History taking

Definition of health history:

Health history is a chronological and detailed health record of the client. It is purpose is to elicit information regarding all the variables that may affect the client's health status.

OR

The health history is a current collection of organized information unique to an individual. Relevant aspects of the history include biographical, demographic, physical, mental, emotional, socio-cultural, sexual and spiritual data.

Purpose of health history:

1. Perform physical assessment.
2. Review records-laboratory records, other health care records.
3. Interview supports persons.
4. Review literature.
5. Validate assessment data.
6. To identify the nursing needs of the patient.
7. To establish a nursing diagnosis.
8. To prepare a nursing care plan.
9. To give complete nursing intervention.
10. To evaluate the effectiveness of nursing interventions.

Types of health history:

1. **Complete health history:** It described in this text, is a comprehensive history of the patients past and present health status and converts many factors of a patient's life.
2. **Episodic health history:** It is shorter and specific to the patient's current reason for seeking health care.eg the patient who seeks care for a sore throat and fever wound have an episodic health history.
3. **Interval or follow up health history:** It builds on a preceding visit to a health care facility. It documents the patient's recovery from illness, such as the sore throat and fever or progress from a prior visit.
4. **Emergency health history:** It is elicited from the patient and other sources in an emergency situation. Only information required immediately to treat the emergent need of the patient is gathered, after the life threatening condition is no longer present, the nurse may elicit a more comprehensive history from the patient.

Health history contains information in this sequence of categories-

The health history is adapted to include information specific for age and development stage of the person. Nurses have to focus on different information according to age and the development stage of each individual:

1. Biological data and source of history.
2. Reason for seeking care.
3. Present health history or present illness.
4. Past history.
5. Family history.
6. Review of systems.
7. Functional assessment or activity of daily living.

Component of health history:

1. Particulars of patient.
2. Presenting/chief complaints.
3. History of present illness.
4. History of past illness.
5. Drug history.
6. Family history.
7. Personal and social history.
8. Occupational history.
9. Immunization history.
10. Menstrual history (in case female).
11. General examination.
12. Systemic examination.
13. Salient features.
14. Provisional diagnosis.
15. Differential diagnosis.
16. Investigations.
17. Confirmed diagnosis.
18. Treatment.
19. Follow up.

General approach to the health history:

1. Present with professional appearance. Avoid extreme in dress so that your appearances does not become a hindrance to information gathering.
2. Ensure an appropriate environment, eg- god lighting, comfortable temperature, lack of noise and distractions, adequate privacy.
3. Sit facing the facing the patient at eye level, with the patient in a chair or on a bed. Ensure that the patient is as comfortable as possible because obtaining the health history is a lengthy process.
4. Ask the patient whether there are any questions about the interview before it is started.
5. Avoid the use of medical jargon. Use terms the patient can understand.
6. Reserve asking intimate and personal questions for when rapport is established.
7. Return flexible in obtaining the health history. It does not have to be obtained in the extract order it is presented in this chapter or on institutional forms.
8. Remind the patient that all information will be treated confidentially.

Establishment of a nurse-client relationship: A nurse should start assessing the patient's condition through-

1. Greeting.
2. Conversation.
3. Seek permission to take history.

How develop a frame work for history taking:

1. Chief complaints.
2. Biophysical.
3. Psychosocial.
4. Spiritual data.

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Format of a patient assessment form:

Demographic data-

Clients name:……………………Age:………………………Sex:…………………………
Address:……………………………………………………………………….
Hospital name:…………………………..Religion:…………………………………..
Ward:……………………Unit:……………………Bed:……………Reg. no…………………
Educational level………………………………Admission date……………………………
Admission time…………………………..Medical diagnosis…………………………………

Data collection

1. Health history:
   Chief complain…………………………………………………
   History of present illness……………………………………………….
   History of past illness…………………………………………………..
2. Family history:……………………………………………………..
3. Physical examination:…………………………………………………
   General appearance ……………………………………………………
   Temperature…………………………Pulse…………………b/m.
   Respiration ………………………BP……………………..mmHg.
   Height…………………………..Weight………………………..kg.
4. Health pattern assessment:
   Health-perception health management pattern…………………………
   Nutritional metabolic pattern…………………………………………….
   Pattern of elimination…………………………………………………
   Pattern of activity & exercise……………………………………….
   Pattern of sleep& rest……………………………………………….
   Pattern of self-perception & self-concept…………………………………..
   Role relationship pattern………………………………………………….
   Sexual reproductive pattern……………………………………………..
   Pattern of coping & stress tolerance……………………………………..
   Pattern of values & beliefs……………………………………………….
5. Sign and symptoms during care of the patient:…………………………..
6. Treatment during taking care of the patient:…………………………….
7. Laboratory and investigation:

Date	Type of investigation	Result	Normal range

8. Nursing care plan:

Nursing diagnosis	Goal/objective	Planning	Intervention	Evaluation/outcome

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