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NUR 254.01: Pharmacological Products II

Mary Nielsen
University of Montana, Missoula, mary.nielsen@umontana.edu

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NUR 255
MEETING ADULT PHYSIOLOGICAL NEEDS II
NUR 254
PHARMACOLOGICAL PRODUCTS II
Course Name and Number:
NUR 255 Meeting Adult Physiological Needs II
NUR 254 Pharmacological Products II

Course and Time Allotment:
6 total credits
6 hours classroom/lab per week
12 hours clinical per week

Prerequisite Courses: All semester two nursing courses and taken concurrently with NUR 254.

Instructors: Mary Nielsen, MSN, BSN
(W) 396-5153
(H) 273-6605
Email: Mary.Nielsen@umontana.edu

Office Hours: Any time not in class – Just call and set up appointment

Course Description: As a continuation of NUR 155 and NUR 154, this is the study of health promotion, health sciences and shaped by knowledge of nursing. The course focuses on learning the adult client’s response to actual or potential alterations in health and specific disease processes. During the nursing process we will discuss the human responses as structured within the framework of functional health patterns, nursing care, and pharmacological treatment within the context of nursing diagnoses.

The course will encompass the many interrelated components of the adult patient along with the human responses LPNs must consider when planning and implementing care that results from changes in the structure or function of all body systems. Also included will be how these changes effect psychosocial, cultural, spiritual, economical, and personal life of the patient, and how we can assist the patient back to optimal health.

At the completion of this course, the student will be able to:
1. Identify and explain the role of the LPN nurse as caregiver, educator, advocate and leader.
2. Discuss that the attitudes mental habits and skills necessary for critical thinking with each disease process.
3. Discuss the relationship between critical thinking and the nursing process in patient care with each disease process.
4. Describe the importance of nursing codes, standards, and ethics as guidelines for medical surgical patient care with each disease process.
5. Discuss the factors of culture, community and support systems and the effects on patient care with each disease process.
6. Discuss selected trends and issues with each disease process that effect medical-surgical nursing care.
7. Compare and contrast the physical status, risks for alterations in health assessment guidelines, and health behaviors of the young adult, middle adult, and older adult with each disease process.
8. Describe illnesses and behaviors incorporating patient needs of the patient with acute illness and chronic illness with each disease process.
9. Describe the role of the LPN in providing care as part of rehabilitation.
10. Describe the role of the LPN in providing care as part of home care.
11. Discuss collaborative patient care with each disease process, including planning interventions, evaluation and complementary therapies.

Methods of Instruction:
1. Lecture and discussion
2. Demonstration and lab
3. Written assignments
4. Study Guide Worksheets
5. Learning Modules
6. Audio-visual aids/Power Point

Method of Evaluation:
1. Examination
2. Learning Modules
3. Attendance

Attendance Policy:
Regular, timely attendance is expected, and will be taken every class period. If a student misses more than three classes their final course grade will be reduced by one percentage point, and will go down an additional percentage point for each absence thereafter. If the student misses a class it is the student’s responsibility to make up for the absence. Tests are to be taken on blackboard the day they are scheduled. Makeup tests must be scheduled with the instructor. All makeup tests will automatically have a 10% reduction in score unless the student has contacted the instructor before the next class period and received approval for the absence.

Students must attend every agency clinical experience. In the care of an unavoidable absence on an assigned day, the student must call the assigned unit at least 30 minutes prior to the assigned arrival time. Students are allowed one personal leave day for clinical for this course. Tardiness is defined as up to 30 minutes late for an assignment. Chronic tardiness past two occurrences will be considered an absence. A student contract may be formulated with a student with attendance and punctuality problems. Personal appointments made during scheduled clinical hours
will be considered as absences.

**Other Policies:**

**Academic Misconduct:**
All students must practice academic honesty. Academic misconduct is subject to an academic penalty by the course instructor and/or a disciplinary sanction by the University.

All students need to be familiar with the Student Conduct code. The Code is available for review online at [http://www.umt/SA/VPSA/index.cfm/page/1321](http://www.umt/SA/VPSA/index.cfm/page/1321).

Refer to the Practical Nursing Program Handbook for information about uniforms, health requirements, phone calls, liability coverage, etc.

