

Part 1

Strategies for Effective Health Assessment

CHAPTER 1 Interview and History Taking Strategies

CHAPTER 2 Physical Examination Strategies

CHAPTER 3 Documentation Strategies

Chapter 1

Interview and History Taking Strategies

“In taking histories follow each line of thought, ask no leading questions. Never suggest. Give the patient’s own words in the complaint.”

Sir William Osler (1849–1919) (Bean & Bean, 1968)

Functions of the Interview and Health History

Interviewing and taking health histories serve five major functions:

1. Establishing the initial bond between provider and patient (**Figure 1-1**)
2. Laying the foundation for subsequent clinical decision making
3. Providing a legal record of the subjective and objective data (**Box 1-1**) elicited during the clinical interview, which drive clinical judgments
4. Fulfilling a critical component of the documentation required for third-party payer reimbursement for clinical services
5. Serving as an essential element in the peer review process for evaluation of clinical practice, such as application of evidence-based practice and identification of desired patient outcomes

As the primary goal of this text is to help the reader to develop expertise in advanced health assessment, this chapter will focus primarily on functions one and two. Legal and reimbursement

requirements mandate meticulous, comprehensive, and complete documentation of all the components of care, including patient teaching and counseling provided at each provider–patient encounter. These include not only the traditional face-to-face encounters, but also other means of care, such as interaction via e-mail and telephone. Meticulous and comprehensive, however, are not necessarily synonymous with lengthy. The skilled clinician strives to record all essential clinical data concisely and to document the clinical decision making that underlies diagnostic and treatment decisions. The objectives are to provide effective communication to all caregivers, to ensure continuity of high-quality care for the patient, to minimize legal vulnerability for the provider, and to maximize reimbursement for clinical services. From a legal perspective, what is not recorded has not been done. Documentation validates performance (see Chapter 3 for further discussion of documentation).



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FIGURE 1-1 The interview lays the foundation for the provider–patient relationship.

BOX 1-1 SUBJECTIVE AND OBJECTIVE DATA

Subjective data are the information that the patient or other informant provides during the health history. They are so called because they reflect the patient's perception and recall of his current health need(s) and past health. Perception and recall are subject to many influences that make the information less quantifiable and open to multiple interpretations.

In contrast, *objective data* are measurable and verifiable, such as test results and physical examination findings.

Both types of data are subject to error, and both are critical to the caregiving process. Our perceptions filter all our experiences and significantly influence our behavior. Successful patient outcomes are dependent upon successfully integrating both subjective and objective data to formulate individualized plans of care to which the patient will adhere. The health history contains predominantly subjective data. Data, such as test results or copies of past medical examinations, supplement the information that the patient provides during the interview. The combination of subjective and objective data constitutes the patient's database.

Interviewing

Establishing and Maintaining a Relationship with the Patient

Building a sound provider–patient relationship is essential to effective clinical management of patients with complex health and illness needs. Mutual trust is a critical element in the relationship. Also important is the ethical principle of autonomy, which places ultimate healthcare decision making in the hands of the patient. The ability to exercise self-determination is greatly facilitated by clinicians who actively seek to engage their patients as true partners in the caregiving process. The old adage—knowledge is power—is the key to patient empowerment. Patients must feel involved in their health care. How the clinician conducts the initial health history and subsequent data collection interviews exerts a profound influence on the nature of the provider–patient relationship. The clinician and patient form a dyad. In order to guide the patient's decision-making processes and to facilitate adherence to therapeutic interventions, the clinician and the patient must form an ongoing partnership built on mutual trust and respect for the patient's active role in making healthcare decisions.

Providing Culturally Competent Care

Patient populations are becoming increasingly diverse. *Healthy People 2020*, the fourth report of the United States Department of Health and Human Services on the health of the American people, presents compelling evidence of the relationship between ethnicity, socioeconomic status, and health. This document focuses on two overarching health initiatives.

1. Determinants of health and health disparities: "Biological, social, economic, and environmental factors—and their interrelationships—influence the ability of individuals and communities to make progress on these indicators. Addressing these determinants is key to improving population health, eliminating health disparities, and meeting the overarching goals of *Healthy People 2020*." (U.S. Department of Health and Human Services, 2014)
 2. Health across life stages: "[U]sing a life stages perspective this initiative recognizes that specific risk factors and determinants of health vary across the life span. Health and disease result from the accumulation (over time) of the effects of risk factors and determinants. Intervening at specific points in the life course can help reduce risk factors and promote health. The life stages perspective addresses 1 of the 4 overarching goals of *Healthy People 2020*: 'Promote quality life, healthy development, and health behaviors across all life stages.'" (U.S. Department of Health and Human Services, 2010)
- Achieving these goals will necessitate addressing the social determinants of health, making our healthcare delivery system more linguistically and culturally appropriate, and increasing the ability of practitioners to deliver culturally congruent care.

Diverse patient populations present significant challenges to both clinicians and healthcare organizations. As third-party payers and regulatory bodies increasingly look to clinical outcomes data

to measure the performance of individual providers and institutions, the impact of culture on standards of care will be profound. New and emerging patient populations represent a kaleidoscopic image of healthcare beliefs, values, and practices—“Equal care cannot be defined as the same care in a culturally diverse society because this care will not be considered equally good or appropriate by all patients” (Salimbene, 1999, p. 24).

In addition to meeting the social contract to provide high-quality health care to all patients, clinicians must develop caregiving skills that are culturally congruent, and which reflect therapeutic interventions that take into account the patient’s socioeconomic status. History taking is often the first encounter between patient and provider. Cultural competence requires knowledge of the beliefs, values, and practices of the patient populations being served, as well as willingness on the part of the provider to openly reflect on the impact that his or her own attitudes, beliefs, and behaviors have upon the caregiving process.

Ethnocentrism, the belief in the superiority of one’s own beliefs and values, is a major barrier to establishing effective patient–provider relationships. Similarly, ignorance of a cultural group’s norms may lead to a negative interpretation of well-meaning caregiver behaviors. These norms include beliefs about personal space, definitions of health, communication, and eye contact, as well as who makes healthcare decisions. Many well-intentioned caregivers breach these norms out of ignorance, thereby adversely affecting the development of patient trust and adherence to treatment interventions. For example, many Western caregivers consider direct eye contact as indicative of a patient’s forthrightness and honesty. They may interpret a patient’s failure to engage and maintain eye contact as an indication that he may have something to hide. In many cultures, it is considered disrespectful to look directly at an authority figure.

