

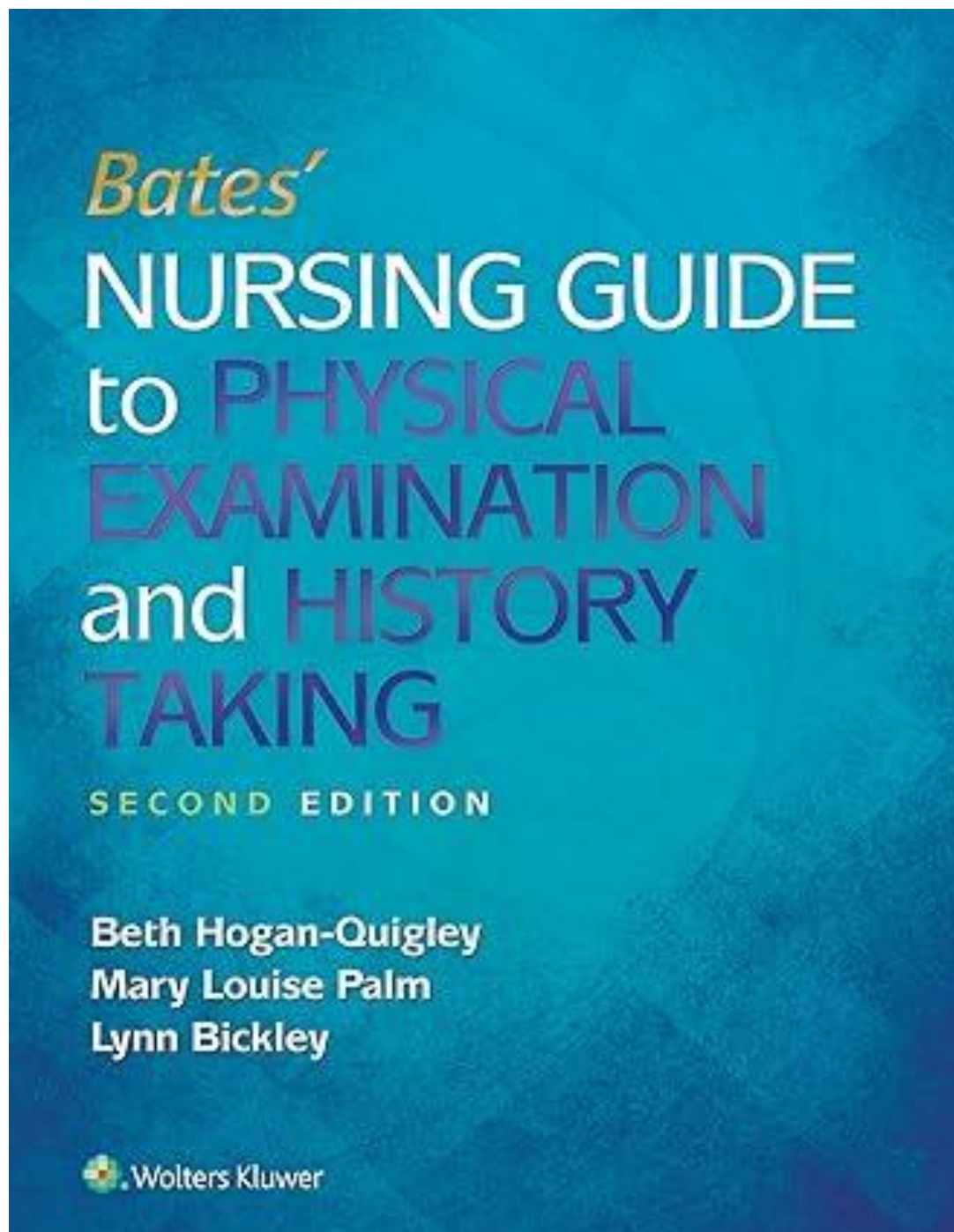
## TEST BANK

# Bates' Nursing Guide to Physical Examination and History Taking

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**2nd Edition**



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## Chapter 1 Introduction to Health Assessment

### Multiple Choice

1. For which of the following patients would a comprehensive health history be appropriate?

- A) A new patient with the chief complaint of —I sprained my ankle
- B) An established patient with the chief complaint of —I have an upper respiratory infection
- C) A new patient with the chief complaint of —I am here to establish care
- D) A new patient with the chief complaint of —I cut my hand

Ans: C

Chapter: 01

Page and Header: 4, Patient Assessment: Comprehensive or Focused

Feedback: This patient is here to establish care, and because she is new to you, a comprehensive health history is appropriate.

