**Health History, Review of Systems,**

**Introduction**

Health assessment consists of 3 major parts. The **clinical history** (which includes the review of functional health patterns), **review of systems (ROS),** and the **physical exam.** The physical exam is usually done by a system’s approach (e.g. head to toe).

The **clinical history** is done at the beginning of the interview while the client is fully dressed. The clinical history consists of the chief complaint, history of the present problem or illness, past medical history, family history, social history, and the ROS. These are discussed in more detail later in the outline.

The **ROS** is a summary of the client’s past and current health and is sometimes done in a self- administered format (or checklist) by the client. There is a sample of a ROS in your text and in your syllabus. Take a moment to look at it and review the questions. You will note that this is a **subjective** history (e.g. what the "subject" or "client" says). It is the responsibility of the practitioner to review each positive or yes statement on the ROS using one of the **symptom analysis** techniques (OLD CART, PQRST, or other). The practitioner uses this information during the physical exam. For example, if your client has a clinical history that includes multiple cardiac risk factors, more attention is paid to the cardiovascular system during the exam.

Information regarding the health history can also be obtained throughout the physical exam.

**The Health History**

**HISTORY FIRST - THEN Physical Exam**

It is essential for the primary nurse to collect data from the client at 1st contact in order to give adequate & comprehensive nursing care.

**I. PURPOSE**

1. Collection of data about an individual's health state.
2. The health history is the primary method for the nurse to establish rapport and trust with the client and to gather information that is needed to develop the care plan.
3. The history taking helps the nurse to assess the client's health needs and problems and gather knowledge within the context of the person's lifestyle, culture, and living conditions.
4. Data gathering through interviews and questionnaires is done using a standardized, systematic method.
5. Helps to determine nursing care needs and nursing diagnosis.

**II. TYPES OF HEALTH HISTORIES**

1. There are many formats available for taking a health history. Four of the more commonly used types of health history formats are the complete history, the interval history, the problem focused history and the emergency health history.
2. The **complete health history** is taken on the initial visit to a clinic or acute care setting. It provides a comprehensive and complete database of the needs of the client. It is usually taken only once and is updated as needed.
3. The **interval health history** (Follow-up history) format collects information during visits subsequent to the initial database collected in the complete health history. The purpose is to collect pertinent information that has occurred since the last visit.
4. The **problem focused or chief complaint focused history** is used to collect data about the most important or chief problem facing the client at the present time.
5. **Emergency Health History** - rapid collection usually in life threatening situations.

**III. ETHICAL CONSIDERATIONS**

1. During the history (and the physical exam) the client and the nurse enter into a partnership which promotes trust and satisfaction.
2. The partnership is directed towards the collection of biological, psychosocial, cultural, and spiritual information about the client and the environment in which the individual is living.
Data includes sensitive information about physical problems, past illness, and injury, socioeconomic factors such as income, occupation, and insurance, health status of family members, lifestyle and living conditions, and culture.
3. Confidentiality and patient autonomy are part Nursing's professional code of ethics. Student nurses should be familiar with the principles for maintaining an ethical client/patient relationship and confidentiality of the data collection. Things to know include the concepts of confidentiality and autonomy and understanding the definitions and meanings of the concepts of beneficence, non-maleficence, utilitarianism, fairness, and justice.

 **N.B.** To learn more about these concepts read about them in your text.

1. Confidentiality
2. Autonomy
3. Beneficence
4. Non-maleficence
5. Utilitarianism
6. Fairness
7. Justice

**IV. COMMUNICATION WITH PATIENTS**

1. Communicating with patients is very important and sets the stage for development of a therapeutic relationship. A therapeutic relationship is built on trust. Patients need to feel they can trust the caregiver in order to provide them with the information the caregiver needs to develop a plan of care.
2. To enhance communication and the development of trust and therapeutic relationship, there are several important points to keep in mind. These include use of a professional approach and manner, confidentiality and ethics, and communication style and technique.
3. The client starts to make an assessment of the nursing student as soon as he/she walks in the door. The nurse should use a friendly but professional approach and dress appropriately for the clinical setting. Generally you will wear nice clothes or a uniform, your lab coat and student’s name tag.
4. Avoid extremes in dress, hairstyle, and mannerism which may be distracting or frightening to older clients.
5. You should be friendly in manner but not patronizing or social. Remember, the client is not coming for tea and conversation; they are present because they have a chief complaint of some urgency.
6. Try to show sensitivity and demonstrate a caring attitude. Do not show judgment or make judgmental statements about clients. Examine your own feelings or past prejudices. They have no place in the therapeutic relationship. Each client is treated equally and with dignity regardless of background and lifestyle.
7. Another thing you can do is to think of some of the ways of handling tensions that may occur during the interview and history taking. For example, how would you interact with clients who are anxious or angry? What would you do if a client was threatening or who was acting inappropriately during an interview? Discuss these different situations and think beforehand how you would handle them. Also, ask some of your classmates how they might handle different situations or ask if they have had any challenging experiences.
8. You will be given a communication technique handout and an opportunity to practice therapeutic communication in the laboratory with a partner before you do the clinical rotation..
9. The nurse should ask questions about alcohol, drugs, sexuality, and sexual preferences during the interview. These are sensitive questions and need a tactful approach.