Through the use of cross-cultural theoretical models, the application of relevant research findings, and valuing of our ethnically diverse patients as teachers about their cultures, the caregiver who is committed to providing culturally competent care will come to understand each culture’s world view from an *emic*, or native, perspective (Jones, Bond, & Cason, 1998). Many excellent resources have been developed to assist clinicians to become more culturally competent as caregivers. Resources for providing culturally competent care are given at the end of the chapter.

Overcoming Difficulties in Provider–Patient Relationships

Some patient relationships will challenge the provider from their onset, such as initial encounters with patients who are angry or hostile. Even when a strong alliance has been established between the provider and the patient, critical events in the caregiving process and/or the influence of significant others may challenge the stability and effectiveness of the relationship. For example, Platt and Gordon (2004) refer to a phenomenon known as the Two Patient Syndrome in which a family member or significant other serves as the translator for the patient. In such a situation, the answers to the provider’s questions may reflect the translator’s perceptions of the patient’s healthcare needs, status, and goals, rather than those of the patient, especially if the family member or significant other is also the primary caregiver for the patient. Similarly, adverse clinical phenomena such as unexpected fetal loss, chronic pain that is unresponsive to treatment, or the need to inform the patient and family of a terminal diagnosis will test the strength of the most well-established provider–patient relationship.

Recognizing and Reacting to Communication Barriers

In order to successfully navigate challenging situations, recognize the feelings/behaviors being manifested by the patient (e.g., sadness, fear, anxiety, anger, hostility). Recognition requires that the provider be an attentive listener and observer and that he or she take the time to reflect and process what he or she sees and hears. Recognition often begins with a perception of distance or strained communication in a relationship that has previously been characterized by warmth and a free flow of communication. When this occurs, stop the usual routine of the visit and share these perceptions with the patient. Identify the perceived behavior or effect and seek the patient’s confirmation as to the accuracy of these observations. If the nature and source of the patient’s behavior are still unclear, reassure the patient that you have listened to him or her but remain confused about why he or she feels the way he or she does. Ask the patient to help you to better understand what he or she is experiencing. Do NOT become argumentative and defensive.

Acknowledge and validate the patient's feelings as appropriate through the use of statements that convey understanding and concern, such as "I can see where that would be very frightening. Do you feel any better now?" Demonstrate empathy (**Figure 1-2**). Coulehan and Block (1997) define empathy as "a type of understanding. It is not an emotional state of feeling sympathetic or sorry for someone. . .being empathic means listening to the total communication—words, feelings, and gestures—and letting the patient know that you are really hearing what she is saying" (p. 6). For most if not all challenges to provider–patient relationships, there is no quick fix, and attempts to implement one are usually perceived by the patient as being dismissive of her or his feelings, thereby disrupting the relationship even more. Support and understanding are essential to building and maintaining a relationship.



FIGURE 1-2 A healthcare provider displays empathy as a patient discusses an upsetting matter.

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Touch may help convey understanding. If it is culturally appropriate and the situation warrants such an action, as in the loss of a loved one or when delivering an unfavorable prognosis, touch can be very therapeutic.

Demonstrate hope. This is particularly important in situations involving poor prognoses. Although the eventual outcome may not be altered, the patient needs to know that the provider will not withdraw because cure is not an option, will remain a consistent source of support, and will help the patient to identify and achieve the life goals that are important in his or her remaining lifespan.

Working with Resistant Patients

Patients who are resistant to therapeutic recommendations represent another challenge to provider–patient relationships. Such resistance often represents a failure of the provider to fully engage the patient as a partner in decisions about his or her health care. Cultural norms and patient ambivalence may also be major factors, as in patients who smoke. Smokers who have not experienced the negative health consequences of smoking often do not perceive themselves to be at risk, and their sociocultural environment may support continuation of this negative health behavior. The provider should continually assess the readiness of the patient to adopt or change a behavior or intervention and be ready to capitalize on any opportunity that may increase the patient's level of readiness. For example, a female smoker previously resistant to smoking cessation interventions may become very responsive if an abnormal Pap smear causes her to be sent for colposcopic examination and she learns about the relationship between smoking and cervical cancer. The grandmother who smokes and cares for her grandchild while his parents work may be resistant to quitting for her own health, but may do so to protect the health of her grandson (e.g., prevention of recurrent ear infections).

Institutional Factors Affecting Patient–Provider Relationships

Most practitioners are employed by healthcare institutions. Many institutional factors affect patient–provider relationships. Cost containment has led to an ever-increasing emphasis on productivity. Increasing patient volume often decreases the time allotted for initial and follow-up patient visits. If the time allocated for the patient sessions is inadequate to obtain all of the necessary historical data, the patient can be asked to complete a linguistically appropriate (appropriate to the patient's primary language) health history form before being seen by the provider.

Prioritization of data collection is essential and is determined by the patient's expressed reason for seeking care (chief complaint), as well as the presenting signs and symptoms. For example, although diet, exercise, and social history influence treatment decisions, past medical history and a focused review of systems take precedence in the acute phase of illness.

Taking a Health History

The health history lays the foundation for care. It guides the relative emphasis placed on each system in the physical examination and the formulation of differential diagnoses and treatment decisions. A weak foundation places the patient at risk for misdiagnosis and inadequate or erroneous treatment; it also identifies the clinician as one who does not practice within acceptable standards of care, making the clinician vulnerable to legal action.

The Health History as a Vehicle for Patient Empowerment

Having the patient participate in developing his or her health history is a powerful tool for building a partnership between patient and provider. A well-designed, culturally and linguistically appropriate health history form helps to move the patient from passive responder to active collaborator in developing the personal database that will drive future decisions about his or her care. It also begins the patient education process. The form requires the patient to complete a review of past and current health and to reflect on the potential impact of healthcare behaviors, beliefs, and values upon his or her health status. Engaging a patient in this reflective process helps to give a sense of ownership over his or her healthcare data and primes receptivity to future patient education.

