Patient History Taking: History of Present Illness

What Is Involved in Gathering a History of a Present Illness?

› Patient history taking (PHT) is the systematic and structured inquiry for obtaining information and assessing the patient to formulate a diagnosis, develop a nursing care plan, and provide appropriate treatment, as ordered

• **What**: The history that is gathered during PHT describes the patient’s reason for the visit, or the patient’s chief complaint, and experience with a present illness. This includes a chronologic description of the signs and symptoms the patient has been experiencing from the time of onset to the present. The history of present illness can be global (e.g., addressing multiple concerns that a patient has [e.g., vomiting, fever, headache]) or focused (e.g., addressing one acute concern [e.g., broken bone]). (For information on other aspects of PHT, see the series of related *Nursing Practice & Skills*)

• **How**: Healthcare providers use a combination of communication techniques (e.g., listening to the patient speak without interruption, asking open- and closed-ended questions, summarizing the information back to the patient) to elicit information from the patient about his or her present illness, then documenting in accordance with facility protocol (e.g., manually or electronically)

• **Where**: PHT is performed in every setting where health care is provided (e.g., inpatient, outpatient, clinic, hospital, home); and should be performed where privacy is maintained and the history taking cannot be overheard

• **Who**: Registered nurses, advanced practice nurses, physician assistants, physicians, social workers, and case managers all conduct PHT interviews. Depending on the patient’s wishes, family members can be present during PHT

What is the Desired Outcome of Gathering the History of a Present Illness?

› The desired outcome of gathering the history of a present illness during PHT, which is typically performed before the initial patient assessment, is to enable the clinician to understand the patient’s current signs and symptoms considering his or her past medical history. A patient’s medical history has a high predictive value in diagnosing current and future health issues. Obtaining a history of present illness is necessary to describe the patient’s chief complaint. Healthcare providers can use this information to identify connections that might exist among symptoms and events or actions, and to guide the physical assessment of the patient

Why is Gathering the History of a Present Illness Important?

› PHT can aid in establishing a therapeutic relationship between the clinician and patient

› Gathering the history of present illness during PHT allows the clinician to identify conditions that are relevant to a patient’s health, create a plan of care, and provide effective and individualized care by

• translating signs and symptoms to an accurate and timely diagnosis

• assessing for change in known conditions

• confirming or altering therapeutic interventions

• providing information for patient education and other interventions

› PHT provides valuable information to direct appropriate care and prevent the use of unnecessary and costly diagnostic tests and procedures
The risk for legal complications is decreased by performance of a comprehensive and quality PHT.

**Facts and Figures**

- Eighty percent of the information needed to make a clinical diagnosis can be obtained by PHT (Young et al., 2010).
- Most diagnoses for common signs and symptoms can be made by considering only the patient’s history (Kroenke, 2014).
- According to researchers, a complete, thorough, and competent interview of patient history can lead to an accurate diagnosis for up to 75–80% of patients (Mazer et al., 2016).
- Researchers aiming to evaluate the effectiveness of the Chronology of Present Illness (CPI; a tool used to guide patient and nurse interactions) found that the 22 internal medicine residents involved in the study indicated positive response. Researchers suggested that due to increased handoffs and increasing number of patients, conducting thorough history-taking notes is becoming gradually more difficult, which makes the utilization of newer and more efficient methods of history-taking crucial for clinical development. For more on CPI, see *What You Need to Know Before Gathering a History of Present Illness* (Mazer et al., 2016).
- The International Classification of Disease, Tenth Clinical Modification/Procedure Coding System (ICD-10) was implemented in 2014 and detailed new procedures that are required of nurses when assessing patients. According to the new procedural listings, nurses should (Talebian, 2014):
  - evaluate workflow thoroughly
  - identify areas that need improvement
  - effectively conduct a gap analysis
  - modify and upgrade all hard- or software
  - educate staff members about proceedings

