse summarizes information obtained during the working phase and validates problems and goals with the client.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 10, Phases of the Interview

3. Which statement by the nurse could be construed as judgmental?
A. "How often do your adult children visit?"
B. "Your husband's death must have been difficult for you."
C. "You must quit smoking because it is offensive to others."
D. "How do you feel about getting older?"

Answer: C

Rationale: Saying that smoking is offensive to others and telling the client that she must quit forces a sense of guilt on the client. The statement may be seen as "preaching" without focusing on assisting the client to attain optimal health. Asking how often the adult children visit or how the client feels about getting older focuses on information gathering. The statement about the husband's death being difficult acknowledges the client's feelings.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Psychosocial Integrity

Integrated Process: Communication and Documentation
Reference: p. 11, Communication During the Interview

4. A nurse is interviewing a client. Which nonverbal behavior by the nurse would best facilitate communication?
A. Standing while the client is seated
B. Using a moderate amount of eye contact
C. Sitting across the room from the client
D. Minimizing facial expressions

Answer: B

Rationale: The nurse needs to avoid extremes in eye contact. Excessive eye contact may make the client uncomfortable; too little eye contact might lead the client to believe that the nurse is hiding something. A moderate amount communicates interest and focus. The nurse should be at the same level of the client. Standing while the client is seated puts the nurse as superior, possibly making the client feel inferior. The nurse should be within 2 to 3 feet of the client during the interview. The nurse should keep facial expressions neutral and friendly.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Reference: p. 11, Communication During the Interview

5. After teaching a group of students about verbal communication techniques, the instructor determines that the teaching was successful when the students identify which of the following as an example of a closed-ended question/statement?
A. "What is your relationship with your children?"
B. "Tell me what you eat in a normal day."

C. "Are you allergic to any medications?"
D. "What is your typical day like?"

Answer: C

Rationale: Closed-ended questions ask for specific information that can be answered with one or two words. Asking about the relationship, what the client eats in a normal day, and what the client's typical day is like are examples of open-ended questions that elicit information about the client's feelings and perceptions.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 11, Communication During the Interview

6. A client is having difficulty describing a chief complaint of chest pain. Which action by the nurse would be most appropriate?
A. Ignore the complaint for now and return to it later.
B. Provide a laundry list of descriptive words.
C. Restate the question using simple terms.
D. Wait in silence until the client can determine the correct words.

Answer: B

Rationale: Providing the client with a list of descriptive words allows the nurse to obtain the answer and reduces the likelihood of the client's perceiving or providing an expected answer. Ignoring the complaint would be inappropriate. Restating the question would be inappropriate because it may be demeaning to the client, especially since he or she is having difficulty in describing the complaint. Silence would be helpful if the client was having trouble organizing his or her thoughts.
Question Format: Multiple Choice

Chapter: 2
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Communication and Documentation
Reference: p. 10, Phases of the Interview

7. The nurse is preparing to assess the mental status of an older adult client. Which of the following would the nurse need to assess first?
A. Sensory abilities
B. General intelligence
C. Severe phobias
D. Irrational cognition

Answer: A

Rationale: The nurse needs to assess the older adult's sensory capabilities, such as vision and hearing. Impaired vision can interfere with the older client's ability to read information requested. Assessing hearing acuity is very important when interviewing older adult clients because hearing loss normally occurs with age and undetected hearing loss is often misinterpreted as mental slowness or confusion.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 13, Special Considerations During the Interview

8. When interviewing a client who does not speak English, the nurse enlists the assistance of a “culture broker,” based on the understanding of what as this person’s primary function?
A. to interpret the language and culture
B. to evaluate the client’s health practices

C. to teach the client about health care
D. to make the client feel comfortable and safe

Answer: A

Rationale: If misunderstanding or difficulty in communicating is evident, the nurse will seek help from an expert who is thoroughly familiar not only with the client's language, culture, and related health care practices but also with the health care setting and system of the dominant culture, often called a culture broker. The role of a culture broker is not to evaluate the client's health practices, teach the client about health care, or make the client feel comfortable and safe.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Remember
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Reference: p. 13, Special Considerations During the Interview

