Chapter 01: The Complete Health Assessment

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which critical thinking skill allows the nurse to think outside of the box when assessing a patient?
1) Divergent thinking
2) Reasoning
3) Creativity
4) Reflection

____ 2. The primary level of preventive health care focuses on which topic?
1) Health promotion
2) Early detection
3) Promotion intervention
4) End-of-life care

____ 3. The nurse is prioritizing data collected during the health assessment. Which data is primary?
1) Pain rating of 4 on a 1 to 10 numeric scale
2) New diagnosis of type 2 diabetes mellitus (DM)
3) Blood pressure of 130/90 mmHg
4) Pulse oximetry reading of 73%

____ 4. Which type of skill is most important when performing a physical assessment?
1) Psychomotor
2) Interpersonal
3) Ethical
4) Affective

____ 5. Which activity is an example of secondary prevention?
1) Wound débridement
2) Immunization
3) Preoperative teaching
4) Long-term nasogastric feedings

____ 6. Which assessment data is considered a symptom?
1) Rapid respirations
2) Sweaty palms
3) Belching
4) Feelings of anxiety

____ 7. Who or what is considered the primary data source for a toddler-age patient?
1) The toddler
2) A parent
3) The medical record
4) Other healthcare providers

____ 8. Which part of the assessment provides the most subjective data?
1) Health history
2) Physical assessment
3) Review of medical records
4) Medication record

____ 9. The nurse is preparing to conduct a health history for a new patient. Where would the nurse gather data for this portion of the assessment?
1) The patient's chart
2) A physical assessment
3) Laboratory tests
4) A discussion with the patient

____ 10. The nurse is preparing to begin a health history for a new patient. Which question is most appropriate for the nurse to begin the process?
1) "What problem brought you here today?"
2) "How old are you?"
3) "Have you had any difficulty breathing?"
4) "What childhood illnesses have you had?"

____ 11. Which is the reason for asking the patient about family history of diseases when conducting a health history interview?
1) To identify functional or dysfunctional family dynamics
2) To identify support systems
3) To identify familial or genetically linked health disorders
4) To identify rehabilitation needs

____ 12. Which data are part of the past health history?
1) Health beliefs
2) Surgeries
3) Genetically linked diseases
4) Age of siblings

____ 13. Which is the purpose of the nursing health history?
1) To determine the patient's response to the health problem
2) To determine the extent of the health problem
3) To determine which medications are appropriate to alleviate the health problem
4) All of the above

____ 14. Which setting is the best place to gather data for a health history?
1) Waiting room
2) Hallway
3) Patient's room
4) On the way to surgery

____ 15. The nurse is preparing to conduct a health history interview with a patient. Which is the best position for the nurse to assume during this process?
1) Leaning over the bed
2) Standing at the bedside
3) Sitting on the bed
4) Sitting on a chair at the bedside

____ 16. The nurse is asking a patient questions about health practices and beliefs. In which portion of the health history will the nurse document these findings?
1) Psychosocial profile
2) Current health problems
3) Past health problems
4) Developmental considerations

____ 17. The patient tells the nurse, “I can never seem to get warm lately and decided to come to the clinic.” The nurse records this under which section of the health history?
1) Past health history
2) Present health status
3) Reason for seeking care
4) Objective assessment data

____ 18. When is it appropriate for the nurse to conduct the focused physical assessment?
1) During the initial assessment for a yearly exam
2) On admission to the hospital for surgery
3) On admission of a patient in acute respiratory distress
4) All of the above

____ 19. Glass thermometers and sphygmomanometers have been replaced by other equipment in many healthcare settings. Which is the rationale for this change?
1) Difficulty with calibration
2) Difficulty with sterilization
3) Mercury toxicity
4) Poor results

____ 20. The bell of the stethoscope is best for detecting which type of sounds?
1) High pitch
2) Low pitch
3) Medium pitch
4) All of the above

