Adult nursing scenario

Nursing history

Identity (biographical data) (client's profile)

name : Sim Man 3G

age: 47 years

gender: Male

occupation : teacher

Level of education : teaching institute

Address: Basra jubala

religion: Muslim

Admission data 28/ October / 2015

transferred from : emergency

client's condition stable

next of kin (informant) (accompanied by) his brother

chief complaint & its duration: **chest pain for 30 minutes before admission**

confirmed medical diagnosis : Angina pectoris

surgical or medical intervention : case of angina pectoris

history of present illness: the condition started as **chest pain for 30 minutes before admission** , retrosternal , burning in nature that occur during physical exertion and is relieved by rest or nitrate within a few minutes . This discomfort can radiate to the neck , lower jaw , left shoulder and left arm ,associated with dyspnea , nausea , vomiting or

lightheadedness. symptoms last more than 15 seconds but less than 15 minutes . the patient admitted to emergency ward where ECG was taken and S. Troponine was measured , the patient referred to CCU . in the CCU cannula has been put and new ECG has been taken to confirm the diagnosis . the medical treatment has started and sample of blood has been drown for lab investigation

the patient now is well .

past medical history :

1- Childhood diseases : measles , mumps , rubella, whooping cough , diphtheria , tetanus , polio , chickenpox , scarlet fever , rheumatic fever
2- Adulthood diseases : diabetes mellitus , hypertension , ischemic heart diseases , rheumatic disease , bronchial asthma , epilepsy , parkinsonism , peptic ulcer , blood diseases (SCD ,G6PD Def. Thalassemia) , cancer and chronic renal failure
3- Psychiatric illness : Depression , HYS , Schizophrenia ,psychopath
4- Injuries& accidents : burn , fracture , head injuries
5- Hospitalization & operations (cause , type& time)
6- Current medications
7- Allergies(dugs , food , others)
8- Immunization & vaccination
9- Blood transfusion

NOTHING SIGNIFICANT OTHER THAN HYPERTENSION and previous admission to CCU for the same reason

Family history

Father : died by IHD
Mother : died by IHD
Brothers & sisters : no any illness
Diseases in the family : cancer , hypertension , heart disease, diabetes , epilepsy , mental illness ,Tuberculosis , kidney disease , arthritis , allergies , asthma , alcoholism , obesity , sickle disease & thalasemia .

NOTHING SIGNIFICANT OTHER THAN HYPERTENSION and IHD

Social history

Children 4
level of education mentioned
interests TV watching
financial status good
life style
smoking : 40 cigarette per day
drinking NO
exercise NO
nutrition meals heavy with fat
general awareness no healthy behavior
interpersonal relationships few friend
past development nothing interesting
living arrangement good housing
any domestic animal NO
water supply RO
sewage disposal Good
travel history NO

possible nursing Dx

1- fluid volume excess
2- fluid volume deficit
3-altered tissue perfusion
4- decreased cardiac output
5- impaired home maintenance
6- activity intolerance
7- pain