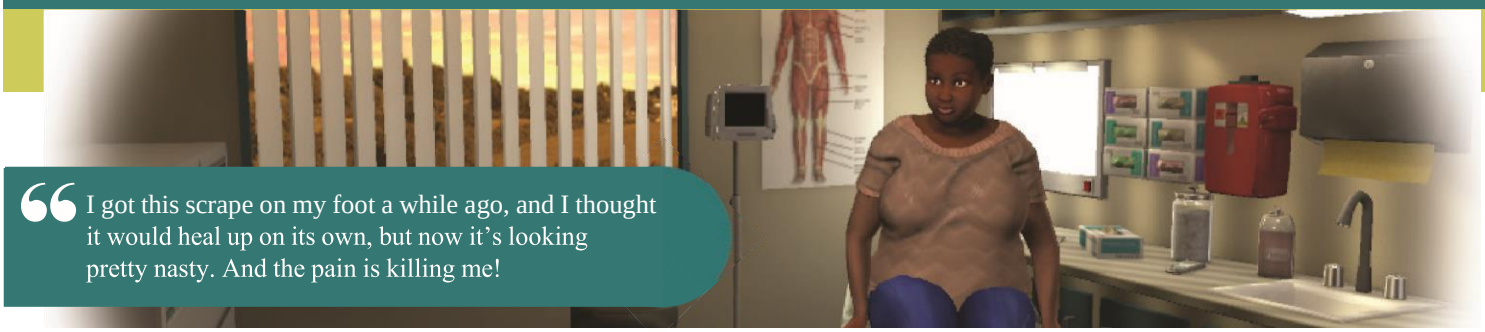
Advanced Health Assessment

Health History - Tina Jones™



Module 1 – Health History

Ms. Jones is a pleasant, 28 -year- old obese African American single woman who presents to establish care and with a recent right foot injury. She is the primary source of the history. Ms. Jones off ers information freely and without contradiction. Speech is clear and coherent. She maintains eye contact throughout the interview.
Timeframe: 1 week after fall (Age: 28)
Reason for visit: Patient presents for an initial primary care visit today complaining of an infected foot wound.

Learning Objectives

Develop strong communication skills

- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately

- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills

- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will refl ect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Information Processing Activity
- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

High Priority

- Acute pain of the foot
- Local infection of skin and subcutaneous tissue of the foot
  Uncontrolled type 2 diabetes mellitus

Low Priority:

- Acanthosis nigricans
- Hypertension
- Menorrhagia
- Obesity
- Oligomenorrhea

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- Dysmenorrhea
- Hirsutism
- Polycystic ovarian syndrome

History of Present Illness

One week after sustaining the cut, Tina Jones develops an infection in the cut on the bottom of her foot; she seeks treatment when the infection starts to swell and produce pus.

Day 1 (Onset): Tina was at home, going down the back steps, and she tripped. She turned her ankle and scraped the bottom of her foot. The wound bled, but she stopped the bleeding quickly and cleaned the wound. She worried that she had sprained her ankle, and her mom drove her to the ER. ("a week ago")

The ER did an x ray (no broken bones), gave her a prescription for Tramadol, and sent her home. In the following days, her ankle seemed fi ne not as serious as she thought.

Day 2 - 4: She cleaned the wound dutifully, twice a day, with soap and water or hydrogen peroxide, let it dry, put Neosporin on it, and bandaged it. The wound wasn't getting worse, but it wasn't healing, either. She expresses that she "took really good care of it." Tina was able to go to work and attend school.

Day 4: Tina went to her cousin's house, where she encountered cats and experienced wheezing. She tried two puff s on her albuterol inhaler, and she had to do a third puff . ("three days ago")

Day 5 - 6: Tina noticed pus in the wound, and swelling, redness and a warm feeling in her foot. Her pain increased to the point she was unable to walk. She began to take the Tramadol to try to manage the pain, but it didn't resolve the pain completely. She missed class and work. ("two days ago")

On the night of Day 6: Tina started to run a fever. They took her temperature at home, and it was 102. ("last night")

Morning of Day 7: Tina finally recognizes that her foot infection is not going to get better, and her mom takes her to the nurse practitioner to get the foot looked at.

Subjective and Objective Model Documentation

Printable "Answer Key" available within the Shadow Health DCE.

Chief Complaint

- **Symptoms** - Foot pain and discharge
- **Diagnosis** - Infected foot wound

Vitals

- Weight (kg) - 88
- BMI - 30.5
- Heart Rate (HR) - 82
- Respiratory Rate (RR) - 16

Medications

1. Acetaminophen 500- 1000 mg PO prn (headaches)
2. Ibuprofen 600 mg PO TID prn (menstrual cramps)
3. Tramadol 50 mg PO BID prn (foot pain)

Allergies

- Penicillin: rash
- Denies food and latex allergies
- Allergic to cats and dust. When she is exposed to allergens she states that she has runny nose, itchy

and swollen eyes, and increased asthma symptoms.

- Pulse Oximetry - 99%
- Blood Pressure (BP) - 139/87
- Blood Glucose - 117
- Temperature (F) - 98.9

4. Albuterol 90 mcg/spray MDI 2 puff s Q4H prn (last use: “a few months ago”)

Abnormal Findings

Reported during Chief Complaint interview

- Reports open foot wound and throbbing pain
- Rates present pain at a 7 out of 10
- Discharge, redness, swelling, and warmth around foot wound
- Reports a fever last night and presents with a fever of 101.1 F

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- Pain affects ability to walk, job performance, and class attendance

Reported during Past Medical History interview

- Diagnosed with asthma in childhood and uses an inhaler 2 to 3 times per week
- Allergic to penicillin, dust and cats, which cause wheezing periods
- Occasional headaches and eye strain
- Increased thirst and more frequent urination
- Recent 10lb unintentional weight loss
- Habitual diet soda drinking
- Diagnosed with Type 2 diabetes
- Does not currently take medication for diabetes and does not monitor blood glucose

Assessment

Right foot wound with evidence of infection

Plan

1. **Clean wound with normal saline and redress with clean gauze.**
2. **Educate patient on when to seek emergent care, signs and symptoms of infection, and daily wound care.**
3. **Return to clinic one week to re-evaluate wound and assess need for antibiotics.**

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- Heavy menstrual flow, heavy cramping, and irregular

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