Content of the Health Record—the Past Medical, Surgical, Family, and Social History

Learning Outcomes

At the end of this chapter, the student should be able to:

4.1 Outline the use of forms as data collection tools.

4.2 Execute a step-by-step procedure to document past medical, surgical, family, and social histories in PrimeSUITE.

4.3 Examine the necessity of properly documenting and correcting inconsistent or unclear information.

4.4 Apply procedures to document vital signs in PrimeSUITE.

Key Terms

Chief complaint
History of present illness
Past family history
Past medical history

Past surgical history
Review of systems
Social history
Vital signs
What You Need to Know and Why You Need to Know It

Before patients are seen by the care provider, they first meet with the healthcare professional to go over the reason for the visit and to capture historical information about their health status. In this chapter we will cover the types of history collected. We will also cover why knowing this information is so important in the care of the patient. As with all documentation in a health record, the history must be accurate because often the past history plays a part in the diagnosis and treatment of the current condition. The history generally begins with the **history of present illness (HPI)**, which is documented in the patient’s (or legal representative’s) own words. It is in the HPI that the patient relates what is wrong, how long it has been present, and whether he has been taking any medications to relieve the symptoms (and did the symptoms improve), etc. As mentioned earlier, either the history is taken from a form that the patient or legal representative completes or it is taken verbally. Most of the time, both the form and a conversation with the patient are needed to accurately capture the patient’s history.

### 4.1 Forms as Data Collection Tools

Take a moment to think of forms that you have completed recently. Most likely they were on paper, and you can probably think immediately of one that was long, cumbersome, and took quite a bit of thought to complete. You can also think of one or two that were organized well, easy to complete, and seemed rather logical. The same goes for forms that are on screen rather than on paper. When we speak of paper forms, we refer to “boxes” that we are filling out. On screen, we often refer to each item of data as a field rather than a box. For our purposes, we will refer to each piece of data on a form as a field. In most healthcare settings, at this point in time, much of the information gathered from a patient will continue to be done through use of a paper form, and then that information will be transferred to the patient’s EHR. Thus, it is important that the design of the paper forms be logical to minimize the amount of time it takes to transfer the information and to minimize the likelihood of having missing or incorrect information end up in the EHR. As the transition to an electronic record progresses, patients will increasingly complete the forms electronically, though paper forms will not disappear completely since there will always be patients who do not want to complete the forms electronically due to lack of a computer, lack of computer literacy, or privacy concerns.

When designing a form, keep in mind the following:

- Name the form—give it a title that correlates to the information gathered on the form.
• Each page of a multipage form should include the patient’s name and the medical record number or chart number to guard against mixing up the records of patients with the same or similar names and to guard against documentation errors in general.

• The information collected should be relevant to the purpose of the form. Only information that is necessary should be collected—a medical history form in a dermatologist’s office will probably not include the patient’s menstrual history, for example. If that information were needed for some reason, it could still be added elsewhere in the patient’s record.

• Related information should be adjacent—for instance the street address, city, and ZIP code of a patient’s address would be located adjacent to one another on the form.

• Clearly mark the field names (also called labels) by use of bolding, colored font, or italics.

• Separate the form into sections, if it is a lengthy form.

• Completion of the form should be easy for the person completing it; in other words it should be obvious whether the answer to each field should be written on the same line as the field heading or needs to go in the line below.

• Each piece of information should be requested only once on a given form.

• Provide sufficient space for the answer to each field.

• Typically, do not duplicate questions that are answered on other forms; an exception to this would be medication allergies—this question is often asked on more than one form due to the importance of the information. It may slip a patient’s mind when completing a form at home but he or she will recall the allergy later in the interview process.

Following the guidelines above will make it easy for the patient to fill out the form. A thoroughly completed form will benefit the care provider as well. Care providers need complete, accurate information quickly, and so proper development of data collection tools—whether on paper or on screen—should be an important task in any healthcare setting.

