9. An aspect of traditional Western medicine that may be troublesome to many Hispanics, Native Americans, Asians, and Middle Eastern groups is Western medicine's attempts to
   a. use a holistic approach that views a particular medical problem as part of a bigger picture.
   b. determine a specific cause for every problem in a precise way.
   c. establish harmony between a person and the entire cosmos.

a. –Do you have any particular sexual likes or dislikes?‖
b. –Do you have any worries or concerns regarding your sexual life?‖
c. –How often do you have intercourse and with whom?‖
d. –Do you have any reason to think you may have been exposed to a sexually transmitted infection?‖

ANS: B
When approaching questioning about a sensitive area, it is recommended that the provider first ask open-ended questions that explore the patient's feelings about the issue. ―Do you have any particular sexual likes or dislikes?‖ is not a question that should be asked in an interview regarding sexual history. ―How often do you have intercourse and with whom?‖ and ―Do you have any reason to think you may have been exposed to a sexually transmitted infection?‖ are not questions that should be asked *initially* in an interview regarding the patient's sexual history.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

14. A guideline for history taking is for caregivers to
    a. ask direct questions before open-ended questions so that data move from simple to complex.
    b. ask for a complete history at once so that data are not forgotten between meetings.
    c. make notes sparingly so that the patient can be observed during the history taking.
    d. write detailed information as stated by patients so that their priorities are reflected.

ANS: C
During the interview, you should maintain eye contact with the patient, observing body language and proceeding from open-ended to direct questions. Asking direct questions first may upset the patient. During the interview you should gather as much information as you need for the current reason the patient is seeking health care. It is important to focus on the patient. Brief notes can be charted, but you should maintain eye contact with the patient, observing body language and proceeding from open-ended to direct questions.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

15. Mr. D complains of a headache. During the history, he mentions his use of alcohol and illicit drugs. This information would most likely belong in the
    a. chief complaint.
    b. past medical history.
    c. personal and social history.
    d. review of systems.

ANS: C
Habits are included within the personal and social history. The chief complaint is the reason the patient is seeking health care. The past medical history is made up of the previous medical conditions that the patient has had. The review of systems is an overview of problems with other body systems.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

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A functional assessment is an assessment of a patient's mobility, upper extremity movement, household management, ADL, and instrumental activities of daily living (IADL).

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

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MULTIPLE CHOICE

1. According to the guidelines for Standard Precautions, the caregiver's hands should be washed
   a. only after touching body fluids with ungloved hands and between patient contacts.
   b. only after touching blood products with ungloved hands and after caring for infectious patients.
   c. only after working with patients who are thought to be infectious.
   d. after touching any body fluids or contaminated items, regardless of whether gloves are worn.

   ANS: D
   Handwashing is to be done after removal of gloves, between patient contacts and after touching body fluids, regardless of whether gloves are used. The nurse should never touch body fluids or blood products with ungloved hands. The nurse should use hand hygiene regardless of a patient's possible infection.

   DIF:Cognitive Level: Remembering (Knowledge)
   OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

2. Which patient is at the highest risk for developing latex allergy?
   a. The new patient who has no chronic illness and has never been hospitalized
   b. The patient who has had multiple procedures or surgeries
   c. The patient who is a vegetarian
   d. The patient who is allergic to contrast dye

   ANS: B
   The patient who has had multiple procedures or surgeries has a higher rate of exposure to rubber gloves and to equipment and supplies that contain latex and therefore is at a higher risk for developing an allergic response.

   DIF:Cognitive Level: Understanding (Comprehension)
   OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

3. Which initial action, in a patient with autonomic dysreflexia, would aid in lowering blood pressure?
   a. Have the patient lie on the left side.
   b. Assist the patient to remove any tight clothing.
   c. Recheck the blood pressure after 5 minutes.
   d. Perform an EKG.

   ANS: B
   Autonomic dysreflexia occurs as a result of dysregulation of the autonomic nervous system. Cutaneous or visceral stimulation below the level of the spinal cord injury initiates afferent

d. tympanometer.

ANS: D

New findings of unknown causes are added to the problem list, but do not let them become a red herring that distracts your attention from the central issues.

DIF:Cognitive Level: Understanding (Comprehension) OBJ:Nursing process—diagnosis
MSC: Safe and Effective Care: Management of Care

3. Which is an accepted method of making a diagnosis?
   a. Relying on intuition
   b. Making maximal use of laboratory tests
   c. Using first assumptions
   d. Using algorithms

ANS: D
Methods to make a diagnosis include recognizing patterns, sampling the universe, and using algorithms. Do not rely on intuition, extensive use of laboratory findings, or always going with your first assumptions.

DIF:Cognitive Level: Remembering (Knowledge) OBJ:Nursing process—diagnosis
MSC: Safe and Effective Care: Management of Care

4. The adage that ―common problems occur commonly‖ advises the practitioner to
   a. always diagnose the patient's problem in terms of what their practice usually sees.
   b. refer any uncommon complaints to specialists as soon as possible.
   c. not consider more than one diagnosis unless necessary.
   d. examine uncommon problems critically before assuming that the issue is an unusual presentation of a common problem.

ANS: C
This adage is to guide the practitioner to pay attention to unexpected or unusual findings but not to consider more than one diagnosis unless necessary and to favor the simplest hypothesis when competing hypotheses exist.

DIF:Cognitive Level: Analyzing (Analysis) OBJ:Nursing process—diagnosis
MSC: Safe and Effective Care: Management of Care

5. The most important guide to sequencing actions should be
   a. probability and utility.
   b. assumption and intuition.
   c. costs and risks of procedures.
   d. reimbursement potential and patient acceptance.

ANS: A
Although all choices are relevant, the prioritized guide is to select actions based on an estimate of the probability of successfully achieving the patient's goals and on the utility of implementation.

a. problems in the order of their chronologic development.
b. the patient's concern about a particular problem.
c. the patient's social and economic circumstances.
d. the most urgent problem.

ANS: D
In developing patient care plans, priority should be given to the most life-threatening and urgent physical needs of the patient. Then focus on addressing the patient's social and economic circumstances.

DIF:Cognitive Level: Understanding (Comprehension) OBJ:Nursing process—diagnosis
MSC: Safe and Effective Care: Management of Care

MULTIPLE RESPONSE

1. When utilizing a joint approach with the patient, which factors are likely to be considered? (*Select all that apply.*)
   a. Consultations
   b. Laboratory studies
   c. Assistive technology
   d. Patient education
   e. Practitioner background

ANS: A, B, C
A joint approach between the patient and practitioner should include laboratory and imaging studies, subspecialty consultation, medications, equipment, special care, diet and activity modification, follow-up visit, and patient education.

