HISTORY & EXAM

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Introduction

- Aim:
  - At the end of the session students should know fundamentals of history taking and take a history of a simple disease
- Objectives:

  At the end of the session students should record:
  - Chief complaint
  - Present illness
  - Past medical history
  - Systemic enquiry
  - Family history
  - Drug history
  - Social history

Importance of History Taking

- Obtaining an accurate history is the critical **first step** in determining the **etiology** of a patient's illness
- A large percentage of the time (70%), you will actually be able make a diagnosis based on the history alone.

How to take a history?

- The sense of what constitutes important data will grow exponentially in future as you learn about the pathophysiology of disease
- You are already in possession of the tools that will enable you to obtain a good history.
- An ability to listen and ask common-sense questions that help define the nature of a particular problem.
- A vast and sophisticated fund of knowledge not needed to successfully interview a patient.

General Approach

- Introduce yourself.
  - Note – never forget patient names
  - Creat patient appropriately in a friendly relaxed way.
  - Confidentiality and respect patient privacy.

- Try to see things from patient point of view. Understand patient underneath mental status, anxiety, irritation or depression.
  Always exhibit neutral position.

- Listening

- Questioning: simple/clear/avoid medical terms/open, leading, interrupting, direct questions and summarizing.

Taking the history & Recording:

- **Always record personal details:**
  - **name,**
  - **age,**
  - **address,**
  - **sex,**
  - **ethnicity,**
  - **occupation,**
  - **religion,**
  - **marital status.**
  - **Record date of examination**

Complete History Taking

- Chief complaint
- History of present illness
- Past medical history
- Systemic enquiry
- Family history
- Drug history
- Social history

CHIEF COMPLAINT

Chief Complaint

- The main reason push the pt. to seek for visiting a physician or for help
- Usually a single symptoms, occasionally more than one complaints eg: chest pain, palpitation, shortness of breath, ankle swelling etc
- The patient describe the problem in their own words.
- It should be recorded in pt's own words.
- What brings your here? How can I help you? What seems to be the problem?

Chief Complaint

Cheif Complaint (CC)

- **Short/specific in one clear sentence communicating present/major problem/issue.**

- **Timing – fever for last two weeks or since Monday**
- **Recurrent –recurring episode of abdominal pain/cough**
- **Any major disease important with PC e.g. DM, asthma, HT, pregnancy, IHD:**
- **Note: CC should be put in patient language.**

Complete History Taking

- Chief complaint
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History of Present Illness

History of Present Illness - Tips

- Elaborate on the chief complaint in detail
- Ask relevant associated symptoms
- Have differential diagnosis in mind
- Lead the conversation and thoughts
- Decide and weight the importance of minor complaints

History of Presenting Complaint(HPC)

- In details of present problem with- time of onset/ mode of evolution/ any investigation;treatment &outcome/any associated +'ve or -'ve symptoms.
- Sequential presentation
  - Always relay story in days before admission e.g. 1 week before the admission, the patient fell while gardening and cut his foot with a stone.
  - Narrate in details – By that evening, the foot became swollen and patient was unable to walk. Next day patient attended Khorshid hospital and they gave him some oral antibiotics. He doesn't know the name. There is no effect on his condition and two days prior to admission, the foot continued to swell and started to discharge pus. There is high fever and rigors with nausea and vomiting.
- In details of symptomatic presentation
  - If patient has more than one symptom, like chest pain, swollen legs and vomiting, take each symptom individually and follow it through fully mentioning significant negatives as well. E.g the pain was central crushing pain radiating to left jaw while mowing the lawn. It lasted for less than 5 minutes and was relieved by taking rest. No associated symptoms with pain/never had this pain before/no relation with food/he is Known smoker,diabetic & father died of heart attack at age of 45.

History of Present Illness - Tips

- Avoid medical terminology and make use of a descriptive language that is familiar to them
- Describe each symptom in chronological order

Pain (OPQRST)

- **O**nset of disease
- **P**osition/site
- **Q**uality, nature, character – burning sharp, stabbing, crushing; also explain depth of pain – superficial or deep.
- **R**elationship to anything or other bodily function/position.

