TEST BANK

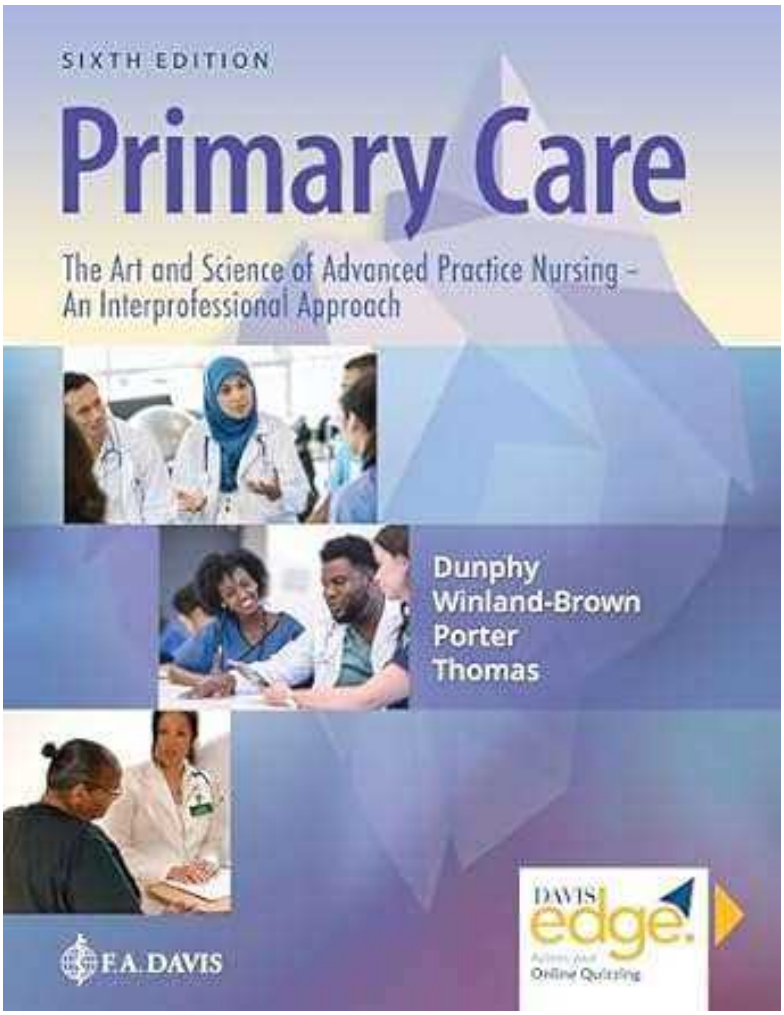
Primary Care

The Art and Science of Advanced Practice Nursing-

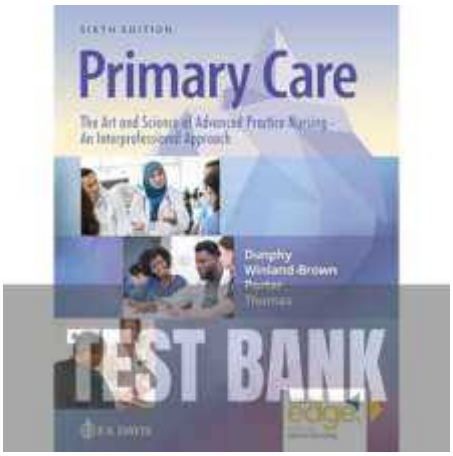
An Interprofessional Approach 6th Edition

Lynne M. Dunphy, Jill E. Winland-Brown, Brian Oscar Porter, Debera J. Thomas

6th Edition



Chapter 4. The Art of Diagnosis and Treatment
Primary Care The Art and Science of Advanced Practice Nursing-an Interprofessional Approach 6th Edition



MULTIPLE CHOICE

1. An 85-year-old man has come in for a physical examination, and the nurse notices that he uses a cane. When documenting general appearance, the nurse should document this information under the section that covers:

a. Posture.
b. Mobility.
c. Mood and affect.
d. Physical deformity.

ANS: B

Use of assistive devices would be documented under the mobility section. The other responses are all other categories of the general appearance section of the health history.

2. The nurse is performing a vision examination. Which of these charts is most widely used for vision examinations?

a. Snellen
b. Shetllen
c. Smoollen
d. Schwellon

ANS: A

The Snellen eye chart is most widely used for vision examinations. The other options are not tests for vision examinations.

3. After the health history has been obtained and before beginning the physical examination, the nurse should first ask the patient to:

a. Empty the bladder.

b. Completely disrobe.
c. Lie on the examination table.
d. Walk around the room.

ANS: A

Before beginning the examination, the nurse should ask the person to empty the bladder (save the specimen if needed), disrobe except for underpants, put on a gown, and sit with the legs dangling off side of the bed or table.

4. During a complete health assessment, how would the nurse test the patients hearing?

a. Observing how the patient participates in normal conversation
b. Using the whispered voice test
c. Using the Weber and Rinne tests
d. Testing with an audiometer

ANS: B

During the complete health assessment, the nurse should test hearing with the whispered voice test. The other options are not correct.

