

Jacqueline Rhoads  
Sandra Wiggins Petersen

# Advanced Health Assessment *and* Diagnostic Reasoning

THIRD EDITION



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# Preface

Daily life activities place physical and emotional demands on people and expose them to a wide variety of diseases and conditions. Consequently, the healthcare provider must be prepared to diagnose and treat a variety of disorders. Health assessment is a complex process, yet many assessment texts address only the physical examination component in any real depth. We developed *Advanced Health Assessment and Diagnostic Reasoning* to include each step of health assessment, demonstrating the links between health history and physical examination and illustrating the diagnostic reasoning process. We wanted to fill in the missing piece in most basic physical examination texts—the thought process one must assume as one assesses an actual case.

Advanced health assessment involves determining existing conditions, assessing capabilities, and screening for disease or other factors predisposing a patient to illness. A thorough health history and physical examination are necessary to correctly diagnose existing conditions and detect risk for other conditions. This text provides the healthcare provider with the essential data needed to formulate a diagnosis and treatment plan.

## Organization of the Text

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This text provides three introductory chapters that cover general strategies for health—history taking, physical examination, and documentation. The remainder of the text consists of clinical chapters covering assessment of various systemic disorders (e.g., gastrointestinal, cardiovascular, musculoskeletal, etc.). Each clinical chapter includes the following sections:

### **Anatomy and Physiology Review**

#### **Health History**

- History of Present Illness
- Past Medical History
- Family History
- Social History
- Review of Systems

#### **Physical Examination**

- Equipment Needed
- Components of the Physical Exam
- Inspection
- Palpation
- Percussion
- Auscultation



**Diagnostic Reasoning****Assessment of Special Populations**

Considerations for the Pregnant Patient

Considerations for the Neonatal Patient

Considerations for the Pediatric Patient

Considerations for the Geriatric Patient

**Case Study Review**

Chief Complaint

Information Gathered During the Interview

**Key Features**

---

Content in this text is presented in a way that is easy to follow and retain. It is also presented so that all of the pieces of assessment “fit together.” Aspects of the health history are given in a two-column format: The first column gives the type of information that the provider should obtain, while the second column provides specific questions or information to note. The second column also takes matters a step further—it gives examples of which conditions the findings may indicate. Aspects of the physical examination are also given in a two-column format: action and rationale. The first (action) column gives the actions clinicians should take (with appropriate steps or strategies), and the second (rationale) column lists normal and abnormal findings and, as applicable, possible indications/diagnoses associated with those findings. To further demonstrate diagnostic reasoning, every clinical chapter contains a “Differential Diagnosis of Common Disorders” table, which summarizes significant findings in the history and physical exam and gives pertinent diagnostic tests for common disorders.

To demonstrate how various aspects of health assessment are applied, a case study is integrated into the chapter (e.g., the case patient’s social history is presented with the general social history content). A case study review concludes the chapter; it recounts the patient’s history and provides sample documentation of the history and physical examination. The sample documentation familiarizes students with proper and complete documentation and use of forms. The case study is complete with a final assessment finding, or diagnosis.

Every clinical chapter also includes “Assessment of Special Populations.” This section highlights important information on assessing pregnant, neonatal, pediatric, and geriatric patients.

## Acknowledgments

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We have looked forward to this opportunity to thank the many people who have been instrumental in the development of this text.

We offer a sincere thanks to the contributors and consultants who have worked so hard to make certain that every chapter covered essential content important to every healthcare provider and student. Without their contributions, this text would not have benefited from that special uniqueness that each of them possesses. We are truly fortunate to know them and to have had them play such a critical role in this project.

We wish to thank the peer reviewers who reviewed the chapters, ensuring that the content was valid and essential. Their extensive, constructive criticism enabled us to feel confident that all aspects of advanced assessment are addressed, making the text a scholarly peer-reviewed textbook.