____ 21. The nurse is unable to palpate pedal pulses bilaterally on an obese patient. Which is the priority action for the nurse to take?
1) Document that pedal pulses are absent
2) Auscultate heart tones
3) Assess gait
4) Assess pulses with a Doppler

____ 22. Which is the best assessment tool to use when testing far vision in 2-year-old children?
1) Snellen alphabet chart
2) Stycar chart
3) Allen cards
4) Pocket vision screener

____ 23. Which is the best method for the nurse to use when documenting a patient’s physical exam?
1) In order of the assessment
2) By the patient's main complaint
3) By system
4) With all normal and abnormal data clustered

____ 24. Which part of the hand does the nurse use to detect vibrations?
1) Fingertips
2) Fingerpads
3) Ball of hand
4) Dorsal surface

____ 25. The nurse is planning to use percussion during the physical examination of a patient. Which is the reason for using percussion?
1) To assess areas of tenderness
2) To assess organ and tissue density
3) To assess areas of inflammation
4) To assess consistency

____ 26. Which action by the nurse is appropriate when using an otoscope to assess the tympanic membrane of an adult?
1) Pulling the earlobe up and back
2) Pulling the earlobe down and back
3) Pulling the earlobe horizontally to straighten the ear canal
4) Avoiding moving the canal out of the normal anatomic position

____ 27. The nurse is preparing to assess the fetal heart rate during the 32nd week of gestation. Which action is appropriate?
1) Using the bell of the stethoscope
2) Using the diaphragm of the stethoscope
3) Using palpation to feel the fetal heart rate
4) Using a fetoscope

____ 28. The nurse is using an ophthalmoscope during a routine head-to-toe assessment. Which is the nurse assessing?
1) External ear canal
2) Tympanic membrane
3) Red light reflex
4) Cranial nerves

____ 29. Which is the correct technique for using the bell portion of the stethoscope?
1) Avoid touching the bell during auscultation
2) Hold the bell lightly on the chest wall
3) Apply light pressure with the bell slightly tilted up
4) Hold the bell firmly against the chest wall

____ 30. The nurse is preparing to assess the patient's thyroid gland. Which action is appropriate?
1) Asking the patient to identify a scent
2) Asking the patient to swallow water
3) Asking the patient to identify a taste
4) Asking the person to repeat "99"

____ 31. The nurse uses a tongue depressor to assess the gag reflex. Which action is appropriate by the nurse?
1) Sending the depressor for sterilization
2) Discarding the depressor in one piece
3) Breaking the depressor and then discarding it
4) Using the depressor for another patient

____ 32. The nurse is assessing the patient's range of motion. Which tool is a requirement for this assessment?
1) Stethoscope
2) Otoscope
3) Ophthalmoscope
4) Ganiometer

____ 33. The nurse is assisting the healthcare provider during a pelvic examination. Which action by the nurse is appropriate?

1) Preparing the hemoccult test
2) Placing the patient in Sims' position
3) Preparing the speculum
4) Placing sterile gloves on the provider

____ 34. The nurse is assessing the circumference of a patient's abdomen. Which will the nurse use when documenting the findings?
1) Millimeters
2) Centimeters
3) Inches
4) Kilograms

____ 35. The nurse is preparing to weigh a patient on a medical-surgical unit. Which is the priority action?
1) Asking the patient to remove his or her shoes for the weight assessment
2) Asking the patient to refrain from eating or drinking before the weight assessment
3) Calibrating the scale
4) Cleaning the scale

Multiple Response
Identify one or more choices that best complete the statement or answer the question.

