**MN552 Advanced Health Assessment**

**Unit 2 SOAP Note Section I Written Guide**

History, Interview, and Genogram Guide

Please select a volunteer friend or family member to interview and gather data to complete this Assignment. The following guide will assist you in gathering subjective data in an organized, systematic manner to prevent omission of important components of the health history. **Please remember to attach a Genogram with this Assignment as one document, if possible. You may search the web to locate a suitable Genogram diagram to input data. Only include 3 generations in the genogram depiction.**

Date of History/Interview:

Source of history and Reliability: (client, family member, chart/record, etc.-sample on page 50 of Jarvis textbook)

1. Biographical Data
   1. Name (use initials only)
   2. Address
   3. Phone number
   4. Primary language
   5. Authorized representative
   6. Age and Date of Birth
   7. Place of Birth
   8. Gender
   9. Race
   10. Marital Status
   11. Ethnic/Cultural Origin
   12. Education ( highest level completed)
   13. Occupation/Professional
   14. Health insurance
2. Chief Complaint (reason for seeking health care):
   1. Brief spontaneous statement in client’s own words
   2. Includes when the problem started ( “chest pain for 2 hours”)
3. History of Present Illness: A well organized, chronological record of client’s reason for seeking care, from time of onset to present. Please include the 8 critical characteristics using the PQRSTU pneumonic.

P – Provocative or palliative (What brings it on? What makes it better or worse?)

Q – Quality or quantity (Describe the character and location of the symptoms; How does it look, feel, sound?)

R – Region or radiation (Where is it? Does the symptom radiate to other areas of the body?).

S – Severity (Ask the patient to quantify the symptom(s) on a scale of 0-10).

T – Timing (Inquire about time of onset, duration, frequency, etc.)

U – Understand Patient’s Perception of the problem (What do you think it means?)

1. Past Medical History
   1. Medical Hx: major illnesses during life span, injuries, hospitalizations, transfusions, and disabilities
   2. Childhood Illnesses: Measles, mumps, rubella, chickenpox, pertussis, strep throat
   3. Surgical Hx; procedures, dates, inpatient or outpatient
   4. Obstetric HX: Number of pregnancies, term deliveries, preterm births, abortions

(spontaneous or induced), number of children living

* 1. Immunizations
  2. Psychiatric Hx: childhood and adult (treated or hx of)
  3. Allergies: Medications, food, inhalants or other (what occurs with reaction)
  4. Current Medications: Include all prescription, herbal/supplements and OTC, dosage, frequency
  5. Last Examination Date: Physical, eye exam, foot exam, dental exam, hearing screen, EKG, chest X-Ray, Pap test, mammogram, serum cholesterol, stool occult blood, prostate, PSA, UA, TB skin test; other health maintenance tests for infants/children may include sickle-cell, PKU, lead level, and hematocrit

1. Family History (list FHx and design a genogram (computer)-include a key with the genogram). The Genogram must include 3 generations.
   1. Include parents, grandparents, spouse, and children.
   2. Health conditions, familial and communicable diseases/illnesses
   3. Note whether family member deceased or living