Patient History Taking: Identifying General Information

What Is Involved in Patient History Taking?

 › Patient history taking (PHT) is the systematic and structured questioning by a healthcare provider of a patient, a patient’s family member, or a close associate (e.g., intimate partner) to gain information about a patient’s past and current health. The health history consists of the patient’s chief complaint (or primary reason for seeking healthcare); history of the current illness; history of past illness, injury, and surgery; family history; psychosocial history; and a review of symptoms. The information obtained assists in determining a medical diagnosis, developing a nursing care plan, and providing appropriate treatment to the patient

 • What: General information gathered during PHT includes biographical information (i.e., patient’s name, age, date of birth, place of birth, marital status, occupation, type of healthcare insurance, emergency contact information) and whether or not the patient has any advance healthcare directives. Measurements of height and weight and information regarding allergies to foods, latex, medication, and the environment can also be gathered at this time. (For detailed information on specific aspects of PHT, see the series of Nursing Practice & Skill papers on PHT. For more information about advance healthcare directives, see Nursing Practice & Skill ... Advance Healthcare Directives: Implementing -- an Overview )

 • How: Patients might be provided with paperwork to complete prior to their scheduled appointment in which healthcare providers use closed-ended questioning to elicit personal biographic information. A height chart and scale can be used to obtain the patient’s height and weight. This information is then documented in accordance with facility protocol and medical record format (e.g., manually or electronically)

 • Where: PHT is performed in every setting where healthcare is provided (e.g., inpatient, outpatient, clinic, hospital, home). Maintaining patient privacy is a critical component of PHT; therefore, PHT should be undertaken in an area where there is no potential for information to be overheard by persons not involved in the patient’s care

 • Who: Registered nurses, advanced practice nurses, physician assistants, physicians, social workers, and case managers all conduct PHT interviews. In addition, admitting clerks, nursing assistants, or medical assistants gather general information from patients. Depending on the patient’s wishes, family members can be present during PHT

What is the Desired Outcome of Identifying General Information during Patient History Taking?

 › The desired outcome of PHT is to enable the clinician to understand the patient’s current symptoms in light of his or her past medical history because a patient’s medical history has a high predictive value in diagnosing current and future health issues. Gathering general information during PHT is necessary for medical record filing purposes, to confirm patient identification, to verify that emergency contact information is on file and current, to obtain information and/or copies of advance healthcare directives, to verify health insurance information, and to track trends (e.g., weight fluctuations) in response to treatment regimens
Why is Identifying General Information during Patient History Taking Important?

› PHT is part of establishing a therapeutic relationship between the clinician and patient
› Gathering general information during PHT allows the clinician to provide effective individualized care by
  • confirming that the clinician is speaking with the correct patient
  • providing the clinician access to the patient’s personal medical information
  • allowing the clinician to track trends in response to treatment regimens (e.g., changes in body mass and height)
  • identifying patient allergies to prevent exposure and decrease the risk for an allergic reaction
  • identifying social issues (e.g., occupation, health insurance, and emergency contacts) that might need to be addressed later in the visit
  • providing a method for proper filing of medical records
  • receiving information regarding the most current advance healthcare directive, if applicable
  • ascertaining the method of financial reimbursement for healthcare services
› The risk for legal complications is decreased by comprehensive and quality PHT

Facts and Figures

› An estimated 28% of home healthcare patients, 65% of nursing home residents, and 88% of discharged hospice patients have at least one advance directive, the most common of which are living wills and Do Not Resuscitate orders (Jones et al., 2011)

What You Need to Know Before Gathering General Information While Taking a Patient History

› The value of the information obtained during history taking is dependent on the reliability of the interviewee
› Patients are more likely to be involved in their care and open to patient education when the relationship between the patient and caregiver involves trust, empathy, and respect
  • Some patients feel more comfortable sharing information about themselves when the healthcare provider self-discloses a small amount of general but relevant information with which the patient can identify at the start of their time together
  • Taking the time during initial appointments to establish a trusting relationship and help patients recognize that the healthcare provider cares about them will lead to increased efficiency in communication with future appointments
› Patients often provide information to healthcare providers in an unstructured manner
  • It is vital for the healthcare provider to utilize a systematic and structured approach to PHT to thoroughly gather general information, to avoid overlooking relevant information regarding the patient’s chief complaint and current symptoms, and to effectively manage the time allotted for patient interviews
› Cultural beliefs and traditions can influence the communication between patients and healthcare providers
  • The healthcare provider should be aware of the cultural differences in the acceptable degree of familiarity between clinician and patient and be conscious of differing practices regarding eye contact, physical touch, and interactions between men and women
  • For more information, see the series of Evidence-Based Care Sheets and Nursing Practice & Skills on providing culturally competent healthcare
› Preliminary steps that should be performed before taking a patient history include the following:
  • Review the facility/unit-specific protocol for PHT, if one is available
    – Typically, a facility protocol will mandate the use of a specific form for PHT. The form is a structured guide that should include biographical and advance directive questions as well as the basic components of a patient’s medical history
  • Review the treating clinician’s order for PHT
    – Note: A specific order for PHT might not be necessary because many facilities require nurses to take a patient’s medical history as part of the standard admission procedure
  • Arrange for the interview to be conducted in a quiet area that affords the patient privacy and comfort (e.g., comfortable chair or bed, appropriate room temperature)
› Gather the following items prior to beginning the patient interview:
  • Facility-approved method of documentation (e.g., patient history form, electronic medical record)
  • Equipment to measure height and weight; verify that the methods to be used are appropriate for the patient’s developmental status and physical condition
  • Educational or reference materials
How to Gather General Information When Taking a Patient History