____ 36. The nurse is conducting a neurologic assessment. Which items are needed? *Select all that apply.*
1) Cotton balls
2) Test tubes
3) Scents
4) Salts
5) Latex gloves

____ 37. The nurse is using a nasoscope during a head-to-toe assessment. Which assessments require the use of this tool? *Select all that apply.*
1) Nostrils
2) Nasal mucosa
3) Scrotum
4) Fontanels
5) Septum

Chapter 01: The Complete Health Assessment
Answer Section

MULTIPLE CHOICE

1. ANS: 3
   Chapter number and title: 1, The Complete Health Assessment
   Chapter learning objective: N/A
   Chapter page reference: 1
   Integrated Processes: Nursing Process: Assessment
   Client Need: Health Promotion and Maintenance
   Cognitive level: Knowledge [Remembering]
   Concept: Assessment, Critical Thinking
   Difficulty: Easy

	Feedback
1	Divergent thinking allows the nurse to analyze different points of view.
2	Reasoning allows the nurse to differentiate fact from assumptions.
3	Critical thinking is a thinking process that is used during the assessment process. Creativity is a critical thinking skill that allows the nurse to think outside of the box.
4	Reflection allows the nurse to step back and consider "if…then" possibilities.

   PTS: 1 CON: Assessment | Critical Thinking
2. ANS: 1
   Chapter number and title: 1, The Complete Health Assessment
   Chapter learning objective: N/A
   Chapter page reference: 2
   Integrated Processes: Nursing Process: Planning
   Client Need: Health Promotion and Maintenance
   Cognitive level: Comprehension [Understanding]
   Concept: Promoting Health
   Difficulty: Easy

	Feedback
1	There are three levels of preventive health care. Primary prevention focuses health promotion.
2	Secondary prevention focuses on early detection, prompt intervention, and health maintenance.
3	Secondary prevention focuses on prompt intervention and health maintenance.
4	Tertiary prevention focuses on rehabilitation, extended care, and end-of-life care.

   PTS: 1 CON: Promoting Health
3. ANS: 4
   Chapter number and title: 1, The Complete Health Assessment
   Chapter learning objective: N/A
   Chapter page reference: 3
   Integrated Processes: Nursing Process: Planning
   Client Need: Physiological Integrity: Physiological Adaptation
   Cognitive level: Analysis [Analyzing]
   Concept: Assessment
   Difficulty: Moderate

	Feedback
1	A pain rating of 4 on a 1 to 10 scale is secondary data. This finding requires prompt attention to prevent further progression or deterioration.
2	A new diagnosis of type 2 DM is tertiary data that is important but does not require immediate intervention. Tertiary data often requires patient teaching.
3	A slightly elevated blood pressure is secondary data. This finding requires prompt attention to prevent further progression or deterioration.
4	Primary data is anything that is a life threatening problem. A pulse oximetry reading of 73% indicates the blood is not being oxygenated appropriately and requires an immediate intervention to correct the problem.

PTS: 1 CON: Assessment

4. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 2
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Analysis [Analyzing]
Concept: Assessment
Difficulty: Easy

	Feedback
1	The psychomotor skills are inspection, palpation, percussion, and auscultation. These are considered the most important assessment skills.
2	Interpersonal skills are assessment skills, but they are not considered to be the most important assessment skills.
3	Ethical skills are assessment skills, but they are not considered to be the most important assessment skills.
4	Affective skills are assessment skills, but they are not considered to be the most important assessment skills.

PTS: 1 CON: Assessment

5. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 2
Integrated Processes: Nursing Process: Planning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive level: Application [Applying]
Concept: Promoting Health
Difficulty: Moderate

	Feedback
1	Wound care, including wound débridement, is an example of secondary prevention.
2	Immunization is an example of primary prevention.
3	Preoperative teaching is an example of tertiary prevention.
4	Long-term nasogastric feedings are an example of tertiary prevention.

PTS: 1 CON: Promoting Health

6. ANS: 4

Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 2
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Easy

	Feedback
1	Objective data is measurable and observable and is referred to as a sign. Rapid respirations are an example of objective data.
2	Objective data is measurable and observable and is referred to as a sign. Sweaty palms are an example of objective data.
3	Objective data is measurable and observable and is referred to as a sign. Belching is an example of objective data.
4	Subjective data is what the patient tells the nurse and is referred to as a symptom. Feelings of anxiety are an example of subjective data.

