It has been suggested that between 70 and 90% of patient diagnoses are made on history taking alone (Keifenheim 2015) so it is essential as an advanced practitioner that you are able to take a good history to facilitate diagnosis and management of conditions.

What is history taking?

History taking is a logical and systematic approach to collecting personal and medical information from the patient to help assess, diagnose and manage health and wellbeing (Mosby's Dictionary 2022). Using a logical and systematic approach clarifies the signs and symptoms and allows for differential diagnoses. A good history is thorough, but also considers patients, thoughts and concerns.

Communication skills

Communicating effectively with your patient is essential to good history taking. The logical order of history taking can make patients feel it is just a tick box exercise. However, this can be avoided by ensuring the consultation is patient centered, using verbal and non-verbal communication to help reassure the patient. Box 1 summarises essential communication skills that should be used for all consultations.

Documentation

A patient's record is another form of communication that documents the patient's healthcare journey during their lifetime (Brooks, 2021). This allows any healthcare professional encountering the patient to understand and interpret previous healthcare information, tests and treatments. You must therefore be sure to complete it in an accurate and timely manner and only include factual and reliable information.

Procedure

There is a consensus in the nursing profession that history taking should be logical and completed in a certain order. This article follows a history taking sequence adapted from Peart (2022) (Box 2). However, while this is a logical and systematic approach in meeting the health professional's agenda, it is not essential to adhere to it religiously or even discuss each aspect in turn. It is just as important to ensure that the consultation remains patient-centered and that you give patients enough time to answer your questions.

Introduction

Your first interaction with the patient can set the tone for the entire consultation, so it is important to make a good impression. Take the time to introduce yourself. The role of advanced nurse practitioner is one of several new and emerging roles (British Medical Association 2022) that patients may not be familiar with, so it can be beneficial to briefly explain your role (Peart, 2022).

History taking is conducted in various healthcare settings. Some like general practice have control over their environment, such as providing private consultation rooms. For others such as emergency departments, the environment may be less than ideal; for example, taking a patient's history on a hospital trolley. However, what the environment might lack in terms of hospitality can be made up for by the practitioner adopting a warm and welcoming manner. If using a consultation room or patient bedside, this should be set up to allow good eye contact with the patient, while allowing easy access to patient records without negatively distracting from the consultation. You could arrange the chairs in a way that promotes face to face interactions but still maintains a comfortable distance whilst ensuring that you can still access the medical records.

Presenting complaint

For patients, the presenting complaint is usually a priority as it is what has led them to seek help in the first place, either by booking a consultation or presenting at an emergency centre. However, while they are normally quick to tell you what the complaint is about, they can still be vague. This means it is important to use appropriate questioning techniques to ensure nothing is missing when taking a patient's history.

First contacts with patients' needs to include open ended questions as this is the time in which patients can describe their symptoms and concerns in their own words (Abe et al. 2022). This encourages patients to answer in their own words; a useful analogy is to think of it as an essay answer as opposed to a multiple-choice response. For examples of open questions see Box 3.

An open question can create a period of silence while the patient considers their response. Do not be afraid of silence. Many health professionals feel the need to fill the silence to prevent feelings of awkwardness. However, exercise patience and refrain from doing this as "Intentional silence can be used to enhance the therapeutic relationship between nurse and patient" (Kemerer, 2016). For example, a moment of silence can give patients time to reflect or to summon the courage to respond. It is also an opportunity to notice how the patient presents themselves nonverbally, such as using their hands or facial expressions. Consider cultural differences; in some cultures it is the accepted norm for people to take their time, think about their answers and to answer when they are ready. While it is necessary to adhere to reasonable time limits, it is important not to press too hard and to be comfortable with silence (Ball et al, 2019).

History of presenting complaint

Once the patient has outlined their complaint, the next step is to explore its history. This requires information on each symptom (Box 4). Such information can be obtained by asking specific questions or following the SOCRATES framework (Curr and Fordham-Clarke, 2022) (Box 5). Although this mnemonic was originally used to assess pain (Gregory, 2019), it can be applied to other symptoms.

Ideas, concerns and expectations

The patient's ideas, concerns and expectations (ICE) can provide additional information during a consultation (Freilich 2019). Exploring ICE gives a greater understanding of what the patient thinks is important and what treatment they think they need. History taking that includes the patient's perspective is likely to be more revealing and is therefore valuable when making a diagnosis. However, this approach may have its drawbacks as for some patients the nature of the questions can lead to feelings of discomfort, prevent the construction of a therapeutic relationship and stop the flow of history (Snow, 2016).

Ideas are the first stage of ICE, where the practitioner asks the patient to say what they think the problem is or what is causing the symptoms (Freilich, 2019). These questions allow the health professional to see what is on the patient's mind and can provide a starting point for diagnosis.

The next logical step is to ask patients about their concerns. Patients can be complex with multiple health problems so do not assume that their concern is straight forward or matches their ideas. For example, a patient who thinks they might have irritable bowel syndrome (IBS) may be more worried about bowel cancer. It is the practitioner's role to set the patient at ease, so they feel able to speak openly. This is where good communication skills come in, as clear communication and showing empathy can reduce a patient's anxiety about the consultation and presenting complaint (Allen, 2021).

The third and final step is to ask patients about their expectations to highlight what they want from the consultation (Freilich, 2019). For example, are they expecting blood tests, scans or medication.

Although using the ICE framework may sometimes feel like you are going off on a tangent, understanding what the patient expects can help with diagnosis and management and make planning easier.