The ultimate goal of all health care is to maximize the health and well-being of the patient. Whether this involves health maintenance and disease prevention or the actual treatment of a medical or surgical condition, many patients will be asked to make major, sustained changes to their current behaviors in order to acquire or sustain their desired level of health. Adherence to a therapeutic regimen is influenced by multiple factors, including the patient's perception of the severity of the need or condition and the costs–benefits associated with adherence. By actively involving the patient in the development and analysis of a personal health history, the clinician lays the groundwork for active participation in identifying healthcare goals and in designing a culturally congruent plan of care. An ongoing, collaborative process supports patient autonomy, enhances adherence, and increases the likelihood of achieving desired clinical outcomes. Strategies for performing an effective interview and health history are outlined in **Box 1-2**.

BOX 1-2 INTERVIEWING AND HISTORY TAKING POINTERS

The interview and health history lay the foundation for effective patient care. Remember the following tips when conducting the interview and health history:

- Demonstrate professional appearance and behavior. Unkempt, overly casual or inappropriate dress, and/or unprofessional behavior do not inspire confidence.
- Provide for privacy. Health histories contain highly confidential information and should be obtained in settings that maximize the patient's privacy. Adolescents and patients who have engaged in behaviors that may be viewed as socially unacceptable may be particularly reluctant to share information. Try to conduct a portion of the adolescent's health history without the presence of a parent or guardian, especially when exploring sensitive areas such as sexuality, drug and/or alcohol use, etc.
- Provide a quiet and nondistracting environment wherever possible. Distractions include provider behaviors such as answering the telephone and pagers. Unless it is essential to your professional role, turn off cell phones and electronic pagers and do not interrupt the flow of the patient's history by answering the telephone.
- Address the patient by the appropriate title (Mr., Mrs., Ms.).
- Always introduce yourself to a new patient and identify your role. For example: "I'm Ms. Rogers, a nurse practitioner. . ."
- Request the patient's permission to conduct the health history.
- Try to obtain historical data with the patient fully clothed. Clothing is important to a sense of personal integrity and identity. Initial appearance may also give the examiner valuable cultural and diagnostic clues.
- Position yourself at the same level as the patient to avoid establishing the provider as being dominant in the relationship (**Figure 1-3**). Similarly, respect cultural norms about personal space and eye contact.



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FIGURE 1-3 The healthcare provider positions herself at eye level with the patient, maintaining eye contact.

- Recognize potential biases that may adversely affect your ability to elicit an accurate and complete health history (e.g., ageism or gender bias).
- Observe the patient for any sensory deficits such as hearing or visual loss and adjust your interviewing techniques and positioning accordingly. When interviewing patients with hearing loss, position yourself so that the patient can see your face and speak more loudly and more slowly.
- Prioritize information needs to maximize conservation of the patient's physical and emotional resources. Patients in pain or acute stress require special consideration.
- Know and respect the cultural norms and values of individual patients and adjust interviewing techniques accordingly. Do not impose cultural norms on the interviewee.
- If language barriers necessitate using a translator, address the questions to the patient, not the translator, and allow adequate time for the translation and response.
- Ask the patient if it is acceptable if you take *brief* notes during the interview. Explain that the health history contains critical information that will influence decisions about care and that it is important not to miss any vital piece of information; however, be judicious in note taking. Do not become so focused on recording the data that you cease to relate to the patient.
- Assure the patient that all of the information that is provided will be kept confidential and used as a basis for care decisions. If the information provided by the patient will be used for other purposes, such as to obtain third-party reimbursement, the patient or parent/guardian must be asked to sign a release authorizing approval for these additional uses of privileged healthcare data.
- Use open-ended questions, whenever possible, to elicit information during the history taking interview. Do NOT suggest symptoms or descriptors to the patient and/or informant, especially in the initial portion of obtaining the history of present illness (HPI). Ask the patient to describe the illness in his or her own words. How and what he or she focuses on gives valuable insight into the patient's perception of the relative importance of the symptoms the patient is experiencing. If additional data are needed after the patient has responded to open-ended questions, ask specific questions to obtain more detail. Avoid asking questions that suggest a particular response or that can be answered with a simple yes or no. The following is an example of *inappropriate* questioning: Would you describe your pain as sharp and stabbing or dull and achy?
- Help patients to become partners in the caregiving process. Ask about their healthcare goals and expectations about their care.

- Give the patient adequate time to respond; do not create a hurried atmosphere, especially when eliciting sensitive information.
- Do not use technical terms or medical jargon. Every health history presents an opportunity for patient education. Give your explanations in language that the patient can comprehend and use.
- Be an attentive, nonjudgmental listener and an alert observer throughout the health history. Do not interrupt prematurely, and control an urge to fill every pause or silence with another question. Give the patient time to reflect on her or his answers to your questions before intervening with a prompt or a direct question. When a prompt is necessary, often a simple statement of support, such as “Please continue,” will encourage a patient to reveal additional information that facilitates clinical decision making.
- Observe nonverbal behaviors throughout the interview, such as significant affective and postural changes. These often occur in areas of the health history that contain sensitive information that requires more in-depth exploration.
- Acknowledge the value of the patient’s information through the use of supportive statements during and at the end of the clinical interview. A statement such as “Mr. Jones, you have provided a very clear picture of your symptoms. This will help us to make much wiser choices about what tests to order,” speaks to partnership and communicates how much the clinician values and relies on the quality of the information provided by the patient. If mechanisms have been set up at your institution to safeguard the electronic transmission of information, you may also want to invite the patient to e-mail you any additional information pertinent to his or her care that he or she may have forgotten to mention during the health history. Follow-up telephone communication is also an option, provided similar safeguards are in place.
- Validate your perceptions when the patient has completed telling you a piece of information or expressed a particular healthcare preference. Verbally summarize your understanding of the data and ask the patient if that is an accurate portrayal of the information that she or he has provided.
- If the interview yields contradictory information, revisit earlier areas of inquiry to check for consistency of response and/or ask the patient to clarify your perceptions.
- Beware of prematurely cutting off a line of diagnostic inquiry. Although a patient’s presenting symptoms may strongly suggest a particular diagnosis, failure to adequately explore alternative explanations may cause the clinician to falsely reject an important differential diagnosis.

Types of Health Histories

Health histories are of two types: comprehensive and focused.