5. A patient states, Whenever I open my mouth real wide, I feel this popping sensation in front of my ears. To further examine this, the nurse would:

a. Place the stethoscope over the temporomandibular joint, and listen for bruits.
b. Place the hands over his ears, and ask him to open his mouth really wide.
c. Place one hand on his forehead and the other on his jaw, and ask him to try to open his mouth.
d. Place a finger on his temporomandibular joint, and ask him to open and close his mouth.

ANS: D

The nurse should palpate the temporomandibular joint by placing his or her fingers over the joint as the person opens and closes the mouth.

6. The nurse has just completed an examination of a patients extraocular muscles. When documenting the findings, the nurse should document the assessment of which cranial nerves?

a. II, III, and VI
b. II, IV, and V
c. III, IV, and V
d. III, IV, and VI

ANS: D

Extraocular muscles are innervated by cranial nerves III, IV, and VI.

7. A patients uvula raises midline when she says ahh, and she has a positive gag reflex. The nurse has just tested which cranial nerves?

a. IX and X
b. IX and XII
c. X and XII
d. XI and XII

ANS: A

Cranial nerves IX and X are being tested by having the patient say ahh, noting the mobility of the uvula, and when assessing the patients gag reflex.

8. During an examination, the nurse notices that a patient is unable to stick out his tongue. Which cranial nerve is involved with the successful performance of this action?

a. I
b. V
c. XI

d. XII

ANS: D

Cranial nerve XII enables the person to stick out his or her tongue.

9. A patient is unable to shrug her shoulders against the nurses resistant hands. What cranial nerve is involved with successful shoulder shrugging?

a. VII
b. IX
c. XI
d. XII

ANS: C

Cranial nerve XI enables the patient to shrug her shoulders against resistance.

10. During an examination, a patient has just successfully completed the finger-to-nose and the rapid-alternating-movements tests and is able to run each heel down the opposite shin. The nurse will conclude that the patients function is intact.

a. Occipital
b. Cerebral
c. Temporal
d. Cerebellar

ANS: D

The nurse should test cerebellar function of the upper extremities by using the finger-to-nose test or rapid-alternating-movements test. The nurse should test cerebellar function of the lower extremities by asking the person to run each heel down the opposite shin.

11. When the nurse performs the confrontation test, the nurse has assessed:

a. Extraocular eye muscles (EOMs).
b. Pupils (pupils equal, round, reactive to light, and accommodation [PERRLA]).
c. Near vision.
d. Visual fields.

ANS: D

The confrontation test assesses visual fields. The other options are not tested with the confrontation test.

12. Which statement is *true* regarding the complete physical assessment?

a. The male genitalia should be examined in the supine position.
b. The patient should be in the sitting position for examination of the head and neck.
c. The vital signs, height, and weight should be obtained at the end of the examination.
d. To promote consistency between patients, the examiner should not vary the order of the assessment.

ANS: B

The head and neck should be examined in the sitting position to best palpate the thyroid and lymph nodes. The male patient should stand during an examination of the genitalia. Vital signs are measured early in the assessment. The sequence of the assessment may need to vary according to different patient situations.

13. Which of these is included in an assessment of general appearance?

a. Height
b. Weight
c. Skin color
d. Vital signs

ANS: C

General appearance includes items such as level of consciousness, skin color, nutritional status, posture, mobility, facial expression, mood and affect, speech, hearing, and personal hygiene. Height, weight, and vital signs are considered measurements.

14. The nurse should wear gloves for which of these examinations?

a. Measuring vital signs
b. Palpation of the sinuses
c. Palpation of the mouth and tongue
d. Inspection of the eye with an ophthalmoscope

ANS: C

Gloves should be worn when the examiner is exposed to the patients body fluids.

15. The nurse should use which location for eliciting deep tendon reflexes?

a. Achilles
b. Femoral
c. Scapular
d. Abdominal

ANS: A

Deep tendon reflexes are elicited in the biceps, triceps, brachioradialis, patella, and Achilles heel.

16. During an inspection of a patients face, the nurse notices that the facial features are symmetric. This finding indicates which cranial nerve is intact?

a. VII
b. IX
c. XI
d. XII

ANS: A

Cranial nerve VII is responsible for facial symmetry.

17. During inspection of the posterior chest, the nurse should assess for:

a. Symmetric expansion.
b. Symmetry of shoulders and muscles.
c. Tactile fremitus.
d. Diaphragmatic excursion.

ANS: B

During an inspection of the posterior chest, the nurse should inspect for symmetry of shoulders and muscles, configuration of the thoracic cage, and skin characteristics. Symmetric expansion and tactile fremitus are assessed with palpation; diaphragmatic excursion is assessed with percussion.

18. During an examination, the patient tells the nurse that she sometimes feels as if objects are spinning around her. The nurse would document that she occasionally experiences:

a. Vertigo.
b. Tinnitus.
c. Syncope.
d. Dizziness.