We owe a heartfelt thanks to Rebecca Stephenson, Acquisitions Editor at Jones & Bartlett Learning. Without her encouragement and support, this third edition would not have happened. We would also like to thank Emma Huggard, Editorial Assistant, Juna Abrams, Associate Production Editor, Vanessa Richards, Production Editor, Brooke Haley, Production Assistant, Wes DeShano, Rights & Media Specialist, and Troy Liston, Media Development Editor.

## Publisher's Note

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The background features a light blue hexagonal grid pattern. Various medical icons are scattered throughout, including a microscope, test tubes, a pill, a cross, a globe, a virus, a wheelchair, and a network diagram. Text elements include 'MEDICAL' in several hexagons and a list of healthcare roles: 'Health Care', 'Doctor', 'Hospital', 'Pharmacist', 'Nurse', 'Dentist', 'First Aid', 'Surgeon', and 'Emergency'.

# Disclaimer

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Some drugs and medical devices presented in this publication have U.S. Food and Drug Administration (FDA) clearance for limited use in restricted research settings. It is the responsibility of the healthcare provider to ascertain the FDA status of each drug or device planned for use in his or her clinical practice.



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# Part 1

## Strategies for Effective Health Assessment

**CHAPTER 1** Interview and History Taking Strategies

**CHAPTER 2** Physical Examination Strategies

**CHAPTER 3** Documentation Strategies



# Chapter 1

Health Care  
Doctor  
Hospital  
Pharmacist  
Nurse  
Dentist  
First Aid  
Surgeon  
Emergency

## Interview and History Taking Strategies

*“In taking histories follow each line of thought, ask no leading questions. Never suggest. Give the patient’s own words in the complaint.”*

Sir William Osler (1849–1919) (Bean & Bean, 1968)

### Functions of the Interview and Health History

Interviewing and taking health histories serve five major functions:

1. Establishing the initial bond between provider and patient (**Figure 1-1**)
2. Laying the foundation for subsequent clinical decision making
3. Providing a legal record of the subjective and objective data (**Box 1-1**) elicited during the clinical interview, which drive clinical judgments
4. Fulfilling a critical component of the documentation required for third-party payer reimbursement for clinical services
5. Serving as an essential element in the peer review process for evaluation of clinical practice, such as application of evidence-based practice and identification of desired patient outcomes

As the primary goal of this text is to help the reader to develop expertise in advanced health assessment, this chapter will focus primarily on functions one and two. Legal and reimbursement

requirements mandate meticulous, comprehensive, and complete documentation of all the components of care, including patient teaching and counseling provided at each provider–patient encounter. These include not only the traditional face-to-face encounters, but also other means of care, such as interaction via e-mail and telephone. Meticulous and comprehensive, however, are not necessarily synonymous with lengthy. The skilled clinician strives to record all essential clinical data concisely and to document the clinical decision making that underlies diagnostic and treatment decisions. The objectives are to provide effective communication to all caregivers, to ensure continuity of high-quality care for the patient, to minimize legal vulnerability for the provider, and to maximize reimbursement for clinical services. From a legal perspective, what is not recorded has not been done. Documentation validates performance (see Chapter 3 for further discussion of documentation).



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**FIGURE 1-1** The interview lays the foundation for the provider–patient relationship.

**BOX 1-1 SUBJECTIVE AND OBJECTIVE DATA**

*Subjective data* are the information that the patient or other informant provides during the health history. They are so called because they reflect the patient's perception and recall of his current health need(s) and past health. Perception and recall are subject to many influences that make the information less quantifiable and open to multiple interpretations.

In contrast, *objective data* are measurable and verifiable, such as test results and physical examination findings.

Both types of data are subject to error, and both are critical to the caregiving process. Our perceptions filter all our experiences and significantly influence our behavior. Successful patient outcomes are dependent upon successfully integrating both subjective and objective data to formulate individualized plans of care to which the patient will adhere. The health history contains predominantly subjective data. Data, such as test results or copies of past medical examinations, supplement the information that the patient provides during the interview. The combination of subjective and objective data constitutes the patient's database.

