Health assessment Course (NUR 106)
First year – first term

Date: 15 /1/2020 **Time:** 2 hours

Question parts: 4 **No. of pages: 9** **total marks 80 marks**

Section I:Multiple Choice Questions: (20 marks)

Please circle the best correct answer only:

1. **Assessment is performed when the client enters the hospital, which called:**

a) Problem-focused.
b) Initial comprehensive.
c) Emergency.
d) On-going.

2. **This type of assessment take place at outpatient clinic visits or home visit which called:**

a) On-going.
b) Problem-focused.
c) Initial comprehensive
d). Emergency.

3. **This type of assessment has shorter time frame and the nurse determine whether problems still exists, which called:**

a) Initial comprehensive.
b) Problem-focused.
c) On-going.
d) Emergency.

4. **Assessment take place in life threatening situations, which called:**

a) Admission.
b) Emergency
c) Time-lapsed.
d) Problem-focused.

5. **Mr. Ahmed was scheduled for a physical assessment. When percussing the client's chest, the nurse would expect to find which assessment data as a normal sign over his lungs?**

a) Dullness
b) Hyperresonance
c) Resonance
d) Tympany

6. Before the beginning of a physical examination, to make the patient more comfortable, what should be done first?

a) Give patient a warm blanket
b) Ask if patient wants a glass of water
c) Offer patient to empty his/her bladder
d) Provide a small

7. **The most frequently used assessment technique is:**

a) Palpation
b) Percussion
c) Inspection
d) Auscultation

8. Flatness is a type of sound that can be heard while percussing. What are some of its characteristics?

a) A dead stop of sound, absolute dullness, very short duration and can be heard over bones
b) A muffled thud, short in duration, and can be heard over the liver
c) Clear and hollow sound, moderate in duration and can be heard over normal lung tissue
d) Musical and drum like, sustained longest duration, and can be heard over stomach

9. The sense uses for palpation

a) Vision
b) Smell
c) Hearing
d) Touch

10. Which of the following nerve is assessed when the nurse ask the client to close their eyes, occlude one nostril, and then ask a client to identify a common aromatic substance held under their nose?

a) Olfactory
b) Oculomotor
c) Optic
d) Trigeminal

11. Which of the following nerves are assessed when the nurse using a cotton ball to apply superficial light touch to an area of the client's extremities. The client should be able to determine the location and type of touch?

a) Cranial
b) Peripheral
c) Spinal accessory
d) Vagus

12. When assessing the client's cerebellar function for balance and coordination, the nurse should?

a) Evaluate vital signs
b) Assess level of consciousness
c) Assess deep tendon reflexes
d) Use Romberg's test

13. Which of the following is assessed when the nurse gently squeezing the pads of a patient's fingers until them blanche, the pressure is then released and the time for the capillaries to refill is recorded?

a) Capillary refill time
b) Pitting edema.
c) Clubbing of the fingers
d) Cardiac biomarkers

14. Which of the following is not done when assessing heart status?

a) Inspecting the anterior chest wall.
b) Palpating the location of the apical pulse.
c) Measuring Capillary refill time.
d) Measuring the oxygen saturation

15. Which of the following sounds is a medical emergency and is loud, rough, continuous, and high-pitched?

a) Rhonchi.
b) Wheezes.
c) Stridor.
d) Murmurs

16. Which of the following is assessed when palpating the chest wall?

a) Thoracic expansion
b) Pitting edema
c) Measure the oxygen saturation
d) Cardiac biomarkers

17. Which of the following findings on musculoskeletal system with palpation indicates problems of joints ?

a) Limitation of movement
b) Color of skin
c) Muscle strength
d) Tenderness

18- When the person tells the assessor as description of the pain or felling. Which of following named this data?

a) Subjective
b) Correlation of objective
c) Objective
d) Correlation of subjective

19. Which of the following should the nurse ask the patient when assessing the eye?

a) Double vision
b) Edema
c) Redness
d) Ocular funds

20. Which of the following should the nurse observe when assessing the ears?

a) Any dizziness
b) Any hearing difficulty
c) Tinnitus and discharge
d) Size and shape

Section II: Please, read the statement carefully and write the letter (T) if the statement is true and the letter (F) if the statement is false. (30 marks)