The registration form used in Chapter 3 is an example of a form that has individual fields in block format. The medical history form in Figure 4.1 is an example of one that has a more free-form format rather than individual fields.

As noted earlier, though forms do exist today, many “paperless” offices are requesting their patients to complete their history form online. Think of the last time you applied for a job or when you applied to the college you are attending. Most likely you did so online rather than with a paper application. The rules noted above about ease of completion apply to online forms as well as paper forms. You have no doubt experienced the frustration of completing a confusing, lengthy form online! In Chapter 10, when we discuss coming trends, we will discuss this subject in more detail.
Figure 4.1 Medical history form
A patient’s past medical history often contains information that is pertinent to his current health status. It is important that the care provider be aware of the patient’s past medical history, which includes:

- Medical conditions (past and current) for which the patient has been treated or which he or she is experiencing
- Date of onset and date resolved for each
- Known allergies (particularly to medications) as well as the actual reaction
- Immunization status, particularly in children
- Current list of medications, including name, dosage, frequency, and reason it is being taken
- A review of systems (ROS), that is, a body system inventory of symptoms he or she may be having

Many offices include the patient’s current condition on the history form, or the particulars of the current condition may be documented in the progress note for the visit. The information about the current condition includes:

- Chief complaint (the reason the patient is being seen that day; generally speaking, the reason he made the appointment)
- History of present illness: location of the condition (for example, pain in the right shoulder); type of pain (ache, sharp pain, etc.); severity (mild, severe); duration (how long the complaint has been present); and any associated signs and symptoms (for example, difficult to raise arm above head when pain is present)

The past surgical history includes information about procedures the patient has undergone. If a patient, Carolyn Wright, is experiencing right lower quadrant pain, yet her history shows she had an appendectomy 14 years ago, the care provider will concentrate diagnostic testing for other possibilities. Past surgical history includes:

- Name of operation or procedure
- Date that the procedure was performed (may be approximate)
- Name of surgeon who performed the procedure
- Anesthesia reactions or complications, if any

The past family history includes information that will alert the care provider to any conditions that may affect the patient’s overall health now or in the future. For example, Neil Alexander is a 45-year-old patient who has been experiencing chest pains and shortness of breath. He notes that his father and paternal grandfather both had a myocardial infarction (heart attack) before the age of 50. In this case, that information is important to the care provider in order to make diagnostic and treatment decisions for the patient. Past family history includes:

- Name of condition(s)
- Family member(s) who had the condition(s)
Sometimes, whether immediate family members (parent, sibling) are still alive and, if not, the date/cause of death

The **social history** is important because the care provider needs to know the patient’s habits in order to assess possible causes of conditions or potential health concerns that could arise as a result of the habits or the lifestyle of a patient. An example would be a patient who is overweight, works in a sedentary job, and has noted that she does not exercise or participate in any other strenuous activity. That patient would be at risk for heart disease, stroke, and other serious medical conditions. Elements of a social history include:

- Smoking history – past or current use
- Other tobacco use (snuff, pipe, cigar, for example)
- Alcohol use – current or past
- Recreational drug use
- Socioeconomic data – occupation, education, marital status
- Sexual activity and use of protection
- Exercise and physical activity

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**EXERCISE 4.1**

Go to http://connect.mcgraw-hill.com to complete this exercise.

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**Enter a Patient’s Past Medical History**

In this exercise, we will be following the past medical history of a patient, Nancy Evans. She has arrived and checked in for her appointment with Dr. Rodriguez at Greensburg Medical Center. The healthcare professional has called Mrs. Evans back to the exam room for the initial portion of the visit. Mr. Evans has accompanied the patient to the appointment, and is in the exam room as well. The healthcare professional begins by accessing Nancy Evans’ Facesheet screen in PrimeSUITE as noted in Figure 4.2.
The reason for the visit, confusion, already appears on the screen because that information was collected at the time the appointment was made. The healthcare professional will verify that information, and change it if necessary before going on to the Past Medical History. In our scenario, that information is correct. The reason for the visit is also known as the chief complaint and it is the reason, as noted by the patient, that an appointment was made with the care provider.

