UNIT TERMINAL OBJECTIVE
3-1  At the completion of this unit, the paramedic student will be able to use the appropriate techniques to obtain a medical history from a patient.

COGNITIVE OBJECTIVES
At the completion of this unit, the paramedic student will be able to:

3-1.1 Describe the techniques of history taking. (C-1)
3-1.2 Discuss the importance of using open ended questions. (C-1)
3-1.3 Describe the use of facilitation, reflection, clarification, empathetic responses, confrontation, and interpretation. (C-1)
3-1.4 Differentiate between facilitation, reflection, clarification, sympathetic responses, confrontation, and interpretation. (C-3)
3-1.5 Describe the structure and purpose of a health history. (C-1)
3-1.6 Describe how to obtain a comprehensive health history. (C-1)
3-1.7 List the components of a comprehensive history of an adult patient. (C-1)

AFFECTIVE OBJECTIVES
At the completion of this unit, the paramedic student will be able to:

3-1.8 Demonstrate the importance of empathy when obtaining a health history. (A-1)
3-1.9 Demonstrate the importance of confidentiality when obtaining a health history. (A-1)

PSYCHOMOTOR OBJECTIVES
None identified for this unit.
DECLARATIVE

I. Overview
   A. Purpose
      1. This information is gathered on a patient by patient, case by case basis
   B. Several parts
      1. Specific purpose
      2. Together they give structure
   C. Does not dictate sequence

II. Content of the patient history
   A. Date
      1. Always important
      2. Time may also be a consideration
   B. Identifying data
      1. Age
      2. Sex
      3. Race
      4. Birthplace
      5. Occupation
   C. Source of referral
      1. Patient referral
      2. Referral by others
   D. Source of history
      1. Patient
      2. Family
      3. Friends
      4. Police
      5. Others
   E. Reliability
      1. Variable
         a. Memory
         b. Trust
         c. Motivation
      2. Made at the end of the evaluation, not the beginning
   F. Chief complaint
      1. Main part of the health history
      2. The one or more symptoms for which the patient is seeking medical care for
   G. Present illness
      1. Identifies chief complaint
      2. Provides a full, clear, chronological account of the symptoms
   H. Past history
      1. General state of health
      2. Childhood illnesses
      3. Adult illnesses
      4. Psychiatric illnesses
      5. Accidents and injuries
      6. Operations
      7. Hospitalizations
I. Current health status
   1. Focuses on present state of health
   2. Environmental conditions
   3. Personal habits
      a. Current medications
      b. Allergies
      c. Tobacco use
      d. Alcohol, drugs and related substances
      e. Diet
      f. Screening tests
      g. Immunizations
      h. Sleep patterns
      i. Exercise and leisure activities
      j. Environmental hazards
      k. Use of safety measures
      l. Family history
      m. Home situation and significant other
      n. Daily life
      o. Important experiences
      p. Religious beliefs
      q. Patients outlook

J. Review of body systems

III. Techniques of history taking
A. Setting the stage
   1. Reviewing the medical history
      a. Briefly review any previous medical records available
      b. Important insight
         (1) Referral
         (2) Life experience
         (3) Past diagnosis and treatment
   2. The environment
      a. Proper environment enhances communication
      b. Place for you and the patient to sit
      c. Be cautious of power relationship
      d. Personal space
   3. Your demeanor and appearance
      a. Just as you are watching the patient, the patient will be watching you
      b. Messages of body language
      c. Clean, neat, professional appearance
   4. Note taking
      a. Difficult to remember all details
      b. Most patients are comfortable with note taking
         (1) If concerns arise, explain your purpose
         (2) Do not divert your attention from the patient to take notes

B. Learning about the present illness
   1. Greeting the patient
      a. Greet by name
      b. Shake hands
c. Avoid the use of unfamiliar or demeaning terms such as Granny or Hon, etc.

