Patient History Taking: Details of Lifestyle

What Is Involved in Gathering Details of Lifestyle During Patient History Taking?

› Patient history taking (PHT) is the systematic and structured questioning by a healthcare provider of a patient and/or of a patient’s spouse/partner or another family member to gain information to assist in determining a medical diagnosis, developing a nursing care plan, and providing appropriate treatment to the patient

• What: Details of the patient’s lifestyle that are gathered during PHT focus on a description of the patient’s physical activity, sleep pattern, alcohol use, tobacco use, caffeine intake, illicit drug use, sexual history, and potential exposures that increase health risk during social activity (e.g., exposure during travel; exposure to animals). Typically, gathering details of the patient’s lifestyle during PHT is performed after asking about information on the patient’s family medical history and prior to performing the physical assessment. (For more information on other aspects of PHT, see the series of related Nursing Practice & Skills)

• How: Healthcare providers use direct questioning and a combination of verbal communication techniques (e.g., letting the patient speak without interruption, using a combination of open-and closed-ended questions, reiterating the information heard in summary form) to elicit information from the patient about his/her lifestyle, which 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, and PHT should be scheduled in a location where there is no potential for information to be overheard by persons who are 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. Depending on the patient’s wishes, family members may be present during PHT

What is the Desired Outcome of Gathering Details of Lifestyle?

› The desired outcome of gathering details of the patient’s lifestyle is to enable the treating clinician to identify participation in high-risk behavior by the patient and the presence of risk factors for impaired health. Healthcare providers use this information to guide them in the management of the patient’s current health concern, creation of a comprehensive plan of care for the patient, and establishment of a screening routine for the patient to prevent or detect negative health consequences of lifestyle

Why is Gathering Details of Lifestyle Important?

› PHT is part of establishing a therapeutic relationship between the clinician and patient

› Gathering details of the patient’s lifestyle during PHT allows the healthcare provider to identify the patient’s

  • daily level of activity
  • level of participation in high-risk behavior
  • overall sense of wellbeing and satisfaction with life
Gathering details of the patient’s lifestyle during PHT assists the healthcare provider in creating a diagnosis and establishing a realistic and appropriate individualized plan of care by

- identifying signs and symptoms that may be related to lifestyle or habits (e.g., alcohol consumption, sexual exposure)
- providing an area of focus for the physical examination
- interpreting current signs and symptoms as a potential diagnosis
- identifying potential health risks due to lifestyle choices and establishing a screening process for early identification of disease

Information gathered on the patient’s lifestyle combined with current signs and symptoms can provide valuable information to the clinician, and in some cases can help avoid the need for costly diagnostic tests and procedures

The risk for legal liability is decreased by the performance of a comprehensive and quality PHT

**Facts and Figures**

- There is a high incidence of patients who seek medical attention at primary care clinics, emergency rooms, and hospitals who have a lifestyle that includes regular consumption of significant amounts of alcohol. Researchers recommend a thorough assessment when taking a patient history identifying the lifestyle that indicates an alcohol or substance abuse to be able to intervene early in the admission, if necessary (Glass et al., 2017)
- The United States Centers for Disease Control and Prevention (CDC) reported that in 2015 over 30 million Americans had diabetes. It is critical that a thorough lifestyle assessment includes assessing for lifestyle changes that the patient has made because of having diabetes or symptoms of potential diabetes (CDC, 2017)
- Researchers have reported that over three million Muslims are living in the United States in 2017. The population of Muslims is expected to grow significantly. Clinical providers need to be aware of health-related lifestyle issues that may be present among Muslim patients and collect relevant data so that Muslim patients receive culturally appropriate care (Ahmad, 2017)

**What You Need to Know Before Gathering Details of Lifestyle**

- The value of the information obtained during PHT is dependent on the reliability of the patient or family member being interviewed
- Patients are more likely to be involved in care and open to patient education when the relationship between the patient and caregiver is one of trust, empathy, and respect
  - Patients may feel more comfortable sharing information if the healthcare provider shares a general personal experience with which the patient can identify at the start of the interview
  - Taking the time during initial appointments to establish a trusting relationship and helping patients recognize that the healthcare provider cares about them will lead to increased efficiency in communication during future appointments
- Patients may perceive the healthcare provider to be in a position of power and feel intimidated by openly sharing their health concerns or expanding on concerns unless they are asked to do so directly by the healthcare provider
  - The healthcare provider should use techniques (e.g., agreeing with or acknowledging the patient’s valid ideas, seeking the patient’s opinion) that empower the patient during PHT
  - The healthcare provider should verbalize to patients an understanding of how difficult it can be to discuss personal health issues and concerns with strangers
- Questions that are asked while obtaining details of the patient’s lifestyle can be sensitive and uncomfortable for patients
  - Patients may not understand why it is important to provide lifestyle information and may become frustrated with questioning
    - The healthcare providers should explain to the patient that gathering lifestyle information is helpful to identify behaviors and choices that could affect their health
    - It is important to reinforce that all information collected is part of the confidential medical record
- Cultural beliefs and traditions can influence communication, health maintenance practices, and the diet patients follow
  - The healthcare provider should be aware of 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
- Preliminary steps that should be performed before PHT 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 the basic components of a patient’s medical history
In the absence of an approved form, many clinicians use certain mnemonics to be sure they have been thorough in recording the patient’s medical history

