

# The Art of Taking a Medical History

## Donna McCune, CCS-P, COE

Have you ever assembled a jigsaw puzzle? The many pieces interlock to create a picture, a work of art. Medical records resemble a jigsaw puzzle, with many pieces that build off one another to create a picture of the patient. The medical history is a large piece of the picture. The history is the foundation on which the visit is built. It frequently establishes the extent of the examination and treatment and is important to the selection of the CPT code, determining reimbursement.

A medical history is the collection of data obtained by interviewing the patient. It sounds simple enough, but taking a medical history is truly an art. It requires a team effort by technicians and physicians. The successful history taker is compassionate, conversational, and creative. Take a moment and think about what types of questions are asked. They are very personal. Certain responses may result in life-altering consequences (e.g., surgery). From a reimbursement standpoint, the patient's history ultimately decides who pays for the visit the patient or the insurance company. This article emphasizes the importance of documenting the elements of the history, but more important, provides techniques for improved history taking.

### History Elements

Most health care workers are familiar with the concept of S-O-A-P note documentation. The history is the S, or subjective, portion of the note and includes the patient's personal data, medical history, family history, and complaint. The Health Care Financing Administration and American Medical Association consider the history component of the examination to include some or all of the following elements:

- ✍ chief complaint (CC)
- ✍ history of present illness (HPI)
- ✍ review of systems (ROS)
- ✍ past personal, family, and/or social history (PFSH)

The extent of information obtained and documented will vary with the nature of the problem. For example, the new mother who presents with a scratched cornea from her baby's fingernail requires substantially less history than the 68-year-old newly diagnosed diabetic patient with decreased visual acuity. Clinical judgment will determine the extent of history needed.

### Chief Complaint

The CC states why the patient is in your office. It is a brief description of the reason for today's visit including symptoms, conditions, problems, diagnoses, physician-recommended return, or other explanation. It is usually stated in the patient's own words. This entry is an essential part of every chart note. There must be a reason the patient is sitting in the examination chair. Patients who return annually may respond, "No problems; just here for my annual eye exam" or "You sent me a postcard." One of my favorites is the patient who responds, "Doctor takes such good care of me, my vision has never been better." Notations such as these are troublesome. They have a significant effect on coding and reimbursement. For the Medicare patient, the CC determines whether the service is covered.

The *Medicare Carriers Manual*, Part 3 &sect; 2320 reads as follows:

**The coverage of services rendered by an ophthalmologist is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition. When a beneficiary goes to an ophthalmologist with a complaint or symptoms of an eye disease or injury, the ophthalmologist's services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her ophthalmologist for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition.**

**Translation:** Patients who present with "no problems" or are "here for my annual exam" find themselves responsible for payment of their visits even if the physician finds a medical diagnosis. A link between the complaint and the diagnosis is essential.

There are chronic conditions that are monitored regularly, such as age-related macular degeneration (ARMD) and glaucoma. It is acceptable to write as the CC "3-month follow-up visit requested by MD for COAG" or

"Vision check due to ARMD." Physician-recommended returns are included in the definition of CC and are covered by Medicare.

There are creative ways to elicit a complaint from the patient. First, consider why a patient may be reluctant to give you a complaint. Mrs. Jones tells your technician that her vision is fine, she has no problems, and her glasses need a little tune-up. Her last visit indicates 2+ nuclear sclerotic cataracts and ARMD. A quick check reveals a visual acuity of 20/70 in the right eye and 20/80 in the left. What might happen to Mrs. Jones if she admits to difficulty with her vision?

The first thing that comes to mind is the fear of surgery or the possibility that you will take away her car keys, independence, and mobility. The artful history taker may ask such questions as, "Do you drive in the evenings?" "Do you enjoy watching television?" A casual question may open the door to a patient's real complaint. A more direct approach is to remind the Medicare beneficiary that without a complaint, he or she will most likely have to pay for today's visit.

Figure 1. History of Present Illness (HPI).

Location	Quality	Severity	Modifying Factors
Right eye	Glare	A lot	Activity
Eye lid	Haze	Slightly	Light
Behind eye	Sticky	Dull	Trauma
Head	Tired	Sharp	Medication
Timing	Context	Duration	Associated Signs
Suddenly	While driving	Once	Redness
Infrequently	In low light	Rarely	Puffy
Today	During sports	Hour(s), Day(s)	Cloudy
In AM	At work	Always	Discharge

When the technician meets an unresponsive or troublesome patient, the physician needs to know before an inappropriate or inaccurate chart entry is made. A simple technique is to leave the complaint area blank and clue in the physician on a temporary "sticky" note. This avoids conflicting notations (e.g., the technician writes "no problems" and the physician writes "needs surgery").