The healthcare professional clicks on the Past Medical History screen from the Facesheet.

Though a medical history form had been completed last year, the healthcare professional asks Mrs. Evans about any other conditions she has. Mrs. Evans and her husband confirm that she has osteoporosis and osteoarthritis, but no other medical conditions. The healthcare professional asks about any previous surgeries. Mr. Evans responds that she had an appendectomy back in 1971 and she had a cataract removed from her right eye in 2007. They are the only surgical procedures Mrs. Evans has had, but she does have one child, so the healthcare professional asks Mrs. Evans about her reproductive history. Mrs. Evans says that she was pregnant once and has one child. The pregnancy was a full-term pregnancy.

Follow these steps to complete the exercise on your own once you have watched the demonstration and tried the steps with helpful prompts. Use the information provided in the scenario above to complete the information.

1. Click Past Medical History.
2. Click Osteoarthritis.
3. Click Osteoporosis.
4. Click PSHx.
5. Click Appendectomy.
6. Click details.
7. The Procedure Date field is filled out. Press the tab key to confirm your entry.
8. Click OK.
9. Click Cataract removal.
10. Click details.
11. The Procedure Date field is filled out. Press the tab key to confirm your entry.
12. Click Notes.
13. The Notes field is filled out. Press the tab key to confirm your entry.
14. Click OK.
15. Click RHx.
16. Click Total Preg.
17. The space bar is now pressed on the keyboard.
18. 1 is now pressed.
19. Click Full Term 0.
20. The space bar is now pressed on the keyboard.
21. 1 is now pressed.
22. Click the x in the upper right corner of the reproductive history screen to close it.

✓ You have completed Exercise 4.1
Enter a Patient’s List of Current Medications

In this exercise the patient’s current medications are entered. Part of the functionality of PrimeSUITE is the differentiation between those medications prescribed by Greensburg Medical Center and to those that were prescribed by another provider or are bought over the counter.

This process begins by accessing Mrs. Evans’ Facesheet in PrimeSUITE and then selecting Medication List (see Figure 4.2, on page 70). Mrs. Evans shares with the healthcare professional that she takes ibuprofen for her osteoarthritis. She takes 800 mg tablets, 3 times a day. She also takes glucosamine chondroitin every day. These are tablets as well, and she takes the 750-600 mg tablets. She is also taking alendronate, which is a drug for post-menopausal osteoporosis prevention. These are taken in tablet form as well, 35 mg one time a week.

Follow these steps to complete the exercise on your own once you have watched the demonstration and tried the steps with helpful prompts. Use the information provided in the scenario above to complete the information.

1. Click Medication List.
2. Click Record Medication in the Outside Prescribed Medication section.
3. The Medication Name field is filled out. Press the tab key to confirm your entry.
4. Click ibuprofen.
5. Click Osteoarthritis.
6. Click Oral.
7. Click 800 mg Oral Tablet.
8. Click OK.
9. Click Sig and select the appropriate option.
10. Click OK.
11. Click Record Medication in the Outside Prescribed Medication section.
12. The Medication Name field is filled out. Press the tab key to confirm your entry.
13. Click glucosamine-chondroitin.
14. Click 750-600 mg Oral Tablet.
15. 2 is now pressed.
16. Click on the line to the left of the yellow sticky note to Modify the frequency.
17. Click QD.
18. Click Done.
19. Click Add Another.
20. The Medication Name field is filled out. Press the tab key to confirm your entry.
21. Click alendronate.
22. Click Post-Menopausal Osteoporosis Prevention.
23. Click 35 mg Oral Tablet.
24. Click OK.
25. Click Save.