## Interviewing

### Establishing and Maintaining a Relationship with the Patient

Building a sound provider–patient relationship is essential to effective clinical management of patients with complex health and illness needs. Mutual trust is a critical element in the relationship. Also important is the ethical principle of autonomy, which places ultimate healthcare decision making in the hands of the patient. The ability to exercise self-determination is greatly facilitated by clinicians who actively seek to engage their patients as true partners in the caregiving process. The old adage—knowledge is power—is the key to patient empowerment. Patients must feel involved in their health care. How the clinician conducts the initial health history and subsequent data collection interviews exerts a profound influence on the nature of the provider–patient relationship. The clinician and patient form a dyad. In order to guide the patient's decision-making processes and to facilitate adherence to therapeutic interventions, the clinician and the patient must form an ongoing partnership built on mutual trust and respect for the patient's active role in making healthcare decisions.

### Providing Culturally Competent Care

Patient populations are becoming increasingly diverse. *Healthy People 2020*, the fourth report of the United States Department of Health and Human Services on the health of the American people, presents compelling evidence of the relationship between ethnicity, socioeconomic status, and health. This document focuses on two overarching health initiatives.

1. Determinants of health and health disparities: "Biological, social, economic, and environmental factors—and their interrelationships—influence the ability of individuals and communities to make progress on these indicators. Addressing these determinants is key to improving population health, eliminating health disparities, and meeting the overarching goals of *Healthy People 2020*." (U.S. Department of Health and Human Services, 2014)
2. Health across life stages: "[U]sing a life stages perspective this initiative recognizes that specific risk factors and determinants of health vary across the life span. Health and disease result from the accumulation (over time) of the effects of risk factors and determinants. Intervening at specific points in the life course can help reduce risk factors and promote health. The life stages perspective addresses 1 of the 4 overarching goals of *Healthy People 2020*: 'Promote quality life, healthy development, and health behaviors across all life stages.'" (U.S. Department of Health and Human Services, 2010)

Achieving these goals will necessitate addressing the social determinants of health, making our healthcare delivery system more linguistically and culturally appropriate, and increasing the ability of practitioners to deliver culturally congruent care.

Diverse patient populations present significant challenges to both clinicians and healthcare organizations. As third-party payers and regulatory bodies increasingly look to clinical outcomes data

to measure the performance of individual providers and institutions, the impact of culture on standards of care will be profound. New and emerging patient populations represent a kaleidoscopic image of healthcare beliefs, values, and practices—“Equal care cannot be defined as the same care in a culturally diverse society because this care will not be considered equally good or appropriate by all patients” (Salimbene, 1999, p. 24).

In addition to meeting the social contract to provide high-quality health care to all patients, clinicians must develop caregiving skills that are culturally congruent, and which reflect therapeutic interventions that take into account the patient’s socioeconomic status. History taking is often the first encounter between patient and provider. Cultural competence requires knowledge of the beliefs, values, and practices of the patient populations being served, as well as willingness on the part of the provider to openly reflect on the impact that his or her own attitudes, beliefs, and behaviors have upon the caregiving process.

Ethnocentrism, the belief in the superiority of one’s own beliefs and values, is a major barrier to establishing effective patient–provider relationships. Similarly, ignorance of a cultural group’s norms may lead to a negative interpretation of well-meaning caregiver behaviors. These norms include beliefs about personal space, definitions of health, communication, and eye contact, as well as who makes healthcare decisions. Many well-intentioned caregivers breach these norms out of ignorance, thereby adversely affecting the development of patient trust and adherence to treatment interventions. For example, many Western caregivers consider direct eye contact as indicative of a patient’s forthrightness and honesty. They may interpret a patient’s failure to engage and maintain eye contact as an indication that he may have something to hide. In many cultures, it is considered disrespectful to look directly at an authority figure.

Through the use of cross-cultural theoretical models, the application of relevant research findings, and valuing of our ethnically diverse patients as teachers about their cultures, the caregiver who is committed to providing culturally competent care will come to understand each culture’s world view from an *emic*, or native, perspective (Jones, Bond, & Cason, 1998). Many excellent resources have been developed to assist clinicians to become more culturally competent as caregivers. Resources for providing culturally competent care are given at the end of the chapter.