DIF:Cognitive Level: Remembering (Knowledge) OBJ:Nursing process—evaluating
MSC: Safe and Effective Care: Management of Care

Chapter 05: The Health Record
Ball: Seidel's Guide to Physical Examination, 10th Edition

MULTIPLE CHOICE

1. Which part of the information contained in the patient's record may be used in court?
   a. Subjective information only
   b. Objective information only
   c. Diagnostic information only
   d. All information

ANS: D
Anything that is entered into a patient's record, in paper or electronic form, is a legal document and can be used in court.

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2. Ms. S reports that she is concerned about her loss of appetite. During the history, you learn that her last child recently moved out of her house to go to college. Rather than infer the cause of Ms. S's loss of appetite, it would be better to
   a. defer or omit her comments.
   b. have her husband call you.
   c. quote her concerns verbatim.
   d. refer her for psychiatric treatment.

   ANS: C
   It is best to document what you observe and what is said by the patient rather than documenting your interpretation. Listening and quoting exactly what the patient says is the better rule to follow.

   DIF:Cognitive Level: Applying (Application)
   OBJ:Integrated process—communication and documentation
   MSC: Physiologic Integrity: Basic Care and Comfort

3. Which is an effective adjunct to document the location of findings during the recording of the physical examination?
   a. Relationship to anatomic landmarks
   b. Computer graphics
   c. Comparison with other patients of same gender and size
   d. Comparison to previous examinations using light pen markings

   ANS: A
   Abnormal or normal findings are best described in relationship to universal topographic and anatomic landmarks.

   DIF:Cognitive Level: Understanding (Comprehension)
   OBJ:Integrated process—communication and documentation
   MSC: Physiologic Integrity: Basic Care and Comfort

4. The position on a clock, topographic notations, and anatomic landmarks
   a. are methods for recording locations of findings.
   b. are used for noting disease progression.
   c. are ways for recording laboratory study results.
   d. should not be used in the legal record.

   ANS: A
   Descriptions of the locations of findings are universally referenced by using positions on a clock, topographic notations, or anatomic landmarks.

   DIF:Cognitive Level: Remembering (Knowledge)
   OBJ:Integrated process—communication and documentation
   MSC: Physiologic Integrity: Basic Care and Comfort

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5. Regardless of the origin, discharge is described by noting
   a. a grading scale of 0 to 4.
   b. color and consistency.
   c. demographic data and risk factors.
   d. associated symptoms in alphabetic order.

not necessarily warrant medication, surgery, or treatment.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Integrated process—communication and documentation
MSC: Physiologic Integrity: Basic Care and Comfort

ANS: D

Orientation to person, place, and time are measures of states of consciousness and awareness.

DIF:Cognitive Level: Understanding (Comprehension)

c. stupor.
d. dementia.

ANS: D
Dementia is the loss of both immediate and recent memory while retaining remote memories. ADHD is associated with recent and remote memory impairment. Impaired judgment is a thought process dysfunction. Stupor is impaired consciousness.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

11. You ask the patient to follow a series of short commands to assess
a. judgment.
b. attention span.
c. arithmetic calculations.
d. abstract reasoning.

ANS: B
Asking the patient to follow a series of short commands will test attention span.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

12. Which observation would be most significant when assessing the condition of a patient who has judgment impairment?
a. Repeated failure to fulfill family obligations
b. Forgetting family members' birth dates

DIF:Cognitive Level: Remembering (Knowledge)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

15. Flight of ideas or loosening of associations is associated with
    a. aphasia.
    b. dysphonia.
    c. multiple sclerosis.
    d. psychiatric disorders.

ANS: D

Flight of ideas, loosening of associations, word salads, neologisms, clang associations, echolalia, and utterances of unusual sounds are all associated with psychiatric disorders.

DIF:Cognitive Level: Understanding (Comprehension)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

16. The Glasgow Coma Scale is used to
    a. determine the cause of decreased consciousness.
    b. diagnose disorders that alter level of consciousness.
    c. quantify consciousness.
    d. predict response to stimulant medications.

ANS: C

The Glasgow Coma Scale is used when a patient has an altered level of consciousness and is used to quantify consciousness.

DIF:Cognitive Level: Remembering (Knowledge)

ANS: A

ADHD occurs before 7 years of age. ADHD is not related to mental retardation, dementia, or prolonged periods of catatonic behavior.

DIF:Cognitive Level: Understanding (Comprehension)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

20. An aversion to touch or being held, along with delayed or absent language development, is characteristic of
    a. attention-deficit/hyperactivity disorder.
    b. autism.
    c. dementia.
    d. mental retardation.

ANS: B

Autistic disorder involves a combination of behavioral traits (lack of awareness of others, aversion to touch or being held, odd or repetitive behaviors, or preoccupation with parts of objects) and communication deficits (usually echolalia [parrot speech]).

DIF:Cognitive Level: Understanding (Comprehension)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

21. You are interviewing a 20-year-old patient with a new-onset psychotic disorder. The patient is apathetic and has disturbed thoughts and language patterns. The nurse recognizes this behavior pattern as consistent with a diagnosis of
    a. depression.
    b. autistic disorder.
    c. mania.

ANS: D

Schizophrenia manifests as a psychotic disorder of early adult onset, with disturbances in language and speech, emotions and social withdrawal, and apathy. Depression and mania do not have the language or speech component. Autistic disorders are not psychotic disorders, and they usually begin before 3 years of age.

DIF:Cognitive Level: Applying (Application)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

22. While interviewing a patient, you ask him to explain the –Lion and the Mouse‖ to assess
    a. reading comprehension.
    b. attention span.
    c. mood and feeling.
    d. reasoning skills.

ANS: D

Having the patient explain fables or metaphors determines abstract reasoning skills.

DIF:Cognitive Level: Applying (Application)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

23. The Mini-Mental State Examination (MMSE) should be administered for the patient who
    a. gets lost in her neighborhood.
    b. sleeps an excessive amount of time.
    c. has repetitive ritualistic behaviors.
    d. uses illegal hallucinogenic drugs.

ANS: A

ANS: A, B, D

Aphasia, apathy, and disintegration of personality are all characteristics of dementia. Odd behaviors and lack of awareness of others are characteristics of autism.

DIF:Cognitive Level: Understanding (Comprehension)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

COMPLETION

1. Under most conditions, adult patients should be able to repeat forward a series of _____numbers.

ANS:

five to eight (or) 5 to 8

five to eight

5 to 8

Most adults should be able to immediately recall a series of five to eight numbers forward and a series of four to six numbers backward.

DIF:Cognitive Level: Remembering (Knowledge)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

2. The examiner should be concerned about neurologic competence if a social smile cannot be elicited by the time a child is_____old.

ANS:

2 to 3 months

two to three months

2- to 3-months

b. in childhood.

c. after the skeletal growth is completed.

d. once sexual maturation is complete.

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18. Infants born to the same parents are normally within which range of weight of each other?
    a. 6 ounces
    b. 12 ounces
    c. 1 pound

b. greater than head circumference by 2 inches.

c. smaller than head circumference by about 4 inches.

d. at least 2 inches smaller than head circumference.