2. The patient’s comfort
   a. Be alert to patient comfort levels
   b. Inquire about the patient’s feelings
   c. Watch for signs of uneasiness

3. Opening questions
   a. Find out why the patient is seeking medical care or advice
   b. Use a general, open-ended question
   c. Follow the patient’s leads
      (1) Facilitation
          (a) Your posture, actions or words should encourage the patient to say more
          (b) Making eye contact or saying phrases such as “Go-on” or “I’m listening” may help the patient to continue
      (2) Reflection
          (a) Repetition of the patient’s words that encourage additional responses
          (b) Typically does not bias the story or interrupt the patient’s train of thought
      (3) Clarification
          (a) Used to clarify ambiguous statements or words
      (4) Empathetic responses
          (a) Use techniques of therapeutic communication to interpret feelings and your response
      (5) Confrontation
          (a) Some issues or response may require you to confront patients about their feelings
      (6) Interpretation
          (a) Goes beyond confrontation, requires you to make an inference
      (7) Asking about feelings

4. Getting more information
   a. Attributes of a symptom
      (1) Location
          (a) Where is it
          (b) Does it radiate
      (2) Quality
          (a) What is it like
      (3) Quantity or severity
          (a) How bad is it
          (b) Attempt to quantify the pain
             i) 1 - 10 scale
             ii) Other scales
      (4) Timing
          (a) When did it start
          (b) How long does it last
      (5) The setting in which it occurs
          (a) Emotional response
          (b) Environmental factors
      (6) Factors that make it better or worse
(7) Associated manifestations

C. Clinical reasoning
   1. Results of questioning may allow you to think about associated problems and body systems

D. Direct questions
   1. To gather additional information, direct questions may be required
   2. Should not be leading questions
   3. Ask one question at a time
   4. Use language that is appropriate

E. Taking a history on sensitive topics
   1. Alcohol and drugs
   2. Physical abuse or violence
   3. Sexual history

IV. Special challenges

A. Silence
   1. Silence is often uncomfortable
   2. Silence has meaning and many uses
      a. Patients may use this to collect their thoughts, remember details or decide whether or not they trust you
      b. Be alert for nonverbal clues of distress
   3. Silence may be a result of the interviewer’s lack of sensitivity

B. Overly talkative patients
   1. Faced with a limited amount of time interviewers may become impatient
   2. Although there are no perfect solutions, several techniques may be helpful
      a. Lower your goals, accept a less comprehensive history
      b. Give the patient free reign for the first several minutes
      c. Summarize frequently

C. Patients with multiple symptoms

D. Anxious patients
   1. Anxiety is natural
   2. Be sensitive to nonverbal clues

E. Reassurance
   1. It is tempting to be overly reassuring
   2. Premature reassurance blocks communication

F. Anger and hostility
   1. Understand that anger and hostility are natural
   2. Often the anger is displaced toward the clinician
   3. Do not get angry in return

G. Intoxication
   1. Be accepting not challenging
   2. Do not attempt to have the patient lower their voice or stop cursing; this may aggravate them
   3. Avoid trapping them in small areas

H. Crying
   1. Crying, like anger and hostility may provide valuable insight
   2. Be sympathetic

I. Depression
   1. Be alert for signs of depression
2. Be sure you know how bad it is

J. Sexually attractive or seductive patients
   1. Clinicians and patients may be sexually attracted to each other
   2. Accept these as normal feelings, but prevent them from affecting your behavior
   3. If a patient becomes seductive or makes sexual advances, frankly but firmly make clear
      that your relationship is professional not personal

K. Confusing behaviors or histories
   1. Be prepared for the confusion and frustration of varying behaviors and histories
   2. Be alert for mental illness, delirium or dementia

L. Limited intelligence
   1. Do not overlook the ability of these patients to provide you with adequate information
   2. Be alert for omissions
   3. Severe mental retardation may require you to get information from family or friends

M. Language barriers
   1. Take every possible step to find a translator
   2. A few broken words are not an acceptable substitute

N. Hearing problems
   1. Very similar to patients with a language barrier
   2. If the patient can sign, make every effort to find a translator

O. Blind patients
   1. Be careful to announce yourself and to explain who you are and why you are there

P. Talking with family and friends
   1. Some patients may not be able to provide you with all information
   2. Try to find a third party who can help you get the whole story