**Health History and Screening of an Adolescent or Young Adult Client**

Save this form on your computer as a Microsoft Word document. You can expand or shrink each area as you need to include the relevant data for your client.

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| Student Name: | Date: |
| **Biographical Data** |
| Patient/Client Initials: | Phone No: |
| Address: |
| Birth Date: | Age: | Sex: |
| Birthplace:  | Marital Status: |
| Race/Ethnic Origin:  |
| Occupation: | Employer: |
| Financial Status: (*Income adequate for lifestyle and/or health concerns. Is there a source of health insurance? Employment disability?)* |
| Source and Reliability of Informant: |
| Past Use of Health Care System and Health Seeking Behaviors: |
| Present Health or History of Present Illness: |
| **Past Health History** |
| General Health**:** *(Patient’s own words)* |
| Allergies: *(include food and medication allergies)*  | Reaction: |
| Current Medications: |
| Last Exam Date: | Immunizations: |
| Childhood Illnesses: |
| Serious or Chronic Illnesses: |
| Past Health Screening *(see “Well Young Adult Behavior Health Assessment History Screening” below)* |
| Past Accidents or Injuries: |
| Past Hospitalizations: |
| Past Operations: |
| **Family History***(Specify which family member is affected.)* |
| Alcoholism (ETOH use/abuse): |
| Allergies: |
| Arthritis: |
| Asthma: |
| Blood Disorders: |
| Breast Cancer: |
| Cancer (*Other)*: |
| Cerebral Vascular Accident *(Stroke):* |
| Diabetes: |
| Heart Disease: |
| High Blood Pressure: |
| Immunological Disorders: |
| Kidney Disease: |
| Mental Illness: |
| Neurological Disorder: |
| Obesity: |
| Seizure Disorder: |
| Tuberculosis: |
| **Obstetric History** (if applicable) |
| Gravida: | Term: | Preterm: | Miscarriage/Abortions: |
| Course of Pregnancy *(length of pregnancy, delivery date, method of delivery, length of labor, complications, baby’s weight, baby’s condition):* |
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| **Well Young Adult Behavioral Health History Screening** |
| **Socio-Demographic Content and Questions:**What organizations or activities (community, school, church, lodge, social, professional, academic, sports) are you involved in? How would you describe your community?Hobbies, skills, interests, recreational activities?Military service: Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ If yes, overseas assignment? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_Close friends or family members who have died within past 2 years?Number of relatives or close friends in this area?Marital status: Single\_\_\_\_\_\_ Married\_\_\_\_\_\_\_\_Divorced\_\_\_\_\_\_\_\_\_Separated\_\_\_\_\_\_\_\_\_  In serious relationship\_\_\_\_\_\_\_\_ Length of time\_\_\_\_\_\_\_\_\_ |
| **Environmental Content and Questions:**Do you live alone? Yes\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_When did you last move?Describe your living situation?Number of years of education completed?Occupation? If employed, how long? Are you satisfied with this work situation? Do you consider your work dangerous or risky? Is your work stressful?Over the past 2 years have you felt depressed or hopeless?  |
| **Biophysical Content and Questions**Have you smoked cigarettes? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_How much? Less than ½ pack per day\_\_\_\_\_ About 1 pack per day?\_\_\_\_\_\_ More than 1 and ½ packs per day\_\_\_\_\_\_Are you smoking now? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ Length of time smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever smoked illicit drugs? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_ Do you smoke these now? Yes\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_Do you ingest illicit drugs of any kind? Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_If so, what drugs do you use and what is the route of ingestion?\_\_\_\_\_\_\_\_\_How long have you used these drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Review of Systems***(Include both past and current health problems. Comment on all present issues.)* |
| General Health State *(present weight – gain or loss, reason for gain or loss, amount of time for gain or loss; fatigue, malaise, weakness, sweats, night sweats, chills ):* |
| Skin *(history of skin disease, pigment or color change, change in mole, excessive dryness or moisture, pruritis, excessive bruising, rash or lesion):*Health Promotion *(Sun exposure? Skin care products?):* |
| Hair *(recent loss or change in texture):*Health Promotion *(method of self-care, products used for care)*: |
| Nails *(change in color, shape, brittleness):*Health Promotion *(method of self-care, products used for care):* |
| Head *(unusual headaches, frequency of headaches, head injury, dizziness, syncope or vertigo):* |