33. Ms. Otten is a 45-year-old patient who presents with a complaint of weight gain. Which medication is frequently associated with weight gain?
    a. Diuretics
    b. Oral hypoglycemics
    c. Laxatives
    d. Steroids

    ANS: D

    Medications that contribute to weight gain include steroids, oral contraceptives, antidepressants, and insulin.

    DIF:Cognitive Level: Understanding (Comprehension)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

34. Ms. Davis is a 27-year-old patient with a BMI of 33. Based on her BMI, your diagnosis would be
    a. normal body weight.
    b. overweight.
    c. obese.
    d. extremely obese.

    ANS: C

    An obese BMI is 30 to 39.9. A normal BMI is less than 24. An overweight BMI is 25 to 29.9. An extremely obese BMI is greater than 40.

    DIF:Cognitive Level: Analyzing (Analysis)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

infants born at the same number of weeks' gestation.

ANS:

90

The hypodermis layer consists of adipose tissue that serves to generate heat and provide insulation, shock absorption, and a reserve of calories.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

3. The secretory activity of the sebaceous glands is stimulated by
   a. body heat.
   b. ambient temperature.
   c. sex hormones.
   d. dietary protein.

ANS: C
The sebaceous glands, when stimulated by the sex hormones, produce a lipid-rich substance that keeps the skin moist.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

4. Mrs. Tuber is a 36-year-old patient who comes into the health center with complaints that her fingernails are not growing. Which structure is the site of new nail growth?
   a. Cuticle
   b. Perionychium
   c. Matrix
   d. Nail bed

ANS: C

14. Unusual white areas on the skin may be caused by
    a. adrenal disease.
    b. polycythemia.
    c. vitiligo.
    d. Down syndrome.

    ANS: C

    The absence of melanin produces unpigmented white areas known as *vitiligo*.

    DIF:Cognitive Level: Remembering (Knowledge)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

15. Which cultural group has the lowest incidence of nevi?
    a. Native Americans
    b. African Americans
    c. Mexican Americans
    d. Asians

    ANS: B

    Nevi are more common in persons who burn, rather than tan; therefore, African Americans have the lowest rates of nevi.

    DIF:Cognitive Level: Remembering (Knowledge)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

16. You are inspecting the lower extremities of a patient and have noted pale, shiny skin of the lower extremities. This may reflect

ANS: B

Petechiae are smaller than 0.5 cm in diameter. Ecchymoses are larger than 0.5 cm in diameter. Spider veins and telangiectasias are vascular lesions.

DIF:Cognitive Level: Understanding (Comprehension)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

21. A flat, nonpalpable lesion is described as a macule if the diameter is
    a. larger than 1 cm.
    b. smaller than 1 cm.
    c. 3 cm exactly.
    d. too irregular to measure.

ANS: B

A *macule,* by definition, is a flat, circumscribed area smaller than 1 cm in diameter and is measurable. An example of a macular rash is measles.

DIF:Cognitive Level: Remembering (Knowledge)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

22. Mrs. Britton is a 34-year-old patient who presents to the office with complaints of skin rashes. You have noted a 4.3-cm, rough, elevated area of psoriasis. This is an example of a
    a. plaque.
    b. patch.
    c. macule.
    d. papule.

ANS: D

Persons with chronic atopic or allergic conditions tend to rub the eyes sufficiently to cause an extra crease or pleat of skin below the eye, called the Dennie-Morgan fold.

DIF:Cognitive Level: Applying (Application)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

32. Linea nigra is commonly found on the abdomens of
    a. infants and children.
    b. adolescents.
    c. pregnant patients.
    d. older adults.

ANS: C

Pregnant patients commonly develop pigmentation of the abdomen from the symphysis pubis to the top of the fundus in the midline.

DIF:Cognitive Level: Understanding (Comprehension)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

33. Cherry angiomas are a common finding in
    a. adults older than 30 years.
    b. newborns.
    c. pregnant women.
    d. sunbathers.

ANS: A

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

c. place the light firmly against the skull.
d. shine the light inside the infant's mouth.

ANS: C

The correct technique for transillumination of the infant's skull is to place the light source tightly against the skull so that no light escapes.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

13. Which of the following is true regarding a cephalohematoma?
a. It is bound by suture lines.
b. The affected part feels soft.
c. It is obvious at birth.
d. The margins are poorly defined.

ANS: A

The condition is subperiosteal, under the bone, and contained by the margins of the suture lines; it does not cross the suture line. It is often unnoticed at birth and typically feels firm, with its edges well defined.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

14. Nuchal rigidity is most commonly associated with
a. thyroiditis.
b. meningeal irritation.

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

19. Mr. Donaldson is a 64-year-old patient with complaints of headaches. As the examiner, you are palpating his head during your physical examination. Which of the following would be your first step?
    a. Palpate the patient's hair, noting texture, color, and distribution.
    b. Palpate the temporomandibular joint.
    c. Palpate the skull from front to back.
    d. Palpate the temporal artery.

ANS: C

Palpate the skull in a gentle rotary movement first, progressing systematically from front to back.

DIF:Cognitive Level: Understanding (Comprehension)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

Chapter 12: Eyes

Ball: Seidel's Guide to Physical Examination, 10th Edition

MULTIPLE CHOICE

1. Mrs. Alden is a 29-year-old pregnant patient in her third trimester. She tells you that her vision has been a little blurred, and she thinks she needs to get new contact lenses. You should advise her to
    a. get new lenses as soon as possible to avoid complications.
    b. wait until several weeks after delivery to get new lenses.
    c. go to the nearest emergency department for evaluation.
    d. change her diet to include more yellow vegetables.

ANS: B

ANS: B
Lagophthalmos is a term used to describe the condition in which eyelids do not completely meet when closing. Glaucoma involves elevated pressure in the eye. Exophthalmus involves bulging eyes. A hordeolum is better known as a stye.

Papilledema is caused by increased intracranial pressure along the optic nerve, pushing the vessels forward (cup protrudes forward) and dilating the retinal veins. Retinal vein pulsations and visual defects are not visible with an ophthalmoscope. On examination, papilledema is characterized by loss of definition of the optic disc.

DIF:Cognitive Level: Applying (Application)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

26. Which maneuver can be done to reduce the systemic absorption of cycloplegic and mydriatic agents when examining a pregnant woman if the examination is mandatory?
    a. Have the woman keep her eyes closed for several minutes.
    b. Instill half the usual dosage.

