

# Nursing Health History

## Definition of Health History

- **Systematic collection of subjective data which stated by the client, and objective data which observed by the nurse.**
- **That using to determine a client functional health pattern status.**

# Phases of taking health history

## Two phases:-

- ➡ The interview phase which elicits the information (primary sources)
- ➡ The recording phase (secondary sources).

# Guidelines for Taking Nursing History

- Private, comfortable, and quiet environment.
- Allow the client to state problems and expectations for the interview.
- Orient the client the structure, purposes, and expectations of the history.

## **Guidelines for Taking Nursing History cont.**

- **Communicate and negotiate priorities with the client**
- **Listen more than talk.**
- **Observe non verbal communications e.g. "body language, voice tone, and appearance".**

- ▶ Review information about past health history before starting interview.
- ▶ Balance between allowing a client to talk in an unstructured manner and the need to structure requested information.
- ▶ Clarify the client's definitions (terms & descriptors)

➡ **Avoid yes or no question (when detailed information is desired).**

➡ **Write adequate notes for recording?**

➡ **Record nursing health history soon after interview.**

# Types of Nursing Health History

- ➡ **Complete health history:** taken on initial visits to health care facilities.
- ➡ **Interval health history:** collect information in visits following the initial data base is collected.
- ➡ **Problem- focused health history:** collect data about a specific problem

# Components of Health History

## 1-Biographical Data: This includes

- ➡ Full name
- ➡ Address and telephone numbers (client's permanent contact of client)
- ➡ Birth date and birth place.
- ➡ Sex
- ➡ Religion and race.
- ➡ Marital status.
- ➡ Social security number.
- ➡ Occupation (usual and present)
- ➡ Source of referral.
- ➡ Usual source of healthcare
- ➡ Source and reliability of information.
- ➡ Date of interview.



## 2- Chief Complaint: “Reason For Hospitalization

### Examples of chief complaints:

- ▶ Chest pain for 3 days.
- ▶ Swollen ankles for 2 weeks.
- ▶ Fever and headache for 24 hours.
- ▶ Pap smear needed.
- ▶ Physical examination needed for camp.

# 3-History of present illness

Gathering information relevant to the chief complaint, and the client's problem, including essential and relevant data, and self medical treatment.

## Component of Present Illness

- Introduction: "client's summary and usual health".
- Investigation of symptoms: "onset, date, gradual or sudden, duration, frequency, location, quality, and alleviating or aggravating factors".
- Negative information.
- Relevant family information.
- Disability "affected the client's total life".

## 4- Past Health History:

The purpose: (to identify all major past health problems of the client)

This includes:

- ▶ Childhood illness e.g. history of rheumatic fever.
- ▶ History of accidents and disabling injuries

### **Past Health History. Cont.**

- ▶ History of hospitalization (time of admission, date, admitting complaint, discharge diagnosis and follow up care.
- ▶ History of operations "how and why this done"
- ▶ History of immunizations and allergies.
- ▶ Physical examinations and diagnostic tests.

# 5-Family History

The purpose: to learn about the general health of the client's blood relatives, spouse, and children and to identify any illness of environmental genetic, or familiar nature that might have implications for the client's health problems.

## Family History. Cont...

- ➡ Family history of communicable diseases.
- ➡ Heredity factors associated with causes of some diseases.
- ➡ Strong family history of certain problems.
- ➡ Health of family members "maternal, parents, siblings, aunts, uncles...etc."
- ➡ Cause of death of the family members "immediate and extended family".

# 6-Environmental History:

## Purpose

“To gather information about surroundings of the client”, including physical, psychological, social environment, and presence of hazards, pollutants and safety measures.“

# 7- Current Health Information

**The purpose is to record major current health related information.**

- ➡ Allergies: environmental, ingestion, drug, other.
- ➡ Habits "alcohol, tobacco, drug, caffeine"
- ➡ Medications taken regularly "by doctor or self prescription"
- ➡ Exercise patterns.
- ➡ Sleep patterns (daily routine).
- ➡ The pattern life (sedentary or active)

# 8- Psychosocial History:

## Includes:

- ▶ How client and his family cope with disease or stress, and how they responses to illness and health.
- ▶ You can assess if there is psychological or social problem and if it affects general health of the client.

## 9- Review of Systems (ROS)

- Collection of data about the past and the present of each of the client systems.
- (Review of the client's physical, sociologic, and psychological health status may identify hidden problems and provides an opportunity to indicate client strength and disabilities



# Physical Systems

## Which includes assessment of:-

- General review of skin, hair, head, face, eyes, ears, nose, sinuses, mouth, throat, neck nodes and breasts.
- Assessment of respiratory and cardiovascular system.
- Assessment of gastrointestinal system.
- Assessment of urinary system.
- Assessment of genital system.
- Assessment of extremities and musculoskeletal system.
- Assessment of endocrine system.
- Assessment of hematopoietic system.

**Assessment of social system.**

**Assessment of psychological system.**

## 10- Nutritional Health History

### “Discussed Before”

## 11- Assessment of Interpersonal Factors.

**This includes :-**

- Ethnic and cultural background, spoken language, values, health habits, and family relationship.
- Life style e.g. rest and sleep pattern
- Self concept perception of strength, desired changes
- Sexuality developmental level and concerns
- Stress response coping pattern, support system, perceptions of current anticipated stressors.