Taking a patient history: the role of the nurse


Abstract
History taking is a key component of patient assessment, enabling the delivery of high-quality care. Understanding the complexity and processes involved in history taking allows nurses to gain a better understanding of patients’ problems. Care priorities can be identified and the most appropriate interventions commenced to optimise patient outcomes.

Authors
Tonks Fawcett
Senior lecturer in nursing studies, University of Edinburgh.
Sarah Rhynas
Teaching fellow in nursing studies, University of Edinburgh.
Correspondence to: T.Fawcett@ed.ac.uk

Keywords
Assessment, care planning, communication, history taking, nursing skills

Aims and intended learning outcomes
This article explores history taking as a key component of patient assessment. The goals of history taking are explored, with specific reference to medical and biographical history taking, to promote and enhance knowledge of the complex skills involved. This article does not detail how to take a history as this is explained elsewhere (Lloyd and Craig 2007). Rather, the focus is on how to think about and foster the skills of history taking to understand the patient’s circumstances and experience of a particular healthcare problem or need. After reading this article and completing the time out activities you should be able to:

- Explain the importance of history taking in the context of patient assessment.
- Outline guidelines for taking a patient history.
- Discuss how biographical details can complement medical history taking.
- Explore how key history taking skills and processes can be used to optimum effect when planning care for different patient groups.
- Consider how history taking skills might be fostered or improved in the future.

Introduction
Although nurses acknowledge that patient assessment is the cornerstone of nursing care, they are perhaps less comfortable with the idea of formally taking a patient history (Lloyd and Craig 2007, McKenna et al. 2010). History taking was not included in nursing textbooks in the past as it was seen
as the remit of medical colleagues. However, from the 1970s onwards, the nursing process of assessment, planning, implementation and evaluation was embedded; history taking (including concomitant communication skills) became an integral, albeit informal part of nursing assessment. The focus of history taking involves not only identifying signs and symptoms of illness, but also the individual’s experience of illness. Taking a patient history is increasingly being undertaken by nurses as their roles and responsibilities expand. This is particularly the case for nurses working in advanced practice roles in a medical setting.

The person-centred approach to care, which has become dominant in recent healthcare strategies (Department of Health (DH) 2001, DH 2009, Scottish Government Health Department 2010), advocates that nurses get to know their patients better to understand their problems and needs. These changes demand that nurses develop their history taking skills to acknowledge medical, social, psychological and biographical domains. This article defines history taking, looking at how it was perceived in the past, what changes have occurred and the different focus of various healthcare professionals. Nurses can conceptualise history taking using a philosophical framework such as holistic patient-centred care, which promotes a different but complementary approach to the biomedical model. Key skills and processes involved in history taking are explored and systematic and reflective approaches considered.

Medical history taking

The medical component of a patient history is essential to make an accurate diagnosis and establish appropriate treatment. Kale (2001) argued that the literature base regarding history taking is lacking, and concluded that ‘history taking is an art, a performing art learned at the bedside watching a master artist in action’. History taking in its simplest form involves asking appropriate questions of patients or their relatives or carers to obtain information to aid diagnosis. It is identified as a core clinical skill for professional competence.

Traditionally, the success of medical history taking depended on the depth of doctors’ clinical knowledge, enabling them to identify any disturbance to normal physiology and explore, via questioning, any possible underlying pathophysiology that would explain presenting symptoms. However, medical history taking of this nature takes little account of the uniqueness of patients and the social, cultural and psychological factors that may play a role in illness. Medical history taking usually follows a structured format, particularly in the hospital setting (Longmore et al 2010). Mnemonics are often used to assist and promote comprehensive history taking. They should not, however, be viewed simply as tick lists, but rather as a means of triggering the person taking the history to cover particular areas of importance. Fischer (1995) argued that doctors ‘make a history’ rather than ‘take a history’, focusing on what is heard, observed, felt intuitively and learnt over time; the process can only be completed when the doctor and patient agree on both the problem and its cause.

At the core of successful history taking is skilled and patient-centred communication through which a rapport is established between the nurse and patient, who work together to achieve a shared understanding of the nature of the problem and how best to address it (Gask and Usherwood 2002). Effective communication is key to elicit an accurate and detailed patient history and models such as the Calgary-Cambridge framework (Kurtz and Silverman 1996) can be used to achieve this.