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MULTIPLE CHOICE

1. Mr. Sprat is a 21-year-old patient who complains of nasal congestion. He admits to using recreational drugs. On examination, you have noted a septal perforation. Which of the following recreational drugs is commonly associated with nasal septum perforation?
   a. Heroin

c. Loss of high frequency
d. Bone conduction heard longer than air conduction
e. Sounds may be garbled, difficult to localize
f. Unable to hear in a crowded room

ANS: C, E, F
Age-related hearing loss is associated with degeneration of hair cells in the organ of Corti, loss of cortical and organ of Corti auditory neurons, degeneration of the cochlear conductive membrane, and decreased vascularity in the cochlea. Sensorineural hearing loss first occurs with high-frequency sounds and then progresses to tones of lower frequency. Loss of high-frequency sounds usually interferes with the understanding of speech and localization of sound. Conductive hearing loss may result from an excess deposition of bone cells along the ossicle chain, causing fixation of the stapes in the oval window, cerumen impaction, or a sclerotic tympanic membrane.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

2. Which signs and symptoms occur with a sensorineural hearing loss? (*Select all that apply.*)
   a. Air conduction shorter than bone conduction
   b. Lateralization to the affected ear
   c. Loss of high-frequency sounds
   d. Speaks more loudly
   e. Disorder of the inner ear
   f. Air conduction longer than bone conduction

ANS: C, D, E, F
The signs and symptoms of sensorineural hearing loss include loss of high-frequency sounds, speaks more loudly, disorder of the inner ear, air conduction longer than bone conduction, and lateralization to the unaffected ear.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

COMPLETION

1. When you ask the patient to identify smells, you are assessing cranial nerve_____.

ANS:
I

The first cranial nerve, the olfactory nerve, is tested when you ask a patient to identify different smells.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

b. do nothing because his color is pink.
c. note that his rate is below normal.
d. report that he has an above-average rate.

ANS: D

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

12. Which type of apnea requires immediate action?
    a. Primary apnea

The Apgar score of 1 in an infant reflects slow or irregular breathing.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

Chapter 15: Heart
Ball: Seidel's Guide to Physical Examination, 10th Edition

MULTIPLE CHOICE

1. Mr. O, age 50 years, comes for his annual health assessment, which is provided by his employer. During your initial history-taking interview, Mr. O mentions that he routinely engages in light exercise. At this time, you should
   a. ask if he makes his own bed daily.
   b. have the patient describe his exercise.
   c. make a note that he walks each day.
   d. record "light exercise" in the history.

   ANS: B
   When Mr. O says that he engages in light exercise, have him describe his exercise. To qualify his use of the term *light*, ask him the type, length of time, frequency, and intensity of his activities.

   DIF:Cognitive Level: Applying (Application)
   OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

2. Which of the following information belongs in the past medical history section related to heart and blood vessel assessment?
   a. Adolescent inguinal hernia
   b. Childhood mumps
   c. History of bee stings
   d. Previous unexplained fever

   ANS: D
   Previous unexplained fever should be included in the past medical history of a heart and blood vessel assessment. This incidence may be related to acute rheumatic fever, with potential heart valve damage.

   DIF:Cognitive Level: Understanding (Comprehension)
   OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

3. A patient you are seeing in the emergency department for chest pain is believed to be having a myocardial infarction. During the health history interview of his family history, he relates that his father had died of "heart trouble." The most important follow-up question you should pose is which of the following?

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10. To estimate heart size by percussion, you should begin tapping at the
    a. anterior axillary line.
    b. left sternal border.
    c. midclavicular line.
    d. midsternal line.

a. Sharp pain
b. Pain relieved by sitting up
c. Pain relieved by resting
d. Friction rub heard to right of sternum
e. History of kidney failure
f. Result of viral infection
g. Result of medications such as procainamide

ANS: A, B, E, F, G
Pericarditis may be seen with a viral infection, kidney failure, or medications such as procainamide. Symptoms include pain relieved by sitting up or leaning forward. A friction rub is heard at the left of the sternum, at the third or fourth intercostal space.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

Chapter 16: Blood Vessels
Ball: Seidel's Guide to Physical Examination, 10th Edition

MULTIPLE CHOICE

1. Induration, edema, and hyperpigmentation are common associated findings with which of the following?
   a. Peripheral arterial disease
   b. Venous ulcer
   c. Arterial embolic disease
   d. Venous thrombus

   ANS: B
   A venous ulcer also results from chronic venous insufficiency and demonstrates induration edema and hyperpigmentation. Peripheral arterial edema results in ischemia, in which the foot or leg is painful and cold; nonulceration is common as the muscles atrophy. Arterial embolic disease includes occlusion of the small arteries, resulting in blue toe syndrome and splinter hemorrhages in the nail bed. A venous thrombus presents with minimal ankle edema, low-grade fever, tachycardia, and possibly a positive Homan sign.

   DIF:Cognitive Level: Applying (Application) OBJ:Nursing process—diagnosis
   MSC: Physiologic Integrity: Reduction of Risk Potential

2. The most prominent component of the jugular venous pulse is the
   a. a wave.
   b. c wave.
   c. v wave.
   d. x slope.

   ANS: A

d. The ulcers are generally located on the tips of toes.

ANS: C
Venous ulcers are generally found on the medial or lateral aspects of the lower limbs, most often in older adults. Induration, edema, and hyperpigmentation are common. Heart failure, hypoalbuminemia, peripheral neuropathy, diabetes mellitus, nutritional deficiencies, and arterial disease cause the venous ulcers to develop. The major symptom of venous ulcers is not severe leg pain. In patients with venous ulcers, the affected leg is not commonly pale and hairless, and pulses are not difficult to palpate. Venous ulcers are not generally located on the tips of toes.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Reduction of Risk Potential

10. When examining arterial pulses, the thumb may be used
a. especially if vessels have a tendency to move.
b. never for palpating pulses.
c. checking the jugular venous pressure.
d. during the Allen test.

ANS: A
The thumb may be used, especially if the vessels have a tendency to move when probed by the fingers. The thumb is particularly useful in fixing the brachial and even the femoral pulses. You cannot palpate for jugular venous pressure waves. The Allen test is used to ensure ulnar patency prior to radial artery puncture.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Reduction of Risk Potential

11. To assess a patient's jugular veins, the patient should first be placed in which position?
a. Supine
b. Semi-Fowler
c. Upright
d. Left lateral recumbent

ANS: A
To assess jugular veins, place the patient in the supine position. This causes engorgement of the jugular veins. Then gradually raise the head of the bed until the pulsations of the jugular vein become visible between the angle of the jaw and the clavicle. Jugular veins cannot be palpated.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Reduction of Risk Potential

12. Observation of hand veins can facilitate the assessment of
a. mitral valve competency.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Reduction of Risk Potential

16. A venous hum heard over the internal jugular vein of a child
    a. usually signifies untreatable illness.
    b. usually has no pathologic significance.
    c. usually requires surgical intervention.
    d. must be monitored until the child is grown.

ANS: B
A venous hum is caused by the turbulence of blood flow in the internal jugular veins. It is common in children and usually has no pathologic significance. To detect a venous hum, auscultate over the right supraclavicular space at the medial end of the clavicle and along the anterior border of the sternocleidomastoid muscle. It is louder during diastole.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Reduction of Risk Potential

17. You are palpating bilateral pedal pulses and cannot feel one of the pulses. The feet are equally warm. You find that both great toes are pink, with a capillary refill within 2 seconds. Which of the following statements is correct?
    a. Immediate emergency surgery is indicated.
    b. Pedal pulses are not always palpable.
    c. Unilateral pulses are never normal.
    d. Venogram studies will be needed.