| Eyes *(difficulty or change in vision, decreased acuity, blurring, blind spots, eye pain, diplopia, redness or swelling, watering or discharge, glaucoma or cataracts):*Health Promotion *(wears glasses or contacts and reason, last vision check, last glaucoma check, sun protection):* |
| Ears *(earaches, infections, discharge and its characteristics, tinnitus or vertigo):*Health Promotion *(hearing loss, hearing aid use, environmental noise exposure, methods for cleaning ears):* |
| Nose and Sinuses *(discharge and its characteristics, frequent or severe colds, sinus pain, nasal obstruction, nosebleeds, seasonal allergies, change in sense of smell):*Health Promotion *(methods for cleaning nose):* |
| Mouth and Throat *(mouth pain, sore throat, bleeding gums, toothache, lesions in mouth, tongue, or throat, dysphagia, hoarseness, tonsillectomy, alteration in taste):*Health Promotion *(Daily dental care – brushing, flossing. Use of prosthetics – bridges, dentures. Last dental exam/check-up.):* |
| Neck *(pain, limitation of motion, lumps or swelling, enlarged or tender lymph nodes, goiter):* |
| Neurologic System *(history of seizure disorder, syncopal episodes, CVA, motor function or coordination disorders/abnormalities, paresthesia, mood change, depression, memory disorder, history of mental health disorders):*Health Promotion *(activities to stimulate thinking, exam related to mood changes/depression):* |
| Endocrine System *(history of diabetes or insulin resistance, history of thyroid disease, intolerance to heat or cold):*Health Promotion *(last blood glucose test and result, diet):* |
| Breast and Axilla *(pain, lump, tenderness, swelling, rash, nipple discharge, any breast surgery):*Health Promotion *(performs breast self-exam – both male and female, last mammogram and results, use of self-care products):* |
| Respiratory System *(History of lung disease, smoking, chest pain with breathing, wheezing, shortness of breath, cough – productive or nonproductive. Sputum – color and amount. Hemoptysis, toxin or pollution exposure.):*Health Promotion *(last chest x-ray, smoking cessation):* |
| Cardiac System *(history of cardiac disease, MI, atherosclerosis, arteriosclerosis, chest pain, angina):*Health Promotion *(last cardiac exam):* |
| Peripheral Vascular System *(coldness, numbness, tingling, swelling of legs/ankles, discoloration of hands/feet, varicose veins, intermittent claudication, thrombophlebitis or ulcers):*Health Promotion *(avoid crossing legs, avoid sitting/standing for long lengths of time, promote wearing of support hose):* |
| Hematologic System *(bleeding tendency of skin or mucous membranes, excessive bruising, swelling of lymph nodes, blood transfusion and any reactions, exposure to toxic agents or radiation):*Health Promotion *(use of standard precautions when exposed to blood/body fluids):* |
| Gastrointestinal System *(appetite, food intolerance, dysphagia, heartburn, indigestion, pain [with eating or other], pyrosis, nausea, vomiting, history of abdominal disease, gastric ulcers, flatulence, bowel movement frequency, change in stool [color, consistency], diarrhea, constipation, hemorrhoids, rectal bleeding):*Health Promotion *(nutrition – quality/quantity of diet; use of antacids/laxatives):* |
| Musculoskeletal System *(history of arthritis, joint pain, stiffness, swelling, deformity, limitation of motion, pain, cramps or weakness):*Health Promotion *(mobility aids used, exercises, walking, effect of limited range of motion):* |
| Urinary System *(recent change, frequency, urgency, nocturia, dysuria, polyuria, oliguria, hesitancy or straining, urine color, narrowed stream, incontinence; history of urinary disease; pain in flank, groin, suprapubic region or low back):*Health Promotion *(methods used to prevent urinary tract infections, use of feminine hygiene products, Kegel exercises):* |
| Male Genital System *(penis or testicular pain, sores or lesions, penile discharge, lumps, hernia):*Health Promotion *(performs testicular self-exam):* |
| Female Genital System *(menstrual history, age of first menses, last menstrual cycle, frequency of cycles, premenstrual pain, vaginal itching, discharge, premenopausal symptoms, age at menopause, postmenopausal bleeding):*Health Promotion *(last gynecological checkup, pap-smear and results, use of feminine hygiene products):* |
| Sexual Health *(presently involved in relationship involving intercourse or other sexual activity, aspects of sex satisfactory, use of contraceptive, is relationship monogamous, history of STD):*Health Promotion *(safe-sex practices):* |

**Nursing Diagnoses:**

Based on this health history and health screening, identify three nursing diagnoses that would be applicable for this client as well as your rationale for your selection of each nursing diagnosis. Include:

One “actual” nursing diagnosis with rationale for choice of this diagnosis.

One wellness nursing diagnosis with rationale for choice of this diagnosis.

One “risk for” nursing diagnosis based on the health screening with rationale for choice of this diagnosis.