Health History Assessment:

Mr. X (75 yrs) is citizen of India. He is saying alone in his two storey building alone because his wife expired five years before. His financial condition is weak as he is not doing anything to earn money and he is earning little pension. As a result, he is not able to have assistant for his daily activities. He was shifted to adult care center 1 month back for treating his multiple diseased conditions. He is belonging to the community where people don't believe in medical practioners and these people don't wish to share their diseased condition and feeling with others. He was diagnosed with diabetes, fatty liver cirrhosis, hypertension, osteoporosis, and obesity since last 20 years. He is consuming medicines like, metformin, atenolol, spironolactone and orlistat. He had addiction of alcohol and smoking since last 40 years. He is allergic to eggs. His father was also having diabetes and hypertension. Due to poverty, in his childhood, he didn't get nutritious food and his growth and development was not proper in his growing age. His son is not taking care of him and this makes him socially isolated as he is not willing to socialize with other community members. His cultural background is also not allowing him to share his diseased condition and feeling with other community members because his cultural background hindering him from doing this. As he was living alone, most of the time he was in depressed condition.

After his admission to the adult care system, his vital signs were tested and following were the observations from these testing. In recent times, his vital systems were tested and below are the observations.

Physical Examination and Diagnostic test:

Head, ears, eyes, nose and throat (HEENT) Observations:

Head: No headache, dizziness

Ears: Normal hearing.

Eyes: Normal vision and no spots in the eye.

Nose: No assessment.

Throat: No swelling.

Cardiovascular: Sporadic mild pain in the chest, occasional palpitations.

Pulmonary: Normal breathing and no cough.

Gastrointestinal: No GIT pain, stool consistency is normal, and loss of appetite.

Genitourinary: Urgency in urination

Neurologic: Numbness.

Mukosleletal: With lifting of little weight, there is the abdominal pain.

Endocrine: No assessment.

Vital signs : Blood pressure (B.P.) – Systolic 125 mmHg and diastolic 85 mmHg, Blood sugar level – 130 mg/dl, Body weight – 85 kg, Live function test – AST - 65 IU, ALT - 55 IU

Forced expiratory volume (FEV1) – 80 %. Dual-energy X-ray absorptiometry (DEXA) exhibited low bone mineral density (BMD).

Evaluation of the above mentioned results of Mr. X reflects that he is suffering through diabetes, hypertension and osteoporosis (Dains et al., 2012; Jarvis, 2015).

Education:

As Mr. X is having diabetes, he should maintain healthy lifestyle. Mr. X should consume proper nutrition, maintain ideal body weight, perform routine physical activity and routine health checkup from diagnostic lab. Mr. X should consume medications as directed by the practitioner and consumption of these medications should be timed with meals. He should not use medications in excess or he should not discontinue medications. Excess use of medications may lead to hypoglycemia. Mr. X should have fixed meal plan and he should consume fruits, vegetables, leant meat, low saturated fat products and whole grain food items. He should consume good amount of fiber and drink plenty of water. He should consume fewer amounts of sugar and salt. He should maintain regular exercise schedule as it is helpful in maintaining blood sugar level and reducing stress on him. Mr. X should check his blood sugar level if he is having problems like blurry vision, urgency in urination, sweating and confusion. Mr. X also should know about, how to check blood sugar level by using glucose strips, so that he can monitor his blood sugar level and modify diet plan and exercise accordingly. Also, it would be helpful for him to visit practitioner (Haas et al., 2014; Healy et al., 2013).

Mr.X should consume enough amount of protein, calcium and vitamin D for the prevention of osteoporosis. Mr. X should consume approximately 500 mg calcium daily in divided doses. Also, he should consume approximately 800 international units of vitamin D on daily basis. Mr. X should avoid smoking and consumption of caffeine, salt and alcohol. Mr. X should perform moderate exercise, which would be helpful in preventing fracture, maintaining balance and consequently prevention of fall. Mr. X should consume glucocorticoid medication under supervision of practitioner for prevention of osteoporosis (Lewiecki et al., 2013; Mosekilde et al., 2013).

Education provided to Mr. X would be helpful in reducing his disease condition. Diabetes and osteoporosis is associated with him since long time. His cultural and psychological aspects were hindering him form sharing his diseased condition with health care professional. Hence, he didn't get proper holistic care for his diseased condition. However, this education would definitely help him to control diabetes and manage osteoporosis. Mr. X was not getting proper support from his family and community members. Hence, he didn't get proper treatment for his diseased condition. However, through this education he would get holistic treatment for his diseased condition (Falvo, 2010).

Reflection:

I interviewed Mr. X in the morning session because he was with fresh mood. I interviewed him in garden of the adult care center. I approached him in a very polite way so that he would feel comfortable in this interview process because his cultural backhound hindered him form opening up about his diseased condition. Surprisingly, I got very positive response from Mr. X during interview session. In contrast to his cultural background, he shared all the aspects of his health to me. As he didn't know some of the medical terminologies, he couldn't explain me, few of his problems. I took help of his neighbor to know about his diseased condition. He became emotional during his interview because he doesn't have any support from his family members. I didn't anticipate this thing from Mr.X. Physical examination went in a very smooth way as he cooperated very nicely. I got all the information about Mr.X, to provide holistic care to him. Next time I will give education to the patient about the medical terminologies related to particular case. Hence, it would be helpful for the patient to explain health condition in a better way.

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