Comprehensive Health History

A comprehensive health history should be performed on all nonemergent, new patients who will be receiving ongoing primary care from a particular provider or group of clinicians. Comprehensive health histories contain all of the following elements:

- **Patient identifiers.** These include name, gender, age, ethnicity, occupation, source of referral, and date and time of the clinical encounter.
- **Reliability.** It is particularly critical to assess the reliability of the individual providing the historical data. In most instances, it will be the actual patient. However, in some clinical situations (e.g., patients with severe trauma, the very elderly, children), a person other than the patient will provide all or most of the data. It is imperative that the clinician identifies the source(s) of the data and records her or his judgment about the reliability of the information provided. For example, a clinician might record the following statement: Reliability—patient has difficulty describing the severity and progression of his symptoms and uses contradictory terms to describe the character of the chest pain.

In some situations, assessment of the reliability of the information is complicated by language barriers. When a translator is required, the clinician should address questions to the patient and/or caregiver, not the translator, and should allow adequate time for the translator to reformulate the questions for the patient.

Additional factors may influence the reliability of the information presented, including such patient/informant emotions as fear and shame. The clinician should try to create a supportive, nonjudgmental interviewing environment, which will encourage full disclosure of health and social information by the patient.

- **Chief complaint (CC).** This term reflects a medical or problem-oriented focus to care. Many patients seek care for health maintenance/disease prevention reasons, for example well child visits. A more encompassing term is *reason for seeking care*.
- **History of present illness (HPI).**
- **Past medical history (PMI).**
- **Family history (FH).**
- **Social history (SH).**
- **Review of systems (ROS).**

Focused Health History

A focused health history is performed in emergency situations and/or when the patient is already under the ongoing care of the clinician and presents with a specific problem-oriented complaint.

Focused histories include:

- **Identifying data.**
- **Chief complaint.**
- **History of present illness.**
- **Data from the patient’s past medical history, family history, and social history that are pertinent to the chief complaint.**
- **Problem-oriented review of systems.** For example, a known adult patient complaining of substernal or epigastric pain would be asked questions related to the cardiovascular, respiratory, musculoskeletal, and gastrointestinal systems. Focusing attention on these systems would help the clinician to formulate and prioritize differential diagnoses based on the most likely origin of the patient’s symptoms.

Components of the Comprehensive Health History

Chief Complaint

Use the patient’s own words to describe the reason for her visit. Ask the patient to tell you why she has sought care: “*Mrs. Brown, what brings you to the office today?*” Record the patient’s response using her actual words; do NOT rephrase the stated reason using medical terminology. For example:

Correct: I’ve had a runny nose and sore throat for 3 days.

Incorrect: Patient states that she has experienced coryza and pharyngitis × 3 days.

History of Present Illness

These data represent an amplification of the patient’s reason for seeking care. The thoroughness and quality of the data in the history of present illness are the driving forces in determining which systems the clinician will focus on in the review of systems and subsequent physical examination. This judgment requires that the clinician think critically in analyzing the data and apply evidence-based research findings.

The goal in obtaining the history of present illness is to get a comprehensive description of the characteristics and progression of symptoms for which the patient seeks care. For several decades, clinicians have used the mnemonic device **PQRST** to help ensure that all the necessary data are gathered regarding the patient’s presenting symptoms:

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|-----------|---|
| P: | <i>precipitating</i> factors (What provokes the symptom?) |
| Q: | <i>quality</i> (Describe the character and location of symptoms.) |
| R: | <i>radiation</i> (Does the symptom radiate to other areas of the body?) |
| S: | <i>severity</i> (Ask the patient to quantify the symptom[s] on a scale of 0–10, with 0 being absence of the symptom and 10 being the most intense.) |
| T: | <i>timing</i> (Inquire about the onset, duration, frequency, etc.) |

Although PQRST is useful in accurately describing symptoms, it does not capture many of the elements of health and illness as experienced by the patient. The following mnemonic device integrates ethnocultural considerations into the data gathering process and facilitates the provision of culturally congruent care. It also serves as a reminder to clinicians that patient outcomes determine whether an acceptable standard of care has been met. Successful outcomes are inextricably linked to care that is culturally and linguistically competent. The mnemonic device is **CLIENT OUTCOMES**.

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|-----------|---|
| C: | <i>character</i> of the symptoms, including intensity/severity |
| L: | <i>location</i> , including radiation (if present) |
| I: | <i>impact</i> of the symptoms/illness on patient's activities of daily living (ADL) and quality of life |
| E: | <i>expectation</i> (client's) of the caregiving process |
| N: | <i>neglect</i> or abuse, including any signs that physical and emotional neglect or abuse plays a role in the patient's condition |
| T: | <i>timing</i> , including onset, duration, and frequency of symptoms |
| O: | <i>other</i> symptoms that occur in association with the major presenting symptom |
| U: | <i>understanding/beliefs</i> (client's) about the possible causation of the illness/condition |
| T: | <i>treatment</i> (medications and other therapies that the patient has used to try to alleviate the symptoms/condition) |
| C: | <i>complementary</i> alternative medicine (CAM), including a description of the patient's use of these agents or practices |
| O: | <i>options</i> for care that are important to the patient (e.g., advance directives) |
| M: | <i>modulating</i> factors, meaning factors that precipitate, aggravate, or alleviate the patient's symptoms/condition |
| E: | <i>exposure</i> to infectious agents, toxic materials, etc. |
| S: | <i>spirituality</i> , including spiritual beliefs, values, and needs of the patient |

Past Medical History

This section of the health history collects information about all of the patient's past health and illnesses, with particular emphasis on disease processes, surgical procedures, and hospitalizations. The term is somewhat of a misnomer; although a patient may report having been diagnosed with essential hypertension 4 years ago, the condition will continue to be an active disease process requiring ongoing evaluation and treatment in the present. Thus "past" in many cases refers to the point in time at which a condition was initially diagnosed, not that it no longer affects the patient.