The stages of the Calgary-Cambridge framework outlined in Box 1 detail elements that should be covered during consultation with the patient (Kurtz et al 2005). The key tenet of the framework is to combine the pathological description of disease with the patient’s subjective experience of illness, the importance of which has been emphasised by nurses (Eisenberg 1977). This patient-centred approach will help establish a trusting relationship between the patient and nurse, ensure sufficient information is gathered for decision making and lead to a mutually agreed treatment plan.

A nursing perspective

Nurses tend to have a more intimate and personal relationship with patients than their medical colleagues. Even in acute care settings, relationships between nurses and patients can be developed through more frequent contact, at quieter moments and over longer periods.
of time. Encounters between the nurse and patient need not take place exclusively within the confines of a formal consultation and nurses are not therefore strictly bound by formal models of communication. Nurses tend to communicate with patients during moments of intimate care, for example in the middle of the night or while bathing a patient, when individuals may be more likely to speak openly and informally. Communication from a nursing perspective should encompass getting to know the patient better to understand his or her problems and specific needs. History taking of this nature may:

- Be incremental and cumulative rather than confined to a formal interview.
- Consist of short exchanges, from which incidental information is gleaned that helps the nurse understand the patient’s perspective or experience of events.
- Include an exchange of insights, with the patient sharing feelings of concern, need or threat, and the nurse proffering ideas to provide support and assistance.

**Person-centred care**
The changing demands of policymakers regularly shape the roles of and agendas for nurses in the NHS. These political influences have changed the face of nursing in recent years. For some nurses working in advanced practice roles, diagnosis is the key aim of history taking. These nurses seek to combine the philosophical learning they gained during their earlier nursing careers with the more structured consultations, paperwork and diagnostic aims of their newly developed roles, modelled to some extent on medical frameworks. For many other nurses working at all levels in the NHS and in the care home sector, history taking has taken on a new dimension in light of providing person-centred care (DH 2007).

Person-centred care and individualised care have become popular terms in nursing and dominate nursing literature, particularly with regard to the care of older people. Nurses recognise that care should be tailored to the patient, offering choice and enhancing control rather than simply directing patients to inflexible services (Innes et al 2006). Nolan et al (2006) acknowledged the importance of person-centred care, but also recognised the need for patients to establish supportive relationships with family members as well with nursing staff and carers.

**BOX 1**

<table>
<thead>
<tr>
<th>Calgary-Cambridge framework for effective communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Initiating the session</td>
</tr>
<tr>
<td>- Establish initial rapport.</td>
</tr>
<tr>
<td>- Identify the reasons for the consultation.</td>
</tr>
<tr>
<td>2) Gathering information</td>
</tr>
<tr>
<td>- Explore the patient’s problem.</td>
</tr>
<tr>
<td>- Understand the patient’s perspective.</td>
</tr>
<tr>
<td>- Provide structure to the consultation.</td>
</tr>
<tr>
<td>3) Building the relationship</td>
</tr>
<tr>
<td>- Develop rapport.</td>
</tr>
<tr>
<td>- Involve the patient.</td>
</tr>
<tr>
<td>4) Providing structure to the interview</td>
</tr>
<tr>
<td>- Summarising.</td>
</tr>
<tr>
<td>- Signposting.</td>
</tr>
<tr>
<td>- Sequencing.</td>
</tr>
<tr>
<td>- Timing.</td>
</tr>
<tr>
<td>5) Explanation and planning</td>
</tr>
<tr>
<td>- Provide the correct amount and type of information</td>
</tr>
<tr>
<td>- Aid accurate recall and understanding.</td>
</tr>
<tr>
<td>- Achieve a shared understanding (incorporating the patient’s perspective).</td>
</tr>
<tr>
<td>- Plan shared decision making.</td>
</tr>
<tr>
<td>6) Close the session</td>
</tr>
</tbody>
</table>

(Kurtz et al 2005)

However care is conceptualised, the practical demands of providing patient-centred care may be difficult for nurses to achieve in a ward setting, where time may be limited (Dewing 2004, Edvardsson et al 2010). Person-centred care that considers the individual as a whole person is essential to optimise the success of any intervention, and thorough history taking is a component of this.

