

Health history essay sample

[Health & Medicine](#), [Cancer](#)



Biographical: The client, P. P. is a 51 year-old female. Her date of birth is January 28, 1961, and she was born in Utica, NY. The client is of Italian-American descent. She is a registered nurse who currently works from home as a workers compensation RN, and holds a position in a labor and delivery unit at a local hospital. Chief Complaint/Present Health: P. P. suffers from seasonal and household allergies that lead to respiratory irritation, which requires rounds of steroids, inhalers, and antibiotics around the time the seasons change. Living in upstate New York, the spring, summer, and fall exacerbate these symptoms. Some household cleaning products such as oven cleaner, and bleach also bring out the allergy. The main symptom is a harsh, dry cough with some wheezing. This has not been a lifelong problem, starting about 3 years ago. She has had chest x-rays that were all thankfully negative, and has recently made an appointment with a Pulmonologist to rule out any other possibilities. Client states she feels generally well every day, with no chronic problems. Past History: This 51 year-old female did not have any serious problems as an infant or child, besides the chicken pox at a young age, which she does not recall.

As for immunizations, the client is up to date on her vaccines, which is important in her line of work. She denies receiving the influenza vaccine, stating that after getting her first one ever a few years ago her allergies started. P. P. has had 4 pregnancies, and 4 deliveries, none requiring a c-section. She has lived with endometriosis since her teen years, and in 2006 had a benign uterine fibroid tumor that required her to have another emergency room visit ending in a total hysterectomy. She mentions that she did go to her annual gynecological check ups, and this was not found until

the pain started. Since the hysterectomy, the client has been on a hormone patch, the only daily medicine she uses. The client was diagnosed with gallstones about 15 years ago, and had a laparoscopic cholecystectomy in 2003. The procedure was an emergency surgery, and was not scheduled in advance. Family History: Mother deceased in 1996 from colon cancer, father in 1992 from a major heart attack.

The patient states her paternal family always suffered from kidney stones, reason unknown. Maternal grandmother deceased when the patient was a teenager, from unknown complications, client states old age. Paternal grandmother deceased when the client was a young girl, from unknown complications, and the paternal grandfather from a stroke also when the client was young. Paternal aunts are all deceased, from breast cancer in 2011, a brain tumor in 1999, and another from stroke in 2004. Paternal uncle alive and well, with a diagnosis of prostate cancer, controlled. The only maternal aunt deceased in 1985 from breast and colon cancer. The only maternal uncle had lung cancer, and has been deceased for many years, (the client cannot recall the year). P. P. has one brother, alive and well but has high triglycerides, and also recently found anemia (unknown origin at this time). The client has 4 children, alive and well, with no health problems. Psychosocial: P. P., (the client) states that she has a great support system. She has a fiancé that she has been with for more about 10 years, and the 4 adult children. She has one cousin that is very close to her family. After sleeping for about 6 hours a night, the client wakes up and has coffee, a shower, and starts her work from home.

At lunch-time she usually goes for a walk. The client states for she always has breakfast, usually toast with jam, salad or sandwich for lunch, and for dinner she often cooks family dinners of a wide variety. She is on a bowling league and a golf team. The clients drinks wine at social outings and does not smoke. Review of Systems: Skin, hair, nails: Client says she has melasma on her face. Does not excessively sweat, no rashes, lesions, etc. No balding or dandruff. States her nails and hair are strong and not brittle. Head and neck: Denies swelling, sore throat, stiff neck, enlarged lymph nodes. Occasional sinus headaches occur. Eyes: Uses reading glasses. No infection, tearing, problems with vision. Ears: No hearing problems. No buzzing, ringing, or drainage. Mouth, throat, nose and sinuses: Sinus headaches. No gum disease, lesions, nose bleeds. Does not complain of frequent colds, sore throat, or stuffy nose.

Thorax and lungs: At the present no complaints of wheezing, pain, difficulty breathing. Breasts and regional lymphatics: Does not have any discharge or lumps. Head and neck vessel: Blood pressures unknown but “ normal” per client, denies chest pain or edema. Peripheral vascular: No edema, swelling, or color changes on legs/feet Abdomen: Denies any indigestion, problems swallowing, or hernia. Female genitalia: Denies sexual problems/diseases, no pelvic pain, no voiding problems. Use of hormone replacement post hysterectomy in 2006. Anus and rectum: Bowel movement daily, no pain, hemorrhoids, no blood in stool. Musculoskeletal: No swelling, redness, denies problems with ADL’s. States hands started “ aching” about a week ago, heat helps relieve pain. Neurologic: Client denies depression, anger, or loss of strength/coordination. Mood is generally happy.

References

Weber, J., & Kelley, J. H. (2010). Health assessment in nursing. (4th edition ed., p. Chapter 2). Philadelphia, PA: Lippincott Wilkins Williams.