Patient History Taking: Family Medical History

What is Involved in Gathering a Family Medical History?

> Patient history taking (PHT) is the systematic and structured questioning by a healthcare provider of a patient, a patient’s family member, or close associate (e.g., intimate partner) to gain information to assist in determining a medical diagnosis, developing a nursing care plan, and providing appropriate treatment to the patient

• **What:** Taking a family medical history during PHT involves asking about and documenting a brief description of the health history of the patient’s family members (e.g., grandparents, parents, siblings, aunts, uncles, spouse, and children). This includes the relative’s age, current health status or age at time of death and cause of death, information on genetic disorders (e.g., sickle cell disease), and information on other diseases (e.g., heart disease, diabetes mellitus, kidney disease, pulmonary disease, cancer, blood disorders, mental illness, alcoholism, obesity, allergies). (For more information on other aspects of PHT, see the series of *Nursing Practice & Skill* papers on PHT)

• **How:** Healthcare providers use direct questioning and a combination of verbal communication techniques (e.g., letting the patient speak without interruption, asking closed-ended questions, reiterating the information heard/gathered in summary form) to elicit information from the patient about his/her present illness and family medical history, 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 health care is provided (e.g., inpatient, outpatient, clinic, hospital, home). Maintaining patient privacy is a critical component of gathering a family medical history during PHT and should be undertaken in an area 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 can be present during PHT

What is the Desired Outcome of Gathering a Family Medical History?

> The desired outcome of gathering a family medical history during PHT, which is typically performed following gathering information on the patient’s past medical history and prior to the patient assessment, is to enable the clinician to understand the patient’s family medical history and to provide information on the overall health condition of the patient’s immediate family because a patient’s medical history has a high predictive value in diagnosing current and future health issues. Healthcare providers use information gathered from the family medical history to guide them in the management of the patient’s current health concern and to create a comprehensive plan of care for the patient

Why is Gathering a Family Medical History Important?

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

> Gathering a family medical history during PHT is a quick and simple way to identify potential disease risks and to identify the disease risk reduction needs of the patient
Gathering a family medical history during PHT allows the clinician to understand the health condition of the patient’s family members and their beliefs regarding illness.

Gathering a family medical history during PHT assists the clinician in anticipating the patient’s response to medical advice and in identifying possible risk factors for hereditary or communicable disease.

Gathering a family medical history during PHT assists the health care provider in establishing a diagnosis, formulating a plan of care, and providing effective individualized care by:
- identifying genetic, environmental, and behavioral factors that affect the patient’s health
- identifying conditions or events experienced by family members that can be related to or have impacted the health of the patient
- identifying potential disease risks and establishing a screening process for early identification of disease
- providing an area(s) of focus for performing the physical examination
- translating signs and symptoms into a potential diagnosis

Gathering information on prior signs and symptoms or medical conditions, and diagnostic testing performed on family members in the past provide valuable information to the clinician; and, in some cases, it can assist in avoiding the need for costly diagnostic tests and procedures.

The risk for legal complications is decreased by comprehensive and quality PHT.

**Facts and Figures**

Despite concerns regarding uncertainty of patients about their family medical history, authors of a systematic review found that patient reporting of cancer in first-degree relatives had a positive predictive value of 93% for breast cancer and 85% for prostate cancer (Reid et al., 2009).

Researchers in Vermont determined that there is added value to extending family history beyond first-degree relatives. Using the American Cancer Society (ACS) screening guidelines, 72% of patients eligible for high risk breast cancer screening and 19% eligible for high-risk colon cancer screening would have been missed if an extended family history was not obtained. Similarly, genetic counseling would have been missed in 22% of hereditary breast cancer patients and 68% of hereditary colon cancer patients (Solomon et al., 2016).

Using a multiple-informant approach to gather a family health history can provide more accurate, reliable information, particularly in terms of genetic risks. In a study of 45 families in Cincinnati, inconsistencies among informants (e.g., patients, spouses, caregivers) ranged from 41–61% for identification of common chronic conditions such as heart disease, diabetes, high cholesterol, and hypertension (Lin et al., 2017).

Researchers in Virginia echoed the benefits of using multiple informants to improve clinical assessments and diagnose psychopathology (Alexander et al., 2017).

**What You Need to Know Before Gathering a Family Medical History**

The value of the information obtained during PHT is dependent on the reliability of the patient or family member being interviewed.

Family dynamics vary and are often complex. Patients might not be familiar with or have contact with blood relatives, making it impossible to provide complete information on their family medical history.

- Avoid pressing patients who cannot recall family health information or those who appear uncomfortable when the topic is discussed for information on their family members.

Patients might not understand why it is important to provide information on their family medical history and can become frustrated if they do not know their family medical history.

- Explain to the patient that gathering a family medical history is helpful to the health care provider to identify conditions that tend to occur in the patient’s family and could impact the patient’s health.

Patients are more likely to be self-involved in care and open to patient education when the relationship between the patient and caregiver is one of trust, empathy, and respect.

- Patients feel more comfortable sharing information if the health care provider establishes rapport by sharing general personal experience that the patient can identify with at the start of the interview.

Taking the time during initial appointments to establish a trusting relationship and be sure patients recognize that the health care provider is caring will lead to increased efficiency in communication during future appointments.

