2.3: Components of a Health History

The purpose of obtaining a health history is to gather subjective data from the patient and/or their care partners to collaboratively create a nursing care plan that will promote health and maximize functioning. A comprehensive health history is completed by a registered nurse and may not be delegated. It is typically done on admission to a health care agency or during the initial visit to a health care provider, and information is reviewed for accuracy and currency at subsequent admissions or visits.

A comprehensive health history investigates several areas:

- Demographic and biological data
- Reason for seeking health care
- Current and past medical history
- Family health history
- Functional health and activities of daily living
- Review of body systems

Each of these areas is further described in the following sections.

The “History and Physical” documentation in a patient’s electronic 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.