1. What is the nurse's focus while conducting a health assessment with a client? (Select all that apply.)

A) Completing the health history.
B) Interpreting findings.
C) Formulating a plan of care
D) Implementing a plan of care.
E) Conducting a physical examination.

2. Before beginning a health assessment with a patient, the nurse reviews *Healthy People 2020* because:

A) It helps determine the patient's plan of care.
B) It serves as a guide for the health assessment.
C) It identifies risk factors, health issues, and diseases.
D) It lists specific interventions to address most patient health problems.

3. The nurse is following a structured head-to-toe approach to identify changes in a patient's body systems. Which component of the health assessment is the nurse completing with the patient?

A) Health history
B) Physical examination
C) Goal setting
D) Planning care

4. What will be the nurse's initial role when conducting a health assessment with a client reporting abdominal pain?

A) Teaching the client to draw knees to chest to help minimize the pain
B) Planning care to help minimize the client's pain
C) Collecting data regarding the nature of the pain
D) Identifying pain management interventions with input from the client

5. As the nurse assesses vital signs, he notices the client is shaking. The nurse notes a change in the client's tone and in a loud voice the hospitalized client insists, "You're not my wife. How did you get into my house?". Based upon the client's behavior, which assessment will the nurse now focus upon?

A) Mental
B) Physical
C) Spiritual
D) Interpersonal

6. When doing an overall assessment of a patient, the nurse is able to utilize findings and do what?

A) Identify what level of prevention the patient is at
B) Identify in what areas the patient can educate his or her family
C) Identify in what areas the patient needs the most care
D) Identify the patient's medical diagnosis

7. During a health assessment, the client identifies having a 1 pack per day smoking habit. What should the nurse initially focus upon when approaching the client about the benefits of smoking cessation?

A) Determining whether the client wants to stop smoking
B) Educating the client on the detrimental effects smoking has on the entire body.
C) Identifying smoking as a modifiable risk factor for the client.
D) Sharing with the client that there are various smoking cessation methods available.

8. Which statement by the new nurse demonstrates an understanding of the nurse's responsibility to conduct an effective health assessment of the client?

A) "A health assessment requires both a patient history as well as a physical examination."
B) "I always allow sufficient time to conduct the history portion of the assessment effectively."
C) "I am always trying to improve my assessment skills."
D) "The health assessment is the foundation of quality patient care."

9. The nurse is performing a health assessment with a client who presented to the emergency department after falling as a result of feeling dizzy. Which questions demonstrates that the nurse understands the initial purpose of effectively conducting a health assessment? Select all that apply.

A) "Are you experiencing any pain at this time?"
B) "Are you feeling dizzy now?"
C) "Do you know what may have caused you to fall?"
D) "Do you know what your blood pressure is usually?"
E) "What do you think will help you from falling again?"

10. During a health assessment, a client shares, "I get a little dizzy when I get up from my chair too quickly. "Which question will the nurse ask the client **first** when attempting to identify client needs and potential health risks?

A) "What do you mean by 'a little dizzy'?"
B) "Do you often feel dizzy?"
C) "Have you ever been dizzy enough to fall?"
D) Can you remember when you first started to feel dizzy?"

11. A client is being admitted to the medical unit after being seen in the emergency department. Which statement by the nurse indicates an understanding of the importance of the appropriate timing of a health assessment?

A) "The client has been ordered a nutritional consult; I do the health assessment right after that is finished."
B) "I'll do the health assessment when the client's family leaves so that distractions will be minimal."
C) "I'm going to assess the client now so that I can begin formulating the care plan."
D) "The health assessment will be more thorough if I wait until the client is pain free."

12. A client admitted with reports of nausea and vomiting has not reported any vomiting in the last 6 hours. What initial response should the nurse have regarding this assessment information and its effect on the client's nursing plan of care?

A) Request that the health care team revise the plan of care.
B) Notify the primary health care provider of the change in the client's health status.
C) Recognize the need to reevaluate the client's plan of care.
D) Monitor the client frequently for other changes in health status.

13. The nurse recognizes the value of the Healthy People 2020 guidelines when creating a plan of care that addresses which client-centered goals? Select all that apply

A) living a healthy lifestyle
B) disease prevention
C) improving one's quality of life
D) providing affordable health care services
E) increasing the longevity of one's life

14. Consider the nurse's role in the health assessment of a client. What action will the nurse perform initially when admitting a client to a long-term care facility?

A) collecting information regarding the client's health status
B) stabilizing the client's physical condition
C) developing an effective, respectful nurse–client relationship
D) creating an environment that encourages client autonomy

15. The nurse has completed a health assessment on an older adult client being seen at a neighborhood clinic. What client-specific information should the nurse identify as being a **priority**?

A) lives alone
B) significantly impaired hearing
C) widowed 2 years ago
D) greatly concerned about cost of services

16. Data being collected during a health assessment causes the nurse to believe there may be additional issues that are possibly affecting the client's health and wellness. What action should the nurse take to **best** address the suggestion of additional health concerns?

A) Concentrate first on planning care for the problem identified initially by the client.
B) Extend the time originally allotted for the completion of the initial health assessment.
C) Plan to reassess the client with the focus on the possible additional health issues.
D) Interview the family about the existence of additional health-related issues when they visit.

17. When the client begins to cry, the nurse recognizes the need to focus the assessment on the client's emotional health. What factor will have the **greatest** effect on the nurse's ability to gather information concerning why the client is crying?

A) the client's ability to communicate verbally
B) the nurse's ability to ask relevant questions
C) the type and degree of physical issues the client is experiencing
D) the rapport that exists between the nurse and the client

Answer Key

1. A, E
2. C
3. B
4. C
5. A
6. C
7. A
8. C
9. A, B, D
10. A
11. C
12. C
13. A, B, C, E
14. A
15. B
16. B
17. D