The information gained from this portion of the history often gives the provider important clues about the etiology or contributing factors to the patient's current healthcare need(s). Key elements of the past medical history include:

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| Patient's definition of health and perception of current health status | Ask the patient to fully describe her or his health. |
| Childhood illnesses | Record the date, treatment, and any long-term adverse sequelae, especially any that affect the patient's functional abilities (e.g., postpolio syndrome) or current health status (e.g., past history of untreated streptococcal infection, which may contribute to mitral valve disease of the heart). <i>Illnesses to note include measles/rubella, mumps, pertussis, chickenpox, poliomyelitis, diphtheria, rheumatic fever, scarlet fever, and smallpox.</i> |

Major adult illnesses/conditions Record date of diagnosis, treatment, and whether the condition was successfully treated or requires ongoing care. Assess impact on patient's functional ability and quality of life. *Illnesses/conditions to note include tuberculosis; coronary artery disease, especially myocardial infarction; hypertension; dyslipidemia; diabetes mellitus (specify type); cancer; autoimmune disorders, such as lupus erythematosus; osteo- or rheumatoid arthritis; gout; substance abuse; seropositivity for HIV (HIV+); AIDS; hepatitis (specify type); obesity; and sexually transmitted diseases.*

Allergies Note any allergies to food, beverages (e.g., sulfites in some wines), drugs (see medications below), and environment. Record type and rapidity of symptomatic response to exposure, with particular attention to any respiratory symptoms. Assess the patient's knowledge of potential allergens and identify steps taken to limit exposure. Record treatment, including prescription and over-the-counter (OTC) medications and desensitization therapy. If patient has a history of severe allergic reactions, does she or he carry medical alert data on her or his person at all times? Has the patient been prescribed an emergency treatment product such as an anaphylaxis kit or Epi-Pen, a prefilled, self-injectable epinephrine syringe?

Medications Elicit and record the name, dosage, and frequency of administration of all current, and, to the extent possible, recent past prescription and nonprescription medications. Many patients do not consider vitamins, laxatives, dietary aids and supplements, herbal products, and common drugs, such as aspirin, acetaminophen, and antacids, as being nonprescription medications and will not report their usage unless specifically questioned about them. Fully describe any drug allergies and adverse reactions experienced by the patient while taking any medication. Do NOT accept the statement "I'm allergic to. . ." at face value. Ask the patient to describe what signs (e.g., hive-like rash) or symptoms (e.g., nausea) were experienced and who determined that he is actually "allergic" to the particular drug. It should be noted that not all adverse drug effects are detectable by the patient. For example, HMG Co-A reductase inhibitors, commonly referred to as statins, are used to treat dyslipidemia and may cause elevated levels of liver enzymes in susceptible patients. Ask if the patient has ever been told to discontinue a medication because of abnormal blood chemistries. Also, inquire and fully document any CAM, including foods and beverages, such as herbal teas that the patient consumes as a treatment. This information will help the provider to develop a culturally appropriate plan of care with the patient and will preclude prescribing medications that could produce adverse interactions or have altered efficacy.

Injuries Record the nature of the injury; date; cause (e.g., motor vehicle accident); treatment; outcome, including any long-term sequelae, especially if they affect the patient's functional ability or activities of daily living (ADL).

Hospitalizations Record the reason for the hospitalization, dates, and complications, if any. Obtain the name and address of the facility to obtain the patient's medical records, if necessary.

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| Transfusions | Elicit and record the date, type, number of units administered, and the nature and severity of any reaction. |
| Immunizations | <p>Elicit and record date of last immunization by type, such as diphtheria, pertussis, tetanus, polio, pneumococcal vaccine, influenza, smallpox, cholera, typhoid, anthrax, bacilli Calmette-Guérin (BCG). Also, record the date of the patient's last purified protein derivative (PPD) tuberculin skin test, as well as any other skin testing, such as allergy testing.</p> <p>Important: If the type of immunization requires serial administration of the vaccine, as with immunization against hepatitis B, record the date of each administration to determine if the interval between doses adheres to the recommendations of nationally accepted clinical guidelines. Also, note any unusual reactions to previous vaccinations. Some localized redness and tenderness at an injection site is considered normal, as are minor flu-like symptoms lasting 2 to 3 days. <i>People that have been successfully vaccinated with BCG will have positive PPD tuberculin tests; do NOT administer a PPD test to patients who have received BCG.</i></p> |
| Screening exams | Record the date of the following exams, as appropriate to the patient: Pap smear, mammogram, prostate-specific antigen (PSA), digital rectal exam, cholesterol, lipid profile, blood glucose, eye exam, glaucoma testing, hearing test, PPD (if not recorded under immunizations), chest x-ray (CXR), if patient has been immunized with BCG vaccine, and dental prophylaxis. |
| Psychiatric/mental health | Elicit and record any conditions requiring psychological or psychiatric intervention. Briefly describe treatment interventions. If hospitalization was required, note and cross-reference it to the PMH section on hospitalizations. |

When recording the past medical history, it is helpful to end this portion of the health history with a brief statement summarizing those elements of the history that continue to exert a significant influence on the patient's health, functional ability, and/or sense of well-being.

Family History

Many disease processes follow demonstrable hereditary patterns. Knowledge of the current health status or cause of death of the patient's relatives facilitates risk analysis and promotes early intervention to prevent or delay the onset of many diseases. For instance, a patient with a first-degree (mother, father, sibling) blood relative who has experienced premature onset (women younger than 65 years of age and men younger than 55 years of age) of cardiovascular disease (CVD) is at higher risk for the development of CVD than a patient with no such familial history. The family history should extend back for two generations if the patient can provide the data and should note any intermarriage between close relatives. The family history includes:

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| Major illnesses and health status of relatives | <p>Ask the patient to describe the age, health status, and presence or absence of each of the conditions listed below for each blood relative. If a relative is in good health and has none of the conditions listed below, he can be characterized as being "alive and well" (A&W).</p> <p><i>Conditions to be noted include cancer (specify type); hypertension; stroke; myocardial infarction; coronary artery disease (CAD)/coronary heart</i></p> |
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disease (CHD); neurological conditions, such as epilepsy, Huntington's chorea, and Alzheimer's disease; diabetes mellitus (specify type); tuberculosis; kidney disease; asthma and/or other allergic disorders; arthritis (specify type); anemia (specify type); thyroid disease; and mental illness.

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| Genetic defects | Inquire about disorders that are genetically transmitted such as cystic fibrosis, Tay-Sachs disease, beta thalassemia, hemophilia, Huntington's disease, and polycystic kidney disease. |
| Deaths | Note the cause, age at time of death, and relationship of the person to the patient. |
| Ethnicity | Note the patient's ethnicity, as certain diseases predominate in selected ethnic groups. |

In addition to recording the family history in narrative form, most clinicians find it useful to construct a pictorial representation (genogram), which facilitates rapid transmission of data from one caregiver to another (see Chapter 3 for further discussion of the genogram, along with a sample).

