The Health History

Initial information

- Always document date and time of the encounter.
- Include the patient's identifying information including name, age, date of birth, and gender.
- Identify the source of information, whether it is the patient, a parent or family member, a consultant, someone else, or review of medical records.
- Document the use of any assistance, such as an interpreter or family member.

Chief complaint

- Ask the patient the reason they are seeking care at this time.
- Document using the patient's own words, if possible.

History of present illness (HPI)

- The HPI is a clear, concise, and chronological summary of the problem(s) prompting the visit.
- Ask about symptom attributes, including location, timing (onset, duration, frequency), quality or severity, factors that worsen or alleviate the symptom, and associated manifestations.

Past medical history

- Ask about all medical problems of the patient, both past and current. Include childhood illnesses, and any medical, surgical, psychiatric, or obstetric/gynecologic information.
- Ask about immunizations and age-appropriate screening tests.
- Assess for allergies to medications, food, insects, and environmental factors.
- Ask about current medications, including prescription drugs as well as over-the-counter drugs, vitamins, supplements, and home remedies. Document the name, dose, route and frequency of use.

Family history

- Gather information about the patient's immediate relatives, including age and health; if they are living or deceased; cause of death; age of death of parents, grandparents, siblings, children, and grandchildren

Social history

- Ask the patient about their social history to capture their interests, coping style, strengths, and concerns.
- Components of the social history
    - Gender identification
    - Sexual orientation
    - Occupation
    - Education
    - Relationships and relationship safety
    - Home environment
    - Life experiences

  - Leisure activities
  - Sexual history
  - Spirituality
  - Support systems
  - Tobacco, illicit drug, and alcohol use
  - Exercise, nutrition, and sleeping habits
  - Safety, including seat belt, carseat, and helmet use; sun protection; firearms; and smoke detectors.

Review of systems

- Ask patient about the health of different organ systems.
- For each system, ask, *"Have you ever experienced any…?"*
  - *General:* changes in weight, sleep disturbance, weakness, fatigue, or fever/chills
  - *Skin:* Rashes, lumps, sores, itching, dryness, changes in color; changes in hair, nails or moles
  - *Head, eyes, ears, nose, throat (HEENT):* headache, head injury, dizziness, lightheadedness; vision changes, glasses or contact lenses, pain, redness, excessive tearing, double or blurred vision, spots, specks, flashing lights, glaucoma, cataracts; hearing problems or hearing aid use, tinnitus, vertigo, earaches, infection, discharge; nasal stuffiness, discharge, or itching, nosebleeds, sinus trouble; problems with teeth and gums, bleeding, dentures, sore tongue, dry mouth, frequent sore throats, hoarseness
  - *Neck:* swollen glands, goiter, lumps, pain, or stiffness
  - *Breasts:* lumps, pain or discomfort, skin changes, nipple discharge
  - *Respiratory:* cough, changes in sputum, shortness of breath, wheezing, pain, sleep apnea
  - *Cardiovascular:* cardiac issues, hypertension, rheumatic fever, murmurs; chest pain, palpitations, orthopnea, paroxysmal nocturnal dyspnea, leg swelling
  - *Gastrointestinal:* trouble swallowing, heartburn, appetite change, nausea, change in bowel habits, pain with defecation, rectal bleeding or black or tarry stools, hemorrhoids, constipation, diarrhea, abdominal pain, food intolerance, excessive gas, jaundice, liver, or gallbladder problems
  - *Peripheral vascular:* claudication, leg cramps, varicose veins, clots, swelling, color change with cold weather, redness or tenderness
  - *Urinary:* changes in frequency of urination, polyuria, nocturia, urgency, burning or pain during urination, hematuria, urinary infections, kidney or flank pain, kidney stones, ureteral colic, suprapubic pain, incontinence; in males, change force of the urinary stream, hesitancy, dribbling
  - *Genital:*
    - Male: hernias, discharge or sores on the penis, testicular pain or masses, scrotal pain or swelling, history of sexually transmitted infections (STI), libido, changes in sexual function or satisfaction
    - Female: menstrual details, bleeding between periods or after intercourse, dysmenorrhea, premenstrual tension, menopausal symptoms, postmenopausal

bleeding, vaginal discharge, itching, sores, lumps, STI, changes in sexual interest or satisfaction, dyspareunia

- *Musculoskeletal:* muscle or joint pain, stiffness, arthritis, gout, backache, neck pain
- *Psychiatric:* nervousness, tension, depression, memory change, suicidal ideation
- *Neurologic:* changes in mood, attention, speech, orientation, memory, insight, or judgment; paralysis, numbness or loss of sensation, tingling, tremors, seizures
- *Hematologic:* anemia, easy bruising or bleeding.
- *Endocrine:* Heat or cold intolerance, excessive sweating, polydipsia, polyphagia, or polyuria

PEARLS

- Follow the patient's verbal and non-verbal cues to guide your conversation.
- Use communication skills – verbal and nonverbal – to get the information you need, while also providing empathy.
- Use open-ended questions as needed; for example, "Can you tell me more about that?"
- Anything uncovered during the review of systems that is related to the chief complaint should be documented in the section related to the HPI.

Reference

Bickley, L. S., Szilagyi, P. G., Hoffman, R. M., & Soriano, R. P. (2021). Bate's Guide to Physical Examination and History Taking (13th ed.). Wolters Kluwer Health: Philadelphia.