2. The components of the health history include all of the following except which one?

- A) Review of systems
- B) Thorax and lungs
- C) Present illness
- D) Personal and social items

Ans: B

Chapter: 01

Feedback: The thorax and lungs are part of the physical examination, not part of the health history. The other answers are all part of a complete health history.

3. Is the following information subjective or objective?

Mr. M. has shortness of breath that has persisted for the past 10 days; it is worse with activity and relieved by rest.

- A) Subjective
- B) Objective

Ans: A

Chapter: 01

Feedback: This is information given by the patient about the circumstances of his chief complaint. It does not represent an objective observation by the examiner.

4. Is the following information subjective or objective? Mr. M. has a respiratory rate of 32 and a pulse rate of 120.

- A) Subjective
- B) Objective

Ans: B Chapter: 01

Feedback: This is a measurement obtained by the examiner, so it is considered objective data. The patient is unlikely to be able to give this information to the examiner.

5. The following information is recorded in the health history: —The patient has had abdominal pain for 1 week. The pain lasts for 30 minutes at a time; it comes and goes. The severity is 7 to 9 on a scale of 1 to 10. It is accompanied by nausea and vomiting. It is located in the mid- epigastric area.¶

Which of these categories does it belong to?

- A) Chief complaint
- B) Present illness
- C) Personal and social history
- D) Review of systems

Ans: B Chapter: 01

Feedback: This information describes the problem of abdominal pain, which is the present illness. The interviewer has obtained the location, timing, severity, and associated manifestations of the pain. The interviewer will still need to obtain information concerning the quality of the pain, the setting in which it occurred, and the factors that aggravate and alleviate the pain. You will notice that it does include portions of the pertinent review of systems, but because it relates directly to the complaint, it is included in the history of present illness.

6. The following information is recorded in the health history: —The patient completed 8th grade. He currently lives with his wife and two children. He works on old cars on the weekend. He works in a glass factory during the week.¶

Which category does it belong to?

- A) Chief complaint
- B) Present illness
- C) Personal and social history
- D) Review of systems

Ans: C Chapter: 01

Feedback: Personal and social history information includes educational level, family of origin, current household status, personal interests, employment, religious beliefs, military history, and lifestyle (including diet and exercise habits; use of alcohol, tobacco, and/or drugs; and sexual preferences and history). All of this information is documented in this example.

7. The following information is recorded in the health history: —I feel really tired.¶

Which category does it belong to?

- A) Chief complaint
- B) Present illness
- C) Personal and social history
- D) Review of systems

Ans: A Chapter: 01

Feedback: The chief complaint is an attempt to quote the patient's own words, as long as they are suitable to print. It is brief, like a headline, and further details should be sought in the present illness section. The above information is a chief complaint.

8. The following information is recorded in the health history: —Patient denies chest pain, palpitations, orthopnea, and paroxysmal nocturnal dyspnea.¶

Which category does it belong to?

- A) Chief complaint
- B) Present illness
- C) Personal and social history
- D) Review of systems

Ans: D

Feedback: Review of systems documents the presence or absence of common symptoms related to each major body system. The absence of cardiac symptoms is listed in the above example.

9. The following information is best placed in which category? —The patient has had three cesarean sections.¶

- A) Adult illnesses
- B) Surgeries
- C) Obstetrics/gynecology
- D) Psychiatric

Ans: B Chapter: 01

Feedback: A cesarean section is a surgical procedure. Approximate dates or the age of the patient at the time of the surgery should also be recorded.

10. The following information is best placed in which category?

—The patient had a stent placed in the left anterior descending artery (LAD) in 1999.¶

- A) Adult illnesses
- B) Surgeries
- C) Obstetrics/gynecology
- D) Psychiatric

Ans: A Chapter: 01

Feedback: The adult illnesses category is reserved for chronic illnesses, significant hospitalizations, significant injuries, and significant procedures. A stent is a major procedure but does not involve a surgeon.

11. The following information is best placed in which category?

—The patient was treated for an asthma exacerbation in the hospital last year; the patient has never been intubated.¶

- A) Adult illnesses
- B) Surgeries
- C) Obstetrics/gynecology
- D) Psychiatric

Ans: A Chapter: 01

Feedback: This is information about a significant hospitalization and should be placed in the adult illnesses section. If the patient is being seen for an asthma exacerbation, you may consider placing this information in the present illness section, because it relates to the chief complaint at that visit.

## Chapter 2 Critical Thinking in Health Assessment

### MULTIPLE CHOICE

1. When performing a physical assessment, the first technique the nurse will always use is:
  - a. Palpation.
  - b. Inspection.
  - c. Percussion.
  - d. Auscultation.

ANS: B

The skills requisite for the physical examination are inspection, palpation, percussion, and auscultation. The skills are performed one at a time and in this order (with the exception of the abdominal assessment, during which auscultation takes place before palpation and percussion). The assessment of each body system begins with inspection. A focused inspection takes time and yields a surprising amount of information.