Statements	True / False
1. Assessment is the first stage of the nursing process.	T
2. Nurses document before giving care.	F
3. Documentation act as a source of information	**T**
4. Collaborative documentation enables health care team to share the same documentation tools	**T**
5. A holistic assessment shows respect for patients ‘preferences and dignity.	**T**
6. The assessment is documented in the patient’s nursing records.	**T**
7. When using the auditory senses it is important to have a quiet environment for accurate hearing.	T
8. The pads of the fingers are used because lowery sensitive to tactile discrimination.	F
9. During direct percussion, the strikes are rapid, and the movement is from the wrist.	T
10. Deep palpation is performed with extreme caution because pressure can damage internal organs.	T
11. Several body areas can be assessed in one position for minimizing the number of position changes needed.	T
12. The biographical data this includes are birth date, sex and occupation	t
13. During taking nursing history the nurse shouldn’t allow the client to state problems and expectations for the interview.	F
14. Nutrition assessment plays a major role in health, prevention of disease, and recovery from illness.	T
15. To assess general appearance and mental status the nurse should observe client’s posture and overall hygiene and grooming	t

Statement	Answer
16. Measuring the weight and height provides important assessment data on the client's general health status	T
17. Neurological assessment can differentiate between life and death.	T
18. Vital signs is not importance during neurological system assessment	F
19. The most common problem in cardiovascular disease is chest pain	T
20. Range of motion is the most common assessment techniques for musculoskeletal system.	T
21. Humans are static entities.	F
22. Health assessment provides a base line used to plan client care	T
23. The health assessment is a dynamic and continuous process.	T
24. Documentation must be clear, concise, and accurate	T
25. The nurse should ask the client about sinus pain during assessment of eye	f
26. The nurse should explain when and where the assessment will take place	T
27. Providing privacy is important during physical assessment	T
28. Light palpation always precede deep palpation	T
29. The client's physical condition, energy level, and age should be taken into consideration during physical assessment	T
30. The nurse should be sensitive to the client's verbal and facial expressions indicating discomfort during palpation.	T

Section III: Matching Type Questions *(20 marks)*

part (1) : Match the description in column I with the correct word in column II

Column I	Column II
1. To prevent complication and rehabilitation.	A. Assessment in secondary prevention
2. For early screening and diagnosis.	B. Assessment in tertiary prevention
3. To promote health and prevent disease.	C. Primary source of data
4. Is the patient.	D. Secondary source of data
5. Family members and others medical records.	E. Draping
6. Is the striking of the area to be percussed rapidly with the pads of two, three, or four fingers.	F. Assessment in primary prevention
7. Is a hollow sound such as that produced by lungs filled with air.	G. Indirect percussion
8. Provide not only a degree of privacy, but also warmth	H. Hyper-resonance
9. Is the striking of a middle finger held against the body area to be assessed.	I. Direct percussion
10. It is described as booming and can be heard over an emphysematous lung.	J. Resonance

1	2	3	4	5	6	7	8	9	10
B	A	F	C	D	I	J	E	G	H

part (2) : Match the description in column I with the correct word in column II

Column I	Column II
1. Skinfold thickness, circumference of head, chest, mid-arm	A. Family History
2. Is a balance between nutrient intake and nutrient requirement.	B. Nutritional health status
3. Heredity factors associated with causes of some diseases	C. Direct methods of nutritional assessment
4. A lack of essential nutrients at the cellular level	D. Anthropometric measurement.
5. A biochemical, laboratory methods	E. Marasmus
6. Is most common abnormal heart sounds	F. Electrocardiogram (ECG)
7. Is a measurement of the electrical activity in the heart during a cardiac cycle	G. Bradypnea
8. Occur when a respiratory rate is <10 breaths per minute	H. Murmurs
9. Is an intermittent period of apnea, with a disorganized pattern, rate and depth	I. Tachypnea
10. Occur when a respiratory rate is >16 breaths per minute	J. Biot

1	2	3	4	5	6	7	8	9	10
D	B	A	E	C	H	F	G	J	I

<u>Section IV: Discuss in short note (10 marks)</u>

1. List seven from the basic components of Health History? (7 marks)

1- Biographical Data

2- Chief Complaint

3-Component of Present Illness

4- Family history

5- Environmental History

6- Current Health Information Psychosocial History

7- Nutritional Health History

2. List three from the importance of nutritional assessment? (3 marks)

1-Identification of malnutrition, and its effects on an individual's health status

2-Identification of patterns of overconsumption, and their link with the development of obesity, diabetes, hypertension cardiovascular disease, and cancer

3- Identification of nutritional parameters for optimal health and fitness For being well nourished individuals should have 3-5 meals a day (every 4-6 hours except for the night time when the break should be 12 hours long) of caloric value adjusted to individual needs

Good Luck

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