ANS: B
Dorsalis pedis and posterior tibia pulses may be difficult to palpate or may not be palpable in some well persons. The feet are warm and capillary refill is less than 2 seconds; there is adequate circulation to the feet. Immediate emergency surgery is not indicated. Unilateral pulses may be normal. Venogram studies will not be needed.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Reduction of Risk Potential

MULTIPLE RESPONSE

1. When palpating the carotid artery, which of the following is most important? (*Select all that apply.*)
    a. Rotate the patient's head to the side being examined to relax the sternocleidomastoid.
    b. Excessive carotid sinus massage can compromise blood flow to the brain.
    c. Excessive carotid sinus massage can cause slowing of the pulse.
    d. Palpate both sides simultaneously.

e. Posterior cervical nodes

ANS: A, B, D
During a routine breast examination it is common practice to examine lymph nodes. When enlarged and fixed, lymph nodes can indicate the presence of cancer. Common lymph nodes included in this examination are the supraclavicular, lateral axillary, and posterior cervical lymph nodes.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Reduction of Risk Potential

Chapter 18: Abdomen
Ball: Seidel's Guide to Physical Examination, 10th Edition

MULTIPLE CHOICE

1. Mrs. James is 7 months' pregnant and states that she has developed a problem with constipation. She eats a well-balanced diet and is usually regular. You should explain that constipation is common during pregnancy because of changes in the colorectal areas, such as
   a. decreased movement through the colon and increased water absorption from the stool.
   b. increased movement through the colon and increased salt taken from foods.
   c. looser anal sphincter and fewer nutrients taken from foods.
   d. tighter anal sphincter and less iron eliminated in the stool.

   ANS: A
   Constipation and flatus are more common during pregnancy because the colon is displaced, peristalsis is decreased, and water absorption is increased. Movement through the colon is decreased during pregnancy. The colon does not absorb nutrients. A tighter sphincter tone is not related to pregnancy.

   DIF:Cognitive Level: Applying (Application)
   OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

2. The family history of a patient with diarrhea and abdominal pain should include inquiry about cystic fibrosis because it is
   a. a common genetic disorder.
   b. one cause of malabsorption syndrome.
   c. a curable condition with medical intervention.
   d. the most frequent cause of diarrhea in general practice.

   ANS: B
   Cystic fibrosis is an uncommon, chronic genetic disorder affecting multiple systems. In the gastrointestinal tract, it causes malabsorption syndrome because of pancreatic lipase deficiency. Steatorrhea and abdominal pain from increased gas production are frequent complaints.

DIF:Cognitive Level: Analyzing (Analysis)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. Your patient is a 48-year-old woman with complaints of severe cramping pain in the abdomen and right flank. Her past medical history includes a history of bladder calculi. You diagnose her with renal calculi at this time. Which of the following symptoms would you expect with her diagnosis? (*Select all that apply.*)
   a. Abdominal pain on palpation
   b. Blumberg sign
   c. Cullen sign
   d. CVA tenderness
   e. Fever
   f. Grey Turner sign
   g. Hematuria
   h. Nausea

   ANS: A, D, E, G
   Abdominal pain on palpation, CVA tenderness, fever, hematuria, and nausea are all signs and symptoms of renal calculi. The Cullen sign is ecchymosis around the umbilicus, the Blumberg sign is rebound tenderness for appendicitis, the Grey Turner sign is ecchymosis in the flanks, and the McBurney sign is rebound tenderness at McBurney's point.

   DIF:Cognitive Level: Analyzing (Analysis) OBJ:Nursing process—diagnosis
   MSC: Physiologic Integrity: Reduction of Risk Potential

2. Your patient returns to the office with multiple complaints regarding her abdomen. Which of the following are objective findings? (*Select all that apply.*)
   a. Nausea
   b. Dullness on percussion
   c. Rebound tenderness
   d. Vomiting
   e. Diarrhea
   f. Burning pain in epigastrium

   ANS: B, C, E, F
   Nausea, vomiting and diarrhea, and burning pain in epigastrium are subjective signs. Dullness on percussion and rebound tenderness are objective findings.

   DIF:Cognitive Level: Analyzing (Analysis) OBJ:Nursing process—diagnosis
   MSC: Physiologic Integrity: Reduction of Risk Potential

c. Multiple sex partners
d. Obesity

ANS: C
Cervical cancer is associated with certain HPV strains. Multiple sex partners increase the risk of HPV infection.

DIF:Cognitive Level: Analyzing (Analysis)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

14. The risk of ovarian cancer is increased by
a. the use of oral contraceptives.
b. cigarette smoking.
c. age between 35 and 50 years.
d. early age at first intercourse.

ANS: A
There is a relationship between the number of menstrual cycles and risk of ovarian cancer. Early menarche and menopause after 50 years of age increase the risk.

DIF:Cognitive Level: Analyzing (Analysis)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

15. The form of gynecologic cancer that is increased in obese women is
a. vaginal.
b. cervical.
c. ovarian.
d. endometrial.

ANS: D
Obesity increases a woman's chance of developing endometrial cancer by twofold to fivefold.

DIF:Cognitive Level: Analyzing (Analysis)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

16. The mother of an 8-year-old child reports that she has recently noticed a discharge stain on her daughter's underwear. Both the mother and daughter appear nervous and concerned. You would need to ask questions to assess the child's
a. drug ingestion.
b. fluid intake.
c. risk for sexual abuse.
d. hormone responsiveness.

ANS: C
Vaginal discharge in a child could be related to a chemical irritation from soaps, lotions, or powders or to urinary tract infections. Concerned parents and children should be assessed for

28. Itchy, painful, small red vesicles are typical of
    a. condyloma acuminatum.
    b. condyloma latum.
    c. herpes simplex lesions.
    d. syphilitic chancre.

    ANS: C
    Herpetic lesions are painful, itchy red vesicles; condyloma acuminatum are warty lesions on the genitalia; condyloma latum are secondary syphilis lesions that appear as flat, round, or oval papules covered by a gray exudate; and a chancre is a painless ulcer.

    DIF:Cognitive Level: Understanding (Comprehension) OBJ:Nursing process—diagnosis
    MSC: Physiologic Integrity: Physiologic Adaptation

29. A young, sexually active woman comes to the urgent care clinic complaining of suprapubic abdominal pain. She is afebrile with rebound tenderness to the right side. There is no dysuria and no vaginal discharge or odor. A pelvic examination is done. She has pain with cervical motion, and you palpate a painful mass over the left adnexal area. Your prioritized action is to
    a. swab for gonococcal infection and then dip her urine.
    b. obtain a surgical consult immediately.
    c. remove the foreign body.
    d. dip her urine and then swab for *Chlamydia.*

    ANS: B
    The presenting symptoms of a tubal pregnancy are a surgical emergency. The only diagnostic test should be a pregnancy test.

