

History Taking Framework

Introduction to History Taking

General Procedure

Eliciting a history from a patient is an essential part of being an effective emergency nurse. It:

- Establishes the nurse-patient relationship
- Identifies how the illness has progressed to date
- Establishes how the illness has affected the patient and their family
- Explores the patient's ideas and concerns about the illness Identifies the patient's physical, psychological and social environment
- Provides a platform for medical staff to progress further

Interviewing the patient in private, introducing yourself, helps building a relationship with the patient and explaining the purpose for the interview with approximate time needed.

Taking a history is not just going down a checklist of symptoms. Books have been written about how to consult with patients and there is no set "right way". Eliciting a patient's history does not need to be done in a set order. It is not just information-gathering from the patient, it is a two-way communication in which you need to be aware of what and how you are communication and its impact on the patient.

It does include active listening to the patient, awareness of non-verbal communication, with respect and support of their feelings.

It is important to use your communication skills effectively, in order to data gather and reach a diagnosis, so that you may decide with the patient the appropriate management. Use the communication skills you have learnt and practised, and your own experience when talking with people.

Summary of Procedure and Notes

Summary of History

- Introduction
- Name, age, occupation
- Presenting complaint
- History of presenting complaint(HPC)
- Systemic enquiry
- Past medical history (PMH)
- Family history (FH)
- Social history (SH)
- Drug history
- Drug allergies
- Review
- Summary

NOTES ON PROCEDURE

Introduction

Remember to introduce yourself, wear your name badge and state the purpose of the interview and approximate time needed.

What the patient will be discussing with you may be very personal to them, so remember to stress that the interview is confidential. If you will be presenting their history to colleagues, as in a ward round, ask for their consent. However, you and the patient can agree that parts of the history can stay completely confidential between you.

Try to be aware of basic details such as name and age before you meet the patient.

Confirm with them their name, age and occupation. This may give you valuable information which can help with diagnosis and management. Remember to ask retired patients their previous occupations.

We recommend that you do not use a patient's first name unless invited to by the patient.

Presenting Complaint

This is the opening question. Remember, it is important to start with an open question.

Try a variety of questions and see which you prefer. Your choice may depend on the circumstances of the interview. Some options include:

- What has the problem been?
- What made you go to the doctor?
- Can you tell me the background to how you came to be in hospital?

History of Presenting Complaint (HPC)

This is the main part of the history and you will need to spend time discussing this with the patient.

There are two parts to the HPC: -

- 1) A description and exploration of the patient's problem
- 2) How the problem affects the patients personally

1. A Description and exploration of the patient's problems

You can start with: "Can you tell me more about your problem?"

Allow the patient to tell you in his or her words; this can take a couple of minutes of uninterrupted talk from the patient.

Allowing the patient to talk without interruption enhances patient satisfaction and efficacy of the interview. They are likely to need verbal and non-verbal encouragement from you to maintain the flow. You can gain a great deal of information during this time:

- Observe the patient – do they appear anxious, depressed?
- What are their ideas about their illness? It is difficult to address the patient's concerns if this issue is not explored
- Listen to their story, the diagnosis may become apparent
- Gauge what the patient knows about their illness, so you can respond to them effectively.

Next, think about trying to direct your line of questioning to test diagnostic hypotheses at this stage. For example, with a patient who has a chest pain, it is important to assess if the pain comes on with exercise if you suspect they have angina.

Asking about symptoms can follow a similar line of questioning:

- When did the problem start?
- Is it a new or old problem?
- What did it feel like?
- How often does it occur?
- What starts it off?
- How long does it last?
- What makes it worse?
- What makes it better?
- Does anything else happen to you at the same time, before or after?
- What medicines have you tried? (prescribed or over the counter)
- What effect have they had?

Questions about pain should cover the following points:

Site	where is the pain?
Radiation	Does the pain go anywhere else?
Character	What's the pain like? (Think colicky, constant, dull, sharp, gripping etc)
Severity	How severe is the pain? Does it wake you at night? Does it stop you doing what you are doing at the time?
Timing	How long does it last? How often does it occur?
Association	Does it come with any other symptoms? Are there any precipitating or relieving factors?

You will learn more about how to direct your line of questioning on your clinical firms throughout the course.

2. How the problem affects the patient personally

This should not be forgotten!

This also connects with the assessment of mental state, particularly inquiring about symptoms of depression.

You can ask:

- How has this illness affected you generally?
- How does this make you feel overall?

It is important to find out about the patient's own interpretation of their illness.

