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describe the purpose of a health history enumerate the components of a health history discuss how culture age and ethnicity influence obtaining a health history demonstrates therapeutic communication when obtaining a health history obtain a comprehensive health history document the results of the health history 3 history of htn 4 years shown below it is useful to make an initial list simply 4 history of tah bso to keep track of all problems uncovered in the interview 5 history of peptic ulcer disease 1 9 in this list and exam 10 13 6 penicillin allergy 7 fh of early ascvd 8 epigastric pain 9 low back pain 10 hypertension 11 comprehensive adult history and physical sample summative h p by m2 student this sample summative h p was written by a second year medical student from ucf com class of 2020 at the end of cop 2 while not perfect it best exemplifies the documentation skills students are expected and able to acquire by the end of p 2 organization assess the patient s functional status ability to complete the activities of daily living consider documentation of any important life experience such as military service religious affiliation and spiritual beliefs review of systems include patient s yes or no responses to all questions asked by system the history and physical documentation in a patient s medical record is completed by a health

care provider on admission to a health care agency it is very similar to the health history obtained by a nurse and is helpful to read when caring for a patient for an overview of their treatment plan a medical history typically follows the history of the present illness if obtained by the treating clinician the medical history can reveal diagnosed medical conditions past medical conditions and potential future health risks for the patient updated on sep 1 2023 a comprehensive medical history is vital for an accurate diagnosis developing personalized treatment plans and establishing a good rapport with your patients on today s osmosis blog let s take note of some helpful tips for recording a high quality medical history the centers for medicare and medicaid services cms documentation guidelines for evaluation and management services have four history levels each of which comprises four elements 1 to qualify for a given history level certain elements are required as depicted in table 1 guidelines for medical record documentation consistent current and complete documentation in the medical record is an essential component of quality patient care the following 21 elements reflect a set of commonly accepted standards for medical record documentation documentation of each patient encounter should include at minimum the reason for the visit relevant history physical exam findings and prior diagnostic test results assessment clinical impression or diagnosis plan for care and date and legible identity of the observer the purpose of obtaining a health history is to gather subjective data from the patient and or the patient s family so that the health care team and the patient can collaboratively create a plan that will promote health address acute health problems and minimize chronic health

conditions information obtained during a health history interview is typically documented on agency specific forms see chapter resources a for a sample health history form used for documentation purposes 1 enumerate the components of a health history 2 describe how the nursing process guides the structure of a health history 3 discuss how culture age and ethnicity influence obtaining a health history 4 demonstrates therapeutic communication when obtaining a health history 5 obtain a comprehensive health history 6 the pain was described as heavy and toothache like it was not noted to radiate nor increase with exertion she denied nausea vomiting diaphoresis palpitations dizziness or loss of consciousness she took 2 tablespoon of antacid without relief but did manage to fall sleep the documentation template includes the following sections chief complaint history of present illness review of systems sexual assault annual screening questionnaire and health literacy assessment artifact type smart documentation form creation date mon 03 26 2018 12 00 version 1 0 unique identifier the review of systems and the past family and or social history may be recorded by ancillary staff or on a form completed by the patient to document that the physician reviewed the what is documentation and why is it important medical record documentation is required to record pertinent facts findings and observations about an individual s health history including past and present illnesses examinations tests treatments and outcomes history and physical examination h p examples the links below are to actual h ps written by unc students during their inpatient clerkship rotations the students have granted permission to have these h ps posted on the website as examples h p 1 specific

details from the history raise the probability of different diagnoses and direct further tests in a productive manner further diagnostic investigations imaging blood tests pulmonary function studies and even parts of the physical examination depend on the history doi 10 12968 bjon 2017 26 18 1033 abstract taking a comprehensive health history is a core competency of the advanced nursing role the purpose of the health history is to source important and intimate knowledge about the patient and allow the nurse and patient to establish a therapeutic relationship

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assess the patient s functional status ability to complete the activities of daily living consider documentation of any important life experience such as military service religious affiliation and spiritual beliefs review of systems include patient s yes or no responses to all questions asked by system

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the history and physical documentation in a patient s medical record is completed by a health care provider on admission to a health care agency it is very similar to the health history obtained by a nurse and is helpful to read when caring for a patient for an overview of their treatment plan

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documentation of each patient encounter should include at minimum the reason for the visit relevant history physical exam findings and prior diagnostic test results assessment clinical impression or diagnosis plan for care and date and legible identity of the observer

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the purpose of obtaining a health history is to gather subjective data from the patient and or the patient s family so that the health care team and the patient can collaboratively create a plan that will promote health address acute health problems and minimize chronic health conditions

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the pain was described as heavy and toothache like it was not noted to radiate nor increase with exertion she denied nausea vomiting diaphoresis palpitations dizziness or loss of consciousness she took 2 tablespoon of antacid without relief but did manage to fall sleep

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the documentation template includes the following sections chief complaint history of present illness review of systems sexual assault annual screening questionnaire and health literacy assessment artifact type smart documentation form creation date mon 03 26 2018 12 00 version 1 0 unique identifier

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the review of systems and the past family and or social history may be recorded by ancillary staff or on a form completed by the patient to document that the physician reviewed the

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specific details from the history raise the probability of different diagnoses and direct further tests in a productive manner further diagnostic investigations imaging blood tests pulmonary

function studies and even parts of the physical examination depend on the history

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