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History Taking As Formal/Informal Assessment Method: A Perspective Of Healthcare Professionals

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Abstract

History taking is an integral part of assessment. History taking is basically collecting reliable and valid information from your patient. The objective of this study was to assess the perception of healthcare professionals regarding history taking as formal or informal assessment. A qualitative study design was used for this study. In this explanatory study design researcher developed the holistic picture based on the reported information. A semi structured interview format was developed on the basis of literature review d experts opinion. To verify the format of the formulated questions in semi structured a pilot study was conducted. Eight health care providers were taken as the sample size. Purposive sampling technique was used in this study. Interpretative phenomenological analysis was used to interpret the data. The duration of this study was six months from January 2022 to June 2020. Data was collected through the Semi structured interview taken by eight healthcare providers that were general practitioner, speech language pathologist, occupational therapist and an audiologist respectively. Data was analyzed with the help of interpretative phenomenological analysis. The interpretation of the data showed that history taking is a type of informal assessment. Several themes emerged from the perceptions related history taking that includes importance in diagnosis, Questions, Doctor Patient commitment, History Timing, Barriers, Clinical Assessment. The researcher concluded that history taking is an informal way of assessment that contains different questions that are changeable. The process of history taking depends upon the state of the patient. Healthcare providers face different types of difficulties while the process of history taking.

Keywords: Assessment, Formal Method, Informal method, History taking, Healthcare, Perspective, Qualitative Study

Introduction:

History taking is actually an art. History taking pattern varies according to different age groups I.e. pattern of history taking of children will depend on body physiology, immune response and needs of children.(Pessanha, Schuab, Nunes, & Lopes-Júnior, 2022). History taking requires a lot of attention of healthcare provider. History taking includes open ended questions that contain information about the symptoms of the disease. History taking helps in forming diagnosis. History taking tells about the socio economic status of the patient that will further help the healthcare provider to take decision that which type of the treatment should be given to the patient(Graf et al., 2020).

Good Language, manner, body positioning of the consultant will lead towards good outcome. While taking the history of a child be relax, always smile this will help in providing confidence to the baby to cooperate.(Dietvorst, van der Steen, Reijman, & Janssen, 2022) Always prefer open ended questions and listen to the patient or parent carefully while they are telling their complaints(Abdulghani et al., 2016)

Always listen to your patient because they are telling you the diagnosis. History is basically

the story of the patient so it should be listened with the same attention as you listen someone story. History is never considered a test in medical but keeping in mind the definition of a medical test it becomes evident that history taking is basically a test that rules out our diagnosis.(Yi et al., 2019)

History taking is an important aspect of clinical practice. History taking lead towards the understanding of patient problem. So, it is important that all the medical professionals should be well trained in taking reliable and valid information from the patient.(Lai, Cheng, Wu, & Lin, 2022) The most critical part is that a medical professional should learn that how to develop a constructive relation with the patient. Many studies have shown that most of the students of different medical professions lack basic history taking mastery. The major insufficiency seen in medical students is that they are not able to keep the patient relevant and to describe the actual nature of their complications(Kam, Yune, Lee, Im, & Baek, 2019)

Medical history taking is the core in medical methods. Many scholars believe that history taking is an art in which different evaluation has been made up till now. So, history taking is changeable process. (Neto, Cavalcanti, & Correia, 2022)

Communicative behaviors of the professional changes according to the problem of the patient and practice of an individual professional. More and more practice of a medical professional leads towards good history taking.(Pickett & Gurenlian, 2020)

Valid and reliable history is very helpful during the treatment. Half of the diagnosis is dependent on good history taking before any of the clinical examination and laboratory test.(Spadt & Tannenbaum, 2021)