**How Various Assessment Methods Will Be Used to Improve the Course:**
1. Student evaluations of course each semester.
2. Advisory committee input relative to employment setting needs and expectations of entry-level LPNs.
4. Change to scope of practice as made by the Board of Nursing in the statutes and rules.
5. Collaboration between classroom and clinical instructors to maintain clinical currency of the didactic portion of the course.
6. NCLEX mock licensure exam results pertinent to course content.

**Required Textbooks:**
1. Hopper, D. & Williams, L. (1999), *Understanding Medical Surgical Nursing* (Second edition) F.A. Davis
2. Nursing dictionary of choice (Mosby is recommended.)
4. Nursing lab and diagnostic test handbook of choice.
5. Anatomy and Physiology text of choice.

**Course Outline**

Unit I: Needs of the Individual with Compromised Respiratory Function (Ch 26, 27, 28)
Unit II: Needs of the Individual with Compromised Cardiac Function (Ch 15-22)
Unit III: Needs of the Individual with Compromised Neurological Function (Ch 45, 46, 47)
Unit IV: Needs of the Individual with Compromised Hematopoietic & Lymphatic System (Ch 23, 24, 25)
Unit V: Needs of the Individual with Compromised Immunologic, Cancer & AIDS (Ch 52, 53, 54, 10)
Unit VI: Needs of the Individual with Compromised Mental Health Disorders (Ch 55)
Unit VII: Needs of the Individual with Compromised Sensory Function (Ch 48, 49)
Learning Experiences:
1. There is a learning module that is assigned and considered an assignment to be handed in and graded for each unit. These can be found on blackboard under assignments. These modules can be completed independent or as a small group.

Final Grade Criteria

I. Individual Scores
   Total of 7 tests making up 80% of the final grade.
   Total of 7 modules making up 20% of the final grade.

   A. Each test is scored by dividing the number correct by the total number possible. This will equal the final percent score for the test.
      \[
      \begin{align*}
      90\% - 100\% & = A \\
      80\% - 89\% & = B \\
      70\% - 79\% & = C \\
      60\% - 69\% & = D \\
      59\% and below & = F
      \end{align*}
      \]

   B. Each learning module assignment is scored by dividing the number correct by the total number possible. This will equal the final percent score of the assignment.
      \[
      \begin{align*}
      90\% - 100\% & = A \\
      80\% - 89\% & = B \\
      70\% - 79\% & = C \\
      60\% - 69\% & = D \\
      59\% and below & = F
      \end{align*}
      \]

II. Final Scores
   A. The final class grade is determined by:
      1. Adding final points of each test and dividing the total number possible – multiplying this by 80%.
      2. Adding final points of each workbook assignment by the total number possible – multiplying this by 20%.
      3. Adding the total from test scores with the total from the workbook assignment scores equaling the final grade.
      \[
      \begin{align*}
      90\% - 100\% & = A \\
      80\% - 89\% & = B \\
      70\% - 79\% & = C \\
      60\% - 69\% & = D \\
      59\% and below & = F
      \end{align*}
      \]
The grading system is computed and filed on blackboard and is available to students.

The final grade in this class must be a “B” or better to pass. Anything lower than 80% will mean the course must be repeated. The course may only be attempted twice before removal from the program occurs.

**CLINICAL OBJECTIVE:**

At the completion of this course, the student will have had the opportunity to develop nursing objectives to meet the more advanced needs of adult medical/surgical clients. The clinical experience is a coordinated learning experience utilizing the nursing process and relevant theoretical base.

**STUDENT OBJECTIVES:**

<table>
<thead>
<tr>
<th>STUDENT OBJECTIVES:</th>
<th>LEARNING OBJECTIVES:</th>
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<tbody>
<tr>
<td>I. By the completion of NUR 255, the student will be expected to care for selected clients experiencing the following:</td>
<td>I. Clinical Settings</td>
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<tr>
<td>A. Alterations in neuro sensory function</td>
<td>A. Acute care</td>
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<tr>
<td>B. Alterations in cardiovascular function</td>
<td>1. Neuro Unit</td>
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<tr>
<td>C. Alterations in respiratory function</td>
<td>2. Cardiovascular Unit</td>
</tr>
<tr>
<td>D. Alterations in inflammatory function</td>
<td>3. Surgical Unit</td>
</tr>
<tr>
<td>E. Alterations in urologic functions</td>
<td>4. Medical Unit</td>
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<td>F. Alterations in immunologic function</td>
<td>5. Oncology Unit</td>
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<tr>
<td>G. Alterations in hematological function</td>
<td>6. Cardiovascular Lab</td>
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<td>II. By the completion of NUR 255, the student will have completed clinical prep forms, critical path papers and performed more advanced health assessments, as designated by clinical instructors.</td>
<td>II. Clinical paper formats and focuses</td>
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<tr>
<td></td>
<td>A. Medications Form</td>
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<td>B. Critical Path. Paper</td>
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<td></td>
<td>C. Physical Assessment Guide</td>
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<td>D. Clinical Focus Objectives</td>
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<td>III. By the completion of NUR 255, the student will demonstrate competence in the nursing process, communication, cultural diversity situations, human needs, ethical/legal issues, professional role and management as delineated on the clinical instructors.</td>
<td>III. NUR 255 Clinical Evaluations</td>
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WRITTEN WORK - CRITICAL PATHWAY PAPER – For students on specific SPH floor units with assigned patients