**What You Need to Know Before Gathering a History of a Present Illness**

- The validity of the information obtained during history taking depends on the reliability and veracity of the interviewee (e.g., patient, family member, intimate partner, or another close associate who is being interviewed).
- Patients are more likely to be involved in their care, and open to patient education, when the relationship between the patient and clinician is one of trust, empathy, and respect.
  - Take time during the initial encounter with patients to establish a trusting relationship, and convey competence and a caring disposition, to increase efficiency in communication during subsequent patient contacts.
  - Disclose brief, general information about related personal experiences, to help patients identify and feel more comfortable providing information, at the beginning of the interview.
- Patients can perceive the healthcare clinician to be in a position of power and feel intimidated to openly express their concerns or to expand on concerns unless they are prompted by the healthcare clinician.
  - The healthcare clinician should use techniques that encourage patient communication, including agreeing with or acknowledging the patient’s valid ideas and seeking the patient’s input and feedback.
  - The healthcare clinician should tell patients that he/she understands how difficult it can be to discuss personal issues and concerns with a stranger.
- Patients express concerns to healthcare clinicians in various ways, including indirectly through storytelling, disclosing relevant information at the end of the PHT session, and body language.
  - Patients often provide information to healthcare clinicians in an unstructured manner.
  - It is important that the healthcare clinician utilize a systematic and structured approach to PHT to thoroughly gather important information, to avoid overlooking relevant information, and to effectively manage the time allotted for patient interviews.
  - Patients provide more comprehensive information regarding their health concerns and use specific examples when asked directed questions (e.g., “What were your symptoms two months ago?”), instead of vague or closed-ended questions.
  - Patients are usually not able to associate symptoms with a disease pattern, and they might unintentionally omit important information; therefore, it is important for the treating clinician to probe for information the patient might have overlooked (e.g., signs and symptoms of a suspected condition) to elicit more detailed information from the patient.
- CPI involves chronologically documenting the patient’s symptoms without omissions, in contrast to the current method of history-taking that can tempt nurses and physicians to “leave out” details that don’t fit their narrative.
  - CPI can help physicians obtain accurate diagnoses and avoid oversight of underlying disorders.
  - CPI specifically focuses on the chronological progression of symptoms as its key framework.
CPI allows physicians to assess for symptom evolution, over time, to relieve the stress from cognitive overload that is often experienced when making sense of various combinations of symptoms.

Assessing pain is important to determine the underlying disease and disorder. Patients often describe pain with ambiguity, therefore understanding the correlation between the intensity and location of pain and pain-inducing disorders is crucial, to obtain an accurate diagnosis. Patients with:

- **abdominal aortic aneurysms** can experience a tearing or ripping sensation. The pain is usually constant, sudden, and severe.
- **ectopic pregnancies** can experience sharp, crampy pain in the lower abdomen that is generally severe and constant.
- **appendicitis** can experience gradually worsening pain that’s often alleviated when maintaining the fetal position.
- **diverticulitis** can experience aching, cramping pain that gradually increases in severity and manifests with disturbed bowel activity (e.g., constipation, diarrhea, bloating).
- **gallbladder disease** can experience a rapid onset of inconsistent pain (usually dull) ranging from mild to severe and nausea and vomiting.

Patients might discuss multiple concerns during PHT:

- Ask patients to list their concerns before coming to their appointment, to identify their most important issues and allow the healthcare clinician to focus on the patient’s highest priorities.
- Schedule additional appointments for patients with multiple health concerns to adequately address each issue, as needed.

Cultural beliefs and traditions can influence the communication, health maintenance, and diet of patients. The healthcare clinician should be aware of cultural differences, and differing practices regarding eye contact, physical touch, and interactions between men and women, and between the clinician and the patient; and be prepared to implement culturally competent care.

For more information, see the series of *Evidence-Based Care Sheets* about providing culturally competent healthcare.

Preliminary steps that should be performed before taking a patient history of present illness include:

- Review the facility/unit protocol for taking a patient history, if one is available.
  - Typically, facility protocol mandates the use of a specific form when recording a patient history. The form is a structured guide that should include the basic components of a patient’s medical history as outlined above.
  - In the absence of an approved form, many clinicians use various mnemonics (e.g., SOAP; subjective, objective, assessment, plan) to ensure that all pertinent medical history has been obtained and recorded.
- Review the treating clinician’s order for PHT, if applicable.
  - 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.
- Reserve an appropriate room in advance so the interview can be conducted in a quiet area that affords the patient privacy and comfort (e.g., closed curtain/door, comfortable chair or bed, appropriate room lighting and temperature).

Gather the following items before beginning the patient interview:

- Facility-approved method of documentation (e.g., patient history form, electronic medical record).
- Educational or reference materials.