PTS: 1 CON: Assessment

7. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 3
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Easy

	Feedback
1	The primary source of data is data collected from the patient. The toddler-age patient is a primary source for data.
2	Secondary sources of data are family members, other healthcare providers, friends, and documentation within the medical record. A parent is a secondary source of data.
3	Secondary sources of data are family members, other healthcare providers, friends, and documentation within the medical record. The medical record is a secondary source of data.
4	Secondary sources of data are family members, other healthcare providers, friends, and documentation within the medical record. Other healthcare providers are secondary sources of data.

PTS: 1 CON: Assessment

8. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 3
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Assessment
Difficulty: Easy

	Feedback
1	The health history portion of the complete physical assessment provides the nurse with the most subjective data.
2	The physical assessment provides the nurse with objective data.
3	A review of the medical records provides the nurse with objective data.
4	The medication record provides the nurse with objective data.

PTS: 1 CON: Assessment

9. ANS: 4
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 2
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Easy

	Feedback
1	The nurse would gather objective data for the patient from the chart.
2	The nurse would gather objective data for the patient from the physical assessment.
3	The nurse would gather objective data for the patient from the laboratory test results.
4	The nurse will gather data for the health history directly from the patient during the health history interview portion of the complete physical assessment.

PTS: 1 CON: Assessment

10. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 3
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment, Communication
Difficulty: Moderate

	Feedback
1	The nurse who is conducting a health history for a new patient would begin the interview process by asking the patient what problem brings the patient to the healthcare provider for treatment.
2	Although asking the patient to state his or her age is appropriate for the health history portion of the complete physical examination, it is best to begin with why the patient is seeking care.
3	Although asking the patient about breathing difficulties is appropriate for the health history portion of the complete physical examination, it is best to begin with why the patient is seeking care.
4	Although asking the patient about childhood illnesses is appropriate for the health history portion of the complete physical examination, it is best to begin with why the patient is seeking care.

PTS: 1 CON: Assessment | Communication

11. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 18
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Easy

	Feedback
1	The nurse conducts a psychosocial profile to identify family dynamics.
2	The nurse conducts a psychosocial profile to identify support systems.
3	The nurse asks the patient about family history of diseases to identify familial or genetically linked health disorders.
4	The nurse plans for rehabilitation needs based on the physical assessment and plan of care

PTS: 1 CON: Assessment

12. ANS: 2
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 17
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Assessment
Difficulty: Easy

	Feedback
1	Health beliefs are assessed during the psychosocial profile.
2	Data collected during the past health history portion of the health history interview includes childhood illnesses, surgeries, hospitalizations, serious injuries, allergies, immunizations, and recent travel or military service.
3	Genetically linked diseases are assessed during the family history portion of the health history interview.
4	The ages of siblings are assessed during the family history portion of the health history interview.

PTS: 1 CON: Assessment

13. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 1
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Easy

	Feedback
1	The purpose of the health history is to collect subjective data for the patient. Subjective

	data allows the nurse to determine the patient's response to the current health problem.
2	The physical assessment will allow the nurse to collect objective data to determine the extent of the patient's current health problem.
3	It is outside of the scope of nursing practice to determine appropriate medications for the patient.
4	Subjective data allows the nurse to determine the patient's response to the current health problem. The physical assessment will allow the nurse to collect objective data to determine the extent of the patient's current health problem. It is outside of the scope of nursing practice to determine appropriate medications for the patient.

PTS: 1 CON: Assessment

14. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 17
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	The waiting room will not provide for patient confidentiality when collecting a health history.
2	The hallway will not provide for patient confidentiality when collecting a health history.
3	The health history is an interview in which the nurse collects personal data about the patient. It is essential to maintain the patient's confidentiality when this occurs. Therefore, the best place to conduct a health history is in the patient's room.
4	The health history must be gathered before the patient provides informed consent for the surgery; therefore it is not appropriate to gather this information on the way to surgery.