You have completed Exercise 4.2
As we discussed earlier, a patient's history is gathered by use of a form as well as through an interview with the patient. Sometimes, what a patient has documented on the history form is contradictory to what comes out during the interview. When entering any information about a patient, for instance if you are reviewing a past medical history with the patient, and you see on the past medical history form that the patient had an appendectomy in 1997 yet she tells you verbally that she has never had any surgeries, you need to question the patient to determine the correct answer. Though the patient completed the form, she could have checked the wrong box on the form, or she may have forgotten that she had the surgery. Sometimes, patients choose not to tell the healthcare professional or care provider all of the facts. Often, the healthcare professional senses the fact that the patient is being evasive or is only partly answering questions. It is part of the healthcare professional’s role to act in such a way that instills trust; communicating why these questions are being asked is often all that is needed for a patient to become more comfortable. The fact that there is a discrepancy (or that there is information missing) should never be ignored, and should be documented. The medical practice or hospital must have written policies on how to handle such situations.

An example of a policy statement regarding inconsistent information is: *In the event that an error or inconsistency is found in a health record or in the information given verbally by a patient/legal representative,*
an attempt should be made to verify the information and document same. The circumstances surrounding the discrepancy should be documented sufficiently in the health record to explain the situation thoroughly.

PrimeSUITE, as in other EHR software, has built-in mechanisms to amend, delete, or add documentation. Though a change to documentation may occur, the original version of the documentation is always retrievable. In the example given above regarding the discrepancy about the patient’s surgery, the explanation of the discrepancy can be documented in a details box that is found in the past surgical history section of the record. Later in this worktext, we will further examine correcting and amending entries and will test your knowledge through PrimeSUITE exercises.

4.4 Documenting Vital Signs

The patient’s vital signs are taken by the healthcare professional—some offices take them before completing the history and others take them after. PrimeSUITE software includes a very helpful feature—the ability to see a patient’s vital signs over time. The tracking of the vital signs can be seen in graph form or chronologically. This will help the provider assess such conditions as hypertension or significant weight gain (or loss).

Like the history documentation, entering the vital signs is done from the vital signs section of the Facesheet.

The vital signs include the patient’s blood pressure, heart rate, respiratory rate, temperature, height, weight, body mass index (BMI), and oxygen saturation. Technically, height and weight are not vital signs, but both are taken around the same time as the vital signs and are therefore included in that section of the record.

**Enter a Patient’s Vital Signs**

PrimeSUITE allows documentation of the position the patient is in when the blood pressure is taken. The positions include sitting, standing, or lying down.

In our example, the healthcare professional is in the process of taking Nancy Evans’ vital signs. She asks Nancy to sit on the exam table and takes her blood pressure. The reading is 110/65. Her heart rate is 68 beats per minute (bpm) and regular, with a respiratory rate of 22. Mrs. Evans’ temperature is 97.6 F. Her weight was taken before coming into the exam room, and she weighed 135 pounds. She is 5 feet 2 inches (62 inches) tall. Her oxygen saturation today is 99%.

Follow these steps to complete the exercise on your own once you have watched the demonstration and tried the steps with helpful prompts. Use the information provided in the scenario above to complete the information.

1. Click Vital Signs.
2. Click Add New Vitals.

The body mass index (BMI) is now a standard entry in most health records. BMI is a formula showing body weight adjusted for a patient’s height. A healthy BMI is between 18.5 and 24.9. EHR software will automatically compute the BMI once the patient’s height and weight are entered in the vital signs.
3. The **Systolic** field is filled out. Press the tab key to confirm your entry.
4. The **Diastolic** field is filled out. Press the tab key to confirm your entry.
5. **Tab** is now pressed to advance to the next field.
6. The **Heart Rate** field is filled out. Press the tab key to confirm your entry.
7. **Tab** is now pressed to advance to the next field.
8. The **Respiratory Rate** field is filled out. Press the tab key to confirm your entry.
9. The **Temperature** field is filled out. Press the tab key to confirm your entry.
10. The **Weight** field is filled out. Press the tab key to confirm your entry.
11. Press **tab** to advance through the oz. field.
12. Press **tab** again to advance through the height (in feet) field.
13. The **Height (inches)** field is filled out. Press the tab key to confirm your entry.
14. The **O2 Saturation** field is filled out. Press the tab key to confirm your entry.
15. Click **Add Vitals**.
16. Click the small “x” in the top right corner of the vitals history screen to close it.