9. Upon entering an exam room, the client states, "Well! I was getting ready to leave. My schedule is very busy and I don't have time to waste waiting until you have the time to see me!" Which response by the nurse would be most appropriate?
A. "Our schedule is very busy also. We got to you as soon as we could."
B. "No one is holding you captive, you are free to leave at any time."
C. "Would you like to speak to the office manager about your complaint?"
D. "You seem very angry. I am ready to begin your exam now."

Answer: D

Rationale: When the nurse encounters an angry client, it is best to acknowledge the feelings of the client in a calm, reassuring, and in-control manner. Telling the client that the schedule is busy, that no one is holding him or her captive, or

asking if he or she would like to speak to the office manager are inappropriate and do not acknowledge the client's feelings.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Reference: p. 13, Special Considerations During the Interview

10. When describing the purpose for obtaining a comprehensive health history to a client, which of the following would the nurse include as primary?
A. Completes the client's health record.
B. Assures a trusting interpersonal relationship.
C. Evaluates the seriousness of the client's risk factors.
D. Provides a focus for the physical exam.

Answer: D

Rationale: The information gained in a comprehensive health history lays the groundwork for identifying client health problems that need further exploration and validation during the physical exam. It is one aspect of the client's health record and helps to provide some indication about possible risk factors for the client. Trust is necessary to complete the health history
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 14, Complete Health History

11. Which of the following questions would be most important for the nurse to ask first when obtaining the health history?
A. "Do you have adequate health insurance coverage?"

B. "Are you generally fairly healthy?"
C. "What is your major health concern at this time?"
D. "Did you bring all your medications with you?"

Answer: C

Rationale: Asking the question about the client's major health concern assists the client to focus on his or her most significant issues and answers the nurse's question "why are you here?" or "how can I help you?" The nurse should inquire later on about the client's health insurance, but not if it is adequate. Asking if the client is fairly healthy is a closed-ended question that doesn't allow the client to verbalize concerns. Asking about medications would be appropriate later on during the interview when discussing the medications that the client takes.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 14, Complete Health History

12. After teaching a group of students about the review of systems component of the health history, the instructor determines that the teaching was successful when the students identify which data as an example?
A. "High school diploma plus 2 years of college"
B. "Caregiver reliable source of information"
C. "Menarche at age thirteen"
D. "Lungs clear to auscultation bilaterally"

Answer: C

Rationale: A review of systems is the client's description of his or her health status for each body system. The data is given to the interviewer as it was stated. High school diploma and caregiver as a reliable source of information

reflect biographical data. Lungs clear to auscultation reflect physical examination data.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 20: Review of Systems for Current Health Problems

13. A new graduate nurse asks another more experienced nurse about the best way to assess a client's dietary habits. Which suggestion would be most appropriate?
A. Ask the client to explain the food pyramid.
B. Obtain a 24-hour diet recall.
C. Ask about the contents of one meal.
D. Determine how often the client eats.

Answer: B

Rationale: Asking the client to recall what consists of an average 24-hour intake is the best way to assess a client's nutrition because it provides information about quantity and types of food as well as food habits that are and are not healthy. Asking the client to explain the food pyramid would provide no information about the client's intake. Focusing on one meal or determining how often the client eats would provide very limited information about his or her nutrition.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 22, Lifestyle and Health Practices Profile

14. The nurse is assessing the client's activity and exercise level. Which client statement would indicate to the nurse that the client is getting the recommended amount of exercise?
A. "I walk on the treadmill once or twice a week."
B. "I play basketball with a team each week."
C. "I go to an aerobics class for 1 hour three times a week."
D. "I swim for 30 minutes each Saturday morning."