PTS: 1 CON: Assessment

15. ANS: 4
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 3
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment, Communication
Difficulty: Moderate

	Feedback
1	Leaning over the bed could potentially invade the patient's personal space and is not recommended.
2	Standing at the bedside does not allow the nurse to work at the same level as the patient.
3	Sitting on the bed could potentially invade the patient's personal space and is not recommended.

4	When conducting a health history interview it is important for the nurse to work at the same level as the patient. Therefore the nurse would sit in a chair at the patient's bedside.

PTS: 1 CON: Assessment | Communication

16. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 21
Integrated Processes: Communication and Documentation
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	The nurse asks questions about the patient's health practices and beliefs during the health history interview. The nurse would document this information in the psychosocial profile.
2	Health practices and beliefs are not documented in the section for current health problems.
3	Health practices and beliefs are not documented in the section for past health problems.
4	Health practices and beliefs are not documented in the section for developmental considerations.

PTS: 1 CON: Assessment

17. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 17
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive level: Application [Applying]
Concept: Assessment, Communication
Difficulty: Moderate

	Feedback
1	It is not appropriate to document the reason for the current visit in the past health history section.
2	It is not appropriate to document the reason for the current visit in the present health status section.
3	The nurse documents the reason for the patient's visit in the current health status section of the health history. The current health status indicates why the patient is seeking care.
4	It is not appropriate to document the reason for the current visit in the objective assessment data.

PTS: 1 CON: Assessment | Communication

18. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A

Chapter page reference: 27
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	When performing an initial assessment for a yearly exam a complete health history and a head-to-toe physical assessment is required.
2	When admitting a patient for a surgery a complete health history and head-to-toe physical assessment is required.
3	Focused assessments are only partial ones, dealing only with systems that relate to the patient's problem, so less data are collected. A focused assessment is appropriate when the patient's condition or time restraints preclude a comprehensive assessment. The patient who is experiencing acute respiratory distress requires a focused respiratory assessment to implement life-saving interventions.
4	A patient in respiratory distress would benefit from a focused assessment. An initial assessment for a yearly exam and the admitting assessment before surgery both require complete health histories and physical assessments.

PTS: 1 CON: Assessment

19. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 12
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Easy

	Feedback
1	Difficulty with calibration is not the reason glass thermometers and sphygmomanometers have been replaced with other equipment.
2	Difficulty with sterilization is not the reason glass thermometers and sphygmomanometers have been replaced with other equipment.
3	Glass thermometers and sphygmomanometers have been replaced with other equipment because of the risk for mercury toxicity that is associated with the use of this equipment.
4	Poor results are not the reason glass thermometers and sphygmomanometers have been replaced with other equipment.

PTS: 1 CON: Assessment

20. ANS: 2
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 12
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment

Difficulty: Moderate

	Feedback
1	The diaphragm is used for auscultating high-pitch sounds.
2	The bell of the stethoscope is used to auscultate low-pitch sounds.
3	Either the bell or the diaphragm can be used to auscultate medium-pitch sounds.
4	The bell of the stethoscope is not appropriate for auscultating high-pitch sounds. The bell and the diaphragm can both be used to auscultate medium-pitch sounds.

PTS: 1 CON: Assessment

21. ANS: 4
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 12
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Analysis [Analyzing]
Concept: Assessment
Difficulty: Difficult

	Feedback
1	The nurse would document that the pedal pulses are absent if unable to palpate or assess them with the Doppler.
2	Although it is appropriate to auscultate a patient's heart sounds during a physical assessment, this is not a priority action.
3	Although it is appropriate to assess gait during a physical assessment, this is not a priority action.
4	If a nurse is unable to palpate a patient's pedal pulses, the priority action is to use a Doppler to assess the patient's pedal pulses.