**MAXIMIZING COMMUNICATION**

1. Internal Assets - are those traits which the interviewer brings to the setting

-genuine liking of people

-empathy - recognizing and accepting the other persons feelings without criticism, judgment. **Not** feeling sorry for the client (this is **sympathy**!).

-active listening

2. External Assets - factors within the environment that you can control.

-privacy

-comfortable physical setting

-maintain eye contact

-refuse interruptions

-appropriate dress

**COMMUNICATION TECHNIQUES TO AVOID**

\* **Collect data - DON'T PASS JUDGMENT!**

**DON'T:**

-reassure

-give advice

-use professional jargon (USE LAYMAN'S TERMS)

-interrupt

-talk too much

**PRINCIPLES OF DATA COLLECTION**

1. Word questions so client can understand.
2. Keep questions brief and simple.
3. Ask one question at a time.
4. Use open-ended questions whenever possible.
5. Clarify the client’s responses if necessary.
6. Summarize when the history is lengthy.

**SETTING FOR THE INTERVIEW**

1. There are some things to think about in terms of the setting. You should use a comfortable setting for data collection. The room should be warm, quiet, and have chairs and a writing area. Greet the patient; offer a handshake and introduce yourself.
2. Always take time to sit down and face the patient.
3. Have good eye contact.
4. The patient should be in street clothes (it is preferable not to have the client undress during the interview).
5. The room should have a door which can be closed to insure privacy.
6. Maintain a conversational voice tone.
7. Explain all procedures.
8. Avoid distractions in the setting such as TV, radio, and other people.
9. A beeper or telephone which goes off during the interview demonstrates to the client that you are either too busy to attend to their needs, or don't care. Any type of interruption is unfair to the client and affects the development of trust, caring, and the therapeutic relationship.

**VI. OUTLINE FOR CLINICAL HISTORY**

You will use an organized format for asking the history and review of systems (ROS) questions. a commonly used format used by staff nurses, advanced practice registered nurses, clinical specialists, and medical staff is shown below. .

1. ***Chief complaint:*** Brief description of client's problem in the client's words. One to two words only (i.e. sore throat, leg pain, etc.)!
2. ***History of present illness:*** Chronological course of events and state of present health. Use a symptom analysis method such as OLDCART (onset, location, duration, character, attenuates, relieves, treatment used) for each symptom mentioned. This is where you "explain" the chief complaint.
3. ***Past medical history:*** Data of childhood and adult illnesses, immunizations, surgeries, serious injuries, medications, allergies, and blood transfusion. Be sure to include allergies to medications, foods, and environmental factors. Don't forget to ask about latex and food allergy.
4. ***Personal and social history:*** Socioeconomic and cultural data. You may use a cultural assessment form if you want to be very thorough. Otherwise you will want to know about marital status, living arrangements, significant others, environmental factors, ethnic group and religion ( cultural practices that may affect health recovery are noted) primary language and educational level, lifestyles or personal habits e.g amount, frequency and duration of substance used (tobacco, alcohol etc) Knowing if the patient has insurance and adequate income for living and health related expenses is very important. If the client has barely enough to live on for food and rent, giving them prescriptions and expecting them to follow the medication regimen may not be possible.
5. ***Family History:*** Diagram of disease and family illnesses and death. Since many diseases have a hereditary component, this information is important. A genogram may be helpful for displaying the family history. Client’s support system is essential in times of stress. Ethnic affiliation –.
6. ***Functional Health Patterns:*** This is a part of the screening history. Information is gathered as it relates to Activity/Exercise, Sleep/Rest, Nutrition Elimination, Cognitive/Perceptual, Role/Relationships, Coping/Stress, Self-perception/Concept, Value/Belief and Sexuality & Reproduction. These categories are known as "Gordon’s Functional Health Patterns" .
7. ***Review of Systems:*** An organ system checklist with detailed information depending on what the client’s problems are and in which systems. Physiologic and psychological data is organized according to body systems. This data can be gathered by interview or letting the patient fill in a checklist. Each symptom checked as a "yes" is further analyzed using the OLDCART method mentioned.
8. ***Concluding Questions:*** At the end of the interview ask the client if there is anything else that needs to be discussed. Do not forget this question as many times clients will bring up something on their minds that they did not tell you earlier.
9. Lastly, review principles of confidentiality mentioned earlier. Everything the patient has told you is confidential and is not to be discussed with anyone other than the healthcare team. No one who is not caring for the patient has the right to know about what is discussed with the team or has the right to see the patient's medical record. Confidentiality of information is especially critical with the use of computerized data bases and medical records. Part of the nursing code of ethics is that the patient record is confidential.