This allows clinicians to get to the real reason why patients have come to see them – for example; the patients may be worried they have cancer. Of equal importance, patients will not be satisfied if their concerns have not been listened to and addressed.

The patient may already know what the problem of diagnosis is, or their thoughts or concerns may have come out earlier when you asked the patient to describe what has happened to them. If it hasn't then you can ask:

- What do you think is the matter?
- Are you worried it may be something in particular?

Remember to acknowledge how the patient feels. We know it is common sense, but it's amazing how often this is forgotten.

Systemic (or Functional) Enquiry

As illnesses affect different parts of the body, and many illnesses may be multi-system, it is important to ask about connected symptoms. In addition, when a patient may go to the operating theatre it is important to assess their "operative" risk, so detailed questions regarding their cardio-vascular and respiratory system need to be covered.

You can ask:

- Have you noticed anything else wrong?

More specific questions may need to be asked, remember to ask them without using medical jargon. For example, when asking about rectal bleeding, you can ask:

- Have you ever passed any blood with your stools?

You need to cover the following areas:

- Respiratory Systems: Dyspnoea, wheeze, cough, sputum, haemoptysis, chest pain
- Cardiovascular Systems: Chest pain, orthopnoea, paroxysmal nocturnal dyspnoea, ankle swelling, palpitations and intermittent claudication
- Gastrointestinal System: Abdominal pain, nausea, vomiting, haematemesis, bowel habit, blood P/R, melaena
- Urogenital System: frequency, nocturia, polydipsia, loin pain, haematuria
- Menarche, menopause, cycle, intermenstrual bleeding, post coital bleeding
- Central Nervous Systems: Headaches, visual disturbances, sleep, hearing, tinnitus, light headedness, blackouts, fits, unsteady gait, weakness and paraesthesiae
- Musculoskeletal: Myalgia, arthralgia, back pain, joint swelling

- Psychiatric: The mental state Examination will be taught more formally in your psychiatric attachment. Remember, depression is common and may often co-exist with physical ill health.

At this stage, do not worry if many of these terms are unfamiliar to you. You will learn more about them in the course of your studies. At each stage you will need to think about how you convert the medical terminology into questions both you and the patient will understand.

Past Medical History (PMH)

Always ask the patient if they have or have had any serious illnesses. The precise details will depend on the clinical condition and the circumstances.

Include:

- Operations
- Hospital admissions
- Ask specifically about hypertension, Ischaemic Heart Disease, strokes or TIAs, Diabetes, asthma, jaundice, TB, Rheumatic Fever

Family History (FH)

This gives a clue to any predisposition to any illnesses and may highlight specific concerns the patient may have about a certain disease.

You could ask: -

- Are your parents alive or have they died?
- Are there any diseases running through the family?

Ask the patient what their parent(s) died from and at what age. If they have died, be sensitive to how the patient may feel about this. It is always important to acknowledge a death. You can say:

- I am very sorry to hear that, it must have been very upsetting

Then ask similar questions about brothers and sisters and children.

Social History (SH)

This is a very important part of the patient's history. It provides information about:

- The patient as a person
- How the illness affects the patient and their family
- What are the home circumstances?
- Relationship to HPC-for example, smoking and IHD

Questions you can ask include:

- How are things at home?
- Who is at home?
- Are there any problems at home?

Remember to ask about:

- Accommodation
- Job
- Hobbies
- Social Life
- Diet
- Alcohol
- Smoking
- Recreational drug use

Asking about alcohol and drug use can sometimes be difficult. It is easier to be very open and straight-forward. You can just ask:

- Do you drink alcohol?
- If yes, how much a day?
- Do you use any recreational drugs?

If you suspect a patient has an alcohol or drug problem then more detailed questioning can occur. However, this is beyond this overview.

It is also important to assess a patient's "activities of Daily Living". This is an assessment of how much support a patient requires to live on a day to day basis.

It includes asking about: -

- Help with dressing
- Help with washing/toileting
- Help with eating
- Help with walking
- Help with shopping
- Outside agencies involved in care e.g. home help

Drug History

List of all patients' drugs and doses. Remember over the counter and alternative medicines. Some patients can be quite vague about their tablets-try and persevere.

Try to assess compliance:

- What problems do you have with your medicines?
- Do any of your medicines give you side effects?

Drug allergy

Identify any drug allergies the patient may have, and details of what happens, for example, rash or anaphylaxis

Review

It is always useful to summarise the history and main points back to the patient. It ensures that the patient and you agree and often stimulates the patient to remember other important facts.