- Review the treating clinician’s order for PHT
- A specific order for PHT may not be necessary because many facilities require PHT by nurses as part of the standard admission procedure
- Review the patient’s medical records to identify previous lifestyle concerns that should be addressed or further researched during PHT
- Conduct the interview in a quiet area that affords patient privacy and comfort (e.g., in a comfortable chair or in bed, in a room that has an appropriate temperature)

Gather the following supplies prior to beginning the patient interview:

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

How to Gather Details of Lifestyle

- 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, and explain your clinical role; assess 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 telephone, when language barriers exist
  - Explain the procedure for PHT and its purpose, including the importance of gathering information on the patient’s lifestyle; provide emotional support and additional information 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 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 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 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 securely maintained and available only to clinicians who are responsible for his/her care
- Ask the patient questions about lifestyle (e.g., “What hobbies do you enjoy?,” “How do you spend your free time?”), including sleep patterns, alcohol use, tobacco use, caffeine intake, illicit drug use, sexual history (e.g., to identify risk factors for sexually transmitted diseases), and social exposures (e.g., animals, travel)
  - Ask specific questions about alcohol and substance use (e.g., when he/she drinks, how much he/she drinks)
    - Convey a nonjudgmental demeanor when questioning patients to enable gathering the most information without making the patient uncomfortable or unwilling to share information
    - Asking a patient to describe the number of drinks he/she consumes daily/weekly will provide a more accurate description of consumption than asking for amounts in units of measure (e.g., ounces)
    - A helpful mnemonic that can be used to investigate details of the patient’s alcohol use is the CAGE (Cut, Annoyed, Guilt, Eye Opener) questionnaire
      - C: Do you feel the need to cut down?
      - A: Have you been annoyed by people asking you to cut down?
      - G: Do you experience guilt related to the amount or frequency that you drink?
      - E: Do you ever drink as an eye opener to steady your nerves in the morning?
- Ask both current and past smokers detailed questions regarding tobacco use, including
  - age they began smoking
  - number of years they smoked
  - type of smoking device (e.g., cigarette, pipe, cigar) used
• number of times they smoke each day
• when they quit smoking, if appropriate

• Explain to the patient that you are interested in all aspects of his/her health, including sexual health, and allow him/her the opportunity to express any concerns or questions he/she may have about sexual health

• Allow the patient to speak without interruption about lifestyle concerns

– Patients may use this time to discuss their feelings (e.g., fear) about lifestyle factors (e.g., drinking or sexual habits), which can aid in evaluating their coping ability
– Demonstrate empathy for the patient. Do not interrupt until the patient has been able to fully express and clearly identify his/her concerns

› When appropriate, ask the patient to clarify responses (e.g., “Do you feel that 6 hours of sleep each night is enough for you?”)

› Allow the patient an opportunity to
• ask questions
• clarify information he/she has shared

› Summarize and repeat the information as needed throughout the interview to confirm understanding and accuracy

› 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
• Quotation marks to denote the patient’s exact words, if used
• A complete and detailed description of the patient’s lifestyle
• Cultural information that is relevant to the patient’s care
• Substances being used by the patient to avoid potentially dangerous interactions
• All patient/family member education, including topics presented, response to education provided, plan for follow-up education, barriers to communication, and techniques that promoted successful communication

Other Interventions That May be Necessary Before, During, or After Gathering Details of Lifestyle

› Review the patient’s medical records, if available, to identify previous lifestyle concerns prior to PHT

› Allow adequate time to document following each patient interaction to be sure that detailed and accurate information is recorded

What to Expect After Gathering Details of Lifestyle

› Information gathered during PHT combined with information on the patient’s chief complaint will guide the healthcare provider in performing a focused physical examination, ordering diagnostic tests, and formulating an individualized treatment regimen

• Information gathered during PHT combined with physical examination findings and test results will be used in diagnosing and treating the patient
• The patient’s lifestyle (e.g., sleep pattern, use of substances that may interact with pharmacologic management of the current health condition) will be taken into account and an individualized treatment plan will be created for the patient

› All information disclosed by the patient will be maintained in strict confidence to maintain patient privacy

Red Flags

› Failure to identify the use of alcohol or illicit drugs by the patient can result in dangerous interactions between medications and the unknown substances

› Failure to question the patient about sexual behavior can prevent the healthcare provider from identifying potential health risks and using the opportunity to educate the patient regarding safer sexual practices

› A lack of understanding of a patient’s cultural beliefs and customs can lead to misunderstanding by the healthcare provider during PHT, resulting in patient discomfort, poor communication, and inadequate patient information. (For more information, see the series of Evidence-Based Care Sheets on providing culturally competent care)

› Failure to identify the patient’s beliefs regarding illness and response to medical advice can lead to miscommunication and frustration in the management of the patient’s current condition
What Do I Need to Tell the Patient/Patient’s Family?

› Prior to the interview for PHT, encourage the patient and/or family to
  • be prepared to discuss lifestyle information and its impact on adherence to healthcare recommendations and the prescribed treatment regimen
  • write questions, concerns, and ideas and bring these to the appointment
  • identify the main health concerns at the start of the PHT to be sure there is adequate time to address the most pressing issues
  • bring the names and contact information for all healthcare providers that have recently or are currently treating the patient
› Advise the patient that all information is recorded in secure medical records that can only be accessed by healthcare providers involved in treating the patient

References