**DEFINITIONS**

When conducting the health history, make sure you only use "layman's" terms so as not to confuse the patient. **The Review of Systems** checklist contains many terms you may not be familiar with. Below are some explanations.

  **Malaise** -uneasy feeling of weakness or discomfort

**Lesions** - areas of pathologically altered tissue

**Diplopia** - double vision

**Photophobia** - sensitivity to light

**Glaucoma** - disease of the eye with increased intraocular pressure

**Tinnitus** - ringing in the ears

**Vertigo** - dizziness

**Epistaxis** - nose bleeds

**Dysphagia** - difficulty swallowing

**Pruritus** - itching

**Gynecomastia** - enlargement of breast tissue in males

**Dyspnea** - shortness of breath

**Orthopnea** - shortness of breath while lying down

**Hemoptysis** - coughing up blood

**Cyanosis** - bluish color of skin (due to decreased oxygenation)

**Paroxysmal nocturnal dyspnea** - sudden shortness of breath at night

**Palpitations** - rapid pounding of heart

**Syncope** - fainting

**Varicose Veins** - enlarged, twisted superficial veins

**Hematemesis** - vomiting blood

**Jaundice** - yellow skin or sclera

**Melena** - black, tarry stools (indicates blood)

**Urgency** - have to urinate NOW (can't hold it)

**Dysuria** - painful urination

**Nocturia** - frequent urination at night

**Hematuria** - blood in urine

**Hesitancy** - difficulty starting urine stream

**Post-coital bleeding** - bleeding after intercourse

**Muscle Atrophy** - muscle shrinking

**Paresthesia** - numbness and tingling

**Paralysis** - lacking/loss of movement

**Tics** - spasms of muscle contractions, twitching

**Tremors** - quivering

**Spasms** - involuntary sudden movement or convulsive muscle contraction

**Insomnia** - inability to sleep

**Delusions** - false beliefs

**Hallucinations** - false perceptions (can be visual, auditory or olfactory)

**VII.  AGE AND CONDITION RELATED VARIATIONS IN OBTAINING HISTORY AND ROS**

* The format is somewhat different for infants, children, and adolescents. For example for newborns, data is collected about pregnancy, labor and delivery course and birth condition. Dietary and developmental issues are also important. You may use other tools such as the Denver Developmental Screening Test (DDST) for infants and children. Age specific social history includes things such as thumb sucking and temperament (such as temper tantrums) or other behaviors.
* System review is also a little different depending on age and condition related variations. For example, you cannot collect history from infants, as they have not developed language skills. Young children can be asked some questions, but most of the data is collected from parents. Older individuals may or may not be reliable historians, depending on cognitive functioning and memory. The format needs to be modified for these age and condition specific factors. You will be provided the appropriate forms for the clinical setting where you are practicing and for the age and condition related variations discussed.
* For adolescents, ask about relationships, self-esteem, sexual relations, school, and recreational drugs. Use an exploring method of interview when working with adolescents. Also, adolescents may not want to talk with parents around or answer personal questions about sexuality issues, drugs, smoking and alcohol, so provide an opportunity for discussion away from parents.
* With older adults, explore age specific concerns. These might include sexual intimacy issues which are common in this age group. Other questions that are appropriate might relate to pain in the joints, fatigue, and shortness of breath. It is important to differentiate the normal symptoms of aging from those that are more serious and may be indicators of impending heart failure or other chronic illness. It is also important to evaluate the reliability of the data as a few older folks may have dementia and memory problems.
* You can revise existing forms to accommodate for age and developmental conditions. Most clinical sites will have their own forms and format. You can also supplement the format with age specific tools such as the DDST mentioned earlier, or a mental status exam such as the Mini Mental Status Exam (MMSE) tool for older confused patients. For patients with head injury or neurological deficits, an appropriate assessment tool for gathering data may be the Glasgow Coma Scale, which is used as part of the neurological exam. This tool may be used to assess cognitive function and level of consciousness before starting a history and ROS to assess if the patient is a reliable source.
* Concentrate on building good communications skills and techniques with your clients. Use every opportunity to practice and evaluate your newly developing skills. Most of the tools presented are applicable across ages. It is also important to ask about concerns related to abuse, violence, or drug use in the home.