History taking is a form of interview. Medical students can be skilled by practicing history taking in group form. This basically is relevant for both the interviewing person and the observing student. Before interacting with the patient, student should develop their own pre-determined history taking structure which should include different follow up questions.(Dudas, 2022) So, when two per two students are taking interview of a patient, they should make sure that only one person speaks and he is the only person who writes in patient notes and assess the patient accordingly.(Launer, 2022) The other observers should not intervene in any way in front of the patient, because if he intervenes it is not a good gesture and is a very poor performance of professionalism in front of the patient. And if he or she wants to give an input then it should be given at the end of the session, or even afterwards, the feedback should always be positive, and if the patient wants to add on something or we have to make sure that if the patient is comfortable in front of two students, for giving history, or if he or she is not comfortable, he or she should not be forced to give history in front of two students. (Mortaghi Ghasemi, 2019). Similarly, while we have a general practitioner, he should also be observing the student and adding any detail or correcting any information or giving feedback to the students at the end of the history taking and he should also make sure that it is not done in front of the patient.(Bostanabad et al., 2018)

Research was conducted in hamburg city of germany in 2018 by vogel, meyer and harendza in which verbal and nonverbal communication skills including empathy of undergraduate medical students during history taking was studied. The main goal of the study was to access that how adequately undergraduate medical students can use their communication skills while history taking and whether these skills are related to empathy and gender. The method used during this study was three step performance assessment in which 30 medical students took histories of five patients resulting in 150 patient-doc interaction videos. Validated questionnaire of care for empathy and observational scale for verbal and nonverbal communication skills was used to analyze the videos. According to the results female students showed high score for verbal and nonverbal communication as compare to male students. Nonverbal communication corresponds with

verbal communication and empathy while verbal communication skills do not correspond with empathy. Conclusion was that undergraduate students use different communication patterns while taking the history and while interacting with the patient. Special difference was detected between the communication skills of male and female students. Results suggest that different trainings should be given to students that improve their history taking skills.(Vogel, Meyer, & Harendza, 2018)

Research was conducted in University College Hospital, London, UK in by dally and lopez on history taking skills of functional gastrointestinal disorders which stated that clinicians depend on history taking and Rome IV criteria to diagnose FGIDS rather than depending on any lab investigations. Improving one's history taking skill is important as it will lead towards early and immediate diagnosis and good patient outcome by avoiding over investigation. They suggested a structure for history taking that adopts bio psycho-social model of disease. According to it assessment includes open ended questions that rule out the signs and symptoms. Social history helps in ruling out the predisposing, precipitating, perpetuating and protective factors, which will lead towards treatment recommendations. Conclusion was made that history taking helps in rapport building with patients, validify their problem and as well as it reduces stigma.(Daly & Zarate-Lopez, 2021)

Research was conducted in Salford Royal NHS Foundation Trust, Salford by milne and lorna in 2022 on History taking in patients with suspected hematological disease. It stated that the most important skill of nursing practice is the ability to take concise history and examination that will lead towards differential diagnosis and answer the question that which consultant should be referred. It also stated specific consultation questions and required clinical assessments of a patient with a potential hematological diagnosis.(Milne, 2022)

Research was conducted in vienna, austria by Seitz and Raschauer in 2019 on Competency in medical history taking. It evaluated the student competence to take effective history. Reports from the students' supervisors and training physicians were used. A total of 24 physicians from several different departments were interviewed. A qualitative content analysis was then performed. According to analysis the students lack expertise and were unable to take a structured medical history.(Seitz, Raschauer, Längle, & Löffler-Stastka, 2019). The objective of this study is to explore the perspective of healthcare professional regarding the history taking assessment method. The research question of this study was how do contemporary Healthcare Professionals perceived history taking assessment method in Pakistani cultural context?