**How to Gather History of Present Illness**

- Identify the patient according to facility protocol.
- Establish privacy by closing the door to the examination room in the outpatient setting or closing the door to the patient’s room and/or drawing the curtain surrounding the patient’s bed in the inpatient setting.
- Introduce yourself to the patient and family member(s), if present, and explain your clinical role; assess for knowledge deficits and anxiety regarding PHT.
- Determine whether the patient/family requires accommodations for communication (e.g., due to illiteracy, language barriers, or deafness); arrange to meet these needs, if present.
  - Use professional certified medical interpreters either in person or via phone to resolve language barriers.
- Explain the procedure for PHT and its purpose; provide emotional support and additional information as needed.
- Ask family members and other visitors to leave the room to promote privacy, as appropriate.
- 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 biographic 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 in the household, and emergency contact information.
• Ask returning patients specific questions about topics discussed at the previous visits (e.g., activities in which they were involved or health issues that were previously of concern)
• Be aware of personal 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 that is available only to clinicians involved in his or her care
  › Assess the patient’s psychosocial status [e.g., available support system], preferred learning style, and for learning barriers, to consider when creating an individualized plan of care
  › Identify any cultural or religious beliefs that can affect the patient’s illness and course of treatment
  › Assess for family history of illness
  › Ask the patient to describe his or her strategy to maintain good health
    • Answers should detail the patient’s sleep hygiene and patterns, exercise routine, diet, and coping ability
  › Identify the patient’s relationship status or patterns, which can include relationships with family members, significant others, friends, or other social groups
  › Assess for suicide risk according to facility protocol
  › Ensure that the patient is in a relaxed state with the immediate personal needs met; and the absence of physical or emotional distress, as appropriate
  › Ask the patient to describe the reason for the visit or chief complaint, including the date and time of onset, changes in symptoms or condition since onset, and current condition
  • Ask direct questions about the signs and symptoms the patient is experiencing
  • Ask the patient to provide information about the time frame and sequence of symptom onset, resolution, or changes
    – Ask the patient
      - to describe the baseline before symptom development
      - when and where the symptoms first occurred and any subsequent changes
      - when and where symptoms changed in quality or disappeared
      - if the symptoms have occurred in the past
    – A helpful mnemonic that can be used to further investigate details of the patient’s history of present illness is OLD CARTS
      - Onset (e.g., actions or events associated with onset, speed of onset)
      - Location (e.g., body location where symptoms occurred or radiated to)
      - Ask the patient to point to the affected area
      - Duration (e.g., how long the symptoms last and frequency [e.g., continuous, intermittent])
      - Character/course (e.g., Describe how the symptoms feel [e.g., burning, throbbing, stabbing, radiating]? Describe the timing of symptoms [e.g., morning, afternoon, evening], Describe any variation in symptoms over time?)
      - Aggravating/associated symptoms (e.g., factors that make symptoms worse, signs and symptoms associated with the patient’s chief complaint)
      - Relieving factors (e.g., What alleviates symptoms [e.g. changing diet, changing positions, taking medication], remedies that have worked previously)
      - Treatment (e.g., outcome of attempted treatment)
      - Severity (e.g., use a scale to quantify pain level [e.g., a numerical 1–10]; a pictogram with faces showing increasing levels of distress)
  • Ask the patient whether symptoms are improving or worsening
  • Identify whether the patient has experienced changes in activity or level of functioning because of symptoms
  › Provide opportunities for the patient to speak, without interruption, about any concerns and ideas regarding symptoms
  › Patient disclosure of personal feelings about the illness/medical condition, can aid in evaluating coping skills and strategies
  › Express empathy for the patient and his or her experience with the illness
  › Avoid offering feedback until the patient has had the opportunity to fully express and clearly identify personal concerns
  › Encourage the patient to identify support persons (e.g., friends, family members) for assistance and emotional support
  › Summarize and restate the patient-reported information, as needed, throughout the interview to confirm the understanding of what the patient said
  › Document all information gathered during PHT in the patient’s medical record, including:
    • Date and time of the patient interview regarding present illness
• Complete and detailed description of the patient’s reason for the visit
• Quotation marks that denote the patient’s exact words, when used
• Any cultural information that is relevant to the patient’s care
• Alternative therapies being utilized by the patient, to identify and avoid potentially dangerous interactions, and whether the treating clinician was notified
• All patient/family member education provided, including topics presented, response to the education, the plan for follow-up education, barriers to communication, and techniques that promoted successful communication

Other Interventions That Can be Necessary Before, During, or After Gathering a History of Present Illness
› Review the patient’s medical records to identify previous and current concerns, treatment, and medication use, to verify that the information gathered during PHT is accurate and complete
› Allow adequate time to document patient information and each patient interaction to ensure that detailed and accurate information is recorded

What to Expect After Gathering a History of Present Illness
› Information gathered during PHT combined with the patient’s chief complaint will guide the healthcare clinician in performing a directed physical examination, ordering appropriate laboratory and other diagnostic tests, and requesting consultation with other clinicians and services, as appropriate
› Information gathered during PHT combined with physical examination findings and test results will be used in diagnosing and treating the patient appropriately
› Strict adherence to privacy laws and facility protocol will be maintained to protect information disclosed during PHT

Red Flags
› Failure to identify the patient’s unvoiced concerns, and the effect of the patient’s current symptoms on his or her level of functioning and lifestyle, can cause the patient to lose confidence in the clinician during the PHT process
› Failure to consider the impact that the patient’s cultural beliefs and customs have on self-care practices, attitudes about health and illness, and patient–clinician communication, can result in an inadequate exchange of information regarding the history of a present illness. (For information, see the series of Evidence-Based Care Sheets on providing culturally competent care)
› The failure to verify the use of alternative or complementary therapy can result in dangerous interactions between prescribed medication and the alternative or complementary therapy

What Do I Need to Tell the Patient/Patient’s Family?
› Before the interview, encourage the patient to
• write down any questions, concerns, and ideas and bring these to the appointment
• identify the main concerns at the start of PHT to be sure there is adequate time to address the issues that are most important to the patient
• bring medication the patient is currently taking to the appointment to ensure the information is collected accurately
› Advise the patient that all information collected is recorded in secure medical records so that only healthcare providers who are responsible for his or her care have access to this information

References