Medical history

Once ICE is complete, resume the sequence with a general medical history. This can sometimes be difficult to obtain, as patients often do not remember it or consider it relevant to their current complaint (Fisher, 2016). In this case, closed questions can be helpful (Box 6). Although sometimes patients will not know the answers to some of your questions regarding their medical history, you will be able to access their medical records to review past medical history(Abdelrahman and Abdelmageed, 2014).

Medications

Another part of taking an effective history is getting a detailed medication history (Nickless and Davies, 2016). A comprehensive list of medicines and doses prescribed must be identified and discussed. Remember, just because the patient has been prescribed a drug does not mean they are taking it. Likewise, do not assume a patient who collects a prescription every month is complying with the prescribed dosage. Ask the patient directly about this as it reduces the risk of false information clouding your diagnosis.

As well as prescription drugs, ask the patient what over-the-counter medications they might be taking and at what dose (Knott and Tidy, 2021). Do not forget to enquire about vitamins or herbal supplements as these may also have potential side effects or contraindications with prescribed medications (Tatum, 2021). It may also be appropriate to ask about illicit drugs, but make sure you do this in a non-judgmental way.

The next step is to ask about allergies. Don't limit this to drug allergies as all potential allergens need documenting. It is important for the patient to understand the difference between allergies and intolerance. If patients experience a normal side effect to a medicine, they may mistake it for an allergy when it is an intolerance.

Family history

Family history is not always needed, but it is good practice to ask about family history if it might be relevant to the presenting complaint. However, some patients may have no idea of their family history; for example, if they are adopted or estranged from their biological parents.

Social history

This includes lifestyle or environmental factors that may increase a patient's risk of disease or affect an existing diagnosis. Box 7 shows factors to consider when asking about social history. Which are relevant depends on the patient and the presenting complaint, so use your clinical judgement. An obvious example is that whether it is appropriate to ask a child about alcohol and smoking will largely depend on their age. Certain questions may be distressing for some patients, so be sure to convey why you are asking them and how it will help your assessment and their diagnosis.

[sub head] Review systems

After reviewing the patient's history, the final part of the sequence before the summary is to review bodily systems not covered in the first presenting complaint. Box 8 shows a list of symptoms from the main systems, which it might be appropriate to use. It should be noted

that this is not an exhaustive list; equally, depending on the presenting complaint and patient, it might not be appropriate to go through them all.

Summary

Once you have completed the history, it is helpful to repeat back to the patient the timeline of events and information obtained. This enables you to check whether the information is accurate and has been interpreted correctly, as well as highlighting any further or missing details. You may also find it helpful to review the ICE framework if used.

The summary can lead to the patient's questions. If you are not sure of the answers, tell them you don't know and will get back to them with more information. Do not give patients false hope unless you can answer their questions with absolute certainty.

Conclusion

History taking is a logical and systematic approach to the collection of personal and healthcare information, but the approach still needs to be patient-centered and where possible include patient ideas, concerns and expectations. Use of ICE and SOCRATES acronyms provides healthcare professionals with a simple structure to follow both for asking questions and documenting medical history consultations.

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Box 1. Communication skills

Mode of communication	**Skills**
Active listening	Listen without interruption, allowing the patient time to answer your questions. Be aware of your body language and other non-verbal communication when the patient is speaking
Empathy	While practising good listening, be mindful of the patient's verbal and non-verbal communications and respond appropriately
Eye contact	Maintain good eye contact throughout the consultation, enough to engage the patient without making them feel uncomfortable
Body language	Adopt an open and relaxed body language to help the patient feel at ease, while maintaining professionalism. Consider leaning slightly forward in your chair and make sure your arms and legs are not crossed.

Box 2 History taking sequence (adapted from Peart 2022)

Introduction
Presenting complaint
History of presenting complaint
Medical history
Medication
Family history
Social history
Review of systems
Summary

Box 3. Examples of open-ended questions

Can you tell me about what has brought you here today?
How can I help you today?
What health concerns do you have?

Box 4. Specific information required for symptoms

Location of the presenting complaint and when or how it started
Severity of the symptoms and how this affects quality of life
What improves/aggravates symptoms
Whether the person has experienced something like this before, what it was and how it was dealt with
Whether the person done anything on their own to try and improve symptoms

Box 5. SOCRATES framework for assessing a symptom*)* (Curr and Fordham-Clarke, 2022)

Mnemonic meaning	**Question**
Site	Where is the symptom?
Onset	When and how did the symptom start? Was it gradual or sudden?
Radiation	Do the symptoms move elsewhere?
Associated symptoms	Are there other symptoms associated with this?
Time	How have the symptoms changed over time?
Exacerbating or relieving factors	Does anything make it better or worse?
Severity	How severe is the symptom on a scale of 1-10 (where 10 is the most severe)?

Box 6. Examples of closed questions for taking a medical history

General	**Specific**
Have you ever been admitted to hospital?	Do you have diabetes?
Have you got anything inside your body you were not born with?	Do you have high/low blood pressure?

Box 7. Lifestyle factors

Lifestyle factors
Alcohol consumption
Smoking
Support – family/friends
Occupation
Recent travel history

Box 8 Symptoms from major systems

System	**Symptoms**
Cardiovascular	Any chest pain, palpitations, dyspnoea
Respiratory	Cough, shortness of breath, wheeze
Gastrointestinal	Abdominal pain, bowel changes, heartburn
Genitourinary	Discharge, dysuria
Neurological	Numbness, weakness, visual changes
Psychiatric	Depression, anxiety
General	Weight loss, rashes, joint pain