



# Complete Health History

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# Nursing Health History

- It is the systematic collection of subjective data that is used for determining a client's functional health pattern status for the purpose of nursing diagnosis.
- It is also a chronological and detailed health record of a client.


# Cont...d

- Purpose of health history;
  - To collect subjective data.
  - To form data base (with objective and laboratory data).
  - To make judgement or diagnosis.

# Systemic approach hx taking

- Forms vary, but most forms contain the following information.
  1. Biographical data
  2. Chief complaint
  3. History of present illness

# Cont...d

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4. History of past illness
  5. Family history
  6. Review of systems

# 1. Biographical data

- Date – in rapidly changing.
- Identifying data- name, age, sex, race, ethnicity, birthplace, occupation, marital status, etc.
- Source of referral.
- Source of history.

## 2. Chief complaint

- Reason for seeking care.
- Patient own words, enclosed in quotation mark to indicate the client's exact word.
- One or two symptoms and there duration.
- Does not include wellness need.
- Not attempt to develop nursing diagnosis.

# 3. History of present illness

- The amplification of the chief complaint.
- Short for well person, general state of health.
- For ill person it includes chronological record of eight critical characteristics.



# Cont...d

- Location-radiating Vs localized
- Quality (character)-burning, aching, e.t.c
- Quantity (severity)- volume, number and size, e.t.c
- Timing (onset, duration and frequency)

# Cont...d

- Setting
- Aggravating or relieving factors
- Associated manifestations
- Clients perception-meaning of symptoms to the client

# 4. History of past illness

- Childhood illnesses
- Accident or injuries
- Serious or chronic illness
- Hospitalization
- Operations
- Obstetric history

# 5. Family history

- Age and health status of the mother, father, and each of the siblings, or the age at death and cause.
- Have genetic significance for the client.
- Construct family tree, or genogram to show this information.

# 6. Review of systems

- Purpose;
  - To evaluate the past and present health status of each body system.
  - To double check in case any significant data were omitted in the present illness section.

# Cont...d

- Order of examination-head to toe.
- Avoid writing negative, positive, normal, and abnormal.
- Record just for the presence or absence of symptoms.

# Cont...d

- General:

- Ask for usual wt., recent wt. changes, weakness, fatigue, fever, chills, e.t.c.

- Skin:

- Ask for rashes, lumps, sores, itching, dryness, color change, changes in hair or nails, e.t.c

# Cont...d

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- Head:

- Ask for headache, head injury, e.t.c.

- Eyes:

- Ask for vision, glasses, contact lenses, pain, changes in color, tearing, double vision, blurring of vision, spots, flashing of flights, glaucoma, and cataracts.



# Cont...d

- ● ● ●
- Ears:

- Ask for hearing, tinnitus, vertigo, earaches, infection, discharge. If hearing is decreased, use of hearing aids.

- Nose and sinuses:

- Ask for frequent colds, nasal stuffiness, discharge or itching, bleeding, sinus trouble.

# Cont...d

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- Mouth and throat:
  - Ask for conditions of teeth and gums, bleeding gums, sore tongue, dry mouth, frequent sore throat, hoarseness.
- Neck:
  - Ask for lumps, swollen glands, goiter, pain or stiffness in the neck.

# Cont...d

- Breasts:

- Ask for lumps, pain or discomfort, nipple discharge, self –examination.

- Respiratory:

- Ask for cough, sputum, hemoptysis, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy, chest pain, shortness of breath, cyanosis.

# Cont...d

- Cardiovascular:

- Ask for edema, rheumatic fever, leg cramps, varicose veins, dyspnea (degree of exercise tolerance), palpitation, orthopnea (number of pillows required), paroxysmal nocturnal dyspnea, chest pain, syncope, strider, hypertension.

# Cont...d

- Peripheral vascular:
  - Ask for coldness, numbness, tingling, leg swelling, hand or feet discoloration, varicose vein or ulcer.