Because we are creatures of habit and typically complete paperwork from top to bottom, we tend to forget that the CC can be augmented any time during the examination. It is not uncommon for the patient to wait until the physician is about to leave the examination room before giving the reason for the visit. This lengthy discussion about the CC is not to imply that every patient will have a problem, but the majority will.

## History of Present Illness

The CC and the HPI have a similar connotation. The HPI is a chronological description of the present illness from the first sign or symptom or from the previous encounter to the present. It contains subjective symptoms not observable by another (e.g., pain and nausea) and objective symptoms that are observable (e.g., redness, swelling). Figure 1 shows the elements of the HPI and some common examples for each element.

Many patients offer an abbreviated description of their problem. Some volunteer little or no information and assume you know why they are there. This is when the artistry of history taking becomes crucial. It is up to the history taker to ask leading questions and draw the information from the patient. The technician sometimes gets the cold shoulder from patients. For example, a construction worker presents with a foreign body in his eye. He assumes the technician can see that his eye is red and irritated and thus conclude that something must be in there. The skilled history taker will engage the patient in a conversation and draw out the information necessary to write a complete HPI in the patient's own words. This element has a significant effect on selecting the appropriate level of service. Using the evaluation and management codes, a brief HPI (i.e., fewer than four descriptors) for a new patient may not be coded any higher than CPT 99202.

## Review of Systems

An ROS is a listing of any signs or symptoms the patient may be experiencing or has experienced organized by body system. The ROS is not a history. It is a review of systems directly related to the eye problem(s) identified in the HPI as well as any pertinent current medical problem(s). There are 14 possible systems: constitution (general health), integumentary, eyes, musculoskeletal, ears nose throat, neurological, cardiovascular, hematologic lymphatic, respiratory, allergic/immunologic, gastrointestinal, psychiatric, genitourinary, and endocrine.

Take the examples of the mother with a scratched eye and the new diabetic. An ROS for the mother would involve her general health and her eye. The ROS for the diabetic would be more extensive and would likely cover all systems. There is a direct correlation between the number of systems evaluated and the level of service. Reimbursement is made for a higher level of service only when it is medically necessary to perform an extensive examination.

## Past Personal, Family, and/or Social History

The PFSH has three parts:

- ✍ past personal (current medications, allergies, prior illnesses/injuries, operations/admissions)
- ✍ family (members living, health status, hereditary conditions related to the present complaint or illness)
- ✍ social (marital status, employment, tobacco, alcohol, drug use).

Once again, clinical judgment will determine the amount of information required. Review of the PFSH may reveal conflicting information. Be mindful of the patient who lists a hypertensive drug but denies hypertension. To facilitate collecting the PFSH, consider mailing a history questionnaire to patients before their appointment. Educate your staff about the elements of the history to improve their history-taking ability. Role-playing between physicians and technicians is a constructive way to teach how to elicit responses from patients. The staff will need to know how to deal with and obtain appropriate documentation for the patient who appears to be drunk, disorderly, confused, or psychologically challenged. Is it appropriate to write "patient is drunk" in the history? Of course not. You can, however, indicate that the patient has alcohol on his or her breath by writing ETOH (chemical abbreviation for alcohol).

Although it is usually not advisable to ask about sexual history on your preprinted history questionnaire, there are occasions in which such questions are appropriate. Be aware that charts with a documented history of a sexually transmitted disease are handled differently. A special record release is required to transfer these records. The federal and all state governments have medical record laws that pertain to diseases such as AIDS and hepatitis. Check with your state medical societies regarding the privacy laws in your area.

## Confidentiality

Any discussion involving medical records is incomplete without mentioning confidentiality. No comprehensive federal law exists to safeguard the confidentiality of personally identifiable health information. The Health Insurance Portability and Accountability Act of 1996 provides that if Congress does not enact confidentiality standards for medical records by August 1999, the Department of Health and Human Services must establish them through its regulatory authority. Bills have been presented to ensure protection; none have been enacted. Practices should have written policies addressing confidentiality of patient medical records. This includes conducting the "patient interview" in private. It is inappropriate to gather the patient's medical history in an area in which other patients can hear the conversation (i.e., waiting room, open screening area).

## Medical Necessity

Cataract surgery and neodymium: YAG capsulotomy are two of the top four procedures audited by Medicare. Do your histories support medical necessity? If so, your records contain entries that include

- ✍ a dysfunction, such as "can't work," "can't drive," or "can't read"
- ✍ the patient's desire for surgery and the likelihood that vision will improve postoperatively
- ✍ proof that the patient is medically fit for safe surgical intervention
- ✍ a statement that glasses do not provide satisfactory vision for the patient's needs.

Proposed documentation guidelines emphasize the necessity for a complete medical history. The CPT© and ICD-9-CM© codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record.

## **Jigsaw Puzzle**

Putting together a jigsaw puzzle is an art; so is taking a medical history. Think of the medical history as the outside frame of the puzzle. It is much easier to complete the inside portion of the puzzle with a completed frame.