Materials and Methods:

The researcher desired to access the perspective of healthcare professionals on history taking assessment method. For this researcher needed an in depth analysis of their views and practices.so Qualitative research design was used in this study, in which researcher shapes a holistic picture which is based upon the reports of information (Goodwin, 1995).Purposive sampling technique was used in research study, in which primarily participants were selected on the basis of convention criteria, their availability and willingness to participate in research (Goodwin, 1995).Data was collected from eight healthcare professionals which belongs to different work settings. Data was collected from the healthcare professionals on the bases of semi structured qualitative interviews. Eight interviews were very rich in information consist of experiences and perspective or views and as well as content which were supporting for analysis for which researcher used IPA. Semi Structured tool of data collection is a widely used method of researching. It is best suited for exploring specific topics and facets of the account presented by an interviewee. Moreover, these interviews are designed to offer a fairly open framework of data collection which enables a highly focused and a 2 way communication.

(Goodwin, 1995). Quite unlike the use of questionnaires, this method is highly appropriate for gathering information on the experience of individuals. It should be noted that semi structured interviews are initiated with generalist questions and then move towards the areas which demand specificity. In other words, the areas which require further clarification and exploration are focused upon through the use of specific questions. One of the main purposes of this tool is to gather quantitative as well as qualitative information from the account offered by the sample. (Goodwin, 1995). In addition, it is used to gather general information that is generated from asking specific questions. Another reason for which this tool has been used is primarily because it allows for the assessment and analysis of information in a variety of ways. It means that semi structured interviewing is a form of data collection that is highly compatible with numerous forms of data analysis. (Goodwin, 1995).Another reason behind the large scale popularity of these interviews is that they happen to be easier to arrange in order to gather qualitative information. It does not mean, however, that the process of conducting semi structured is an easy process. There are a number of complexities and intricacies that should be pondered through the process. There is no doubt in saying that the use of semi structured interviews requires a great deal of preparation. (Goodwin, 1995). For data collection health professionals of different settings were considered. Data analysis procedure used in the study was interpretative phenomenological analysis and tool used was an unstructured interview in which the subjects were given 40 minutes each. Eight health care professionals taken were general practitioner, speech language pathologist, occupational therapist and audiologist. For this study, IPA has been employed for the purpose of interpreting the data. It encompasses the method of strategic reduction, analysis of comments, specific and generalist statements and through the search of common and differential meanings inside the data. It includes and describes the accounts of the specific experiences offered by the participants. In other words, it offers an account of instances of the lived experiences of a number of individuals in relevance to a particular concept or phenomena (Polkinghorne, 1989). After the interview had been conducted, researcher followed the phase of data transcription into a written format.

Results:

Table 1: Master Table of Superordinate Themes (N=8).

Superordinate Theme	Subordinate themes	Keywords
1. Diagnosis	Making diagnosis Getting diagnosis Not getting diagnosis Differential diagnosis	"History taking is the first step that we use in making a diagnosis as soon as the patient comes into the hospital. It helps us in getting the diagnosis or if not getting the diagnosis it helps us getting close the diagnosis".
2. Questions	List of questions Related to disease Information about disease Presenting complain Associated symptoms Disease specific	"We ask specifically design questions so that we can treat the illness or that the disease that the person is having correctly. We can change the list of questions according to the patient and according to the settings if I am suspecting tuberculosis or polio

				in Pakistan in this demographic area then I'll ask questions related to that. Similarly, for patients coming in state of pregnancy, I'll my questions would be a bit different from the patients coming on regular basis. Similarly, if there is a children, if there is a child, sorry, if there is a child, my questions would be different. If it's first child or second child, then my questions will be different. So yes, we can change the questions, the list of questions, but the basic headings, the basic questions, stays the same. Say we start from the bio data. So I can change questions in bio data, I can add questions and bar data, but the basic bar data questions would be would stay the same. Similarly, the presenting complaint, the history of presenting complaint, Associated symptoms, then we have a specific systemic history. So all of those are gonna stay the same. But asking a question, systemic question, related to giving Dignosis, for a patient who presents with pain and leg is irrelevant. So I won't be asking questions related to gi T, but I'll be asking questions related to MSK musculoskeletal system. So yeah, you can change it.
3.	Doctor Commitment	Patient	Personal information Commitment Confidentiality Hypothesis Socio economic status	I'll need the personal information of that person. Again, I won't be exposing that information. Since there is a very, very strong commitment, a doctor has with his patient commitment that they have, so I'll prefer that confidentiality rather, than sharing that information. So personal information, then the

