RUA: Health History and Physical Assessment

[redacted]

Chamberlain University College of Nursing

NR 304 Health Assessment II

Professor Everett

[redacted]

Health History Assessment

I opted to conduct a health assessment on a female Teacher, using the pseudonym Mrs.A. Mrs.A graciously agreed to participate in the assessment process and dedicated a thirty-minute session to complete it. Before initiating the assessment, I provided Mrs.A with a detailed procedure overview, explaining each step thoroughly. Throughout our session, Mrs.A and I collaborated seamlessly, with no disruptions, enabling us to execute the entire assessment comprehensively. It was essential to me that Mrs.A fully understood the purpose and process of the assessment, and I ensured clarity and transparency at every stage of our interaction.

Health History: Subjective Data

1. **Demographic Data:** The individual interviewed for this health history and physical examination is a 35-year-old female, Mrs. A, who works as a teacher. She resides in a suburban area with her husband and two children. She reports her ethnicity as Caucasian.

2. **Reason for Care:** Mrs. A presents for a routine health check-up to address recurring headaches and fatigue concerns.

3. **Present Illness (PQRST of Current Illness)**: Mrs. A reports experiencing frequent headaches over the past six months. She describes these headaches as a pressure-like sensation around her temples and the back of her head, often occurring in the late afternoon. The headaches are not associated with nausea, vomiting, or visual disturbances. She also mentions feeling fatigued despite getting adequate sleep and experiencing occasional dizziness upon standing.

4. **Perception of Health:** Mrs. A perceives her health as generally good but acknowledges feeling more tired than usual lately. She expresses concern about her recurring headaches and their impact on her daily activities.