### Overcoming Difficulties in Provider–Patient Relationships

---

Some patient relationships will challenge the provider from their onset, such as initial encounters with patients who are angry or hostile. Even when a strong alliance has been established between the provider and the patient, critical events in the caregiving process and/or the influence of significant others may challenge the stability and effectiveness of the relationship. For example, Platt and Gordon (2004) refer to a phenomenon known as the Two Patient Syndrome in which a family member or significant other serves as the translator for the patient. In such a situation, the answers to the provider’s questions may reflect the translator’s perceptions of the patient’s healthcare needs, status, and goals, rather than those of the patient, especially if the family member or significant other is also the primary caregiver for the patient. Similarly, adverse clinical phenomena such as unexpected fetal loss, chronic pain that is unresponsive to treatment, or the need to inform the patient and family of a terminal diagnosis will test the strength of the most well-established provider–patient relationship.

### Recognizing and Reacting to Communication Barriers

In order to successfully navigate challenging situations, recognize the feelings/behaviors being manifested by the patient (e.g., sadness, fear, anxiety, anger, hostility). Recognition requires that the provider be an attentive listener and observer and that he or she take the time to reflect and process what he or she sees and hears. Recognition often begins with a perception of distance or strained communication in a relationship that has previously been characterized by warmth and a free flow of communication. When this occurs, stop the usual routine of the visit and share these perceptions with the patient. Identify the perceived behavior or effect and seek the patient’s confirmation as to the accuracy of these observations. If the nature and source of the patient’s behavior are still unclear, reassure the patient that you have listened to him or her but remain confused about why he or she feels the way he or she does. Ask the patient to help you to better understand what he or she is experiencing. Do NOT become argumentative and defensive.

Acknowledge and validate the patient's feelings as appropriate through the use of statements that convey understanding and concern, such as "I can see where that would be very frightening. Do you feel any better now?" Demonstrate empathy (**Figure 1-2**). Coulehan and Block (1997) define empathy as "a type of understanding. It is not an emotional state of feeling sympathetic or sorry for someone. . .being empathic means listening to the total communication—words, feelings, and gestures—and letting the patient know that you are really hearing what she is saying" (p. 6). For most if not all challenges to provider–patient relationships, there is no quick fix, and attempts to implement one are usually perceived by the patient as being dismissive of her or his feelings, thereby disrupting the relationship even more. Support and understanding are essential to building and maintaining a relationship.

Touch may help convey understanding. If it is culturally appropriate and the situation warrants such an action, as in the loss of a loved one or when delivering an unfavorable prognosis, touch can be very therapeutic.

Demonstrate hope. This is particularly important in situations involving poor prognoses. Although the eventual outcome may not be altered, the patient needs to know that the provider will not withdraw because cure is not an option, will remain a consistent source of support, and will help the patient to identify and achieve the life goals that are important in his or her remaining lifespan.

### Working with Resistant Patients

Patients who are resistant to therapeutic recommendations represent another challenge to provider–patient relationships. Such resistance often represents a failure of the provider to fully engage the patient as a partner in decisions about his or her health care. Cultural norms and patient ambivalence may also be major factors, as in patients who smoke. Smokers who have not experienced the negative health consequences of smoking often do not perceive themselves to be at risk, and their sociocultural environment may support continuation of this negative health behavior. The provider should continually assess the readiness of the patient to adopt or change a behavior or intervention and be ready to capitalize on any opportunity that may increase the patient's level of readiness. For example, a female smoker previously resistant to smoking cessation interventions may become very responsive if an abnormal Pap smear causes her to be sent for colposcopic examination and she learns about the relationship between smoking and cervical cancer. The grandmother who smokes and cares for her grandchild while his parents work may be resistant to quitting for her own health, but may do so to protect the health of her grandson (e.g., prevention of recurrent ear infections).