			reason that why that person has come to me, alright, so after the reason, the associated things related to that reason, that helps me connect all the dots and helps me go to a diagnosis. After that associated symptom, I it's just like research the one that you are conducting, that I have a hypothesis in my mind that if he is having pain in his stomach, and it is associated with loose stool, and with vomiting, then most probably will be having this this this this disease, then I'll be asking specific systemic questions related to that disease related to all those diseases, so that I can even cut down my list of diagnosis to be more accurate. And after that, in the end, I'll be asking some of the questions which helped me in treat that patient. For example, if I'll be asking questions related to affordability. I'll be asking questions related to his availability, I'll be asking questions later to compliance, I'll be asking questions related to the environment in which he lives. So, these are the basic questions that I personally think helps a doctor in reaching a diagnosis.
4.	History Timing	To the point Systematic Duration	This depends upon the disease or it depends upon the patient. So, we often come across patients who go into very, very detailed tiny details who basically deviate from the history. So, you have to bring that person back to the main point that you're discussing. Similarly, there are few patients who are very, very good in giving history and within few words in lines, they basically describe their whole disease and

			help the doctor. So it depends upon many factors, it depends upon the disease, it depends upon the patient. The average time that one spends in taking history in outpatient department is from 10 to 15 minutes and once that patient is admitted into inpatient department, so, what we do there is in wards we can take detail history, and it sometimes takes up to 25 to 30 minutes in taking the basic history.
5.	Barriers	Accent Limited time Gender Incapability of giving history Reluctance Professionalism Privacy Knowledge	So, the ins in a hospital setup, one of the biggest issues that is faced by me is that is faced by my colleagues is that often there is a language barrier a person is saying something specific and we you are not able to understand him because of the language barrier because of the even because of the accent barrier. Since there are many accents of Punjabi. So, it often becomes very difficult to understand what a person is saying specifically when they go into tait Punjabi and use some specific words. So, it is funny often and but it becomes really, really difficult. So, language barrier is one of the problems then there is time. Limited time, that's another problem when you are sitting in OPD, there is a long list of patients waiting outside and you have very limited time to see all of them. So, you have to skip some of the questions and often it happens that some questions which you think are not important, later on, they become very, very important. So time limitation is another issue, then there is an issue of how good history one gives sometimes the

			patient for that. So it's a variability, sometimes the patient forgets their history, or if a patient presents an ER, and there, there is history of trauma, and you don't know, you have no contact, that person has no contact on him.
6.	Clinical Assessment	Assessment types Formal and informal assessment Reason for assessment	So for me, history is not a formal thing. Alright, so says because it can be changed. You can change the questions that one that you're asking. So there is no predefined form or that you have. So you can take history on a white piece of paper, you can take history in orally, you can take history in your cell phone, so yeah, for me, it's informal.History taking is a part of assessment. It's a very important part of assessment. Alright, so after history taking what's the next step? The next step that we have is the clinical examination or assessment that we do in which we check out the basic signs which correlate to the symptoms that are given to us by the patient say he's having pain in stomach we examine sciatic pain in belly we examine his abdomen, and we do palpation we do. Percussion we do ask rotation. So we do inspection. So these four are the basics, inspection, palpation, percussion, and auscultation. These are the four methods that we use in examination or assessment, then there's general physical examination to have a quick look of the patient, and to see the correlating signs that that person is showing, showing. So by the history, what you have done is that you have taken out 50% of the differentials that are

	in your mind, by examining you take out further 25% of the differentials that you have in your mind. So by rolling them out, your chances of diagnosis increases. I'll be asking the history.

