

## A DESCRIPTIVE ANALYSIS OF PATIENT HISTORY BASED ON ITS RELEVANCE

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### ABSTRACT

Patient history is information obtained from patients and other relevant sources on the possible course of their current illness. It is an integral component of a clinical encounter. Gathering information about medical history is critical for accurate and effective decisions. It is also an important tool in successful physician-patient interactions. A good patient history decreases the burden of an unnecessary laboratory test and healthcare expenditure. This article discusses different components of the patient history and highlights its importance in the accurate diagnosis of an illness.

**Keyword:** Patients; History; Review literature

### INTRODUCTION

Patient history is relevant information obtained from the patients and other sources on the natural history of the current illness. It is not only one of the most important tools to make an accurate diagnosis but also leading clue for the diagnostic utility (1). Patient interaction also fulfills an objective role in fostering a strong doctor-patient relationship. Good eye contact, shaking hands, and expressing active interest in the conversation helps to initiate an open communication and establishes mutual trust. (2)

### MATERIALS AND METHODS

This article discusses different components of a patient's' history and highlights its importance in patient care. We employed a literature search by going through different studies on 'PubMed' and 'Google Scholar.' Keywords used to search and find the

relevant articles include: "history taking" OR "patient history" OR "importance and techniques." The selected articles and journals were compiled based on our study objectives. Pertinent information's were collected and carefully analysed to identify different components of the patient history.

#### Essential components of patient history:

Patient history consists of various components that are useful to explore relevant information about the progression and subsequent evolution of the disease (Fig-1). Here, we discuss each of these components based on their significance.

#### 1.1 Chief complaint (CC):

CC is the key reason for the patient to seek medical attention. It typically follows patient demographics

and is a necessary foundation for the more elaborative succeeding history of the present illness. After the proper introduction, we can start inquiring about the CC with open questions like: "can you please tell me what brings you in today?" or "how may/can I help you?" or "what seems to be the problem?" CC needs to be concise and time constraints based on the chronological order of the particular symptoms. Usually, 2-3 chief complaints suffice in history, and the physician should be considerate to include them from their relevance.

### **1.2 History of the Presenting Illness (HPI):**

HPI is an effective tool in obtaining more comprehensive information about a particular complaint. It takes account of the onset, duration, character, and associated factors of the current illness. Patients are asked to describe the problems that brought them to the hospital using open-ended questions, such as: "please, tell me more about it."

Open-ended questions do not suggest the right answer, instead provides the patient a chance to express their concerns, including the symptoms and thoughts for their visit. They can be tailored to understand patient's statement. Contrary, leading or closed-ended questions or questions with options are beneficial when target information is warranted. They are also effective once a diagnosis is made and therapeutic options need a specific answer. However, closed-ended questions are limited due to response bias, and it is best to avoid them unless absolutely necessary (3).

### **1.3 Past Medical History (PMH):**

PMH is a composite picture of the preceding health status. It includes prior medical conditions, hospitalizations, surgeries, medications, known allergies, and immunizations. It is an essential component of complete patient history and helps a physician determine a change in a patient's state of health in comparison to the previous health condition. Without it, the physician can accidentally discontinue necessary medications, prescribe incorrect medications, and can skip lethal complications (4).

Appropriate communication skills are essential in collecting a detailed PMH. Use of an open-ended question is a useful technique in getting a complete

picture of the patient's illness. Questions like, "please, tell me about any major illnesses you have had" may assist physicians in many clinical scenarios. It is essential to ask for a complete list of medical information to allow the physician to assess and treat the patient properly.

### **1.4 Personal History (PH)/Social History (SH):**

PH is an inexpensive assessment tool to gather valuable information's about diet, hobbies and activities, exercise, and sleeping patterns (5). Substance abuse outside of medical prescriptions, alcohol consumption, and smoking also falls into the patient's personal and social history. For example, lung disease like COPD can be easily diagnosed by the PH of chronic smoking. Here, the best initial management is modifying smoking status through counseling or alternative cessation techniques. (6) Similarly, patients' sexual history provides a leading clue to many diseases, including sexually transmitted infections, which necessitates contact tracing and partner treatment.

