

How to Take a Comprehensive Patient History: A Step-by-Step Guide

Rationale:

Taking a thorough patient history is essential for effective diagnosis and effective management of medical conditions. Research indicates that a significant proportion of diagnoses depend solely on history taking (Keifenheim, 2015). This how-to guide aims to equip advanced practitioners with the skills necessary to conduct a systematic and patient-centred history-taking process.

Key Points:

- History taking involves systematically gathering relevant information from patients to inform diagnosis and treatment.
- Effective communication skills build rapport, trust, and ensure clear communication between healthcare providers and patients.
- Documentation in patient records is essential for maintaining accurate medical histories, facilitating communication among healthcare providers, and providing a legal and ethical document.
- Following a structured approach to history taking, it is essential to assess patient complaints and symptoms of symptoms and symptoms.

Reflective Activity:

'How to' articles can help to update your practice and ensure it remains evidence based. Apply this article to your practice. Reflect on and write a short account of:

- How might this article improve your practice when undertaking history taking?
- How could you use this information to educate nursing students or your colleagues on the appropriate technique and evidence base on how to take a patient's history?

Preparation and Equipment:

- Ensure access to patient records ensuring confidentiality and security requirements have been considered and adhered to.
- Familiarise yourself with communication techniques.
- Prepare a comfortable and conducive environment for the consultation.

Preparatory Steps:

- Introduce yourself and explain your role to the patient and gain consent for the consultation
- Set up the consultation environment for optimal communication and access to records.
- Prepare any necessary documentation tools or templates.

Procedure:

1. Introduction:

Begin by establishing a rapport with the patient through a warm introduction, fostering a sense of trust and rapport. Define your role ensuring transparency and mutual understanding. It is essential to create an environment where the patient feels valued, respected, and comfortable sharing their concerns. It is important to consider the importance of eye contact, non-verbal such as body posture.

2. Presenting Complaint:

Encourage the patient to articulate their presenting complaint, fostering autonomy and agency in their healthcare journey. Utilise open-ended questions (examples given in table 1) to delve deeper into the nuances of their symptoms, allowing for a comprehensive understanding. Embrace moments of silence, giving the patient the space and time needed to express themselves fully.

Table 1 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?

3. History of Presenting Complaint:

Work through the patient's history with precision and purpose, using specific questions or structured frameworks like SOCRATES (see table 1). This systematic approach facilitates thorough exploration, uncovering critical details that may inform subsequent assessments and management decisions.

Table 2 SOCRATES framework for assessing a symptom (adapted from 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?
Character	How would you describe the symptom? Is it constant, or does it come and go?
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)?

4. Ideas, Concerns, Expectations (ICE):

Engage in a dialogue exploring the patient's ideas, concerns, and expectations of their condition and treatment journey (Pendleton et al 2003) . Engage in active listening and empathetic communication to validate their experiences and address any concerns or anxieties. This patient-centred approach fosters collaboration and encourages patients to play an active role in their care.

5. Medical History:

Explore the patient's medical history with diligence and sensitivity, probing past diseases, surgeries, and chronic diseases. Employ closed questions or utilise medical records when necessary to provide comprehensive data collection. This holistic understanding of the patient's medical background provides the basis for informed decision-making and individualised care.

6. Medications:

Conduct a thorough exploration of the patient's medication history, encompassing prescription drugs, over-the-counter medications, vitamins, and supplements. Clarify medication adherence and inquire about allergies or intolerances, mitigating potential risks and optimising treatment effectiveness.

7. Family History:

Inquire about the patient's first-generation family medical history (parents and siblings), recognising its potential impact on the present complaint. Inquire about this conversation with sensitivity, recognising that some patients may have limited knowledge or complex family dynamics. This information provides valuable insights into genetic predispositions and familial health issues.