Answer: C

Rationale: The recommended exercise regimen is aerobic-type exercise for 20 to 30 minutes at least three times a week. Walking on a treadmill once or twice per week, playing basketball once a week, or swimming for half an hour once a week would not fit the aerobic exercise recommendations.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 22, Lifestyle and Health Practices Profile

15. The nurse is preparing to assess a female client's activities related to health promotion and maintenance. Which question would provide the most objective and thorough data?
A. "Do you always wear your seatbelt when driving?"
B. "How much beer, wine, or alcohol do you drink?"
C. "Do you use condoms with each sexual encounter?"
D. "Could you describe how you perform self-breast exams?"

Answer: D

Rationale: Asking the client to describe self-breast examination is an open-ended question that allows the client to verbalize openly about the activity and provides the nurse with information that allows determination of correctness of technique.

Asking about wearing a seatbelt, how much alcohol the client drinks, or using condoms with sexual activity are closed-ended questions that would provide information of one or two words.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Analyze
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 25, Self-Concept and Self-Care Responsibilities

16. A nurse is creating a genogram for a client's family health history. The nurse would use which of the following to denote the client's female relatives?
A. Circle
B. Square
C. Triangle
D. Rectangle

Answer: A

Rationale: When creating a genogram, female relatives are usually indicated by a circle and male relatives by a square. Triangles and rectangles are generally not used.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Remember
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 20, Family Health History

17. The nurse is in the introductory phase of the client interview. Which of the following activities would be appropriate?
A. Collaborating with the client to identify problems
B. Explaining the purpose of the interview

C. Determining the client's reason for seeking care
D. Obtaining family health history data

Answer: B

Rationale: During the introductory phase, the nurse explains the purpose of the interview, discusses the types of questions that will be asked, explains the reason for taking notes, and assures the client about the confidentiality of the information. Collaborating to identify problems, determining the reason for seeking care, and obtaining family health history data are components of the working phase.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 10: Phases of the Interview

18. A client states, "My wife died two months ago today." Which of the following responses would be most appropriate?
A. "What did she die of?"
B. "How does that make you feel?"
C. "You probably must be sad."
D. "Are you feeling sad, depressed, angry, or upset?"

Answer: B

Rationale: The client's statement about his wife's death provides the nurse with an opportunity to gather information about the client's current state. Asking the open-ended question, "How does that make you feel?" would be most appropriate to obtain key information. Asking what the wife died from is a closed-ended question that ignores the client's feelings. Telling the client that he probably feels sad is imposing the nurse's personal values on the client. Asking

the client the laundry list of feelings would be demeaning and doesn't allow the client to put his feelings into his own words.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Reference: p. 11, Communication During the Interview

19. A group of students is reviewing for a quiz on verbal and nonverbal communication. The students demonstrate a need for additional studying when they identify which of the following as an example of nonverbal communication?
A. Attitude
B. Silence
C. Laundry list
D. Facial expression

Answer: C

Rationale: Laundry list is an example of a verbal communication technique. Attitude, silence, and facial expression are examples of nonverbal communication.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 11, Communication During the Interview

20. The nurse is completing a review of systems for a client. Which of the following information would the nurse document related to the client's musculoskeletal system? Select all that apply.
A. Joint stiffness

B. Rhinorrhea
C. Shortness of breath
D. Chest pain
E. Muscle strength
F. Swelling

Answer: A, E, F

Rationale: When reviewing the client's musculoskeletal system, the nurse would obtain information related to swelling, redness, pain, stiffness of joints, ability to perform activities of daily living, and muscle strength. Rhinorrhea would be a component of assessing the client's nose and sinuses; shortness of breath and chest pain would be included as part of assessing the client's lungs and heart.
Question Format: Multiple Select
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 20, Review of Systems for Current Health Problems

21. A nurse is interpreting and validating information from an older adult client who has been experiencing a functional decline. The nurse is in which phase of the interview?
A. preintroductory
B. introductory
C. working
D. summary and closing