2. The nurse is preparing to perform a physical assessment. Which statement is *true* about the physical assessment? The inspection phase:
  - a. Usually yields little information.
  - b. Takes time and reveals a surprising amount of information.
  - c. May be somewhat uncomfortable for the expert practitioner.
  - d. Requires a quick glance at the patients body systems before proceeding with palpation.

ANS: B

A focused inspection takes time and yields a surprising amount of information. Initially, the examiner may feel uncomfortable, *staring* at the person without also *doing something*. A focused assessment is significantly more than a quick glance.

3. The nurse is assessing a patient's skin during an office visit. What part of the hand and technique should be used to best assess the patient's skin temperature?
- Fingertips; they are more sensitive to small changes in temperature.
  - Dorsal surface of the hand; the skin is thinner on this surface than on the palms.
  - Ulnar portion of the hand; increased blood supply in this area enhances temperature sensitivity.
  - Palmar surface of the hand; this surface is the most sensitive to temperature variations because of its increased nerve supply in this area.

ANS: B

The dorsa (backs) of the hands and fingers are best for determining temperature because the skin is thinner on the dorsal surfaces than on the palms. Fingertips are best for fine, tactile discrimination. The other responses are not useful for palpation.

4. Which of these techniques uses the sense of touch to assess texture, temperature, moisture, and swelling when the nurse is assessing a patient?
- Palpation
  - Inspection
  - Percussion
  - Auscultation

ANS: A

Palpation uses the sense of touch to assess the patient for these factors. Inspection involves vision; percussion assesses through the use of palpable vibrations and audible sounds; and auscultation uses the sense of hearing.

5. The nurse is preparing to assess a patient's abdomen by palpation. How should the nurse proceed?
- Palpation of reportedly tender areas are avoided because palpation in these areas may cause pain.
  - Palpating a tender area is quickly performed to avoid any discomfort that the patient may experience.
  - The assessment begins with deep palpation, while encouraging the patient to relax and to take deep breaths.
  - The assessment begins with light palpation to detect surface characteristics and to accustom the patient to being touched.

ANS: D

Light palpation is initially performed to detect any surface characteristics and to accustom the person to being touched. Tender areas should be palpated last, not first.

6. The nurse would use bimanual palpation technique in which situation?

- a. Palpating the thorax of an infant
- b. Palpating the kidneys and uterus
- c. Assessing pulsations and vibrations
- d. Assessing the presence of tenderness and pain

ANS: B

Bimanual palpation requires the use of both hands to envelop or capture certain body parts or organs such as the kidneys, uterus, or adnexa. The other situations are not appropriate for bimanual palpation.

7. The nurse is preparing to percuss the abdomen of a patient. The purpose of the percussion is to assess the \_\_\_\_\_ of the underlying tissue.

- a. Turgor
- b. Texture
- c. Density
- d. Consistency

ANS: C

Percussion yields a sound that depicts the location, size, and density of the underlying organ. Turgor and texture are assessed with palpation.

8. The nurse is reviewing percussion techniques with a newly graduated nurse. Which technique, if used by the new nurse, indicates that more review is needed?

- a. Percussing once over each area
- b. Quickly lifting the striking finger after each stroke
- c. Striking with the fingertip, not the finger pad
- d. Using the wrist to make the strikes, not the arm

ANS: A

For percussion, the nurse should percuss two times over each location. The striking finger should be quickly lifted because a resting finger damps off vibrations. The tip of the striking finger should make contact, not the pad of the finger. The wrist must be relaxed and is used to make the strikes, not the arm.

9. When percussing over the liver of a patient, the nurse notices a dull sound. The nurse should:

- a. Consider this a normal finding.
- b. Palpate this area for an underlying mass.
- c. Reposition the hands, and attempt to percuss in this area again.
- d. Consider this finding as abnormal, and refer the patient for additional treatment.

ANS: A

Percussion over relatively dense organs, such as the liver or spleen, will produce a dull sound. The other responses are not correct.

10. The nurse is unable to identify any changes in sound when percussing over the abdomen of an obese patient. What should the nurse do next?

- a. Ask the patient to take deep breaths to relax the abdominal musculature.
- b. Consider this finding as normal, and proceed with the abdominal assessment.
- c. Increase the amount of strength used when attempting to percuss over the abdomen.
- d. Decrease the amount of strength used when attempting to percuss over the abdomen.

ANS: C

The thickness of the persons body wall will be a factor. The nurse needs a stronger percussion stroke for persons with obese or very muscular body walls. The force of the blow determines the loudness of the note. The other actions are not correct.