### Institutional Factors Affecting Patient–Provider Relationships

Most practitioners are employed by healthcare institutions. Many institutional factors affect patient–provider relationships. Cost containment has led to an ever-increasing emphasis on productivity. Increasing patient volume often decreases the time allotted for initial and follow-up patient visits. If the time allocated for the patient sessions is inadequate to obtain all of the necessary historical data, the patient can be asked to complete a linguistically appropriate (appropriate to the patient's primary language) health history form before being seen by the provider.

Prioritization of data collection is essential and is determined by the patient's expressed reason for seeking care (chief complaint), as well as the presenting signs and symptoms. For example, although diet, exercise, and social history influence treatment decisions, past medical history and a focused review of systems take precedence in the acute phase of illness.



**FIGURE 1-2** A healthcare provider displays empathy as a patient discusses an upsetting matter.

## Taking a Health History

The health history lays the foundation for care. It guides the relative emphasis placed on each system in the physical examination and the formulation of differential diagnoses and treatment decisions. A weak foundation places the patient at risk for misdiagnosis and inadequate or erroneous treatment; it also identifies the clinician as one who does not practice within acceptable standards of care, making the clinician vulnerable to legal action.

### The Health History as a Vehicle for Patient Empowerment

Having the patient participate in developing his or her health history is a powerful tool for building a partnership between patient and provider. A well-designed, culturally and linguistically appropriate health history form helps to move the patient from passive responder to active collaborator in developing the personal database that will drive future decisions about his or her care. It also begins the patient education process. The form requires the patient to complete a review of past and current health and to reflect on the potential impact of healthcare behaviors, beliefs, and values upon his or her health status. Engaging a patient in this reflective process helps to give a sense of ownership over his or her healthcare data and primes receptivity to future patient education.

The ultimate goal of all health care is to maximize the health and well-being of the patient. Whether this involves health maintenance and disease prevention or the actual treatment of a medical or surgical condition, many patients will be asked to make major, sustained changes to their current behaviors in order to acquire or sustain their desired level of health. Adherence to a therapeutic regimen is influenced by multiple factors, including the patient's perception of the severity of the need or condition and the costs–benefits associated with adherence. By actively involving the patient in the development and analysis of a personal health history, the clinician lays the groundwork for active participation in identifying healthcare goals and in designing a culturally congruent plan of care. An ongoing, collaborative process supports patient autonomy, enhances adherence, and increases the likelihood of achieving desired clinical outcomes. Strategies for performing an effective interview and health history are outlined in **Box 1-2**.

#### BOX 1-2 INTERVIEWING AND HISTORY TAKING POINTERS

The interview and health history lay the foundation for effective patient care. Remember the following tips when conducting the interview and health history:

- Demonstrate professional appearance and behavior. Unkempt, overly casual or inappropriate dress, and/or unprofessional behavior do not inspire confidence.
- Provide for privacy. Health histories contain highly confidential information and should be obtained in settings that maximize the patient's privacy. Adolescents and patients who have engaged in behaviors that may be viewed as socially unacceptable may be particularly reluctant to share information. Try to conduct a portion of the adolescent's health history without the presence of a parent or guardian, especially when exploring sensitive areas such as sexuality, drug and/or alcohol use, etc.
- Provide a quiet and nondistracting environment wherever possible. Distractions include provider behaviors such as answering the telephone and pagers. Unless it is essential to your professional role, turn off cell phones and electronic pagers and do not interrupt the flow of the patient's history by answering the telephone.
- Address the patient by the appropriate title (Mr., Mrs., Ms.).
- Always introduce yourself to a new patient and identify your role. For example: "I'm Ms. Rogers, a nurse practitioner. . ."
- Request the patient's permission to conduct the health history.
- Try to obtain historical data with the patient fully clothed. Clothing is important to a sense of personal integrity and identity. Initial appearance may also give the examiner valuable cultural and diagnostic clues.
- Position yourself at the same level as the patient to avoid establishing the provider as being dominant in the relationship (**Figure 1-3**). Similarly, respect cultural norms about personal space and eye contact.