Answer: C

Rationale: During the working phase, the nurse interprets and validates information about the client’s chief concern, their recent functional decline, their feelings about this and how the decline is impacting their activities of daily living (ADLs). The preintroductory phase takes place prior to the nurse and client

meeting when the nurse collects information from the medical record that will be beneficial during the introductory and working phase of the interview. During the summary and closing phase, the nurse summarizes the information obtained during the working phase, and identifies with the client health issues and goals for future care.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion
Integrated Process: Nursing Process
Reference: p. 10, Phases of the Interview

22. A nurse is interviewing a client with a different cultural background. Which nonverbal behavior should the nurse adopt to best facilitate communication during this phase of assessment?
A. Standing while the client is seated
B. Using a moderate amount of eye contact
C. Sitting across the room from the client
D. Minimizing facial expressions

Answer: B

Rationale: The nurse needs to avoid extremes in eye contact. Excessive eye contact may make the client uncomfortable; too little eye contact might lead the client to believe that the nurse is hiding something. A moderate amount communicates interest and focus. The nurse should be at the same level as the client. Standing while the client is seated puts the nurse in a superior position, possibly making the client feel inferior. The nurse should be within 2 to 3 feet of the client during the interview. The nurse should keep facial expressions neutral and friendly.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Psychosocial Integrity

Integrated Process: Communication and Documentation
Reference: 13, Special Considerations During the Interview

23. A nurse is eliciting a client's health history and the client asks, "Can I take the herb ginkgo biloba with my other medications?" What action would be best if the nurse is unsure of the answer?
A. Explain that you will find out the information for the client.
B. Change the subject and return to this topic later.
C. Teach the client to only take prescribed medications.
D. Encourage the client to ask the pharmacist or primary care provider.

Answer: A

Rationale: The nurse should address all questions asked by a client as best as possible and should make every effort to find unknown answers. Ignoring the question and telling the client to ask the pharmacist interferes with trust and does not ensure adequate follow-up. Telling the client to take only prescribed medication ignores the client's feelings and may not be accurate.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies
Integrated Process: Teaching/Learning
Reference: p. 11, Communication During the Interview

24. The nurse is gathering subjective data to complete a health history on a 68-year-old client. During the interview, the client mentions their frequent use of alcohol and recreational drugs. This information belongs in which section of the health history?

A. chief complaint
B. past medical history
C. lifestyle and health practices

D. review of systems

Answer: C

Rationale: The information gathered about substance use provides the nurse with data concerning lifestyle and a client's self-care ability (health practices). This information does not belong in the chief complaint, past medical history, or review of systems sections. Substance use can affect the client's health and cause loss of function or impaired senses. In addition, certain substances can increase the client's risk for disease. Here, clients describe how they are managing their lives, their awareness of healthy versus toxic living patterns, and the strengths and supports they have or use.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 22, Lifestyle and Health Practices Profile

25. A nurse provides care in a rural hospital that serves a community that has few minority residents. When interviewing a client from a minority culture, the nurse has enlisted the assistance of a "culture broker." How can this individual best facilitate the client's care?
A. By interpreting the client's language and culture
B. By evaluating the client's culturally based health practices
C. By teaching the client about health care
D. By making the client feel comfortable and safe

Answer: A

Rationale: A "culture broker" is someone who is thoroughly familiar not only with the client's language, culture, and related health care practices, but also with the health care setting and the system of the dominant culture. The individual can assist in preventing misunderstandings or difficulty in communicating.

Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance: Self-Care
Integrated Process: Communication and Documentation
Reference: p 23, Lifestyle and Health Practices Profile

26. During the interview, the client informs the nurse that their abdominal pain has caused them to be fearful. The client worries that they may have ulcers or cancer. The nurse is aware that rephrasing is an excellent way to clarify subjective information. Which is the **best** response from the nurse?
A. "How is your pain right now?"
B. "When did your pain start?"
C. "Is the pain sharp, dull, or radiating?"
D. "You are thinking that you may have a serious illness?"