11. The nurse hears bilateral loud, long, and low tones when percussing over the lungs of a 4- year-old child. The nurse should:

- a. Palpate over the area for increased pain and tenderness.
- b. Ask the child to take shallow breaths, and percuss over the area again.
- c. Immediately refer the child because of an increased amount of air in the lungs.
- d. Consider this finding as normal for a child this age, and proceed with the examination.

ANS: D

Percussion notes that are loud in amplitude, low in pitch, of a booming quality, and long in duration are normal over a childs lung.

12. A patient has suddenly developed shortness of breath and appears to be in significant respiratory distress. After calling the physician and placing the patient on oxygen, which of these actions is the best for the nurse to take when further assessing the patient?

- a. Count the patients respirations.
- b. Bilaterally percuss the thorax, noting any differences in percussion tones.
- c. Call for a chest x-ray study, and wait for the results before beginning an assessment.
- d. Inspect the thorax for any new masses and bleeding associated with respirations.

ANS: B

Percussion is always available, portable, and offers instant feedback regarding changes in underlying tissue density, which may yield clues of the patients physical status.

13. The nurse is teaching a class on basic assessment skills. Which of these statements is *true* regarding the stethoscope and its use?

- a. Slope of the earpieces should point posteriorly (toward the occiput).
- b. Although the stethoscope does not magnify sound, it does block out extraneous room noise.
- c. Fit and quality of the stethoscope are not as important as its ability to magnify sound.
- d. Ideal tubing length should be 22 inches to dampen the distortion of sound.

ANS: B

The stethoscope does not magnify sound, but it does block out extraneous room sounds. The slope of the earpieces should point forward toward the examiners nose. Long tubing will distort sound. The fit and quality of the stethoscope are both important.

14. The nurse is preparing to use a stethoscope for auscultation. Which statement is *true* regarding the diaphragm of the stethoscope? The diaphragm:

- a. Is used to listen for high-pitched sounds.
- b. Is used to listen for low-pitched sounds.
- c. Should be lightly held against the persons skin to block out low-pitched sounds.
- d. Should be lightly held against the persons skin to listen for extra heart sounds and murmurs.

ANS: A

The diaphragm of the stethoscope is best for listening to high-pitched sounds such as breath, bowel, and normal heart sounds. It should be firmly held against the persons skin, firmly enough to leave a ring. The bell of the stethoscope is best for soft, low-pitched sounds such as extra heart sounds or murmurs.

15. Before auscultating the abdomen for the presence of bowel sounds on a patient, the nurse should:

- a. Warm the endpiece of the stethoscope by placing it in warm water.
- b. Leave the gown on the patient to ensure that he or she does not get chilled during the examination.
- c. Ensure that the bell side of the stethoscope is turned to the on position.
- d. Check the temperature of the room, and offer blankets to the patient if he or she feels cold.

ANS: D

The examination room should be warm. If the patient shivers, then the involuntary muscle contractions can make it difficult to hear the underlying sounds. The end of the stethoscope should be warmed between the examiners hands, not with water. The nurse should never listen through a gown. The diaphragm of the stethoscope should be used to auscultate for bowel sounds.

16. The nurse will use which technique of assessment to determine the presence of crepitus, swelling, and pulsations?

- a. Palpation
- b. Inspection
- c. Percussion
- d. Auscultation

ANS: A

Palpation applies the sense of touch to assess texture, temperature, moisture, organ location and size, as well as any swelling, vibration or pulsation, rigidity or spasticity,

17. The nurse is preparing to use an otoscope for an examination. Which statement is *true* regarding the otoscope? The otoscope:

- a. Is often used to direct light onto the sinuses.
- b. Uses a short, broad speculum to help visualize the ear.
- c. Is used to examine the structures of the internal ear.
- d. Directs light into the ear canal and onto the tympanic membrane.

ANS: D

The otoscope directs light into the ear canal and onto the tympanic membrane that divides the external and middle ear. A short, broad speculum is used to visualize the nares.

18. An examiner is using an ophthalmoscope to examine a patients eyes. The patient has astigmatism and is nearsighted. The use of which of these techniques would indicate that the examination is being correctly performed?

- a. Using the large full circle of light when assessing pupils that are not dilated
- b. Rotating the lens selector dial to the black numbers to compensate for astigmatism
- c. Using the grid on the lens aperture dial to visualize the external structures of the eye
- d. Rotating the lens selector dial to bring the object into focus

ANS: D

The ophthalmoscope is used to examine the internal eye structures. It can compensate for nearsightedness or farsightedness, but it will not correct for astigmatism. The grid is used to assess size and location of lesions on the fundus. The large full spot of light is used to assess dilated pupils. Rotating the lens selector dial brings the object into focus.