8. Social History:

Explore the relationship between lifestyle factors, environmental exposures, occupation and social habits that may influence the patient's health. Exercise discretion and empathy when addressing potentially sensitive topics, respecting the patient's boundaries and cultural differences. This holistic assessment reveals contextual factors that shape the patient's health and informs holistic care planning.

9. Review Systems:

Conduct a comprehensive examination of bodily systems beyond the presenting complaint, based on the patient's history and symptoms. Do this assessment to the individual's unique circumstances, prioritising relevant systems based on clinical judgment. This comprehensive approach ensures thorough assessment and facilitates early detection of potential comorbidities or systemic problems.

10. Summary:

Define the wealth of information gathered from the history-taking process into a succinct summary, reaffirming key points and clarifying any concerns. Validate the patient's understanding and address any ongoing concerns or concerns, fostering a collaborative and transparent care partnership. This dialogue promotes shared decision-making and encourages patients to engage in their healthcare journey.

Evidence base

In contemporary healthcare practice, the significance of history taking into account the diagnostic process cannot be overstated. It is the foundational point on which accurate diagnoses and tailored treatment plans are created. Flugelman (2021), emphasises the crucial role of history taking, resulting in a significant proportion of patient diagnoses to this meticulous procedure alone (Adleman 2023) is statistical revelation highlights the indispensability of history, especially for nurses at the forefront of patient care.

Further supporting evidence from various studies and healthcare institutions corroborates the pivotal role of history taking in healthcare delivery. For instance, Howick et al., (2018) demonstrated that effective communication and thorough history taking significantly contribute to the accuracy and patient satisfaction. Similarly, Asif et al. (2017) found that comprehensive history taking resulted in fewer diagnostic errors and improved patient outcomes.

History taking is a source of patient-centred care, an approach that is increasingly recognised as essential in contemporary healthcare delivery. By actively engaging patients in the discussion surrounding their health concerns, nurses are not only providing relevant clinical information but also facilitating patients to participate in their own journey. This collaborative approach promotes trust, enhances patient autonomy, and promotes adherence to treatment plans, ultimately resulting in improved health outcomes as well as also acknowledges the role of the expert patient.

Additionally, history taking allows advanced nurse practitioners to adopt a holistic approach, considering not only the presenting complaint but also the broader context of the patient's life and health history. This comprehensive understanding allows for the identification of factors that contribute to the patient's condition, facilitating targeted interventions and preventive measures.

Furthermore, history taking is a platform for effective communication and collaboration within the healthcare team. By documenting patient histories and sharing relevant information with colleagues, advanced nurse practitioners contribute to continuity of care, interdisciplinary understanding, and informed decision-making.

Understanding the Essence of History Taking:

History taking is more than identifying symptoms; it is a systematic approach to gathering personal and medical data, crucial for healthcare assessment and management (Mosby's Dictionary, 2022). Studies emphasise its role in accurate diagnosis and patient care, with thorough research leading to better outcomes (Committee on Diagnostic Error in Health Care et al. 2015). The understanding of patients' narratives enhances rapport and diagnostic accuracy (Molina-Mula and Gallo-Estrada 2020). By examining medical and lifestyle factors, nurses can tailor care plans for improved outcomes (Ajibade 2022). In nursing, history taking is an art and science, crucial for providing compassionate, patient-centred care (Levine 2017).

The Role of Communication Skills:

Effective communication is not just a tool but the cornerstone of successful nursing history taking. Despite the structured nature of the process, nurses must strive to create a patient-centred environment that fosters trust and understanding (Kwame & Petrucka 2018). Verbal cues such as tone of voice and choice of words, along with non-verbal cues such as body language and facial expressions, are essential in reassuring patients and establishing rapport.

Brooks (2021) emphasises the importance of essential communication skills in nursing practice. These skills are beyond mere verbal exchange; they encompass active listening, empathy, and cultural sensibilities. By incorporating these skills into their interactions with patients, nurses can transcend the clinical realm and establish meaningful connections. Through empathetic listening and understanding (Babaii et al. 2021), nurses can delve deeper into patients' concerns, allowing for a more comprehensive history-taking experience.