Answer: D

Rationale: Rephrasing information in a professional statement such as "You are thinking that you may have a serious illness?" is an effective way to clarify subjective information. Asking "How is your pain at this time?" is an open-ended question, used during the interview to elicit client feelings and perceptions. It would not help to clarify subjective information, nor is it an example of rephrasing. Asking"When did your pain start?" is an example of a closed-ended question, and it is not an example of rephrasing. Closed-ended questions typically begin with the words "when" or "did" and are useful in clarifying or obtaining more information in response to open-ended questions. Asking "Is the pain sharp, dull, radiating?" is an example of "the laundry list," a way to ask questions that provides the client with a list of words to choose from in describing symptoms, conditions, or feelings. It is not an example of rephrasing to clarify subjective information.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply

Client Needs: Health Promotion
Integrated Process: Communication and Documentation
Reference: p. 12, Verbal Communication

27. To assess the client's self-concept and self-care responsibilities, the nurse will ask which of the following question(s)? Select all that apply.
A. "How would you describe yourself?"
B. "How often do you have medical checkups?"
C. "Are you having any family problems?"
D. "Do you practice safe sex?"
E. "What gives your family hope in times of trouble?"

Answer: A, B, D

Rationale: The nurse is aware that how clients perceive themselves, their self-concept and self-care, includes an investigation of all behaviors attempted by the client to promote health. Questions about family problems and what gives the family hope during times of trouble are not directly related to the client's perception of self or what actions the client takes to promote health.
Question Format: Multiple Select
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 25, Self-Concept and Self-Care Responsibilities; p.22, Lifestyle and Health Practices Profile

28. The nurse is nearing the end of the interview. Which question(s) about the client's extracurricular activities will the nurse ask to determine the client's level of social development? Select all that apply.
A. "Are you involved in any community groups?"
B. "How do you feel about your community?"
C. "Have you had any major changes in the past year?"

D. “What do you do for fun and relaxation?”
E. “What things do you do to stay healthy?”

Answer: A, B, D

Rationale: Asking about involvement in community groups, how the client feels about the community, and what the client does for fun and relaxation are inquiries about social activities that assist the nurse in determining the client’s level of social development. Asking about whether the client has had any major changes in the past year and the things the client does to stay healthy are not related the client’s level of social development but may have been asked by the nurse when completing the health history for the client.
Question Format: Multiple Select
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 25, Social Activities

29. The nurse is questioning a 19-year-old client about personal relationships with family members or significant others in order to assess problems and potential support from the client’s family of origin. Which question would be the **best** question for the nurse to ask?

A. “What do you hope to accomplish in your life?”
B. “What gives you strength and hope?”
C. “Who is the most important person in your life?”
D “Are you satisfied with the level of education you have?”

Answer: C

Rationale: When asking the client about who is most important in their life, the nurse is inquiring about personal relationships in order to assess problems and potential support from the client's family of origin. Asking what the client hopes

to accomplish in their life or what gives the client strength and hope are questions related to beliefs and values, not relationships, but may be asked by the nurse when assessing problems or strengths. Asking about the client's satisfaction with the level of education is not related to the client's relationships, but questions about the client's perception and satisfaction with current education are useful to assess stress and fulfillment in life.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 25, Relationships

30. The nurse has completed collecting primary data and is finishing a health history for a newly admitted client on the medical-surgical unit. Which statement **best** reflects primary data?