**FIGURE 1-3** The healthcare provider positions herself at eye level with the patient, maintaining eye contact.

- Recognize potential biases that may adversely affect your ability to elicit an accurate and complete health history (e.g., ageism or gender bias).
- Observe the patient for any sensory deficits such as hearing or visual loss and adjust your interviewing techniques and positioning accordingly. When interviewing patients with hearing loss, position yourself so that the patient can see your face and speak more loudly and more slowly.
- Prioritize information needs to maximize conservation of the patient's physical and emotional resources. Patients in pain or acute stress require special consideration.
- Know and respect the cultural norms and values of individual patients and adjust interviewing techniques accordingly. Do not impose cultural norms on the interviewee.
- If language barriers necessitate using a translator, address the questions to the patient, not the translator, and allow adequate time for the translation and response.
- Ask the patient if it is acceptable if you take *brief* notes during the interview. Explain that the health history contains critical information that will influence decisions about care and that it is important not to miss any vital piece of information; however, be judicious in note taking. Do not become so focused on recording the data that you cease to relate to the patient.
- Assure the patient that all of the information that is provided will be kept confidential and used as a basis for care decisions. If the information provided by the patient will be used for other purposes, such as to obtain third-party reimbursement, the patient or parent/guardian must be asked to sign a release authorizing approval for these additional uses of privileged healthcare data.
- Use open-ended questions, whenever possible, to elicit information during the history taking interview. Do NOT suggest symptoms or descriptors to the patient and/or informant, especially in the initial portion of obtaining the history of present illness (HPI). Ask the patient to describe the illness in his or her own words. How and what he or she focuses on gives valuable insight into the patient's perception of the relative importance of the symptoms the patient is experiencing. If additional data are needed after the patient has responded to open-ended questions, ask specific questions to obtain more detail. Avoid asking questions that suggest a particular response or that can be answered with a simple yes or no. The following is an example of *inappropriate* questioning: Would you describe your pain as sharp and stabbing or dull and achy?
- Help patients to become partners in the caregiving process. Ask about their healthcare goals and expectations about their care.

- Give the patient adequate time to respond; do not create a hurried atmosphere, especially when eliciting sensitive information.
- Do not use technical terms or medical jargon. Every health history presents an opportunity for patient education. Give your explanations in language that the patient can comprehend and use.
- Be an attentive, nonjudgmental listener and an alert observer throughout the health history. Do not interrupt prematurely, and control an urge to fill every pause or silence with another question. Give the patient time to reflect on her or his answers to your questions before intervening with a prompt or a direct question. When a prompt is necessary, often a simple statement of support, such as “Please continue,” will encourage a patient to reveal additional information that facilitates clinical decision making.
- Observe nonverbal behaviors throughout the interview, such as significant affective and postural changes. These often occur in areas of the health history that contain sensitive information that requires more in-depth exploration.
- Acknowledge the value of the patient’s information through the use of supportive statements during and at the end of the clinical interview. A statement such as “Mr. Jones, you have provided a very clear picture of your symptoms. This will help us to make much wiser choices about what tests to order,” speaks to partnership and communicates how much the clinician values and relies on the quality of the information provided by the patient. If mechanisms have been set up at your institution to safeguard the electronic transmission of information, you may also want to invite the patient to e-mail you any additional information pertinent to his or her care that he or she may have forgotten to mention during the health history. Follow-up telephone communication is also an option, provided similar safeguards are in place.
- Validate your perceptions when the patient has completed telling you a piece of information or expressed a particular healthcare preference. Verbally summarize your understanding of the data and ask the patient if that is an accurate portrayal of the information that she or he has provided.
- If the interview yields contradictory information, revisit earlier areas of inquiry to check for consistency of response and/or ask the patient to clarify your perceptions.
- Beware of prematurely cutting off a line of diagnostic inquiry. Although a patient’s presenting symptoms may strongly suggest a particular diagnosis, failure to adequately explore alternative explanations may cause the clinician to falsely reject an important differential diagnosis.