Interpretation & Discussion

The transcribed information gathered through the interviews was subjected to interpretative phenomenological analysis (IPA), because IPA worked through the transcripts generated from the semi-structured interviews. It encompasses the method of strategic reduction, analysis of comments, specific and general statements and through the search of common and differential meanings inside the data. It includes and describes the accounts of the specific experiences shared by the participants (Smith & Shinebourne, 2012). The reason for which IPA was used in this study was due to its suitability for the analysis of lived experience. Since this study is based on exploring the accounts of history taking and assessment, conducted by practicing health professionals, IPA was the most appropriate tool, as it allows for the analysis of experiences in an effective and structured manner. It was also due to its systematic nature that IPA was the most preferred approach for this study. Another main aim of using IPA was that it helped in grasping the quality as well as texture of the experiences of the health professionals. During the coding process, the first and second author had regular meetings and these codes and themes were verified by the third party (A researcher expert in IPA). IPA was used primarily for an in-depth analysis of the verbatims. As a result of this analysis, a number of emergent themes were generated from each of the interview. Similar as well as different emergent themes were subjected to clustering together for the purpose of forming major themes. In addition, tables for each of the major themes were developed in a strategic manner keeping in view the IPA standards for formulating tables. One of the main purposes behind the development of these tables was to gain a better understanding of the health professionals experiences. In addition, the tables are also helpful for those who wish to take an overview of the themes. It should be noted here that the clustering was done keeping in view the common elements and facets among the emergent themes. The next step was to develop tables for master themes. The major themes were combined together in the same manner keeping in view the similarities for each. The tables also help in offering complete information in relevance to each of the emergent themes. The analysis was done in a meticulous manner in order to complete coverage of the themes.

Diagnosis:

The first superordinate theme emerged from the study was “diagnosis”. The main subordinate themes that fall under this master theme is ‘Making diagnosis, getting diagnosis, Not getting diagnosis and Differential diagnosis’’. The health care professional reported that the first step while treating the patient is history taking. It helps in making the diagnosis or getting closed to the diagnosis.

“History taking is the first step that we use in making a diagnosis as soon as the patient comes into the hospital. It helps us in getting the diagnosis or if not getting the diagnosis it helps us getting close the diagnosis”

It is assumed that history taking is the initial step of examining a patient. It plays an important role in making diagnosis.(Kantar et al., 2022) We can make different diagnosis on the basis of history that will ultimately leads toward the final diagnosis. The research conducted in 2014 by muhrer in camden also shows that history is the key to diagnosis.(Muhrer, 2014)

Questions:

The second superordinate theme emerged from the study was “questions”. The subordinate themes fall under this superordinate theme was “list of questions, related to disease, information about disease, presenting complain, associated symptoms and disease specific”. The interviewer reported that changes can be made while asking questions during history taking. Questions should be asked according to the settings.

“We ask specifically design questions so that we can treat the illness or that the disease that the person is having correctly. We can change the list of questions according to the patient and according to the settings if I am suspecting tuberculosis or polio in Pakistan in this demographic area then I’ll ask questions related to that. Similarly, for patients coming in state of pregnancy, I'll my questions would be a bit different from the patients coming on regular basis. Similarly, if there is a child, if there is a child, sorry, if there is a child, my questions would be different. If it's first child or second child, then my questions will be different. So yes, we can change the questions, the list of questions, but the basic headings, the basic questions, stays the same. Say we start from the bio data. So, I can change questions in bio data, I can add questions and bar data, but the basic bar data questions would be would stay the same. Similarly, the presenting complaint, the history of presenting complaint, Associated symptoms, then we have a specific systemic history. So, all of those are going to stay the same. But asking a question, systemic question, related to giving Diagnosis, for a patient who presents with pain and leg is irrelevant. So, I won't be asking questions related to GIT, but I'll be asking questions related to MSK musculoskeletal system. So yeah, you can change it”.