Assignment is to be done on standard size paper, written legibly in ink or typed on one side. Paper torn from a spiral notebook, written in pencil and containing spelling or grammar errors will be unacceptable. The following information will be collected on the patient you choose for clinical. Along with this information there must be included a statement of rational for how this information relates to the patient’s primary diagnosis. Please see Appendix C to also assist you with this assignment.

Outline:
1. Primary diagnosis
2. Biological information
3. Chief complaint or patient=s request for care
4. Present illness history
5. Past medical history
6. Review of systems
7. Lab results with explanation of reasoning for abnormal lab values.
8. Medications with explanation of why your chosen patient is prescribed specific medications.
9. MD’s present interventions and rationale
10. Nursing’s present interventions and rationale
11. Bibliography

*Note: Use the History and Physical Patient Information format to complete this data.

The Critical Pathway Paper is due Monday each week by 7:00 a.m. Work is to be handed in on the assigned date at post clinical conference. No work will be accepted late without prior permission from the instructor. Late assignments will be penalized. If assignments are late three times in one semester, the student may fail the course based on the instructor’s discretion.

Written work will be graded on a Pass/Fail basis. If a student receives a grade of “Fail” on a written assignment, the work will be returned to the student, completed and returned to the instructor within one week. Unsatisfactory written work will result in completion of a Student Contract which may result in failure of course. Unsatisfactory completion of a Student Contract by the scheduled completion date may result in failure of the course.
HOW TO READ A RHYTHM STRIP

1. **Rate**
   - Bradycardia - less than 60
   - Normal - 60 - 100
   - Tachycardia - more than 100

   **Hints:** Each mark on the top of paper is three seconds. Count # of P waves in six sec strip for at. rate.
   - **Alternate method:** Count # of big squares and little squares between one complex or wave and the next. The formula is: 300 - 1250 - 100 - 75 - 60

2. **Rhythm**
   - Is it regular or irregular?
   - Measure R-R intervals to check ventricular regularity.
   - Measure P-P intervals to check atrial regularity.

3. **P Waves**
   - Can you find them? What do they look like?
   - Normal P waves are upright, rounded, and before each QRS. They could be: upright, flat, inverted, or squiggly.

4. **QRS Complexes**
   - Can you find them? What do they look like?
   - Normal QRS complexes are less than .12 sec., they have a small downward deflection (Q wave), a large upward deflection (R wave) and a final downward deflection (S).

5. **T waves**
   - Are they there? What do they look like?
   - Normal T waves are after each QRS, gently slope up and down. They represent ventricular repolarization. The **main thing** to notice with T waves is if PVC’s are hitting very near the top of the T wave or just as it starts downward.

Now that you have identified the elements, look at the intervals:

1. **PR Interval**
   - From beginning of P wave to beginning of QRS.
   - Normal is .12 - .20 sec. (3-5 little boxes) Are all the PR intervals the same?
   - Are they too long, too short, each one different, or none at all?

2. **QRS Duration**
   - Normal is less than .12 sec.
   - If very wide and bizarre, it is probably ventricular beat.

**Where is the primary pacemaker located?**
- SA node - AV node - Ventricle

**Are there any premature ectopic beats?**

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How does it affect the R-R interval?
What type of P wave, if any, is associated with it?
Is the QRS the same of very different?

**Sinus Rhythms**

Have upright P waves before each QRS

- Normal Sinus Rhythm - NSR
  - Rate 60-100
  - Rhythm essentially regular P-P of .12 - .20 sec.
  - QRS follows each P - Normal duration <.12 sec.
  - T wave follows each QRS - may or may not have U wave.