A. information exclusively provided by the client's family
B. information exclusively provided by the client
C. information exclusively provided by the health care provider
D. information taken from the chart by the nurse prior to the interview

Answer: B

Rationale: The client is considered the primary source and all others (including the client's medical record) are secondary sources. In some cases, the client's immediate family or caregiver may be a more accurate source of information than the client. Information provided by the client's family, the health care provider, or taken from the chart by the nurse are examples of secondary sources of information.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance

Integrated Process: Communication and Documentation
Reference: p. 14, Complete Health History

31. The nurse is assessing a client's complaint of lower abdominal pain. The nurse asks the client to rate the pain on a scale of 0 to 10. The nurse is assessing which aspect of the complaint?
A. Character
B. Onset
C. Severity
D. Pattern

Answer: C

Rationale: Rating the pain level reflects the severity of the complaint. The nurse would ask about what the pain feels like to determine the character. Asking about when the pain started helps to determine the onset. Asking about what makes the pain worse or better determines the pattern.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Remember
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Reference: p. 18, History of Present Health Concer

32. The nurse is obtaining information about a client's past health history. Which client statement would best reflect this component of assessment?
A. "My mom's still alive, but my dad died 10 years ago of heart failure."
B. "I have a brother with leukemia and a sister with hypertension."
C. "I had surgery 5 years ago to repair an inguinal hernia."
D. "I have been having some pain when I urinate for the last several days."

Answer: C

Rationale: The past health history focuses on questions related to the client's past from the earliest beginnings to the present. The statement about surgery would apply to this portion of the assessment. The statement about the parents and siblings would apply to the family health history. The statement about pain in urination would apply to the reason for seeking health care.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 18, Personal Health History

33. A nurse is teaching a recent nursing graduate about the significance of verbal and nonverbal communication during client care. The new graduate demonstrates an understanding of these techniques by citing what example of verbal communication?
A. Maintaining an open attitude
B. Using silence appropriately
C. Providing a laundry list of descriptors when needed
D. Maintaining an open and encouraging facial expression

Answer: C

Rationale: Laundry list is an example of a verbal communication technique. Attitude, silence, and facial expression are examples of nonverbal communication.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Reference: p. 11, Communication During the Interview

34. While the nurse is assessing a client's gastrointestinal system, the nurse's findings are unremarkable and the client denies any complications. How would the nurse best document the subjective portion of the assessment?
A. "Client's gastrointestinal health is within normal limits. "
B. "Client denies gastrointestinal signs and symptoms."
C. "Gastrointestinal problems are not present at this time."
D. "Client denies recent constipation, diarrhea, bowel incontinence, or abdominal pain."

Answer: D

Rationale: During the review of body systems, the nurse should document the client's descriptions of her health status for each body system and note the client's denial of signs, symptoms, diseases, or problems that the nurse asks about but are not experienced by the client. If a blanket statement of "no problems" is entered on the health history form, other health care professionals reviewing the history cannot ascertain what specific questions had been asked, if any.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Communication and Documentation
Reference: p. 20, Review of Systems for Current Health Problems

35. A 60-year-old woman with a bunion will undergo surgery later today. The client tells the nurse in the surgical daycare admitting department, "I'm sure I've been asked these questions before. Can't we just focus on my foot and not all these other topics?" How should the nurse best explain the rationale for obtaining a health history?
A. "In general, it's necessary for us to gather as much information about each client as possible."
B. "We want to make sure your nursing care matches your needs as closely as possible."

C. "The care team needs to cross-reference your diagnostic testing with your medical history."
D. "We don't want to focus solely on the medical problem that brought you here."

Answer: B

Rationale: Taking a health history should begin with an explanation to the client of why the information is being requested; for example, "so that I will be able to plan individualized nursing care with you." The other listed statements are not inaccurate, but none directly describes the rationale for the nursing health history.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Communication and Documentation
Reference: p. 14, Complete Health History

36. During the nurse's assessment of the client's exercise and activity habits, the client laughs and then states, "Unless you're including channel surfing, I don't really do much of anything." What would the nurse do next?
A. Briefly describe some of the potential benefits of regular exercise.
B. Ask the client if he understands the risk factors for heart disease and diabetes.
C. Tell the client to exercise 30 minutes at least 3 days a week.
D. Document the client's current activity level as minimal.

