2.4: Health History

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. The health history is typically done on admission to hospital, but a health history may be taken whenever additional subjective information from the patient may be helpful to inform care (Wilson & Giddens, 2013).

Data gathered may be subjective or objective in nature. Subjective data is information reported by the patient and may include signs and symptoms described by the patient but not noticeable to others. Subjective data also includes demographic information, patient and family information about past and current medical conditions, and patient information about surgical procedures and social history. Objective data is information that the health care professional gathers during a physical examination and consists of information that can be seen, felt, smelled, or heard by the health care professional. Taken together, the data collected provides a health history that gives the health care professional an opportunity to assess health promotion practices and offer patient education (Stephen et al., 2012).

The hospital will have a form with assessment questions similar to the ones listed in Checklist 16.

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**Checklist 16: Health History Checklist**

*Disclaimer: Always review and follow your hospital policy regarding this specific skill.*
<table>
<thead>
<tr>
<th>Steps</th>
<th>Additional Information</th>
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| Determine the following: | • Source of history  
| 1. Biographical data | • Name  
| | • Age  
| | • Occupation (past or present)  
| | • Marital status/living arrangement |
| 2. Reason for seeking care and history of present health concern | • Chief complaint  
| | • Onset of present health concern  
| | • Duration  
| | • Course of the health concern  
| | • Signs, symptoms, and related problems  
| | • Medications or treatments used (ask how effective they were)  
| | • What aggravates this health concern  
| | • What alleviates the symptoms  
| | • What caused the health concern to occur  
| | • Related health concerns  
| | • How the concern has affected life and daily activities  
| | • Previous history and episodes of this condition |
| 3. Past health history | • Allergies (reaction)  
| | • Serious or chronic illness  
| | • Recent hospitalizations  
| | • Recent surgical procedures  
| | • Emotional or psychiatric problems (if pertinent)  
| | • Current medications: prescriptions, over-the-counter, herbal remedies  
| | • Drug/alcohol consumption |
| 4. Family history | • Pertinent health status of family members |
| 5. Functional assessment (including activities of daily living) | • Pertinent family history of heart disease, lung disease, cancer, hypertension, diabetes, tuberculosis, arthritis, neurological disease, obesity, mental illness, genetic disorders  
• Activity/exercise, leisure and recreational activities (assess for falls risk)  
• Sleep/rest  
• Nutrition/elimination  
• Interpersonal relationships/resources  
• Coping and stress management  
• Occupational/environmental hazards |
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<tr>
<td>6. Developmental tasks</td>
<td>• Current significant physical and psychosocial changes/issues</td>
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| 7. Cultural assessment | • Cultural/health-related beliefs and practices  
• Nutritional considerations related to culture  
• Social and community considerations  
• Religious affiliation/spiritual beliefs and/or practices  
• Language/communication |

Data source: Assessment Skill Checklists, 2014

**Critical Thinking Exercises**

1. You are taking a health history. Why is it important for you to obtain a complete description of the patient's present illness?

2. You are taking a health history. What is one reason it is important for you to obtain a complete description of the patient's lifestyle and exercise habits?