**Patterns of knowing in nursing**
In a seminal article, Carper (1978) described the fundamental ‘patterns of knowing in nursing’. Four ways by which nurses develop knowledge in a nursing context were identified and are shown in Box 2. Carper’s (1978) work demonstrates that knowledge can take various forms and much of this knowledge can be gained by nurses taking, and subsequently interpreting, patients’ histories. This knowledge can be used to shape patient care. Nurses need to be able to understand and interpret signs and symptoms of illness to work towards a diagnosis. Some will require detailed knowledge to order blood tests, interpret
Learning zone patient assessment

results, make diagnoses and prescribe suitable medication. For these nurses the ‘science’ of nursing is important and will be the focus of the patient history.

Complete time out activity

Even for nurses who have an empirical focus, aesthetic and personal knowledge is also part of the history-taking process, as nurses listen and interpret patients’ stories of their illness and experiences, and identify what matters to them. Nurses should encourage patients to share their stories as part of a therapeutic interaction, while recognising what issues the patient might be uncomfortable about discussing.

The importance of good communication skills is demonstrated by nurses building relationships with patients and their families, often at times of great stress, and by ensuring that interactions are positive for the individuals involved and that adequate information is gathered.

History taking for some nurses may focus on identifying the underlying biomedical problem, while other nurses may have a different focus. For example, advanced practitioners support people who are undergoing treatment by specialist physicians, and many nurses care for individuals admitted to wards in circumstances that are both socially and psychologically challenging. Taking a history that focuses on social and psychological factors may require aesthetic knowledge, but is as challenging as obtaining a biomedically-focused patient history. Achieving person-centred care is innovative with the information they collect, although many hospitals collect this information through the more formal and systematic documentation typically found in admission paperwork. This information informs medical staff, nurses and allied healthcare professionals about the wider circumstances surrounding an individual’s admission. The information gathered is not intended to be comprehensive at the outset, but rather a starting point to inform subsequent interactions with the patient.

History taking of this nature is realistic in a busy admissions unit and provides a starting point for obtaining a more complete picture of the individual on an incremental basis. Information about support services may also be included in biographical notes, although many hospitals collect this information through the more formal and systematic documentation typically found in admission paperwork.

In the context of residential or long-term care, the focus and requirements of history taking are different. Biographical history can take precedence over diagnostic information, and timescales allow nurses and care staff to complete patient histories over a longer period of time. Initial information sheets, sometimes completed by family members, are often viewed as a starting point for a long and detailed life story, making the process of history taking part of the developing therapeutic relationship between the nurse and patient, and culminating in a useful biographical resource.

Complete time out activity

Contextualising history taking

The context of history taking is key if appropriate and accurate information is to be obtained. The process of history taking should be collaborative, involving the patient, family members and the nurse. This rounded approach is useful in all care settings, but can be most effectively illustrated in the care of older people.

The move towards more comprehensive geriatric assessment in the acute sector (Royal College of Nursing 2004, Ellis and Langhorne 2005, Hickman et al 2007) highlight the importance of collecting a social and biographical history, as well as diagnostic material typically found in admission paperwork. This information informs medical staff, nurses and allied healthcare professionals about the wider circumstances surrounding an individual’s admission. The information gathered is not intended to be comprehensive at the outset, but rather a starting point to inform subsequent interactions with the patient.

History taking of this nature is realistic in a busy admissions unit and provides a starting point for obtaining a more complete picture of the individual on an incremental basis. Information about support services may also be included in biographical notes, although many hospitals collect this information through the more formal and systematic documentation typically found in admission paperwork.

In the context of residential or long-term care, the focus and requirements of history taking are different. Biographical history can take precedence over diagnostic information, and timescales allow nurses and care staff to complete patient histories over a longer period of time. Initial information sheets, sometimes completed by family members, are often viewed as a starting point for a long and detailed life story, making the process of history taking part of the developing therapeutic relationship between the nurse and patient, and culminating in a useful biographical resource.

Complete time out activity

Biographical history taking

Often an individual’s biography can help nurses fill in the gaps about a patient and his or her family, allowing interactions to be person-centred. Information gathered from even the most basic of admission forms can be invaluable in helping to put an individual’s mind at ease or allay fears in the stressful first
days of hospital admission. Thereafter, a growing portfolio of personal information can give nurses an insight into the patient’s life, which can help to explain particular behaviours, promote understanding of the person and, ultimately, lead to individualised care. For example, nurses may become increasingly frustrated with a patient who has acute confusion and is repeatedly found emptying the ward linen cupboard and refolding the pillowcases. However, an occupational history obtained from a relative reveals that the woman used to work in a hotel laundry. Insight like this is invaluable if nurses are to gain greater understanding of patients’ challenging behaviour.

