**Table 5-2  Nursing History: Functional Health Pattern Prioriat**

**Demographic Data**
- Name, address, age, occupation

**Important Health Information**
- Past health history
- Medications
- Surgery or other treatments

**Functional Health Patterns**

**Health Perception-Health Management Pattern**
1. Reason for visit?
2. General state of health?
3. Any colds in past year?
5. Health compliance problems?
6. Cause of illness? Action taken? Results?
7. Things important to you while here?
8. Family health history?
9. Illness and injury risk factors: use of cigarettes, alcohol, drugs?
10. Allergies? Immunizations?

**Nutritional-Metabolic Pattern**
1. Typical daily food intake (describe)? Supplements?
2. Typical daily fluid intake (describe)?
3. Weight loss or gain (amount, time span)?
4. Desired weight?
5. Appetite?
6. Food or eating: Discomfort? Diet restrictions?
7. Appetite?
8. Heal well or poorly?
9. Skin problems: Lesions? Dryness?
10. Dental problems?
11. Change in appetite with anxiety?
12. Food preferences?
13. Food allergies?

**Elimination Pattern**
2. Urinary elimination pattern (describe): Frequency? Problem in control? Diuretics?
3. Any external devices?
4. Excess perspiration? Odor problems? Itching?

**Activity-Exercise Pattern**
1. Sufficient energy for desired or required activities?
2. Exercise pattern? Type? Regularity?
3. Spare time (leisure) activities?
5. Perceived ability for (code for level):
   - Feeding
   - Cooking
   - Grooming
   - Bathing
   - General mobility.
   - Dressing
   - Toileting
   - Shopping

**Functional levels code**
- Level 0: Full self-care
- Level I: Requires use of equipment or device
- Level II: Requires assistance or supervision from another person
- Level III: Is dependent and does not participate

**Sleep-Rest Pattern**
1. Generally rested and ready for daily activities after sleep?
2. Sleep onset problems? AIDS? Dreams (nightmares)?
3. Early awakening?
4. Usual sleep rituals?
5. Usual sleep pattern?

**Cognitive-Perceptual Pattern**
1. Hearing difficulty? Aid?
2. Vision? Wear glasses? Last checked?
3. Any change in taste? Any change in smell?
4. Any recent change in memory?
5. Easiest way to learn things?
7. Ability to communicate?
8. Understanding of illness?
9. Understanding of treatments?

**Self-Perception-Self-Concept Pattern**
1. Self-description? Self-perception?
2. Effect of illness on self-image?
3. Relieving factors?

**Role-Relationship Pattern**
1. Live alone? Family? Family structure diagram?
2. Difficult family problems?
3. Family problem solving?
4. Family dependence on you for things? How managing?
5. Family’s and others’ feelings about illness/hospitalization?*
6. Problems with children? Difficulty handling?*
7. Belong to social groups? Have close friends? Feel lonely (frequency)?
8. Work satisfaction (work)? Income sufficient for needs?*
9. Feel part of or isolated to neighborhood where living?

**Sexuality-Reproductive Pattern**
1. Any changes or problems in sexual relations?
2. Effect of illness?
3. Use of contraceptives? Problems?
4. When menstruation started? Last menstrual period?
6. Effect of present condition or treatment on sexuality?
7. Sexually transmitted diseases?

**Coping-Stress Tolerance Pattern**
1. Tense a lot of the time? What helps? Use any medicines, drugs, alcohol?
2. Have someone to confide in? Available to you now?
3. Recent life changes?
4. Problem-solving techniques? Effective?

**Value-Belief Pattern**
1. Satisfied with life?
2. Religion important in your life?
3. Conflict between treatment and beliefs?

**Other**
1. Other important issues?
2. Questions?

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*If appropriate.

*or women.