Answer: A

Rationale: Explaining the benefits of exercise would be an appropriate follow-up to the client's statement. Focusing on negatives (such as lack of exercise as a risk factor for disease) or stating ideal levels of exercise is less likely to prompt

change. The nursing diagnosis may or may not apply, and documentation would not take place immediately following the client's statement.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Teaching/Learning
Reference: p. 11, Communication During the Interview

37. A nurse is obtaining subjective data from an adult client who is new to the clinic. The nurse has asked the client, "Where do you usually turn for help in a time of crisis?" What domain is this nurse assessing?
A. The client's family relationships
B. The client's current level of social and relational stability
C. The client's critical thinking and problem-solving abilities
D. The client's stress management and coping strategies

Answer: D

Rationale: This assessment question helps the nurse ascertain the client's strategies for coping and for managing stress. It does not directly assess social support or family relationships, although these may become apparent from the client's response. This question does not address critical thinking or problem solving.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Reference: p. 22, Lifestyle and Health Practices Profile

38. The nurse is engaged in the working phase of a client interview. Which activities will the nurse complete during this phase? Select all that apply.

A. Family history
B. Validates goals
C. Biographical data
D. Developmental level
E. Reasons for seeking care

Answer: A, C, D, E

Rationale: During the working phase the nurse elicits client comments about family history, biographical data, developmental level and reasons for seeking care. Validating goals occurs during the summary or closing phase of the client interview.
Question Format: Multiple Select
Chapter: 2
Cognitive Level: Remember
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 10, Phases of the Interview

39. The nurse prepares to complete a comprehensive assessment on a client. Which skill is the most important for the nurse to use at this time?
A. Inferring
B. Listening
C. Observing
D. Validating

Answer: B

Rationale: Listening is the most important skill to learn and develop fully in order to collect complete and valid data from the client. Inferring is a technique to obtain more succinct and clear data. Observing or inspection is a technique of examination. Validating is confirming that something exists or the information collected is correct.
Question Format: Multiple Choice

Chapter: 2
Cognitive Level: Remember
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 11, Communication During the Interview

40. In interviewing an older adult client, the nurse detects a hearing loss. Which interviewing skill(s) will the nurse employ to promote trust and a collaborative relationship with the client? Select all that apply.

A. Speak very loudly.
B. Face the client when speaking.
C. Use intermittent eye contact.
D. Show respect.
E. Validate the client's health concern.

Answer: B, C, D, E

Rationale: Facing the client when speaking, using intermittent eye contact, showing respect, and validating the client's health concern are all suitable interviewing techniques used by the nurse. Speaking very loudly will not be helpful for the nurse to use when interviewing an older client.
Question Format: Multiple Select
Chapter: 2
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 13, Gerontologic Variations in Communication; p. 13, Special Considerations During the Interview

41. The nurse plans to assess a client's new symptom. Which characteristics will the nurse assess when using the COLDSPA mnemonic?
A. Criteria, opportunity, label, direction, stamina, progress, action

B. Category, occasion, length of time, decision, strength, plan, attitude
C. Choices, outcomes, learning, determination, status, protrusion, activity
D. Character, onset, location, duration, severity, pattern, associated factors

Answer: D

Rationale: The COLDSPA mnemonic assesses the character, onset, location, duration, severity, pattern and associated factors for a health problem or symptom. The other characteristic choices are incorrect.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Remember
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Communication and Documentation
Reference: p. 18, History of Present Health Concern

42. The nurse prepares a genogram after collecting health history information from a client. For which part of the history is this diagram beneficial?
A. Family history
B. Social concerns
C. Current problem
D. Past medical problems

Answer: A

Rationale: A genogram helps to organize and illustrate the client's family history. This drawing is not used to organize social concerns, current problems, or past medical problems.
Question Format: Multiple Choice
Chapter: 2
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Communication and Documentation
Reference: p. 20, Family Health History