Acquiring aesthetic knowledge is understandably difficult for a novice practitioner. Indeed, by analysing simulated situations of history taking by nursing students, McKenna et al. (2010) identified that students lacked confidence in even simple interpersonal skills (such as opening and closing a conversation), what to ask and how to pick up significant cues embedded in interactions. However, McKenna et al. (2010) demonstrated that the use of a simulated learning environment allowed students the time to engage with patients and develop these skills. However, it was also noted that the opportunities and time required to develop such skills are rare in clinical practice.

**Complete time out activity 5**

**Role of family members**

Family members may be an important source of information when taking a patient history. They can sometimes offer insight that cannot be gained from patients who may be acutely unwell, in pain or cognitively impaired. Nurses need to balance the benefits of obtaining information from family members with the potentially conflicting motivations of patients and their families. Sometimes these differences are not immediately obvious and it is only through repeated interaction with both the patient and family members, as well as skilled questioning, that nurses may come to understand differences in opinion.

**Challenge of history taking**

Whether history taking is focused on establishing a diagnosis, supporting an individual who has received a diagnosis or achieving insight and understanding of a patient’s unique experience, the complexity of this process should not be underestimated. The novice practitioner does not necessarily acquire history-taking skills easily (McKenna et al. 2010). Eliciting a comprehensive patient history can be fraught with uncertainty and the process does not always conform to what Schön (1983) described as the technical rationality often associated with biomedical knowledge. Rather, patient histories can be viewed as a ‘swampy lowland where situations are confusing “messes” incapable of technical solution’ (Schön 1983). Carper (1978) perceived history taking as requiring not only the personal knowledge of an authentic relationship, but also aesthetic knowledge whereby the nurse vicariously experiences the patient’s feelings.

Fostering history taking skills

Lloyd and Craig (2007) and Douglas et al. (2009) give clear and systematic guidelines for taking a comprehensive patient history (Box 3). The importance of effective communication in history taking is evident in both medical and nursing curricula. This is particularly important in cases where taking a patient history may be more challenging. McKenna et al. (2010) highlighted the difficulty of acquiring and developing such skills, and recommended simulated learning opportunities. As commendable as this is, the importance of fostering these skills in practice settings cannot be overstated.

Support offered by student mentors is crucial because they can act as role models, highlighting best practice, creating learning experiences, encouraging questioning and reflection, and providing supportive and constructive feedback. In this way, the novice practitioner can develop key skills in history taking. The notion of peer-assisted learning can also encourage students to support each other and learn through shared experiences. This should always be overseen by experienced nurses. However, for such skills to be fostered and enhanced, the importance of history taking as a skill should be recognised and evident both in educational curricula and the clinical learning environment.

**Complete time out activities 5 and 6**

**Conclusion**

History taking is a key component of patient assessment and is used to identify care priorities and plan care. Although history
Learning zone  patient assessment

**BOX 3**

**Guidelines for taking a patient history**

1. Establish a rapport with the patient and his or her family, including preparation of oneself and the environment.
2. Gather information on:
   - The patient’s overall health status.
   - The current concern, using both open and closed questions.
   - Symptoms experienced and how they have been managed.
   - Medical history, emotional health and medication.
   - Family and social history.
   - Systematic enquiry using systems of the body and activities of daily living.
   - The patient’s perception of his or her wellbeing.
   - The family’s perspective.
3. Closure, with rapport maintained.

(Lloyd and Craig 2007; Douglas et al 2009)

Taking was viewed as the remit of medical colleagues, it is now increasingly undertaken by nurses. History taking that covers medical, social, psychological and biographical aspects is recommended to gain a comprehensive insight into the patient’s health problems and specific care needs. In this way, care can be prioritised and patient outcomes optimised.

Changes in the NHS have brought history taking to the forefront of nursing, with nurses expected to develop history-taking skills aimed at diagnosis and development of person-centred care. There remains, in all healthcare professions, a need for excellent communication skills, which should be specifically fostered to ensure that history taking in any context is both holistic and effective in achieving its purpose NS Complete time out activity.

**References**


Eisenberg L (1977) Disease and illness: distinction between professional and popular ideas of sickness. *Culture Medicine and Psychiatry* 1, 1, 9-23.


Is history taking a dying skill? An exploration using a simulated learning environment. *Nursing Education in Practice* 11, 4, 234-238.