Sinus Arrhythmia

- Same as NSR except rhythm is slightly irregular, usually varies with respirations.
- Normal in some people.
- Clinical significance: none

Sinus Tachycardia - NSR with rate > 100/min

- Clinical: Treat cause. No cardiac drugs indicated.

Sinus Bradycardia - NSR with rate <60/min

- Clinical significance: Expected in athletes. May cause decrease in cardiac output leading to coronary or cerebral insufficiency. May permit other ectopic foci to take over. Evaluate pt. May give atropine, Isuprel or pacemaker, if necessary.

Sinus Block - NSR except one or more beats are skipped. Everything else maps out.

Sinus Arrest - NSR except one or more beats are skipped. Doesn’t map out.

**Atrial Arrhythmias**

**PAC’s**

Premature atrial contractions.
- Beat initiated by ectopic atrial focus and comes before the next expected sinus beat.
- Shape of P wave and PR int. may be a little different, P wave may be superimposed on the preceding T wave.
- Doesn’t affect shape of QRS, usually.
- Usually has compensatory pause.
- Clinical significance: indicate atrial irritability.
- May warn of more serious atrial arrhythmias to come.
- If a lot, treated with drugs. Quinidine, usually.

**PAT-**

Paroxysmal atrial tachycardia.
- Abrupt episode of atrial tachycardia - rate 140-250.
- P wave is buried in preceding T wave, usually/
- Pacemaker is an ectopic atrial focus.
- Clinical significance: May be seen in young adults with normal hearts (don’t treat) or older adults with organic disease. Causes pounding, fluttering, dyspnea, and weakness. Stresses heart and increases need for oxygen. Decreased cardiac output. Dr. may try carotid sinus pressure, Valsalva maneuver, or drugs, such as digoxin, propranolol, or Pronestyl. May cardiovert.
AT. FLUT. - Atrial fibrillation
Rapid regular fluttering of atrium. Usually occurs in diseased heart, whereas PAT in normal heart. P waves have saw-toothed appearance. Atrial rate 250-350/min. QRS is normal, response may be varied. 2:1, 3:1, 4:1, etc. Clinical significance: Poss. decreased cardiac output if ventricular rate too fast. Digitalize. Can lead to CHF. May cardiovert.

AT. FIB - Atrial fibrillation
No P waves - fib waves. Normal shaped, irregular QRS. No PR intervals discernible. Vent. rate may be fast, slow, but almost always irregular. The P waves are coming from different foci in atria. Usually seen in diseased hearts. Clinical significance: if vent. rate too fast, decreased C.O. May cause CHF. May use digitalis, or other drugs. If life threatening, may cardiovert at 50-100 watt/sec.

JUNCTIONAL (NODAL) RHYTHMS have inverted P waves before, within, or after a normal sized QRS. P waves may be squiggly. May act up as backup system if SA node fails to fire. It will initiate impulses 40-60/min. If life threatening, may cardiovert at 50-100 wats/sec.

JPC - JUNCTIONAL PREMATURE CONTRACTION (a.k.a. PJC)
Occurs early during NSR. Inverted P wave. Usually do not require treatment, if infrequent. May indicate tissue irritability if frequent - treat with myocardial depressant.

JUNCTIONAL RHYTHM
Rate 40-60 if escape rhythm. Inverted P waves. May be faster. May happen if SA node quits. Treatment depends on cause and effect on patient.

JUNCTIONAL TACHYCARDIA
Rate 100-180. Sometimes difficult to tell from sinus or atrial tachycardia. If in doubt, call it a supraventricular tachycardia, as long as the QRS appears normal. It sounds good and you can’t go wrong!! Clinical significance: puts stress on the heart, may cause angina, CHF. May use digitalis, verapamil, Inderal, etc.

WANDERING PACEMAKER - P waves, upright, inverted, or squiggly. PR interval may vary. Rhythm may be somewhat irregular. QRS is normal. Clinical significance: may be associated with ischemia, inflammation, or digitalis effects, but may appear with no cardiac disease. Usually no treatment is necessary.

VENTRICULAR ARRHYTHMIAS - have wide, bizarre QRS complexes. Ventricular tissue becomes irritable from ischemia, drug effects, or electrolyte imbalances. Ventricular beats provide very little or no cardiac output, and are very dangerous in a diseased heart. Some people with normal hearts have occasional ventricular beats; this is okay and this is not normally treated.