Social History

This portion of the health history seeks to create a living picture of the patient as a person. In many instances, the patient's beliefs and practices may not be consistent with those of the provider. Remember, the goals of obtaining the health history are to acquire information to support accurate clinical decision making and to establish a partnership/relationship with the patient that will allow for the development of a culturally appropriate plan of care that maximizes adherence. Avoid being judgmental. A condescending or disapproving manner will close communication and deny the provider current and future access to essential information. Key elements in the social history include:

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| Personal data | Note place of birth, birth order, description of childhood family (noting family status: intact, separated/divorced, single parent, happy, abusive, and so on), brief description of childhood and young adulthood, level of education, marital status, and description of current family unit. |
| Occupation | Describe current or former work; work status (full-time, part-time, retired); job training; level of responsibility, if pertinent to the management of the patient's care (such as a hypertensive patient in high-stress position); occupational exposure to health hazards, such as excessive noise, pollution, toxic chemicals or vapors, infectious agents; and availability and use of protective clothing and equipment. As the patient responds to questions about work, try to assess the importance of his or her work to self-image. |
| Housing | Note type (e.g., private home, walk-up apartment); if the patient owns or rents the residence; type and adequacy of heat, cooling, humidification, refrigeration, cooking facilities; any potential hazards, such as asbestos or lead-based paint (which is found in some homes built before the 1970s); safety of the surrounding neighborhood and, if an apartment, the building itself; telephone access; pets; and single level or multiple levels in home (including information about stairs, number of flights, elevator, and other details). Additional information may be sought based on the particular needs of the patient. For example, if a patient presents with asthmatic symptoms, inquire about the type of floor covering in the home—carpeting may harbor dust mites, mold, and other allergens that can trigger asthmatic symptoms. |

Safety

Assess and record data about the patient's actual or potential exposure to environmental hazards as well as her or his safety practices. Environmental considerations include the patient's perception about the safety of her or his neighborhood, work environment, and transportation. It also includes asking about safety needs that are patient specific. For example:

- Does the home have smoke alarms, window guards for child protection in elevated apartments, or a carbon monoxide alarm in a home using fuel oil for heating?
- If the patient has functional limitations, are assistive devices such as bathtub bars in place?

Note safety practices. Practices include such behaviors as use of seat belts and not drinking and driving.

Socioeconomic status

Note the adequacy of personal and/or family income to meet basic requirements for housing, food, and clothing. Does income allow for discretionary expenditures for recreation/travel? Does the patient/family have health coverage? (If so, note type: private, Medicare, Medicaid, and so on.) What is the extent of coverage? Does it include reimbursement for health promotional interventions and dental care? If it includes a prescription plan, is coverage limited to generic drugs or to medications chosen from a preapproved formulary? Other information, such as which diagnostic and treatment procedures (if any) require preapproval, can be determined when a specific expensive test or procedure is being considered.

Diet

Time limitations usually preclude eliciting a comprehensive diet history during the initial health history. Unless management of the patient requires immediate dietary intervention, the patient can be asked to keep a record of food and beverage intake for a typical week, not during vacation or over a holiday. Less extensive diet histories often grossly misrepresent the patient's usual dietary practices and do not facilitate effective clinical management. Ask the patient to record the date, time, type, and amount of food and beverage consumed. Important additional information to be recorded includes:

- Cultural or religious practices that influence dietary practices
- Specific quantities (e.g., Did the patient have a 6-ounce cup of coffee or a 16-ounce mug?)
- How food was prepared (Was it broiled, fried, baked, or prepared some other way? Was it prepared at home or purchased commercially?)
- Use of salt in the preparation or addition as a seasoning
- Use of oil (Was oil used in preparing the food? If yes, specify type. Some oils are very high in saturated fat and trans fatty acids.)
- Type of beverages consumed (Note whether they are caffeinated, alcoholic, or artificially sweetened.)

If at all possible, ask the patient to return the completed diet history to your practice site before the next visit so that you may review it. If the appropriate patient privacy and confidentiality of health information safeguards are in place at your institution, you may be able to receive this information in electronic form.

One more caveat: Dietary practices are influenced by many factors. Some are obvious, as with socioeconomic status. Others are more subtle, as is often the case with many elderly patients living alone. They may have the means to purchase and prepare an adequate diet, but because of loneliness may not do so. Eating is a social experience for most people, and elderly patients living alone, in particular, are at risk for nutritional deficiencies.

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| Exercise | Note type, intensity, duration, and frequency. Which factors influence the patient's participation or nonparticipation in regular, aerobic exercise (e.g., work, homemaking, childcare responsibilities, access to safe recreational areas, or physical limitations, such as obesity, arthritis, or angina)? |
| Sleep | Note the usual number of hours per 24-hour period. Does the patient engage in rotating shift work, which can alter sleep-wake patterns? Does she or he experience difficulty falling or staying asleep? Does she or he consume anything before retiring that may interfere with sleep, such as caffeinated beverages, chocolate, or diuretics? Is there any evidence of sleep apnea, such as snoring, excessive daytime sleepiness, or feeling fatigued upon awakening? Is the patient awakened from sleep by pain or by the need to void? |
| Sexual history | Traditionally, the sexual history has focused almost exclusively on assessing the patient's feelings about and satisfaction with his or her sexual performance. For example, it includes the number and type of partners, frequency of intercourse and other sexual practices, type and use of contraception, ability to achieve and sustain an erection, ability to achieve orgasm, and overall satisfaction. These are important questions and allow for identification of treatable conditions, such as erectile dysfunction. It is also useful to conceptualize sexuality as encompassing a broad range of expressions of intimacy and caring, such as holding, cuddling, and touching. |
| Drug and alcohol use | <p>For all of the substances addressed in this section, the social conditions of use often play a major role in determining amount and pattern of consumption. Knowledge of the conditions under which and with whom a patient may engage in substance abuse can help the provider to develop more effective interventions. Many patients who engage in substance abuse will abuse more than one substance. Smoking is addressed in this portion of the history because of the addictive properties of cigarettes. If a patient smokes, determine how much, how long, and under which conditions he or she smokes (e.g., all the time, only at work, in social situations). Ask who would be exposed to the patient's secondhand smoke. Smoking cessation interventions, however brief, should be carried out at every patient encounter.</p> <p>Inquire about past and current usage of any illicit drugs, such as amphetamines, Ecstasy, cocaine, marijuana, heroin, and steroids. Determine the amount, type, method of administration, and perceived impact on health. If drug administration is by injection, are needles shared? Inquire about alcohol intake, noting type, amount, and frequency. Does the patient drink alone? Some subpopulations may be particularly vulnerable to dependence on alcohol. Alcoholism in the elderly is a growing concern of many healthcare providers and is thought to be related to feelings of loneliness, loss, and decreasing physical and mental ability. If providers suspect alcohol abuse, they can use instruments such as the CAGE questionnaire to further assess the patient's use of alcohol.</p> |
| Social support | How does the patient perceive her or his level of social support? Who/what are the patient's primary sources of support? To what extent does she or he want these individuals or entities to be involved in her or his care? |
| Stress and anger management | Ask the patient to identify sources of stress in his or her life and to describe strategies used to cope with stress. Inquire about the patient's anger management strategies. |