PTS: 1 CON: Assessment

22. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 13
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	The Snellen alphabet chart is appropriate for a school-age child.
2	The Stycar chart is appropriate for patients who are younger than 2 years of age and for illiterate adults.
3	The nurse who is assessing the vision of a 2-year-old patient would use Allen cards. This tool is appropriate for children as young as 24 months.
4	The pocket vision screener is a scaled Snellen chart that is used for patients who recognize the alphabet.

PTS: 1 CON: Assessment

23. ANS: 3

Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 27
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive level: Application [Applying]
Concept: Assessment, Communication
Difficulty: Moderate

	Feedback
1	The order of the assessment may change based on the patient's health status.
2	The nurse begins the health history by asking the patient the reason for the visit.
3	The best method for documenting a patient's physical exam is by system.
4	The nurse would not cluster all normal data and abnormal data.

PTS: 1 CON: Assessment | Communication

24. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 7
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	The fingertips are used to assess fine vibrations.
2	The fingerpads are used to assess fine vibrations.
3	When assessing vibrations, the nurse uses the balls of the hands or the ulnar surface of the hands.
4	The dorsal surface of the hand is used to assess skin temperature.

PTS: 1 CON: Assessment

25. ANS: 2
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 21
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Assessment
Difficulty: Easy

	Feedback
1	Palpation is used to assess areas of tenderness.
2	Percussion is used to determine the density of underlying tissues and to detect abnormalities in underlying organs.
3	Inspection and palpation are used to assess areas of inflammation.
4	Palpation is used to assess consistency.

PTS: 1 CON: Assessment

26. ANS: 1
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 13
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	The nurse will pull the earlobe up and back and insert the otoscope ½ inch when assessing the tympanic membrane of an adult.
2	The nurse will pull the earlobe down and back and insert the otoscope ¼ inch when assessing the tympanic membrane of a child (3 years of age or younger).
3	Pulling the earlobe horizontally is not an appropriate technique for the nurse to use.
4	The ear canal must be manipulated in order to accurately assess the tympanic membrane.

PTS: 1 CON: Assessment

27. ANS: 4
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 27
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Pregnancy, Assessment
Difficulty: Easy

	Feedback
1	The bell of the stethoscope is not used to assess fetal heart rate.
2	The diaphragm of the stethoscope is not used to assess fetal heart rate.
3	Palpation is used to assess uterine contractions. The nurse cannot palpate the fetal heart rate through the mother's abdomen.
4	A fetoscope is used to assess fetal heart rate.

PTS: 1 CON: Pregnancy | Assessment

28. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 13
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Easy

	Feedback
1	An otoscope is used to assess the external ear canal.
2	An otoscope is used to assess the tympanic membrane.

3	An ophthalmoscope is used to assess the red light reflex.
4	A tuning fork is used to assess certain cranial nerves.

PTS: 1 CON: Assessment

29. ANS: 2
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 11
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Assessment
Difficulty: Easy

	Feedback
1	The bell must be stabilized when using it for auscultation.
2	The bell is held lightly on the chest wall when using it for auscultation.
3	The bell should not be tilted up.
4	Although the bell must be stabilized during auscultation, light—not firm—pressure is required.

PTS: 1 CON: Assessment

30. ANS: 2
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 15
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	Scent identification is conducted during a cranial nerve assessment, not during a thyroid assessment.
2	The nurse will ask the patient to swallow water during a thyroid assessment.
3	Taste identification occurs during a cranial nerve assessment, not a thyroid assessment.
4	Asking the patient to repeat “99” is often done when assessing for tactile fremitus, not during a thyroid assessment.