PVC’s - PREMATURE VENTRICULAR CONTRACTIONS
Occur early in the cycle.
No P wave proceeds.
Have wide and distorted QRS.
Have a T wave in the opposite direction as the QRS.
Are usually followed by a compensatory pause.
Unifocal - look the same, come from same site.
Multifocal - look different, come from different sites.
Interpolated - fall between two normal beats without interrupting the rhythm. No compensatory pause.

Clinical significance: very dangerous in patient with MI. Can precipitate vent. fib. if hitting on T wave. They are especially dangerous if they occur
1. more than once in every ten beats.
2. in groups of two or three.
3. are landing near the T wave.
4. are multifocal.
Usually are treated with lidocaine drip. If patient in a bradycardia, they may try to speed him up with atropine instead.

V. TACH - VENTRICULAR TACHYCARDIA - rate fast, QRS wide.
Run of three or more PVCs at rate over 150/min. Leads to very low cardiac output and frequently to V. fib. If patient tolerates slower V. Tach, may push lidocaine then start a drip. If lidocaine doesn’t work and patient loses consciousness, then defibrillate.

V. FIB. - VENTRICULAR FIBRILLATION - Quivering of ventricles.
Coarse, wavy line on the monitor. No complexes. No effective cardiac output. Patient has no pulse. Defibrillate immediately. If patient is alert, it is probably patient movement or loose wires. If patient is not alert, but has a pulse, the rhythm is but ventricular fibrillation.

IDIOVENTRICULAR RHYTHM - Rate 20-40. All complexes wide, distorted, identical QRSs. Treat cause: pacemaker, atropine, Isuprel.

VENTRICULAR STANDSTILL - No vent. Contractions. If in complete heart block, may see only P waves. Otherwise straight line. No pulse. Call code immediately.

AV BLOCK - AV node is diseased and has difficulty conducting P waves to ventricles. Caused by scarring, inflammation, edema in the area - arteriosclerosis, MI.

FIRST DEGREE AV BLOCK - PR interval >.20 sec. Other than that, looks just like NSR.
Impulse takes longer to traverse AV node because of tissue abnormality or drug effect, esp. digitalis. Clinical significance: does not decrease cardiac output. Indicator of poss. tissue damage or drug toxicity. Observe for higher degrees of block, reduce digitalis.

SECOND DEGREE AV BLOCK - Some, but not all, P waves are conducted to ventricles. Two types: Mobitz I (Wenckebach) and Mobitz II.
MOBITZ II- some P waves conduct, some don’t. Normal, consistent PR interval on those that do. Normal looking QRS.

May be every second, third, or fourth P wave that conducts, or only occasional blocked beat. Clinical significance: can result in very slow vent. rate so dec. cardiac output, can cause myocardial/cerebral ischemia. This one is dangerous. May lead to further block. Usually insert demand pacemaker. While you wait, may use atropine or Isuprel to increase at rial rate or temp. pacemaker.

WENCKEBACH (MOBITZ I) PR gets a little longer with each beat until finally one QRS is dropped. QRS appears normal. The R-R interval is irregular, there are more Ps than QRSs.

AV node takes more and more time to conduct a beat, finally one does not get thru. Caused by ischemia or drugs (digitalis). Not as serious. Usually transient and reversible. Observe ventricular rate and effect on patient. Pacemaker generally not necessary.

THIRD DEGREE AV BLOCK - a.k.a. COMPLETE HEART BLOCK
P waves are regular but are not conducting the QRSs. R-R intervals are all different. QRSs are regular but no relationship to P waves. Vent. rate is slow as QRS is coming from a junctional or ventricular pacemaker site.

Caused by MI, inflammation, scarring, or drugs. Treatment of choice is pacemaker. This one is an emergency.

MISC. OTHER ARRHYTHMIAS
BBB - BUNDLE BRANCH BLOCK - Has P waves, QRSs are too wide and kind of squiggly.