    DIF:Cognitive Level: Analyzing (Analysis)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

Chapter 20: Male Genitalia
Ball: Seidel's Guide to Physical Examination, 10th Edition

MULTIPLE CHOICE

1. While examining an 18-year-old man, you note that his penis and testicles are more darkly pigmented than the body skin. You should consider this finding to be
    a. within normal limits.
    b. suggestive of a skin fungus.
    c. suggestive of psoriasis.
    d. caused by excessive progesterone.

    ANS: A
    Darker pigmentation on the penis and testicles, as compared with other body skin, is a normal finding and is not suggestive of a skin fungus, psoriasis, or excessive progesterone.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

2. In an uncircumcised male, retraction of the foreskin may reveal a cheesy white substance. This is usually
   a. evidence of a fungal infection.

General fluid retention can cause scrotal thickening and pitting edema, and is usually seen as a result of cardiac, renal, or hepatic disease. This swelling does not imply a condition of the genitalia, but rather a condition of these related systems.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

10. A characteristic related to syphilis or diabetic neuropathy is testicular
    a. dropping, with asymmetry.
    b. enlargement.
    c. insensitivity to painful stimulation.
    d. recession into the abdomen.

ANS: C
Diabetic neuropathy or syphilis can cause a marked reduction of tactile perceptions. Asymmetry is a normal finding; enlargement and recession are not related to diabetes or syphilis.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

11. On palpation, a normal vas deferens should feel
    a. beaded.
    b. smooth.
    c. ridged.
    d. spongy.

ANS: B
The vas deferens should feel smooth and discrete as it is palpated from the testicle to the inguinal ring. A beaded or lumpy vas deferens might indicate diabetes or the presence of old inflammatory changes.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

12. A premature infant's scrotum will appear
    a. bifid.
    b. loose.
    c. ridged.
    d. smooth.

ANS: D
The premature male scrotum will appear underdeveloped, smooth, without rugae, and without testes; the full-term infant should have a loose, pendulous scrotum, with rugae and a midline raphe.

c. a tumor.
d. an undescended testicle.

ANS: C
A hard, enlarged, painless testicle can indicate a tumor in the adolescent or adult male. Epididymitis and torsion are painful; an undescended testicle is common in infants and is usually resolved by 12 months.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

14. You palpate a soft, slightly tender mass in the right scrotum of an adult male. You attempt to reduce the size of the mass, and there is no change in the mass size. Your next assessment maneuver is to
a. use two fingers to attempt to reduce the mass.
b. palpate the left scrotum simultaneously.
c. lift the right testicle and then compare pain level.
d. transilluminate the mass.

ANS: D
A soft mass is a hernia or hydrocele. If the mass can be reduced, it is probably a hernia; a nonreducible mass should be transilluminated to determine whether it contains fluid and is possibly caused by a hydrocele. Lifting the scrotum should be done when epididymitis is suspected.

DIF:Cognitive Level: Analyzing (Analysis)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

15. The most common cancer in young men ages 15 to 30 years is
a. testicular.
b. penile.
c. prostate.
d. anal.

ANS: A
Because testicular tumors are the most common cancer occurring in young adults, self-examination is encouraged.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

16. The most emergent cause of testicular pain in a young male is
a. testicular torsion.
b. epididymitis.
c. tumor.
d. hydrocele.

ANS: A
Testicular torsion is a surgical emergency. If surgery is performed within 12 hours after the onset of symptoms, the testis can be saved in about 90% of cases. Delayed treatment results in a much lower salvage rate.

d. Failure to pass meconium stool

ANS: D
Failure to pass meconium stool indicates that a newborn has an imperforate anus.

DIF:Cognitive Level: Applying (Application)

OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

18. Prostate-specific antigen (PSA) screening is controversial because
    a. there are many false-negative results.
    b. PSA is produced by many other tissues.
    c. it is less sensitive than digital rectal examination.
    d. no data have proved that it decreases mortality.

    ANS: D
    There are no data confirming that PSA screening decreases mortality from prostate cancer.

    DIF:Cognitive Level: Understanding (Comprehension)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

19. Which finding in an infant may indicate lower spinal deformities?
    a. Perirectal redness
    b. Shrunken buttocks
    c. Rectal prolapse
    d. Dimpling in the pilonidal area

    ANS: D
    Sinuses, tufts of hair, and dimpling in the pilonidal area may indicate lower spinal deformities such as a pilonidal cyst.

    DIF:Cognitive Level: Understanding (Comprehension)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

20. A lower spinal cord lesion may be indicated by which finding?
    a. Lack of an anal wink
    b. Rectal prolapse
    c. Anal fistula
    d. Small flaps of anal skin

    ANS: A
    Lightly touching the anal opening of an infant should produce a contraction referred to as an anal wink. A negative wink may indicate a lower spinal cord lesion.

    DIF:Cognitive Level: Understanding (Comprehension)
    OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

21. Pinworms and *Candida* may both cause
    a. constipation.
    b. hemorrhoids.
    c. perirectal irritation.
    d. perirectal protrusion.

    ANS: C

ANS: C

Except for sacral vertebrae, the spinal vertebrae are separated from one another by disks. Spinal movement is achieved by paraspinous muscles, tendons, and ligaments. Bursae are located in the knee, elbow, shoulder, and hip.

a. venous return.
b. motor neuron.
c. strength.
d. tendon.

ANS: B

The temporomandibular joint is palpated just anterior to the tragus of the ear; the fingertips are placed inside the joint space as the patient opens and closes the mouth.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

19. The temporalis and masseter muscles are evaluated by
    a. having the patient shrug his or her shoulders.
    b. having the patient clench his or her teeth.
    c. asking the patient to fully extend his or her neck.
    d. passively opening the patient's jaw.

ANS: B
Having the patient to bite down and clench their teeth is the method for evaluating the strength of the temporalis and masseter muscles. Cranial nerve V is tested with this same maneuver.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

20. The strength of the trapezius muscle is evaluated by having the patient
    a. clench his or her teeth during muscle palpation.
    b. push his or her head against the examiner's hand.
    c. straighten his or her leg with examiner opposition.
    d. uncross his or her legs with examiner resistance.

ANS: B
Having the patient apply opposite force with differing head motions, against the examiner's hand, assesses the sternocleidomastoid and trapezius muscles.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

21. Expected normal findings during the inspection of spinal alignment include
    a. asymmetric skin folds at the neck.
    b. slight right-sided scapular elevation.
    c. concave lumbar curve.
    d. the head positioned superiorly to the gluteal cleft.

ANS: D
Spinal alignment is considered within normal limits when the patient's head is positioned directly over the gluteal cleft. The skin folds should be symmetric, the scapulae are at even heights, and both the cervical and lumbar curves are convex.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

b. emotional status.
c. sensory function.
d. tendon reflexes.