PTS: 1 CON: Assessment

31. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 12
Integrated Processes: Nursing Process: Implementation
Client Need: Safe and Effective Care Environment: Safety and Infection Control
Cognitive level: Knowledge [Remembering]
Concept: Assessment, Infection Control
Difficulty: Easy

	Feedback

1	A tongue depressor is a disposable single-use item.
2	The tongue depressor should be discarded after patient use, but not in one piece.
3	The tongue depressor is broken into two pieces and discarded after use.
4	A tongue depressor is a single-use, disposable item. It is only used for one patient.

PTS: 1 CON: Assessment | Infection Control

32. ANS: 4
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 14
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment, Mobility
Difficulty: Easy

	Feedback
1	A stethoscope is needed for auscultation.
2	An otoscope is needed to assess the ear.
3	An ophthalmoscope is needed to assess the eyes.
4	A goniometer is needed to assess range of motion.

PTS: 1 CON: Assessment | Mobility

33. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 15
Integrated Processes: Nursing Process: Planning
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment, Female Reproduction
Difficulty: Moderate

	Feedback
1	The nurse would prepare the hemoccult test during a rectal examination, not a pelvic examination.
2	The nurse would place the patient in the lithotomy position during a pelvic examination, not the Sims' position.
3	A speculum is used during a pelvic examination. This action by the nurse is appropriate.
4	Sterile gloves are not necessary during a pelvic examination. The nurse and the provider would wear nonsterile, nonlatex examination gloves.

PTS: 1 CON: Assessment | Female Reproduction

34. ANS: 2
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 14
Integrated Processes: Nursing Process: Assessment
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive level: Comprehension [Understanding}

Concept: Assessment, Communication
Difficulty: Easy

	Feedback
1	Millimeters would be appropriate when measuring a small wound, not when measuring and documenting abdominal girth.
2	Centimeters are used when measuring abdominal girth.
3	Centimeters are used more often than inches during the assessment of abdominal girth.
4	Kilograms are used to measure weight, not when measuring abdominal girth.

PTS: 1 CON: Assessment | Communication

35. ANS: 3
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 14
Integrated Processes: Nursing Process: Implementation
Client Need: Health Promotion and Maintenance
Cognitive level: Analysis [Analyzing]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	While it is customary for the patient to remove his or her shoes during a weight assessment, this is not the priority.
2	It is not necessary to ask the patient to refrain from eating or drinking before the weight assessment.
3	The scale must be calibrated before each use. This is the priority action.
4	Depending on the type of scale, it may be necessary to clean it between patients. This, however, is not the priority action by the nurse.

PTS: 1 CON: Assessment

MULTIPLE RESPONSE

36. ANS: 1, 2, 3, 4
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 14-15
Integrated Processes: Nursing Process: Planning
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Moderate

	Feedback
1.	This is correct. Cotton balls are used during a neurologic examination.
2.	This is correct. Test tubes are used during a neurologic examination.
3.	This is correct. Scents are used to assess smell during a neurologic examination.
4.	This is correct. Salts are used to assess taste during a neurologic examination.
5.	This is incorrect. Nonlatex gloves are used during any physical assessment, including a neurological examination. Latex gloves are not used because of the risk of an anaphylactic

	reaction.

PTS: 1 CON: Assessment

37. ANS: 1, 2, 5
Chapter number and title: 1, The Complete Health Assessment
Chapter learning objective: N/A
Chapter page reference: 14
Integrated Processes: Nursing Process: Planning
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Easy

	Feedback
1.	This is correct. A nasoscope is used for assessing the patient's nostrils during a head-to-toe physical assessment.
2.	This is correct. A nasoscope is used for assessing the patient's nasal mucosa during a head-to-toe physical assessment.
3.	This is incorrect. A transilluminator, not a nasoscope, may be required when assessing a patient's scrotum.
4.	This is incorrect. A transilluminator, not a nasoscope, may be required when assessing a patient's fontanels.
5.	This is correct. A nasoscope is used for assessing the patient's septum during a head-to-toe physical assessment.

PTS: 1 CON: Assessment