2.2: Health History Basic Concepts

During a health history, the nurse collects subjective data from the patient, their caregivers, and/or family members using focused and open-ended questions. Before discussing the components of a health history, let’s review some important concepts related to assessment and communicating effectively with patients.

Subjective Versus Objective Data

Obtaining a patient’s health history is a component of the Assessment phase of the nursing process. Information obtained while performing a health history is called subjective data. **Subjective data** is information obtained from the patient and/or family members and can provide important cues about functioning and unmet needs requiring assistance. Subjective data is considered a **symptom** because it is something the patient reports. When documenting subjective data in a progress note, it should be included in quotation marks and start with verbiage such as, “The patient reports…” or “The patient’s wife states….” An example of subjective data is when the patient reports, “I feel dizzy.”

A patient is considered the **primary source** of subjective data. **Secondary sources** of data include information from the patient’s chart, family members, or other health care team members. Patients are often accompanied by their care partners. **Care partners** are family and friends who are involved in helping to care for the patient. For example, parents are care partners for children; spouses are often care partners for each other, and adult children are often care partners for their aging parents. When obtaining a health history, care partners may contribute important information related to the health and needs of the patient. If data is gathered from someone other than the patient, the nurse should document where the information is obtained.

**Objective data** is information observed through your senses of hearing, sight, smell, and touch while assessing the patient. Objective data is obtained during the physical examination component of the assessment process. Examples of objective data are vital signs, physical examination findings, and laboratory results. An example of objective data is
recording a blood pressure reading of 140/86. Subjective data and objective data are often recorded together during an assessment. For example, the symptom the patient reports, “I feel itchy all over,” is documented in association with the sign of an observed raised red rash located on the upper back and chest.

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**Addressing Barriers and Adapting Communication**

It is vital to establish rapport with a patient before asking questions about sensitive topics to obtain accurate data regarding the mental, emotional, and spiritual aspects of a patient’s condition. When interviewing a patient, also consider the patient’s developmental status and level of understanding. Ask one question at a time and allow adequate time for the patient to respond. If the patient does not provide an answer even with additional time, try rephrasing the question in a different way for improved understanding.

If any barriers to communication exist, adapt your communication to that patient’s specific needs. For more information about potential communication barriers and strategies for adapting communication, visit the “Communication” chapter in Open RN Nursing Fundamentals.

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**Cultural Safety**

It is important to conduct a health history in a culturally safe manner. Cultural safety refers to the creation of safe spaces for patients to interact with health professionals without judgment or discrimination. Focus on factors related to a person’s cultural background that may influence their health status. It is helpful to use an open-ended question to allow the patient to share what they believe to be important. For example, ask “I am interested in your cultural background as it relates to your health. Can you share with me what is important to know about your cultural background as part of your health care?”

If a patient’s primary language is not English, it is important to obtain a medical translator, as needed, prior to initiating the health history. The patient’s family member or care partner should not interpret for the patient. The patient may not want their care partner to be aware of their health problems or their care partner may not be familiar with correct medical terminology that can result in miscommunication.