  Radiation: where moved to

  Relieving or aggravating factors – any activities or position
- **S**everity – how it affects daily work/physical activities. Wakes him up at night, cannot sleep/do any work.
- **T**iming – mode of onset (abrupt or gradual), progression (continuous or intermittent – if intermittent ask frequency and nature.)

  Treatment received or/and outcome.

- Are there any associated symptoms? Check with SR.

Past Medical Illness

Past Medical History

- Start by asking the patient if they have any medical problems
- IHD/Heart Attack/DM/Asthma/HT/RHD, TB/Jaundice/Fits :E.g. if diabetic- mention time of diagnosis/current medication/clinic check up
- Past surgical/operation history
- E.g. time/place/ and what type of operation. Note any blood transfusion and blood grouping.

- History of trauma/accidents
- E.g. time/place/ and what type of accident

Drug History

Drug History

- **<u>Drug History (DH)</u>**
- Always use generic name or put trade name in brackets with dosage, timing and how long. Example: Ranitidine 150 mg BD PO
- Note: do not forget to mention OCP/Vitamins/Traditional medicine/KAP

Drug History

- bd (Bis die) - Twice daily (usually morning and night)
- tds (ter die sumendus)/tid (ter in die) = Three times a day mainly 8 hourly
- qds (quarter die sumendus)/qid (quarter in die) = four times daily mainly 6 hourly
- Mane/(om – omni mane) = morning
- Nocte/(on – omni nocte) = night
- ac (ante cibum) = before food
- pc (post cibum) = after food
- po (per orum/os) = by mouth
- stat – statim = immediately as initial dose
- Rx (recipe) = treat with

Family History

Family History

- Any familial disease/running in families e.g. breast cancer, IHD, DM,HTN schizophrenia, Developmental delay, asthma etc.

Social History

Social History

- Smoking history - amount, duration and type. A strong risk factor for IHD
- Drinking history - amount, duration and type. Cause cardiomyopathy, vasodilatation
- Occupation, social and education background, ADL, family social support and financial situation

Other Relevant History

- Gyane/Obstetric history if female
- Immunization if small child
- Note: Look for the child health card.
- Travel and sexual history if suspected STI or infectious disease
- Note:
- If small child, obtain the history from the care giver. Make sure; talk to right care giver.
- If some one does not talk to your language, get an interpreter(neutral not family friend or member also familiar with both language). Ask simple & straight question but do not go for yes or no answer.

System Review (SR)

- This is a guide not to miss anything
- Any significant finding should be moved to HPC or PMH depending upon where you think it belongs.
- Do not forget to ask associated symptoms of PC with the System involved
- When giving verbal reports, say no significant finding on systems review to show you did it. However when writing up patient notes, you should record the systems review so that the relieving doctors know what system you covered.

System Review

General
- Weakness
- Fatigue
- Anorexia
- Change of weight
- Fever
- Lumps
- Night sweats

Gastrointestinal/Alimentary
- Appetite (anorexia/weight change)
- Diet
- Nausea/vomiting
- Regurgitation/heart burn/flatulence
- Difficulty in swallowing
- Abdominal pain/distension
- Change of bowel habit
- Haematemesis, melaena, haematochagia
- Jaundice

Cardiovascular
- Chest pain
- Paroxysmal Nocturnal Dyspnoea
- Orthopnoea
- Short Of Breath(SOB)
- Cough/sputum (pinkish/frank blood)
- Swelling of ankle(SOA)
- Palpitations
- Cyanosis

Respiratory System
- Cough(productive/dry)
- Sputum (colour, amount, smell)
- Haemoptysis
- Chest pain
- SOB/Dyspnoea
- Tachypnoea
- Hoarseness
- Wheezing

System Review

Urinary System
- Frequency
- Dysuria
- Urgency
- Hesitancy
- Terminal dribbling
- Nocturia
- Back/loin pain
- Incontinence
- Character of urine:color/ amount (polyuria) & timing
- Fever

Genital system
- Pain/ discomfort/ itching
- Discharge
- Unusual bleeding
- Sexual history
- Menstrual history – menarche/ LMP/ duration & amount of cycle/ Contraception
- Obstetric history – Para/