Caused by obstruction in R or L vent. conduction pathways. Ventricle is depolarized slower, repolarized slower. Can occur in normal or diseased hearts.
KEY POINTS: ANALYZING EKG RHYTHM STRIPS

• The beating heart produces a series of cardiac cycles, which together become an EKG rhythm strip.
• Arrhythmias are categorized according to which pacemaker site initiates the rhythm.
• The normal heart rhythm originates in the sinus node and thus is called Normal Sinus Rhythm.
• It is necessary to memorize the rules for each arrhythmia in order to interpret it in the future.
• EKG interpretation is based on how closely the clues gathered from the rhythm strip comply with the rules for a given arrhythmia.
• Because EKG interpretation can be so complex, it is essential to develop a routine format for analyzing rhythm strips and then use it consistently when identifying arrhythmias. An example of such a format is as follows:
  • Rhythm (also called regularity)
  • Rate
  • P Wave
  • PRI Interval (PRI)
  • QRS Complex (QRS)

• Rhythm, or regularity, is determined by measuring the R-R intervals, or possibly the P-P intervals, across the entire strip. If the pattern is not regular, note whether it is regularly irregular, basically regular, or totally irregular. Look for patterns to the irregularity that could indicate ectopics or grouped beating.

• **Rate** can refer to either the ventricular rate (most common) or the atrial rate if they differ. Rate can be calculated in one of three ways:
  1. Count the number of small squares between two R waves and divide it into 1500.
  2. Count the number of large squares between two R waves and divide it into 300. Standard tables giving this information are available and can be memorized for quick reference.
  3. Count the number of R waves in a six-second strip and multiply by ten. This last method should be used only on irregular arrhythmias because it is the least accurate.

• The P wave should be found preceding the QRS complex. It should be upright and uniform. The P waves should be regular across the entire strip, and there should be only one P wave for each QRS complex.
• The PR interval is an indication of the electrical activity taking place within the atria and the AV node. It encompasses all electrical activity above the ventricles. The PRI consists of the P wave and the PR segment. The PR segment is caused by the delay of the impulse at the AV node. The PRI should be constant across the strip, and should measure between .12 and .20 seconds.
• The QRS complex can help you determine whether the rhythm originated from a supraventricular focus or from the ventricles. A supraventricular focus normally produces a QRS less than .12 seconds. However, it is possible for a supraventricular rhythm to have a wider QRS complex if there was a conduction disturbance within the ventricles. If the rhythm originated in the ventricles, the QRS complex will be .12 seconds or greater. A narrow QRS complex indicates that the impulse is supraventricular, while a wide QRS complex can be either supraventricular with a conduction disturbance, or it can be ventricular.
HISTORY AND PHYSICAL PATIENT INFORMATION

FORMAT

I. BIOGRAPHICAL INFORMATION
   1. Full name
   2. Birth date
   3. Sex
   4. Race
   5. Religion
   6. Marital status
   7. Occupation
   8. Source of referral
   9. Source of reliability of information

II. CHIEF COMPLAINT OR PATIENT’S REQUEST FOR CARE
   1. A short statement, preferably in the patient’s own words and recorded in quotation marks, that indicates the patient’s purpose for requesting health care.
      Examples:  “Chest pain for three days”
                  “Swollen ankles for two weeks”
                  “Fever and headache for 24-hours”

III. PRESENT ILLNESS OR PRESENT HEALTH STATUS
   1. Introduction
      A. Patient's Summary
      B. Usual Health
   2. Investigation of Symptoms
      A. Onset
      B. Date
      C. Manner (gradual or sudden)
      D. Duration
      E. Precipitating Factors
      F. Course Since Onset
G. Location
H. Quality
I. Quantity
J. Setting
K. Alleviating or Aggravating Factors

3. Negative Information
4. Relevant Family Information
5. Disability Assessment

IV. PAST HISTORY
1. Past Illness
2. Past Hospitalizations and Reasons
3. Past Surgeries
4. Allergies
5. Immunizations
6. Habits
   A. Alcohol
   B. Tobacco
   C. Drugs
   D. Coffee, Tea

V. REVIEW OF SYSTEMS
1. General
2. Skin, Hair, and Nails
3. Neurology
4. Eyes
5. Ears
6. Nose and Sinuses
7. Mouth and Throat
8. Neck and Nodes
9. Breasts
10. Respiratory
11. Cardiovascular
12. Gastrointestinal System
13. Urinary System
14. Genital System
15. Extremities and Musculoskeletal System
16. Endocrine System
VI. NUTRITIONAL STATUS
1. A description of an average day’s food intake, and assessment of adequacy, inadequacy, or excess of the components of the basic four food groups, and the presence of any past nutritional problems.