A study by Kwame and Petrucka (2021) found that effective communication between healthcare providers and patients was associated with better health outcomes, increased patient satisfaction, and improved adherence to treatment plans. Similarly, a systematic review by Makoul and Clayman (2006) demonstrated that communication skills training for healthcare providers led to enhanced patient-centred communication and improved patient outcomes.

Furthermore, the importance of non-verbal communication in history taking cannot be overstated (Vogel et al., 2018). Research by Hall et al. (2013) showed that non-verbal cues accounted for a significant portion of communication effectiveness, often conveying emotions and attitudes more accurately than verbal cues alone. Therefore, nurses must be attuned to both verbal and non-verbal signals during history taking to ensure effective communication and patient understanding.

Beyond verbal exchange, documentation is a vital conduit of communication in healthcare. Patient records provide insight into their healthcare journey, providing valuable insights for subsequent interactions. Nurses are responsible for meticulously recording facts and reliable information, ensuring continuity of care and seamless coordination among healthcare professionals (Peart, 2022).

Navigating the History-Taking Procedure:

Navigating nursing history requires balancing structure with flexibility, prioritising patient-centeredness. It emphasises the importance of a logical approach while acknowledging the need to

adapt to each patient's unique situation (British Medical Association, 2022; Peart, 2022). Building rapport during initial interactions is crucial to fostering trust and open communication (Dwamena et al., 2012; Stewart et al., 2003). Patient-centred communication improves satisfaction, adherence to treatment, and overall health outcomes (Barry & Edgman-Levitan, 2012). Engaging in shared decision-making empowers patients and enhances engagement, leading to improved outcomes.

The presenting complaint serves as the anchor for history taking, guiding nurses' relevant enquiries. Employing open-ended questions empowers patients to articulate their concerns in their own words, fostering a collaborative approach to care. Nurses must embrace moments of silence, recognising them as opportunities for patients to introspect and express themselves non-verbally—a practice that transcends cultural boundaries (Kemerer, 2016).

Delving deeper into the presenting complaint's history unveils crucial insights into the patient's symptoms (Adleman 2023). Whether utilising structured frameworks like SOCRATES or employing targeted questioning, nurses must adopt a holistic approach that encompasses all aspects of the patient's narrative (Curr and Fordham-Clarke, 2022).

Incorporating the patient's ideas, concerns, and expectations (Pendelton et al 2003) enhances the history-taking process, providing insights into their holistic wellbeing (Freilich, 2019). While this approach fosters deeper understanding, nurses must address potential obstacles such as patient discomfort and therapeutic ruptures with sensitivity and empathy (Snow, 2016).

Closed questions and access to medical records are essential tools in this endeavour, ensuring comprehensive data collection (Abdelrahman and Abdelmageed, 2014). At the same time, the study of drug regimens and allergies requires diligence and openness, enabling nurses to gather relevant information vital for diagnosis and treatment planning.

The social history segment encompasses the multifaceted realm of patients' lifestyles, revealing environmental factors that influence their health. Sensitivity and clinical judgment guide nurses as they navigate potentially challenging topics, ensuring that inquiries align with the patient's age, cultural background, and comfort level (Ball et al., 2019).

Concluding with a Comprehensive Review:

As the history-taking process draws to a close, advanced practitioners synthesise the insights gained from the consultation. A summary serves as a guide, guiding subsequent actions and facilitating shared decision-making with the patient. Addressing lingering questions or uncertainties underscores commitment to patient-centred care and fosters a sense of partnership in the healing journey.

In essence, history taking goes beyond just mere data collection; it embodies the essence of nursing's holistic, patient-centred approach to care. By honing their skills in history taking, nurses can uncover the mysteries of illness but also create bonds of trust and compassion with those under their care.

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