Nervous System
- Visual/Smell/Taste/Hearing/Speech problem
- Head ache
- Fits/Faints/Black outs/loss of consciousness(LOC)
- Muscle weakness/numbness/paralysis
- Abnormal sensation
- Tremor
- Change of behaviour or psyche

Musculoskeletal System
- Pain – muscle, bone, joint
- Swelling
- Weakness/movement
- Deformities
- Gait

SOAP

- **S**ubjective: how patient feels/thinks about him. How does he look. Includes PC and general appearance/condition of patient
- **O**bjective – relevant points of patient complaints/vital sings, physical examination/daily weight,fluid balance,diet/laboratory investigation and interpretation
- **A**ssessment – address each active problem after making a problem list. Make differential diagnosis.
- **P**lan – about management, treatment, further investigation, follow up and rehabilitation

What is History Taking?

- Asking questions of patients to obtain information and aid diagnosis.
- Gathering data both objective and subjective for the purpose of generating differential diagnoses, evaluating progress following a specific treatment/procedure and evaluating change in the patient's condition or the impact of a specific disease process.

(Kings College London 2013)

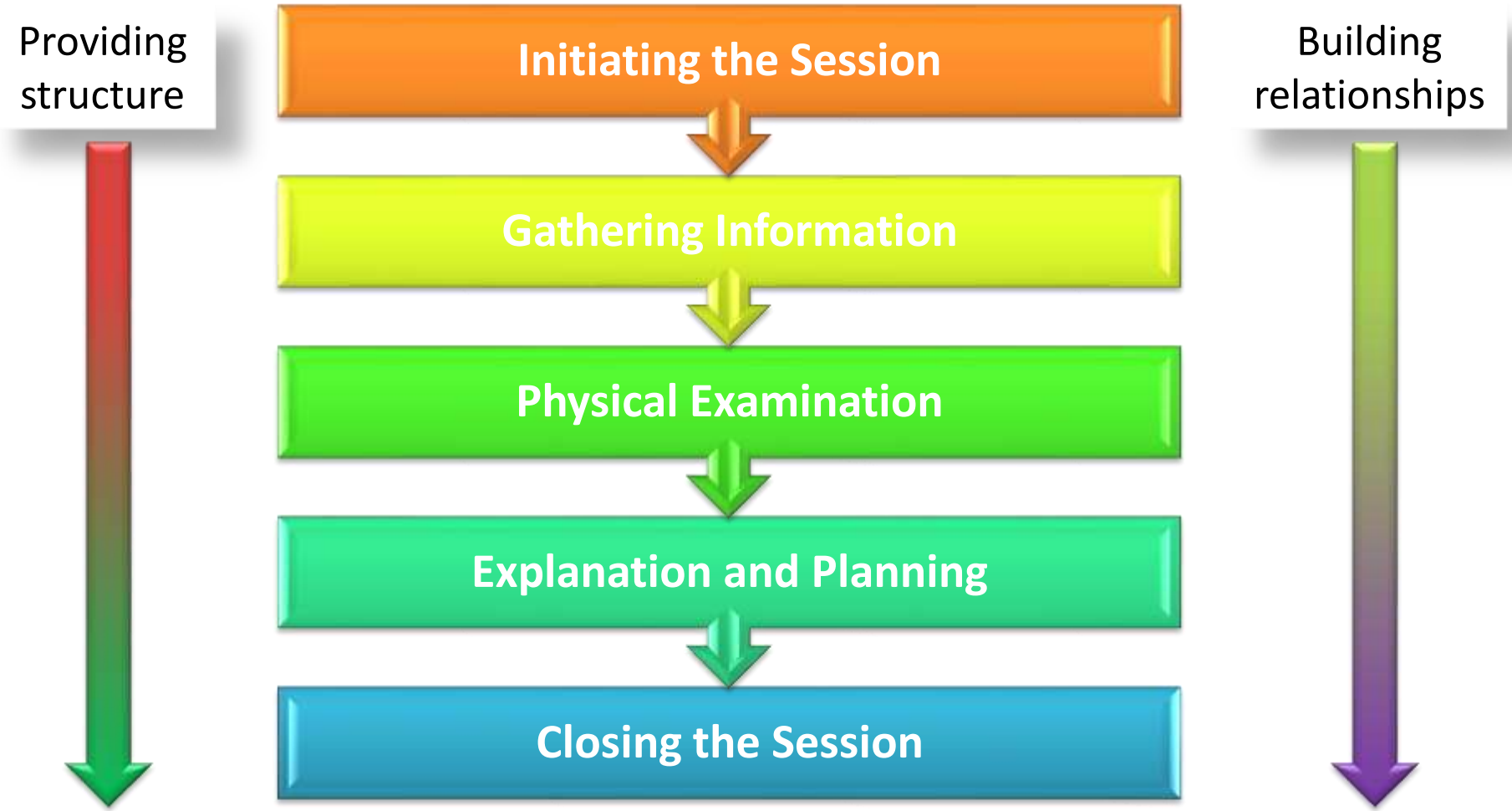
Key Principles of Patient Assessment

- It is estimated that 80% of diagnoses are based on history taking alone.
- Use a systematic approach.
- Practice infection control techniques.
- Establish a rapport with the patient.
- Ensure the patient is as comfortable as possible.
- Listen to what the patient says.

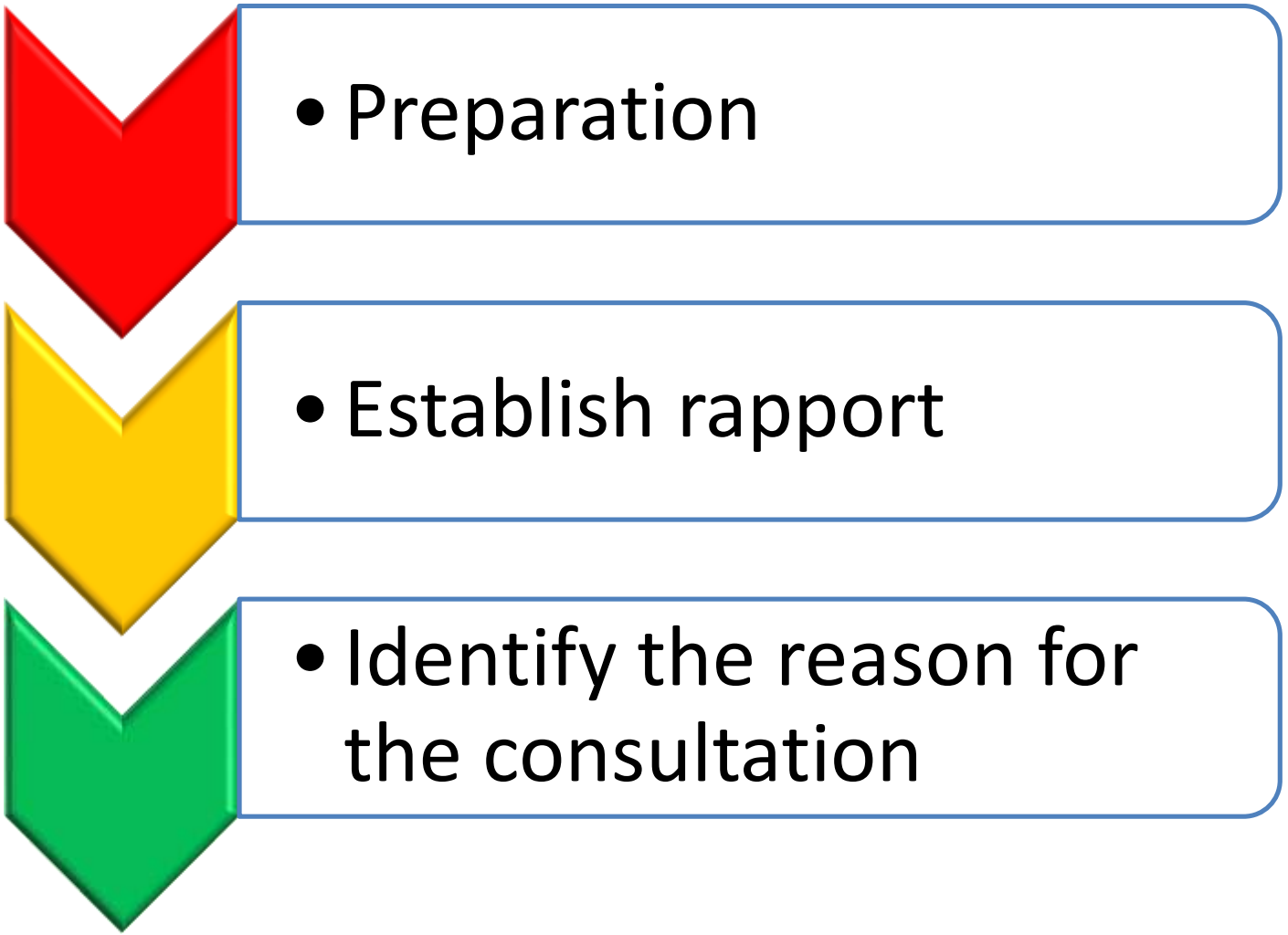
(Scott 2013, Talley and O'Connor 2010, Jevon 2009)