Basic headings of history remain the same I.e demographics, associated symptoms and onset. We can make changes in bio data according to the situation and settings. Questions asked during history should always be disease specific. Questions should be designed in such a way that they reflect the needed information about the disease. Research conducted in greece and USA by hazichristou and kirana in 2016 showed that history is taken with the help of different questionnaires for different diseases.(Hatzichristou et al., 2016)

Doctor Patient Commitment:

The third superordinate theme emerged from the study was “doctor patient commitment”. The subordinate themes fall under this superordinate theme was “personal information, commitment, confidentiality, hypothesis and socio-economic status”. The health professionals reported that while taking personal information the main point that should be kept in mind is doctor patient commitment.

"I'll need the personal information of that person. Again, I won't be exposing that information. Since there is a very, very strong commitment, a doctor has with his patient commitment that they have, so I’ll prefer that confidentiality rather, than sharing that information. So personal information, then the reason that why that person has come to me, alright, so after the reason, the associated things related to that reason, that helps me connect all the dots and helps me go to a diagnosis. After that associated symptom, I it's just like research the one that you are conducting, that I have a hypothesis in my mind that if he is having pain in his stomach, and it is associated with loose stool, and with vomiting, then most probably will be having this this this this disease, then I'll be asking specific systemic questions related to that disease related to all those diseases, so that I can even cut down my list of diagnosis to be more accurate. And after that, in the end, I'll be asking some of the questions which helped me in treat that patient. For example, if I'll be asking questions related to affordability. I'll be asking questions related to his availability, I'll be asking questions later to compliance, I'll be asking questions related to the environment in which he lives. So, these are the basic questions that I personally think helps a doctor in reaching a diagnosis”.

The key point of doctor patient commitment is confidentiality, after taking personal information from the patient it should not be disclosed or shared with others without the permission of patient. Personal information can include the reason that why the patient has come to the professional associated things to that reason. Doctor patient commitment builds patient's trust on to the professional. Personal information related to symptoms and patient clears the picture of the hypothesis that has been made into our mind after listening to the patient. It also clears that what type of treatment should be given to the patient by considering the affordability, availability, compliance and the environment of the patient. Research conducted in 2013 by boer and de in Netherlands reflected that the most preferred factor by the patients is the confidentiality of their personal information.(De Boer, Delnoij, & Rademakers, 2013)

History Timing

The fourth superordinate theme emerged from the study was "history timing". The subordinate themes fall under this superordinate theme was "To the point, systematic, duration". Health professionals reported that average time consumed while history taking is 10 to 15 minutes in outpatient department and 25 to 30 minutes in wards.

"This depends upon the disease or it depends upon the patient. So, we often come across patients who go into very, very detailed tiny details who basically deviate from the history. So, you have to bring that person back to the main point that you're discussing. Similarly, there are few patients who are very, very good in giving history and within few words in lines, they basically describe their whole disease and help the doctor. So it depends upon many factors, it depends upon the disease, it depends upon the patient. The average time that one spends in taking history in outpatient department is from 10 to 15 minutes and once that patient is admitted into inpatient department, so, what we do there is in wards we can take detail history, and it sometimes takes up to 25 to 30 minutes in taking the basic history".

Time consumed during history taken depends on different factors I.e patient elaborating style, the disease and the settings. While sitting in an outpatient department you have a large number of patient and the maximum time you can give to each patient is 30 minutes so automatically time given to history taking is decreased. While standing in a ward you can go into the detail history of the patient there is no as such limit of time. As well as the elaborating style varies from patient to patient some patients do not know how to explain their problem and they gives you irrelevant information in such cases you have to explain the patient that they just have to tell about their problem and any related aspect to that problem. In 2022 milne and lora conducted a research that shows, concise history taking skill should be learned by all health professionals.(Milne, 2022)

Barriers

The fifth superordinate theme emerged from the study was "Barriers". The subordinate themes fall under this superordinate theme was "Accent, Limited time, Gender, Incapability of giving history, Reluctance, Professionalism, Privacy, Knowledge". Health professionals reported that they face different problems while taking history from patients.