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| Recreation/ travel | Which interests or hobbies does the patient have? Does the patient participate regularly in recreational, occupational/professional, or church groups? Note any major travel within the recent past, especially if travel involved potential exposure to untreated water, raw sewage, rodent excrement, contagious disease, and/or parasites. |
| Cultural beliefs and practices | How do cultural beliefs and practices influence the patient's healthcare behaviors? For example, is the patient comfortable performing breast or testicular self-examination? Discuss patterns of communication about healthcare information within the family unit. Who makes healthcare decisions? If pertinent, what are the beliefs about death and dying? Does the patient utilize folk medicine and culturally based healing practices? If so, how might these be integrated into the plan of care? Will the clinician have to negotiate modification of some of these practices to achieve treatment goals? |
| Spirituality | What role do spiritual beliefs and practices play in the patient's life? Are they a key source of support for the patient? How can they become a component of the patient's plan of care? |
| Military service | Note the branch and dates of service, occupational specialty, geographic location of assignment(s), and any potential exposure to hazardous materials or conditions. |

Review of Systems

The last component of the health history is the review of systems (ROS), during which the clinician questions the patient about whether or not she or he has experienced symptoms that may indicate possible pathology in one or more body systems. The nature and depth of the questioning are determined by the reason for which the patient is seeking care (chief complaint), as well as the severity of the condition if she or he presents with an acute problem.

Types of Reviews of Systems

In a nonemergent primary care setting, the review of systems follows one of two forms: comprehensive or focused.

Comprehensive ROS. This type of ROS is conducted when a patient presents for general health maintenance/disease prevention care. The provider asks general questions that are designed to identify if the patient is experiencing symptoms that may suggest an actual or potential problem in one or more body systems. Questioning covers *ALL* body systems.

Subsequent chapters in this text provide in-depth information about conducting a focused ROS. Therefore, only the elements of a comprehensive ROS will be presented below.

Before examining the key questions to be asked for each of the body systems, there are important concepts to note: **significant or pertinent positives** and **significant or pertinent negatives**. Disease states usually produce a cluster of symptoms; however, some are considered to be more indicative of a particular condition than others. For example, chest pain is strongly associated with cardiac disease, although it may also occur with gastrointestinal and musculoskeletal disorders.

The questions commonly included in a comprehensive ROS are those to which a **positive** response suggests the existence of pathology in a given system. Thus, when a patient responds that he or she has experienced the symptom about which he or she is being questioned, that is considered to be a significant **positive** response. When such a response is given during the comprehensive ROS, the clinician will then ask additional questions to better describe the characteristics of the symptom and to determine the presence or absence and description of any associated symptoms. For example, if a patient acknowledges that she or he has experienced chest pain, the clinician will probe further to obtain a full description of the pain (PQRST). The provider would ask questions about the presence or absence of radiation of the pain to the left arm, jaw, or area between the shoulder blades and

about precipitating and alleviating factors (e.g., if the pain was brought on by exertion or emotional excitement/distress, if it subsided with rest).

The provider would ask the patient about the coexistence of associated symptoms, such as nausea or sweating (diaphoresis). If the patient acknowledged experiencing additional symptoms of nausea and diaphoresis during episodes of chest pain, these would be considered to be other significant **positives** in that they tend to confirm that the pain is of cardiac origin. In contrast, negative responses to questioning about these associated symptoms would be considered to be significant **negatives** because the absence of these symptoms decreases the likelihood that the patient's chest pain is cardiac in nature. Eliciting and recording significant positives and negatives are essential to developing sound differential diagnoses and to assessing the potential severity of the patient's symptoms.

Focused ROS. This type of ROS is conducted when a patient presents with a specific chief complaint. Questioning would be directed toward the systems most likely to be involved in producing the patient's symptoms. The patient would not be questioned about symptoms in the remaining body systems. For example, if a patient presented with a sore throat and a sensation of pain and pressure below both eyes, the clinician would ask problem-specific questions about the head and neck, including the eyes, nose, mouth and throat, sinuses, lymph glands, and respiratory system.

Components of a Comprehensive Review of Systems

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| General/ Constitutional | Ask about weight loss or gain, changes in appetite, general state of health, sense of well-being, strength, energy level, ability to conduct usual activities, and exercise tolerance, night sweats, and fever. |
| Skin | Ask about skin changes, including rashes, itching, pigmentation, moisture or dryness, texture; changes in color, size, or shape of moles; changes in hair (growth or loss), and changes of the nails (e.g., clubbing, spooning, or ridges). |
| Eyes | Inquire about injury; double vision; visual acuity (near and far); sudden loss of vision; tearing (unilateral or bilateral); blind spots; pain; blurring of vision; ability to see at night, especially if the patient operates an automobile; photophobia; haloes around lights and headache (suggestive of narrow angle glaucoma); discharge; seeing spots (may indicate "floaters"). |
| Ears | Question about pain, discharge, injury (including barotrauma associated with air travel, diving); hearing acuity; tinnitus; vertigo; balance (inner ear function); frequency and severity of ear infections (include treatment); care of ears, including wax (cerumen) removal if performed. |
| Nose | Ask about nosebleeds (including frequency), colds, obstruction, discharge (including color and quantity), changes in sense of smell, polyps, sneezing, and postnasal drainage. |
| Mouth/Throat | Inquire about dental difficulties, lesions, gingival hyperplasia and bleeding, use of dentures, adequacy of saliva flow, hoarseness, difficulty articulating words (dysarthria), frequency and severity of sore throats (including treatment), and changes in the appearance of the tongue or sense of taste. Ask about neck stiffness, pain, tenderness, masses in thyroid or other areas, and lymphadenopathy (pain or swelling of the lymph nodes). |
| Cardiovascular | Question about chest pain, substernal distress, palpitations, syncope, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, edema, cyanosis, hypertension, heart murmurs, varicosities, phlebitis, and claudication, hemoptysis, and coldness of extremities (note severity and conditions under which this occurs). |

