

Class: NURS 310: Health Assessment

Case Study Assignment: Comprehensive Health Assessment of an Adult Patient with New-Onset Symptoms

Learning Objectives

By the end of this assignment, students will be able to:

1. Apply health assessment frameworks (subjective + objective data) to a realistic patient scenario.
 2. Identify focused assessment priorities based on patient symptoms.
 3. Interpret assessment findings and differential possibilities.
 4. Communicate assessment information clearly using SBAR or similar formats.
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Case Scenario

Patient: *Maria Lopez, 47 y/o*

Chief Complaint: “I’ve been feeling really tired and short of breath for the last two weeks.”

History of Present Illness:

- Onset: Two weeks ago, gradually worsening
- Associated symptoms: Occasional dizziness when standing, heart “racing” at times
- Denies chest pain, fever, or cough
- States she has had heavier-than-normal menstrual periods for the past three months

Past Medical History:

- Seasonal allergies
- No chronic illnesses, surgeries, or hospitalizations

Medications:

- Loratadine as needed

Lifestyle:

- Works as a middle school teacher

- Diet: “Not great—skips breakfast often”
- Sleep: 5–6 hours per night, difficulty falling asleep
- No tobacco; occasional wine; limited exercise

Vital Signs:

- BP 98/62
- HR 108 bpm
- RR 18
- Temp 98.4°F (36.9°C)
- SpO₂ 97% on room air

Physical Examination (Selected Findings):

- General: Appears pale, slightly fatigued
 - Cardiovascular: Tachycardia; regular rhythm
 - Respiratory: Clear bilateral breath sounds; no wheezes or crackles
 - Skin: Pale, capillary refill 3 seconds
 - Neurological: Alert and oriented ×4
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 **In-Class Active Learning Activity**

Format: Small groups (3–4 students), then whole-class synthesis.

Time: 35–40 minutes

Guided Questions for Student Groups

Part A: Subjective Data Collection

1. Identify **at least five follow-up questions** you would ask Maria to gather more complete subjective data.
2. Which aspects of her medical, menstrual, diet, and social history seem most relevant?

Part B: Objective Assessment Priorities

3. Based on the chief complaint and vitals, which **focused assessments** should you perform (e.g., cardiovascular, respiratory, integumentary)?
4. What additional **objective findings** would you want to look for?

Part C: Interpretation

5. List **three possible nursing interpretations or differential considerations** (e.g., anemia, dehydration, arrhythmia). Briefly explain your reasoning.
6. Identify **red flag findings** that would require immediate escalation.

Part D: Nursing Actions

7. What **nursing interventions** are appropriate at this stage?
8. What **patient education** would you provide based on what you know so far?

Part E: Communication (SBAR)

9. Prepare a brief **SBAR report** to present to a provider based on Maria's data.
 10. How would you prioritize which information to include?
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Deliverable (Students Submit)

- 3–5 minute oral SBAR presentation
 - Include:
 - Key findings from subjective + objective assessment
 - Priority concerns
 - Proposed nursing interventions
 - SBAR summary
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Instructor Debrief (Whole-Class)

- Groups share differentials and assessment choices
 - Instructor facilitates discussion on:
 - How different assessment findings change clinical thinking
 - Importance of linking symptoms (fatigue, pallor, tachycardia, heavy menses) to potential anemia
 - Safety priorities and communication clarity
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