2.1: Health History Introduction

Learning Objectives

- Establish a therapeutic nurse-patient relationship
- Use effective verbal and nonverbal communication techniques
- Collect health history data
- Modify assessment techniques to reflect variations across the life span and cultural variations
- Document actions and observations
- Recognize and report significant deviations from norms

“Sickness’ is what is happening to the patient. Listen to them.”[1]

The profession of nursing is defined by the American Nurses Association as “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations.”[2] Simply put, nurses treat human responses to health problems and/or life processes. Nurses look at each person holistically, including emotional, spiritual, psychosocial, and physical health needs. They also consider problems and issues that the person experiences as a part of a family and a community. To collect detailed information about a patient’s human response to illness and life processes, nurses perform a health history. A health history is part of the Assessment phase of the nursing process. It consists of using directed, focused interview questions and open-ended questions to obtain symptoms and perceptions from the patient about their illnesses, functioning, and life processes. While obtaining a health history, the nurse is also simultaneously performing a general survey. Visit the “General Survey Assessment” chapter more information.