# Cont...d

- Gastrointestinal tract:
  - Ask for appetite, nausea, vomiting, dysphagia, heart burn, food idiosyncrasy, abdominal pain, bowel habits, jaundice, hemorrhoids, bloody, tarry or clay colored stool, hepatitis.

# Cont...d

- Urinary system:
  - Ask for flank pain ( steady, colicky, etc.) frequency, dysuria, urgency, hesitancy, hematuria, pyuria, incontinence, e.t.c.
- Genital system:
  - STIs, menstrual history (menarche, interval between periods, duration and

# Cont...d

- amount of flow, intermenstrual bleeding or discharge, post coital bleeding), dyspareunia, menopause, postmenopausal symptoms, penis or testicular pain, sore or lesion, penile discharge, lumps or hernia, e.t.c.



# Cont...d

- Musculoskeletal:
  - Ask for muscle or joint pain, stiffness, arthritis, backache.
- Neurologic:
  - Ask for fainting, black outs, seizures, weakness, paralysis, numbness or loss of sensation, tingling, involuntary movement

# Cont...d

- (tremors, tics, fasciculation), poor memory, lack of orientation.
- Endocrine:
  - Heat or cold intolerance, excessive sweating, diabetes (diagnosed), excessive thirst or hunger, polyuria.

# Functional health pattern approach

- Use of the functional health pattern framework for assessment assists the nurse in differentiating between area for independent nursing intervention and areas requiring collaboration or referral.

# 1. Health perception and Health management pattern

- Description of health (usual); description of present illness (onset, course, treatment).
- Relevance of health to activities.
- Preventive measures; general health care behavior.
- Previous hospitalization, expectation of this hospitalization.
- Potential self care problems.

## 2. Nutritional and Metabolic pattern

- Usual food and fluid intake, appetite.
- Daily eating times
- Recent weight change and reason
- Food restriction or preference, food supplements.
- Swallowing, chewing, eating problems, food allergies.

# Cont...d

- Skin lesion, and general ability to heal.
- Condition of skin, hair, nails, mucus membrane, and teeth.
- Temperature, pulse, respiration, height, weight.

# 3. Elimination pattern

- Bowel-usual time, frequency, colour, consistency.
- Assistive device ( laxatives, suppositories, enemas).
- Constipation diarrhea.
- Bladder-usual frequency, problems with dysuria, or polyuria.
- Skin condition-color, temperature.
- Turgor-lesion, edema, pruritus.

# 4. Activity and Exercise pattern

- Exercise
- Activity
- Leisure
- Recreation pattern
- Limitation in activities of daily living



# 5. Sleep and Rest pattern

- Usual sleep routine
- Sleep pattern
- Perception of quality sleep
- Perception quantity of sleep

## 6. Cognitive and Perceptual pattern

- Sensory adequacy-hearing, sight, smell, touch and taste.
- Prosthetic device (glasses, hearing aids).
- Pain, problem with vertigo.
- Heat or cold sensitivity.
- Language, understanding ,memory abilities.

## 7. Self perception and Self concept pattern

- Self description
- Effect of illness on self
- Perception, body image, identity, self-esteem
- Posture, eye contact, voice and speech patterns

# 8. Role and Relationship pattern

- Life roles and responsibilities.
- Satisfaction and dissatisfaction in family, work, and social relationships.

## 9. Sexuality and Reproductive pattern



- Sexuality patterns; satisfaction or dissatisfaction with sexual patterns.
- Adequate of sexual knowledge.
- Reproductive state (female premenopausal or post menopausal)

# 10. Coping and Stress Tolerance pattern

- General coping strategies
- Stress tolerance
- Stress reduction behaviors
- Support systems
- Ability to manage situations

# 11. Value and Belief pattern

- Values, goals; belief that are basis for decisions
- Value or belief conflict
- Spiritual practices



**Thank you for your attention!!!**