An elaborate family and social history add corresponding links to genetic and infectious diseases. Not all diseases are seen in previous generations, but taking an efficient family history allows the physician to explore the patient's genetic background and predict recurrence rate of any familial diseases. (7) Accurate personal and social information helps with early identification of potentially fatal diseases and avoids progression. The physician needs to start with an open-ended question and follow up with a specific question to gather intended information's. This allows healthcare providers to quickly identify common or even rare diseases that run within the family.

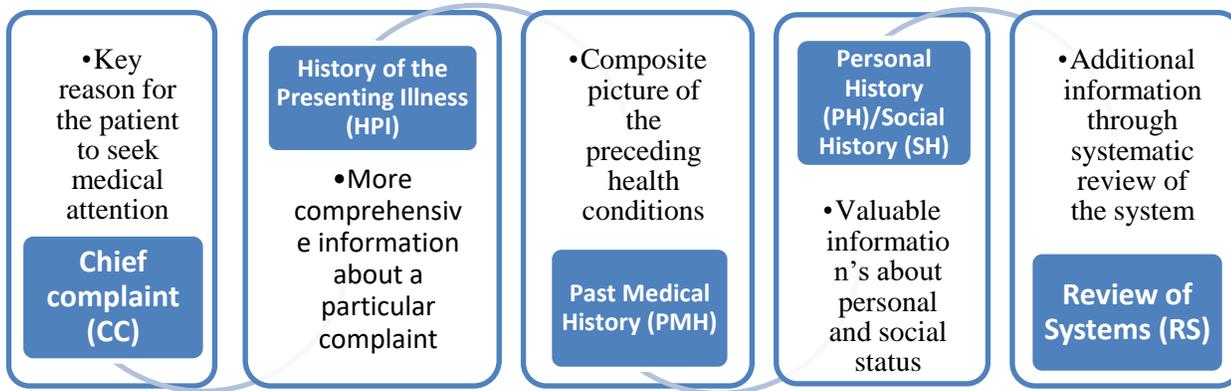
### **1.5 Review of Systems (RS):**

RS represents the final component of a patient's history and provides opportunities to gather any additional information's other than the initial complaint. These additional symptoms gallantly help the healthcare professional to determine and confirm the correct diagnosis accurately, assess the severity, and plan subsequent clinical examination. It reduces uncertainty in diagnosis and draws attention to a particular system, tacitly allowing the healthcare

professional to run standard tests for confirming the illness. Depending on the severity, it also allows

physicians to take a precision based treatment approach.

**Fig-1: Flowchart depicting the sequential components of history taking**



## DISCUSSION

There is an intricate relationship between patient and healthcare providers. The quickest ways to establish and strengthen this trust is through patient history. Patient walking into the clinic are often in pain, stress out, scared, and worried about their condition. When the healthcare providers attentively listen to the patient's concerns and demonstrate excellent communication, it makes the patient feel that their needs are being heard as well as met. This confidence will ensure a positive bond and an increased adherence to the treatment plan.

A good patient history avoids the unnecessary test and protects from expensive procedures (8, 9). It is the cheapest route to the diagnosis. Unnecessary tests with unrelated positive findings result in added stress, which not only causes mental distress but also adds on expenditure (10, 11). It is both time-consuming and non-productive. Undeniably, reduction of extra financial costs enhances patient-centered precision care, increasing the quality of life.

Proper patient history is the quickest and effective way for diagnosis. Relatively, patient history is more significant than physical examination and laboratory tests (12). Undoubtedly, it can provide many useful and vital clues to the present illness and its course. It is necessary that healthcare providers acknowledge the

importance of patient history and prioritize them as an essential diagnostic tool.

## CONCLUSION

A good history is an essential component in patient care and often leads to the diagnosis. It is not only the quickest way to reach a diagnosis, but also the cheapest. It builds trust among patients so that they can confide to the treating physicians for ensuring adherence to the prescribed medications. It is necessary for all healthcare practitioners to acknowledge its importance. We recommend focusing intently on patient history and utilizing it to achieve an optimal health outcome.

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