ANS: C
Superficial pain, touch, vibration, and position perceptions are sensory functions.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

16. You are initially evaluating the equilibrium of Ms. Q. You ask her to stand, with her feet together and arms at her sides. She loses her balance. Ms. Q has a positive
a. Kernig sign.
b. Homan sign.
c. McMurray test.
d. Romberg sign.

ANS: D
The Romberg test has the patient stand with the eyes closed, feet together, and arms at the sides. A slight swaying movement of the body is expected, but not to the extent of falling. Loss of balance results in a positive Romberg test. The Kernig sign indicates meningeal irritation, the Homan sign indicates venous thrombosis, and the McMurray test is a rotation test for demonstrating a torn meniscus.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

17. The finger to nose test allows assessment of
a. coordination and fine motor function.
b. point location.
c. sensory function.
d. stereognosis.

ANS: A
To perform the finger to nose test, the patient closes both eyes and touches his or her nose with the index finger, alternating hands while gradually increasing the speed. This tests coordination and fine motor skills. All the other choices test sensory function without motor function.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

18. You are performing a two-point discrimination test as part of a well physical examination. The area with the ability to discern two points in the shortest distance is the
a. back.
b. palms.

a. sole of the foot and observes whether the toes fan down and out.
b. abdomen and observes whether the umbilicus moves away from the stimulus.
c. inner thigh and observes whether the testicle and scrotum rise on the stroked side.
d. palm and observes whether the fingers attempt to grasp.

ANS: C
Stroking the inner thigh of a male patient (proximal to distal) will elicit the cremasteric reflex. The testicle and scrotum rise on the stroked side. Stroking the sole of the foot elicits a Babinski sign. Stroking the abdomen elicits an abdominal reflex. Stroking the palm elicits a palmar grasp.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

23. When you ask a patient to close his or her eyes and identify an object placed in the hand, you are evaluating
a. stereognosis.
b. graphesthesia.
c. vibratory sensation.
d. extinction phenomenon.

ANS: A
Stereognosis is the ability to recognize an object through touch and manipulation. Tactile agnosia, an inability to recognize objects by touch, suggests a parietal lobe lesion. Graphesthesia tests the patient's ability to identify the figure being drawn on the palm. The vibratory sense uses a tuning fork placed on a bony prominence, and the extinction phenomenon tests sensation by simultaneously touching bilateral sides of the body with a sterile needle.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

24. The ability to recognize a number traced on the skin is called
a. stereognosis.
b. graphesthesia.
c. an extinction phenomenon.
d. two-point discrimination.

ANS: B
The ability to recognize a number traced on the skin is called graphesthesia. Stereognosis is the ability to recognize an object through touch and manipulation. The extinction phenomenon test and two-point discrimination assess a person's ability to discern the number of pinpoints and their location.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

ANS: B
Parietal spinal sensory syndrome (Brown-Séquard syndrome) is noted when pain and temperature sensation occur one to two dermatomes below the lesion on the opposite side of the body from the lesion. Proprioceptive loss and motor paralysis occur on the lesion side of the body.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

26. To assess spinal levels L2, L3, and L4, which deep tendon reflex should be tested?
    a. Triceps
    b. Patellar
    c. Biceps
    d. Achilles

ANS: B
To assess spinal levels L2 to L4, the patellar reflex should be tested. The patellar tendon is the only deep tendon that assesses the lumbar spinal level. The triceps and biceps tendon are tested to assess the cervical spine, whereas the Achilles tendon is tested to assess the sacral spine.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

27. When using a monofilament to assess sensory function, the nurse
    a. uses two simultaneous monofilaments on similar bilateral points and then compares results.
    b. applies both a monofilament and a pin on similar bilateral points and then compares results.
    c. applies pressure to the monofilament until the filament bends.
    d. strokes the monofilament along the skin from proximal to distal areas.

ANS: C
The monofilament is placed on several smooth spots of the patient's plantar foot for seconds. Adequate pressure applied by the monofilament is measured by the bend of the monofilament.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

28. Visible or palpable extension of the elbow is caused by reflex contraction of which muscle?
    a. Achilles
    b. Biceps
    c. Patellar
    d. Triceps

ANS: D

(Complete 2022) Test Bank For Seidel's Guide to Physical Examination An Interprofessional Approach 10th Edition by Jane W. Ball, Joyce E. Dains Chapter 1-26; Ace in your Exams in 1 attempt!

29. It is especially important to test for ankle clonus if
    a. deep tendon reflexes are hyperactive.
    b. deep tendon reflexes are hypoactive.
    c. the Romberg sign is positive.
    d. the patient has peripheral neuropathy.

    ANS: A
    Test the ankle clonus when reflexes are hyperactive. Support the patient's knee in a flexed position and briskly dorsiflex the foot with your other hand. If clonus is present, there is recurrent ankle plantar flexion movement as long as the examiner retains the foot in dorsiflexion. Sustained clonus signifies the hypertonia of an upper motor neuron lesion.

    DIF:Cognitive Level: Analyzing (Analysis)
    OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

30. On a scale of 1+ to 4+, which deep tendon reflex score is appropriate for a finding of clonus in a patient?
    a. 1+
    b. 2+
    c. 3+
    d. 4+

    ANS: D
    1+ indicates a sluggish or diminished reflex. 2+ indicates an active or expected response. 3+ indicates more brisk than expected, slightly hyperactive. 4+ indicates brisk, hyperactive, with intermittent or transient clonus.

    DIF:Cognitive Level: Applying (Application)
    OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

31. Which sign is associated with meningitis and intracranial hemorrhage?
    a. Babinski sign
    b. Asymmetric tonic neck reflex
    c. Doll's eye movement
    d. Nuchal rigidity

    ANS: D
    A stiff neck or nuchal rigidity is a sign associated with meningitis and intracranial hemorrhage. Test this by lifting the head of the patient to touch the chin while the patient lies in a supine position. Pain and resistance to neck motion are associated with nuchal rigidity.

    DIF:Cognitive Level: Analyzing (Analysis)
    OBJ:Nursing process—assessment MSC: Safe and Effective Care: Management of Care

32. Cranial nerve XII may be assessed in an infant by
    a. watching the infant's facial expressions when crying.

Emotional constraints can limit a patient's reliability as a historian. Language barriers, cultural barriers, and an unresponsive or comatose patient can all affect a patient's ability to be a thorough historian. All the other options would not limit a patient's reliability.

DIF:Cognitive Level: Understanding (Comprehension)

ANS: B
With the patient in the lithotomy position, the examiner can inspect the external and internal female genitalia and perform a rectal examination to assess and palpate anal sphincter tone. The other choices require the patient to be in the supine or standing position.

ANS: C
For children, the examination sequence depends on their cooperation for as long as possible. To promote this, examine the child while the parent is holding the child, which maximizes inspection and opportunities for physical examination.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

27. Which cannot be assessed in the crying infant?
a. Tactile fremitus
b. Respiratory rate
c. Lung excursion
d. Facial symmetry

ANS: B
Respirations cannot be counted in the crying infant. Tactile fremitus can be felt when the infant is crying.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

28. The Ballard Gestational Age Test is completed within 36 hours of birth to
a. determine if the menstrual estimated age is correct.
b. determine if the newborn is premature.
c. determine an actual quantitative measure.
d. determine combined objective and subjective observations.