Patients who perceive the healthcare provider to be in a position of power might feel intimidated about openly sharing their concerns, or expanding on concerns unless they are directly asked to by the healthcare provider.
- Use techniques (e.g., agreeing with or acknowledging the patient’s valid ideas, seeking the patient’s opinion) to empower the patient during PHT
- Verbalize to patients an understanding of how difficult it can be to discuss personal health issues and concerns with people they do not know

Cultural beliefs and traditions can influence the communication, health maintenance, and diet of patients
- Be aware of the cultural differences in the acceptable degree of familiarity between clinician and patient; be conscious of differing practices regarding eye contact, physical touch, and interactions between men and women. Be sure to
  - maintain appropriate eye contact, which is key to establishing trust, except in cultures in which direct eye contact is perceived as offensive or confrontational
  - monitor facial expressions, which often manifest unconsciously, to convey a pleasant and welcoming demeanor

Preliminary steps that should be performed before taking a patient history include the following:
- Review the facility/unit specific protocol for taking a patient history, if one is available
  - Typically, a facility protocol will mandate the use of a specific form to use when taking a patient history. 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 various mnemonics to be sure they have been thorough in recording the patient’s medical history
- Review the treating clinician’s order for PHT
  - Note: A specific order for PHT is not usually necessary because most facilities require nurses to take a patient’s medical history as part of the standard admission procedure
- If possible, prior to the interview, encourage the patient to
  - think about the medical histories of family members
  - contact family members to clarify details of his/her family medical history
- Arrange to conduct the interview in a quiet area that affords privacy and comfort (e.g., relaxing 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)
- Educational or reference materials

How to Gather a Family Medical 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 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); arrange 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, including the importance of gathering information on the patient’s family medical history; answer any questions and provide emotional support as needed
- As appropriate, ask family members and other visitors to leave the patient’s room to promote privacy
- Establish a rapport with the patient
  - Display 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)
  - Be aware of your own body language and facial expressions to avoid being interpreted as hurried, unpleasant, or judgmental; demonstrate respect, courtesy, and empathy; promote cultural sensitivity
  - Assure the patient that all information collected will be maintained in a secure manner and available only to clinicians responsible for his/her care

- Use a structured, systematic approach to PHT
  - 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)
• Ask the patient direct but general questions about family medical history (e.g., “How many brothers and sisters do you have?”)
  – Ask the patient the age and state of health or age at time of death and cause of death for each family member identified
• Do not refrain from taking a sexual health history, but do so using a structured and matter-of-fact tone of voice so as not to embarrass the patient (e.g., ask about partners, protection from sexually transmitted diseases, pregnancy prevention)
  › Allow the patient to speak without interruption about concerns and ideas they can have about illnesses in his or her family
• Patients can use this time to discuss personal feelings (e.g., fear) about their illness/medical condition, which can aid in evaluating their coping ability
• Demonstrate empathy for the patient and the experience of his/her illness. Do not offer an opinion until the patient has been able to fully express and clearly identify his/her concerns
  › Summarize and repeat the information heard as needed throughout the interview to confirm understanding
  › At conclusion of patient contact, perform hand hygiene
  › Document all information gathered during PHT in the patient’s medical record according to facility protocol, including the following information, and use information gathered to formulate a plan of care:
    • Date and time of interview
    • Quotation marks to denote the patient’s exact words, if used
    • Any cultural information that is relevant to the patient’s care
    • Alternative therapies being utilized by the patient or family members to identify and avoid potentially dangerous interactions
    • 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 Can be Necessary Before, During, or After Gathering a Family Medical History
  › Review the patient’s medical records to identify previous concerns and treatments
  • Identify topics to address or that require further research during PHT with the patient
  › Allow adequate time to document and make notes following each patient interaction to be sure that detailed and accurate information is recorded

What to Expect After Gathering a Family Medical History
  › Information gathered about family medical history during PHT combined with the patient’s chief complaint will guide the healthcare provider in performing a focused physical examination and ordering medical tests
  • Information gathered during PHT combined with physical exam findings and medical test results will be used in diagnosing and treating the patient
  › All information disclosed by the patient will be maintained in strictest confidence to maintain patient privacy

Red Flags
  › 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 information (for more information, see the series of Evidence-Based Care Sheets on Providing Culturally Competent Care)
  › Failure to identify the patient’s family beliefs regarding illness and response to medical advice can lead to miscommunication and frustration in the management of the patient’s current condition
  › The failure to verify the use of alternative or complementary therapies can result in dangerous interactions between medications and the unknown agents

What Do I Need to Tell the Patient/Patient’s Family?
  › Prior to the interview encourage the patient to
    • collect information on family medical history and bring this information to the appointment
    • write down questions, concerns, and ideas; bring these to the appointment with the clinician
    • identify the main concerns at the start of the PHT to be sure there is adequate time to address the most pressing issues
    • bring medications being taken to the appointment to be sure medication information is collected accurately
    • bring the names and contact information for all healthcare providers that have treated him/her in the past or that are currently treating the patient
Advise the patient that all information collected is recorded in secure medical records so that only his/her healthcare providers are allowed access.

**References**