## Types of Health Histories

Health histories are of two types: comprehensive and focused.

### Comprehensive Health History

A comprehensive health history should be performed on all nonemergent, new patients who will be receiving ongoing primary care from a particular provider or group of clinicians. Comprehensive health histories contain all of the following elements:

- **Patient identifiers.** These include name, gender, age, ethnicity, occupation, source of referral, and date and time of the clinical encounter.
- **Reliability.** It is particularly critical to assess the reliability of the individual providing the historical data. In most instances, it will be the actual patient. However, in some clinical situations (e.g., patients with severe trauma, the very elderly, children), a person other than the patient will provide all or most of the data. It is imperative that the clinician identifies the source(s) of the data and records her or his judgment about the reliability of the information provided. For example, a clinician might record the following statement: Reliability—patient has difficulty describing the severity and progression of his symptoms and uses contradictory terms to describe the character of the chest pain.

In some situations, assessment of the reliability of the information is complicated by language barriers. When a translator is required, the clinician should address questions to the patient and/or caregiver, not the translator, and should allow adequate time for the translator to reformulate the questions for the patient.

Additional factors may influence the reliability of the information presented, including such patient/informant emotions as fear and shame. The clinician should try to create a supportive, nonjudgmental interviewing environment, which will encourage full disclosure of health and social information by the patient.

- **Chief complaint (CC).** This term reflects a medical or problem-oriented focus to care. Many patients seek care for health maintenance/disease prevention reasons, for example well child visits. A more encompassing term is *reason for seeking care*.
- **History of present illness (HPI).**
- **Past medical history (PMI).**
- **Family history (FH).**
- **Social history (SH).**
- **Review of systems (ROS).**

### Focused Health History

A focused health history is performed in emergency situations and/or when the patient is already under the ongoing care of the clinician and presents with a specific problem-oriented complaint.

Focused histories include:

- **Identifying data.**
- **Chief complaint.**
- **History of present illness.**
- **Data from the patient's past medical history, family history, and social history that are pertinent to the chief complaint.**
- **Problem-oriented review of systems.** For example, a known adult patient complaining of substernal or epigastric pain would be asked questions related to the cardiovascular, respiratory, musculoskeletal, and gastrointestinal systems. Focusing attention on these systems would help the clinician to formulate and prioritize differential diagnoses based on the most likely origin of the patient's symptoms.

## Components of the Comprehensive Health History

### Chief Complaint

Use the patient's own words to describe the reason for her visit. Ask the patient to tell you why she has sought care: "*Mrs. Brown, what brings you to the office today?*" Record the patient's response using her actual words; do NOT rephrase the stated reason using medical terminology. For example:

**Correct:** I've had a runny nose and sore throat for 3 days.

**Incorrect:** Patient states that she has experienced coryza and pharyngitis × 3 days.

### History of Present Illness

These data represent an amplification of the patient's reason for seeking care. The thoroughness and quality of the data in the history of present illness are the driving forces in determining which systems the clinician will focus on in the review of systems and subsequent physical examination. This judgment requires that the clinician think critically in analyzing the data and apply evidence-based research findings.

The goal in obtaining the history of present illness is to get a comprehensive description of the characteristics and progression of symptoms for which the patient seeks care. For several decades, clinicians have used the mnemonic device **PQRST** to help ensure that all the necessary data are gathered regarding the patient's presenting symptoms:

<b>P:</b>	<i>precipitating</i> factors (What provokes the symptom?)
<b>Q:</b>	<i>quality</i> (Describe the character and location of symptoms.)
<b>R:</b>	<i>radiation</i> (Does the symptom radiate to other areas of the body?)
<b>S:</b>	<i>severity</i> (Ask the patient to quantify the symptom[s] on a scale of 0–10, with 0 being absence of the symptom and 10 being the most intense.)
<b>T:</b>	<i>timing</i> (Inquire about the onset, duration, frequency, etc.)