ANS: B
Because menstrual histories are inaccurate, the Ballard Gestational Age assessment tool contains newborn characteristics that can determine prematurity.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

29. Mrs. Kia has brought her newborn infant in for a 2-week examination. The examination of the newborn should begin with
a. inspection.
b. palpation.
c. vital signs.
d. auscultation.

ANS: A
The examination of a newborn should begin with inspection; skin color, flaccidity, tension, gross deformities, or distortions of faces should be noted. All the other examination techniques follow inspection.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

30. The best way to ease the apprehension of a 3-year-old child before a physical examination is to
    a. explain that you will be gentle.

(Complete 2022) Test Bank For Seidel's Guide to Physical Examination An Interprofessional Approach 10th Edition by Jane W. Ball, Joyce E. Dains Chapter 1-26; Ace in your Exams in 1 attempt!

OBJ:Nursing process—assessment MSC: Health Promotion and Maintenance

MULTIPLE RESPONSE

c. reassess the patient's temperature.
d. transport the patient via airlift.

ANS: B
The primary assessment is interrupted to manage a life-threatening condition as soon as it is detected. Once the condition is stabilized, the primary assessment is continued. Recording of events as they occur should be completed in a manner that does not interrupt continued care or transport. Reassessment of the patient's temperature is inappropriate because it would interrupt the continued assessment process. Transporting the patient may begin after the primary assessment has been completed to determine the needs of the patient adequately.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—implementing MSC: Safe and Effective Care: Management of Care

4. The term *status epilepticus* is defined as
a. convulsive activity uncontrolled by medication.
b. nonconvulsive brain wave disturbance, with psychomotor dysfunction.
c. prolonged seizures that occur without recovery of consciousness.
d. seizures that result in hypotension, pallor, and prolonged diaphoresis.

ANS: C
Status epilepticus is a prolonged seizure or series of seizures that occur without recovery of consciousness.

DIF:Cognitive Level: Remembering (Knowledge)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

5. Pulsus paradoxus greater than 20 mm Hg, tachycardia greater than 130 beats/min, and increasing dyspnea are signs of
a. intracranial pressure.
b. pulmonary hypertension.
c. status asthmaticus.
d. tetanic contractions.

ANS: C
Status asthmaticus is a severe and prolonged asthma attack that resists the usual therapeutic approaches. The patient experiences dyspnea, can only get out a few words between breaths, and has tachycardia often greater than 130 beats/min and pulsus paradoxus greater than 20 mm Hg. Pulsus paradoxus is more likely in pericardial effusion, constrictive pericarditis, and severe asthma.

DIF:Cognitive Level: Analyzing (Analysis) OBJ:Nursing process—diagnosis
MSC: Physiologic Integrity: Basic Care and Comfort

6. The Cushing triad includes
a. tachycardia.

The Cushing triad is associated with increased intracranial pressure. It includes bradycardia, hypertension, and irregular respirations, even Cheyne-Stokes respirations.

DIF:Cognitive Level: Remembering (Knowledge) OBJ:Nursing process—diagnosis
MSC: Physiologic Integrity: Basic Care and Comfort

7. Blood, vomitus, and foreign bodies are removed from the oropharynx of the unconscious patient by
   a. stimulating the cough reflex.
   b. using a sweeping motion with the finger.
   c. performing a back thrust.
   d. using suction.

   ANS: D
   Suction is used to remove blood, vomitus, or foreign bodies from the airway of an unconscious patient. The other choices put the patient at risk for aspiration or further injury if a neck injury is involved.

   DIF:Cognitive Level: Applying (Application)
   OBJ:Nursing process—implementing MSC: Safe and Effective Care: Management of Care

8. While performing the primary survey on a trauma victim, the patient is answering your questions. You may assume that during the time of the questioning
   a. his airway is open.
   b. he is alert and oriented.
   c. no head injury has occurred.
   d. there is no respiratory compromise.

   ANS: A
   The patency of the upper airway is assessed at the start by asking the patient a question. If the patient answers, this is a sign that the airway is open at this time.

   DIF:Cognitive Level: Analyzing (Analysis)
   OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

9. If trauma above the clavicle is suspected, it is important to
   a. test range of motion of the neck.
   b. remove any headgear.
   c. arrange for neck extension x-ray studies.
   d. stabilize the neck in a neutral position.

   ANS: D
   If trauma above the clavicle is suspected, it is necessary to control the cervical spine by stabilizing the neck in a neutral position. Excessive movement can convert a fracture or dislocation without neurologic damage to one with neurologic damage.

DIF:Cognitive Level: Applying (Application) OBJ:Nursing process—diagnosis
MSC: Physiologic Integrity: Basic Care and Comfort

14. Delayed capillary refill may alert you to
    a. hypovolemic shock.
    b. moderate hypoxemia.
    c. subnormal intracranial pressure.
    d. upper respiratory infection.

ANS: A
Delayed capillary refill means that the vessels are taking an extended time to fill, which is a sign of decreased cardiac output. To assess peripheral perfusion further and detect hypovolemic shock, note the skin color, presence and quality of pulses, and temperature of the extremities.

DIF:Cognitive Level: Applying (Application) OBJ:Nursing process—diagnosis
MSC: Physiologic Integrity: Basic Care and Comfort

15. Capillary refill can be assessed by applying pressure over a nail bed or a(n)
    a. bony prominence.
    b. eyelid.
    c. mucous membrane.
    d. femoral vein.

ANS: A
Capillary refill can be assessed by pressing firmly over a nail bed or bony prominence such as the chin, forehead, or sternum until the skin blanches. Count the seconds it takes for color to return. Less than 2 seconds is a normal finding, and longer than 2 seconds indicates poor perfusion.

DIF:Cognitive Level: Understanding (Comprehension)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

16. The secondary survey of a patient with hypotension would begin with the assessment of
    a. blood type.
    b. level of consciousness.
    c. number of fractures.
    d. swallowing ability.

ANS: B
Secondary assessments are done after life-threatening problems are determined. For the hypotensive patient, it would be most important to begin secondary assessment of cerebral perfusion by determining the patient's level of consciousness.

DIF:Cognitive Level: Applying (Application)
OBJ:Nursing process—assessment MSC: Physiologic Integrity: Basic Care and Comfort

c. pneumothorax.
d. cardiac contusion.

ANS: A
Blunt sternal pressure will be painful if any attached ribs are fractured. Sternal pressure is applied to the chest to assess the stability of the chest wall.

DIF:Cognitive Level: Analyzing (Analysis) OBJ:Nursing process—diagnosis
MSC: Physiologic Integrity: Basic Care and Comfort

24. Which injury is the most common precipitator of blunt trauma?