› Perform hand hygiene
› Identify the patient according to facility protocol
› Establish privacy by closing the door to the patient’s room and/or drawing the curtain surrounding the patient’s bed
› Introduce yourself to the patient and family member(s), if present; explain your clinical role; assess the coping ability of the patient and family and for knowledge deficits and anxiety regarding PHT
  • Determine if the patient/family requires special considerations regarding communication (e.g., due to illiteracy, language barriers, or deafness); make arrangements to meet these needs if they are present
  – Use professional certified medical interpreters, either in person or via phone, when language barriers exist
  • Explain the procedure for PHT and its purpose; answer any questions and provide emotional support as needed
  • As appropriate, ask family members and other visitors to leave the patient’s room in order to promote privacy
› Convey a caring and nonjudgmental attitude to the patient by creating a positive and accepting rapport (i.e., not being influenced by preconceptions or personal bias)
  • Begin the interview by obtaining general biographical data, including the patient’s address, telephone number, sex, age, birthdate, birthplace, marital status, education, religion, race, nationality, cultural background, the names of other members of his or her household, and emergency contact information
  • Ask returning patients specific questions about topics discussed at prior visits (e.g., activities in which they are involved or health issues specific to them)
  • Be aware of your own body language and facial expressions to avoid being interpreted as hurried, unpleasant, or judgmental; demonstrate respect, courtesy, empathy, and cultural sensitivity
› Assure the patient that all information collected will be maintained in a secure manner available only to clinicians responsible for his or her care
› If the patient filled out a questionnaire with general information prior to the visit, review this information for completeness and to question information provided that is not clear or legible
› Ask the patient closed-ended questions in a systematic manner regarding general information (e.g., Can you confirm the spelling of your first and last name? What is your age? What is your date of birth?)
› Verify that accurate information regarding allergies (i.e., medications, latex, foods, environmental) is obtained via questionnaire and/or verbal interaction
› Repeat the information heard, as needed, throughout the interview to confirm understanding
› Ask the patient to step on the freestanding scale to obtain his or her weight; if this is not possible (e.g., due to mobility limitations or weakness), weigh the patient using an alternative method (see the Nursing Practice & Skill series on alternative methods of measuring patient weight)
› Ask the patient to remove his or her shoes and step up to the tool used to measure height, keeping feet flat on the ground during the measurement; if unable, measure the length of the patient’s body in bed (e.g., using a tape measure) from heel to top of head
› Obtain a copy of the most current advance healthcare directive or ask that a copy be provided as soon as possible
› Document all information gathered during PHT in the patient’s medical record according to facility protocol, including the following information:
  • Date and time of interview
  • The patient’s exact words, if documented, in quotation marks
  • Any cultural information that is relevant to the patient’s care
  • Patient/family member education, including topics presented, response to education provided/discussed, plan for follow-up education, and details regarding any barriers to communication and/or techniques that promoted successful communication

Other Interventions That May be Necessary Before, During, or After Gathering General Information While Taking a Patient History

› Review the patient’s medical records to verify that the information recorded in the patient history is accurate and complete
› Contact social worker, case manager, or discharge planner for follow-up on information obtained while gathering general information that could influence or complicate the patient’s treatment regimen or discharge process
› Allow adequate time to document and make notes following each patient interaction such that detailed and accurate information is recorded
What to Expect After Gathering General Information While Taking a Patient History

- General information gathered during PHT combined with the patient’s chief complaint will guide the healthcare provider in performing a directed physical exam and ordering medical tests
  - Information gathered during the PHT combined with physical exam findings and medical test results will be used in diagnosing and treating the patient
- General information gathered during PHT might prompt intervention by the social worker, case manager, or discharge planner
- All information disclosed by the patient will be maintained in strict confidence to protect patient privacy

Red Flags

- A lack of understanding of a patient’s cultural beliefs and customs can lead to miscues by the healthcare provider during PHT resulting in patient discomfort, poor communication, and inadequate information
- Incorrect transcription of a patient’s name or date of birth can lead to incorrect filing of medical records and can cause patients with similar names to be mistaken for one another. Properly labeling both charts with a bright similar name alert decal or sticker per facility protocol can decrease the risk of mistaking one chart with a similar name for the other
- Failure to properly document measurements (e.g., height, weight) with the standard of measure used (e.g., pounds, kilograms, inches) can result in the prescribing of incorrect medication dosages
- Failure to properly document patient allergy identification per the facility protocol can result in life threatening allergic reactions
- Failure to properly document emergency contact information can lead to the nurse’s inability to reach family or friends in the event of a medical emergency involving the patient

What Do I Need to Tell the Patient/Patient’s Family?

- Advise the patient that all information collected is recorded in secure medical records so that only healthcare providers are allowed access to this information
- Reinforce the importance of obtaining actual height and weight measurements versus using verbal information from the patient to record the most accurate information
- State the importance of gathering information on all allergies (i.e., medications, latex, foods, environmental) to prevent accidental exposure to these in the healthcare environment
- Educate the patient on the importance of having updated emergency contact information on file at all times

Note

- Recent review of the literature has found no updated research evidence on this topic since previous publication on May 13, 2016

References