ANS: A

Vertigo is the sensation of a person moving around in space (subjective) or of the person sensing objects moving around him or her (objective) and is a result of a disturbance of equilibratory apparatus

19. A patient tells the nurse, Sometimes I wake up at night and I have real trouble breathing. I have to sit up in bed to get a good breath. When documenting this information, the nurse would note:

a. Orthopnea.

b. Acute emphysema.
c. Paroxysmal nocturnal dyspnea.
d. Acute shortness of breath episode.

ANS: C

Paroxysmal nocturnal dyspnea occurs when the patient awakens from sleep with shortness of breath and needs to be upright to achieve comfort

20. During the examination of a patient, the nurse notices that the patient has several small, flat macules on the posterior portion of her thorax. These macules are less than 1 cm wide. Another name for these macules is:

a. Warts.
b. Bullae.
c. Freckles.
d. Papules.

ANS: C

A macule is solely a lesion with color change, flat and circumscribed, less than 1 cm. Macules are also known as *freckles*

21. During an examination, the nurse notices that a patients legs turn white when they are raised above the patients head. The nurse should suspect:

a. Lymphedema.
b. Raynaud disease.
c. Chronic arterial insufficiency.
d. Chronic venous insufficiency.

ANS: C

Elevational pallor (striking) indicates arterial insufficiency

22. The nurse documents that a patient has coarse, thickened skin and brown discoloration over the lower legs. Pulses are present. This finding is probably the result of:

a. Lymphedema.
b. Raynaud disease.
c. Chronic arterial insufficiency.
d. Chronic venous insufficiency.

ANS: D

Chronic venous insufficiency would exhibit firm brawny edema, coarse thickened skin, normal pulses, and brown discoloration

23. The nurse notices that a patient has ulcerations on the tips of the toes and on the lateral aspect of the ankles. This finding indicates:

a. Lymphedema.
b. Raynaud disease.
c. Arterial insufficiency.
d. Venous insufficiency.

ANS: C

Ulcerations on the tips of the toes and lateral aspect of the ankles are indicative of arterial insufficiency

24. The nurse has just recorded a positive iliopsoas test on a patient who has abdominal pain. This test is used to confirm a(n):

a. Inflamed liver.
b. Perforated spleen.
c. Perforated appendix.
d. Enlarged gallbladder.

ANS: C

An inflamed or perforated appendix irritates the iliopsoas muscle, producing pain in the RLQ.

25. The nurse will measure a patients near vision with which tool?

a. Snellen eye chart with letters
b. Snellen E chart
c. Jaeger card
d. Ophthalmoscope

ANS: C

The Jaeger card is used to measure near vision

26. If the nurse records the results to the Hirschberg test, the nurse has:

a. Tested the patellar reflex.
b. Assessed for appendicitis.
c. Tested the corneal light reflex.
d. Assessed for thrombophlebitis.

ANS: C

The Hirschberg test assesses the corneal light reflex

27. During the examination of a patients mouth, the nurse observes a nodular bony ridge down the middle of the hard palate. The nurse would chart this finding as:

a. Cheilosis.
b. Leukoplakia.
c. Ankyloglossia.
d. Torus palatinus.

ANS: D

A normal variation of the hard palate is a nodular bony ridge down the middle of the hard palate; this variation is termed *torus palatinus*

28. During examination, the nurse finds that a patient is unable to distinguish objects placed in his hand. The nurse would document:

a. Stereognosis.
b. Astereognosis.
c. Graphesthesia.
d. Agraphesthesia.

ANS: B

29. After the examination of an infant, the nurse documents opisthotonos. The nurse recognizes that this finding often occurs with:

a. Cerebral palsy.
b. Meningeal irritation.
c. Lower motor neuron lesion.
d. Upper motor neuron lesion.

ANS: B

Opisthotonos is a form of spasm in which the head is arched back, and a stiffness of the neck and an extension of the arms and legs are observed. Opisthotonus occurs with meningeal or brainstem irritation

30. After assessing a female patient, the nurse notices flesh-colored, soft, pointed, moist, papules in a cauliflower-like patch around her introitus. This finding is most likely:

a. Urethral caruncle.
b. Syphilitic chancre.
c. Herpes simplex virus.
d. Human papillomavirus.

ANS: D

Human papillomavirus appears in a flesh-colored, soft, moist, cauliflower-like patch of papules

31. While recording in a patients medical record, the nurse notices that a patients Hematest results are positive. This finding means that there is(are):

a. Crystals in his urine.
b. Parasites in his stool.
c. Occult blood in his stool.
d. Bacteria in his sputum.

ANS: C

32. While examining a 48-year-old patients eyes, the nurse notices that he had to move the handheld vision screener farther away from his face. The nurse would suspect:

a. Myopia.
b. Omniopia.
c. Hyperopia.
d. Presbyopia.

ANS: D

Presbyopia, the decrease in power of accommodation with aging, is suggested when the handheld vision screener card is moved farther away.