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| Respiratory | Ask about pain (including location, quality, and relation to respiration), shortness of breath (SOB), dyspnea, wheezing, stridor, cough (noting time of day and, if productive, amount in tablespoons or cups per day and color of sputum), hemoptysis, respiratory infections, tuberculosis (or exposure to tuberculosis), and fever or night sweats. Note date of last chest x-ray (CXR), if applicable. |
| Gastrointestinal | Inquire about appetite, dysphagia, indigestion, food idiosyncrasy, abdominal pain, heartburn, eructation, nausea, vomiting, hematemesis, jaundice, polyps, constipation, diarrhea, abnormal stools (e.g., clay-colored, tarry, bloody, greasy, foul smelling), flatulence, hemorrhoids, and recent changes in bowel habits. |
| Genitourinary | <p>Ask about urgency, frequency, dysuria, colic-like pain in flank area, suprapubic pain, facial puffiness, nocturia, hematuria, polyuria, oliguria, unusual (or change in) color of urine, stones, infections, nephritis, hernias, hesitancy, change in size and force of stream, dribbling, acute retention or incontinence (note type, e.g., stress, overflow), changes in libido, potency, genital sores, discharge, and sexually transmitted diseases.</p> <p>Ask male patients about the age of onset of secondary sexual characteristics, achieving and maintaining an erection, ejaculation, fertility, testicular pain or masses, and frequency and technique for performance of testicular self-exam. Ask female patients about age of onset of menses; length and regularity of menstrual cycles; date of last Pap smear; date of last menstrual cycle; dysmenorrhea, menorrhagia, or metrorrhagia; vaginal discharge, vulvar itching; postmenopausal bleeding; dyspareunia; hormone replacement or contraceptive therapy (describe fully and note any possible contraindications to same, such as a history of thrombophlebitis); type and frequency of sexual activity; number of sexual partners; infertility; number and results of pregnancies (gravida, para); complications of pregnancy, delivery, or the postpartum period (e.g., postpartum depression); and type of delivery (e.g., normal, spontaneous vaginal delivery, use of forceps, cesarean section).</p> |
| Breast | <p>Inquire about breast masses/lumps, lesions, tenderness, swelling, nipple discharge, dimpling/retraction of any area of the breast, and frequency and technique of breast self-examination (BSE).</p> <p>Note: Males may also develop breast cancer. They should be questioned about any discharge, masses, etc.</p> |
| Musculoskeletal | Question about the experience of pain, swelling, redness, or heat of muscles or joints; bony deformity; limitation of motion; muscular weakness; atrophy; and cramps. |
| Neurologic | Ask about headaches, lightheadedness, convulsions, paralyses, incoordination, sensory changes (such as paresthesia, anesthesia, and hyperesthesia), changes in mentation, fainting, syncopal episodes, loss of consciousness, difficulties with memory or speech, sensory or motor disturbances, or disturbances in muscular coordination (ataxia, tremor). |
| Mental/Psychiatric | Ask about predominant mood; emotional problems; anxiety; depression (including suicidal ideation if appropriate); difficulty concentrating; if previous historical data suggest, assess for domestic, partner, and/or elder abuse; previous psychiatric care; unusual perceptions; and hallucinations. |

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| Lymphatic | Inquire about local or general lymph node enlargement or tenderness or suppuration. |
| Hematologic | Question about anemia, abnormal bleeding or clotting tendencies, previous transfusions and reactions, and Rh incompatibility. |
| Endocrine | Inquire about polydipsia, polyuria, polyphagia, unexplained changes in weight; changes in skin texture or hair texture and distribution; energy level; appetite; changes in mentation; thyroid enlargement or tenderness; changes in size of head or hands; asthenia; hormone therapy; growth; secondary sexual development; and intolerance to heat or cold. |

Completion of the review of systems concludes the health history. Before moving on to the physical examination, however, it is desirable to ask the patient if there are any health concerns or issues that were either not identified or not covered adequately during the history taking process. Even if the patient declines to add anything, asking conveys a respect and valuing of the patient's role in decision making about her or his health and helps to reinforce the partnership between provider and patient.

Summary

The health history is the foundation upon which all other components of the patient's care are built. The manner and skill with which the clinician elicits the information has a major influence on the development of the provider–patient relationship and the quality of the data that will drive diagnostic and treatment decisions. The decisions and the patient's responses to treatment will be evaluated in terms of measurable outcomes, cost–benefit analysis, and patient satisfaction. Outcomes and patient satisfaction are intimately connected. The expert clinician is culturally competent and conducts all facets of care with an understanding and respect for the cultural dimensions of care. Such care creates a win–win situation: The patient achieves better clinical outcomes and is highly satisfied with his or her care, and the clinician meets institutional and third-party payer expectations that care will achieve evidence-based clinical outcomes in a cost-effective manner. Remember **C-L-I-E-N-T O-U-T-C-O-M-E-S** as you progress from novice to expert in your history taking knowledge and skill.

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Additional Resources

The National Center for Cultural Competence

<http://nccc.georgetown.edu>

The National Center for Cultural Competence (NCCC) at Georgetown University's Center for Child and Human Development has developed instruments for both individual and institutional assessment of cultural and linguistic competency.

Culture Clues

<http://depts.washington.edu/pfes/CultureClues.htm>

"Culture Clues," produced by the University of Washington Medical Center's Patient and Family Education Committee, are of value to a busy clinician. These invaluable clinical tools are designed to allow a caregiver to quickly (in 3 to 5 minutes) acquire a baseline understanding of the defining characteristics, values, and beliefs of a particular cultural group, such as Korean, Latino, Albanian, Vietnamese, and Hard of Hearing. Additional culture clues are under development.