✓ You have completed Exercise 4.4

At this point in the process, the patient has been taken to the exam room, vital signs have been taken, and she is ready to be seen by the care provider, which we will cover in Chapter 5.
### chapter 4 summary

<table>
<thead>
<tr>
<th>LEARNING OUTCOME</th>
<th>CONCEPTS FOR REVIEW</th>
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| **4.1** Outline the use of forms as data collection tools. pp. 66–68 | - Paper form versus computer screen  
- When designing a form, keep the following in mind:  
  - name the form  
  - patient’s name on every page  
  - purpose of the form  
- Keep related information close together on the form  
- Clearly mark field headings  
- Lengthy forms should be separated into sections  
- Ease of completion and of reading  
- Don’t duplicate information on the form  
- Sufficient space for answers on paper forms |
| **4.2** Execute a step-by-step procedure to document past medical, surgical, family, and social histories in PrimeSUITE. pp. 69–73 | - All histories are important in the assessment of patients  
- Past medical history includes: current and past medical conditions; allergies; medications; immunization status; chief complaint; history of present illness; review of systems  
- Surgical history includes all surgeries or procedures the patient has had and the dates (approximate)  
- Past family history is collected to assess whether the patient is predisposed to certain conditions  
- Social history is collected to determine if patient may be at a greater risk for certain conditions |
| **4.3** Examine the necessity of properly documenting and correcting inconsistent or unclear information. pp. 73–74 | - Office or facility must have clear policies to deal with inconsistent information  
- When a discrepancy is found and the patient is present, ask which is correct; amend the record according to policy  
- If the correct information is not certain, document that as well |
| **4.4** Apply procedures to document vital signs in PrimeSUITE. pp. 74–75 | - Vital signs include:  
  - blood pressure  
  - temperature  
  - heart rate  
  - respiratory rate  
  - height  
  - weight  
  - body mass index  
  - blood oxygen  
- PrimeSUITE will show vital signs over time, which may alert the provider to certain risk factors such as high blood pressure or significant weight loss or gain |
MULTIPL-E-CHOICE QUESTIONS
Select the letter that best completes the statement or answers the question:

1. [LO 4.1] An on-screen item of data is known as a:
   a. box.
   b. crate.
   c. carton.
   d. field.

2. [LO 4.3] PrimeSUITE allows you to note discrepancies in the ______ box.
   a. details
   b. discrepancies
   c. information
   d. registration

3. [LO 4.1] It is important to keep the design of paper forms:
   a. cumbersome.
   b. detailed.
   c. logical.
   d. short.

MATCHING QUESTIONS
Match the terms on the left with the definitions on the right.

1. [LO 4.2] review of systems a. reason for a patient’s visit
2. [LO 4.2] surgical history b. patient information such as blood pressure and respiratory rate
3. [LO 4.2] past medical history c. patient information that includes immunizations and allergies
4. [LO 4.2] social history d. patient information that includes frequency of drinking and smoking
5. [LO 4.2] past family history e. patient information that includes duration of the complaint, associated symptoms, and presence of pain
6. [LO 4.2] history of present illness f. comprehensive inventory of patient symptoms such as headaches, vision, heart palpitations, swelling of joints, etc.
7. [LO 4.2] chief complaint g. patient information that includes past procedures and who performed the procedures
8. [LO 4.4] vital signs h. patient information that includes possibly inherited conditions
4. **[LO 4.4]** A patient’s vital signs are taken _______ the patient history interviews.
   a. before  
   b. after  
   c. during  
   d. A and B are correct

5. **[LO 4.2]** Which of the following is not a required patient history?
   a. Family  
   b. Birth  
   c. Social  
   d. Surgical