"So, in a hospital setup, one of the biggest issues that is faced by me is that is faced by my colleagues is that often there is a language barrier a person is saying something specific and we you are not able to understand him because of the language barrier because of the even because of the accent barrier. Since there are many accents of Punjabi. So, it often becomes very difficult to understand what a person is saying specifically when they go into tait Punjabi and use some specific words. So, it is funny often and but it becomes really, really difficult. So, language barrier is one of the problems then there is time. Limited time, that's another problem when you are sitting in OPD, there is a long list of patients waiting outside

and you have very limited time to see all of them. So, you have to skip some of the questions and often it happens that some questions which you think are not important, later on, they become very, very important. So time limitation is another issue, then there is an issue of how good history one gives sometimes the patient for that. So it's a variability, sometimes the patient forgets their history, or if a patient presents an ER, and there, there is history of trauma, and you don't know, you have no contact, that person has no contact on him".

History taking is not a smooth process, different hurdles are faced by the professionals during this process.(Kartika-Ningsih & Djawas) One of the most common problems faced by all health professionals is the language barrier, the problem arises when the patient elaborates his/her problem in his/her mother language and you do not have the access to that language. Gender shyness is also one of the major problems faced in most cases opposite genders are not comfortable in giving their personal history to the health professionals. Sometimes patients are also not in the conscious state for giving history like the one who has gone through the road accident or any trauma. Research conducted in 2018 by V singh in Mumbai showed that problems faced during sexual history taking was awkwardness, time limitation, absence of rapport and absence of privacy in outpatient departments.(Singh, 2018)

Assessment

The sixth superordinate theme emerged from the study was "Assessment". The subordinate themes fall under this superordinate theme was "Assessment types, Formal and informal assessment, Reason for assessment". The health professional's reports that history taking is a part of assessment and is a type of informal assessment

"So for me, history is not a formal thing. Alright, so says because it can be changed. You can change the questions that one that you're asking. So there is no predefined form or that you have. So you can take history on a white piece of paper, you can take history in orally, you can take history in your cell phone, so yeah, for me, it's informal. History taking is a part of assessment. It's a very important part of assessment. Alright, so after history taking what's the next step? The next step that we have is the clinical examination or assessment that we do in which we check out the basic signs which correlate to the symptoms that are given to us by the patient say he's having pain in stomach we examine sciatic pain in belly we examine his abdomen, and we do palpation we do. Percussion we do ask rotation. So, we do inspection. So, these four are the basics, inspection, palpation, percussion, and auscultation. These are the four methods that we use in examination or assessment, then there's general physical examination to have a quick look of the patient, and to see the correlating signs that that person is showing, showing. So, by the history, what you have done is that you have taken out 50% of the differentials that are in your mind, by examining you take out further 25% of the differentials that you have in your mind. So, by rolling them out, your chances of diagnosis increases".

History taking confirms diagnosis to a large degree and to lesser extent, it is confirmed by the assessment. History taking is also a form of assessment that help in diagnosis. There are 2 types of assessment formal and informal assessment. History taking is an informal assessment because changes can be made in it according to the settings and situation. And there is no definitive criteria or platform on the basis of which history should be taken. Assessment is another way to confirm your diagnosis, it lines up all the symptoms and associated features to form a diagnosis.

Research conducted in 2016 by Donnelly, Marie in Ireland showed an important step used in making differential diagnosis is assessment and history taking is the form of assessment.(Donnelly & Martin, 2016)

Conclusion:

This study concluded that history taking assessment method is a necessary but informal way of assessment. Assessment of patient starts from history taking. History taking is the first step of assessment. Questions asked during history taking can be changed according to the settings and situation of the patient. Time taken during history collection varies disease to disease. Different problems are faced by health professionals during history taking. History taking is an informal assessment.

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