Assessing Clients with Eye or Ear Disorders

Exercise
- Use the following health history questions and leading statements, categorized by functional health patterns, with a family member, friend, or client. Identify areas for focused physical assessment based on findings from the health history.

Assessing the Eye and Ear

Health Perception–Health Management
- Describe your vision. Rate it on a scale of 1 to 10, with 10 being excellent vision. Is it the same in both eyes? If not, which eye is better?
- Describe your hearing. Rate it on a scale of 1 to 10, with 10 being excellent hearing. Is it the same in both ears? If not, which ear is better?
- Describe your current vision (hearing) problems. How have these been treated?
- What eye (ear) medications do you use? How often?
- Have you ever had eye (ear) surgery? Explain.
- Describe the type of corrective lenses (hearing aid) that you use. Are you satisfied with these appliances?
- How do you care for them?
- Describe how you care for your eyes (ears).
- When was your last eye (ear) examination? Have you been tested for glaucoma?

Nutritional–Metabolic
- Do you have any redness, swelling, watering, or dryness of your eyes?
- Do you have any swelling or tenderness of the ears, or drainage from your ears?

Activity–Exercise
- Does your vision (hearing) impairment interfere with your usual activities of daily living (such as walking, cooking, grooming, driving, shopping, socializing)? Explain.
- Do you wear protective goggles or earplugs when you engage in activities that increase the risk of injury to the eyes or ears?

Sleep–Rest
- Does your eye (ear) problem interfere with your ability to sleep or rest (for example, because of pain or ringing in the ears)?

Cognitive–Perceptual
- Do you have any difficulty focusing on objects?
- Is your vision blurred? Do you see halos around lights? Do you see “floaters” or flashes of light? Do you see double?
- Do you have pain in or around your eyes (ears)? If so, describe its location, intensity, aggravating factors, and duration. How do you treat it?
- Do you have trouble hearing conversations either in person or on the telephone? Do you have trouble hearing the television? Do you have trouble hearing conversations when you are in crowds?
- Do you have buzzing, ringing, or crackling in your ears?
- Do you feel dizzy?

Self-Perception–Self-Concept
- How has this problem with your eyes (ears) affected how you feel about yourself?
- How has this problem with your eyes (ears) affected how you feel about your normal life?
- How do you feel about wearing corrective lenses or a hearing aid?

Role–Relationship
- Has your eye (ear) problem affected your role in your family? If so, how?
- Has your vision (hearing) loss affected your interactions with others in your family? With friends? At work?
- In social activities?
- Has your eye (ear) problem interfered with your work? Explain.

Sexuality–Reproductive
- Have your usual sexual activities been altered by problems with your eyes (ears)?
Describe how these problems with your eyes (ears) have affected how you feel about yourself as a man (woman).

**Coping–Stress**
- How have you managed with your eye (ear) problem?
- What do you feel is the most stressful time you have had with your eye (ear) problem?
- Describe what you do to cope with stress.
- Who or what will be able to help you cope with the stress caused by your eye (ear) problem?

**Value–Belief**
- Are there significant others, practices, or activities that help you cope with a vision (hearing) impairment?
- Explain.
- How do you think this health problem will affect your future?