6. **[LO 4.1]** Of the following, who will benefit from thoroughly completed paper forms?
   a. Care providers  
   b. Patients  
   c. Receptionists  
   d. All of the above

7. **[LO 4.2]** The patient’s _______ history could possibly help predict a future health condition.
   a. family  
   b. medical  
   c. social  
   d. surgical

8. **[LO 4.4]** A patient’s vital signs are entered via PrimeSUITE’s _______ screen.
   a. Facesheet  
   b. History  
   c. Patient  
   d. Registration

9. **[LO 4.3]** Which of the following is an acceptable way of gathering a patient’s history?
   a. Assessment  
   b. Critique  
   c. Discussion  
   d. Interview

10. **[LO 4.1]** Which piece of information might be included multiple times on a form?
    a. Address  
    b. Allergies  
    c. Marital status  
    d. Patient history

11. **[LO 4.1]** What information should you see on all forms in a patient chart?
    a. Name  
    b. DOB  
    c. Medical record number  
    d. All of the above
12. **[LO 4.2]** A patient’s past surgical history includes the:
   a. approximate date of the procedure.
   b. name of the attending physician.
   c. patient’s recovery time.
   d. type of sutures used.

13. **[LO 4.1]** For ease of completion, related information should be ________ on a form.
   a. adjacent
   b. duplicated
   c. labeled
   d. separate

14. **[LO 4.4]** What does BMI stand for?
   a. Basic Medical Information
   b. Body Mass Index
   c. Body Matter Indicator
   d. Base Measurement Index

15. **[LO 4.2]** Which of the following would include a patient’s exercise regimen?
   a. Family history
   b. Medical history
   c. Social history
   d. Surgical history

16. **[LO 4.3]** Any discrepancies in patient information need to be:
   a. detailed.
   b. documented.
   c. filed.
   d. transcribed.

**SHORT ANSWER QUESTIONS**

1. **[LO 4.1]** Explain why it is important to keep the design of paper forms logical and orderly.

2. **[LO 4.1]** List at least eight things to keep in mind when designing a form as explained in the text.

3. **[LO 4.2]** Explain why a patient’s social history is important.

4. **[LO 4.1]** Why might it be recommended that a patient’s name and chart number/medical record number appear on each page of a multi-page form?

5. **[LO 4.4]** List the vital signs that are typically taken at each patient visit.

6. **[LO 4.1]** Why, in the age of EHRs, is patient information still gathered mainly through the use of paper forms?

7. **[LO 4.2]** Differentiate between the social and family histories.
8. [LO 4.3] Why does a medical office need to have clear policies in place for dealing with discrepancies in patient information?

9. [LO 4.4] PrimeSUITE asks you to record what position—sitting, standing, or lying down—a patient was in when his or her blood pressure was taken. Why does this matter?

10. [LO 4.2] Why might so many patient histories need to be taken?

**APPLYING YOUR KNOWLEDGE**

1. [LO 4.2] Amy Lewis comes to your office for her annual wellness check-up. As the healthcare professional who will be doing her initial interview, create a list of questions you might ask Amy to obtain her social history.

2. [LO 4.4] How can the PrimeSUITE tracking feature assist you in analyzing a patient’s vital signs over time? Give a specific example.

3. [LO 4.1] As an office manager for a large healthcare practice, you have been asked to design a new patient intake form. In the space below, sketch out your form’s layout, keeping in mind the best practices discussed in the chapter.

4. [LO 4.3] Bob Larks is a new patient in your practice, and he brought his informational form with him on his first visit. During the patient history portion of his exam, he says that he does not drink, but while entering that information in Bob’s chart you notice that his initial history stated that he was a “social drinker.” What should you do?

5. [LOs 4.2, 4.3] As a healthcare professional, you are attempting to obtain the medical histories of your patient, Lisa Sanchez. However, you are having difficulty because Lisa is evading your questions and is refusing to respond. What could you do?