Calgary-Cambridge Consultation Guide

(Kurtz et al. 2005)

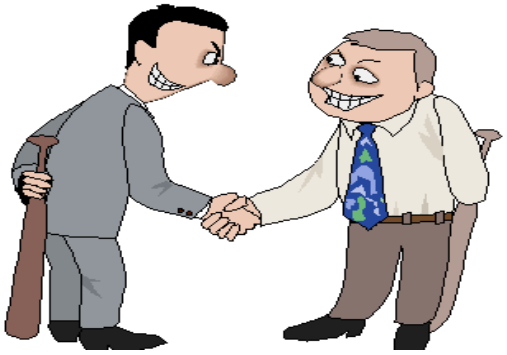


Initiating the Session



Initiating the Session
Establishing rapport

- Initial greeting
- Introductions
- Seeking consent
- Respecting the patient



Initiating the Session
Establishing rapport

Common Pitfalls of History Taking

1. Providing false reassurance
2. Giving unwanted advice
3. Using authority
4. Using “why” questions
5. Using professional jargon
6. Using leading or biased questions
7. Talking too much
8. Interrupting or changing the subject

(Jarvis 2012, Lloyd and Craig 2007)

Initiating the Session
Establishing rapport

• **S**	Sits **square** on facing the patient
• **O**	Maintains **open** body position
• **L**	**Leans** slightly forward
• **E**	**Eye** contact is maintained
• **R**	**Relaxed** (in an appropriate posture) (Kaufman 2008)

Positive and Negative Non-verbal Behaviours

Initiating the Session

Identifying the reason for the consultation

- **Open questions**:
  - Always start with an open ended question and take the time to listen to the patient's 'story'.
- **Closed questions**:
  - Once the patient has completed their narrative to closed questions which clarify and focus on aspects can be used.
- **Leading questions**:
  - Questions based on your own assumptions that lead the patient to the answer you want to hear. These should not be used at all.

Initiating the Session

Identifying the reason for the consultation

Open questions:

- "How can I help you?"
- "You said you have pain on movement, can you tell me which movements makes your pain worse?"

Closed questions:

- "Are you still taking the aspirin your GP prescribed?"
- "Is that an accurate summary of your symptoms?"

Leading questions:

- "You are not allergic to anything are you?"
- "Are your joints painful in cold weather?"

Initiating the Session

- The practitioner's role combines:
  - Establishing rapport
  - Listening
  - Demonstrating empathy
  - Facilitating
  - Clarifying

NB: this role is performed throughout the whole history taking and clinical examination process.

Gathering Information

- The second stage of the Calgary-Cambridge guide involves the exploration of the patient's problem(s), in order to discover:

  ☑ Biomedical perspective

  ☑ Patient's perspective

  ☑ Background information (the context)

Closing the Session

- Forward planning:
  - Discusses the next steps.
  - Possible opportunity for health education.
  - '**Safety netting**' covers an explanation of possible unknown outcomes, what to do if the plan is not working, when and how to seek help.

Closing the Session

- Ensuring appropriate point of closure:
  - Summarises consultation briefly (with the patient), clarifying plan of care.
  - Final check that the patient agrees and is comfortable with the plan, and asks for any corrections, questions and other items to discuss.
  - Include a brief written summary e.g. “This is a 64 year old smoker, with a 3 month history of central chest pain related to exercise. He has a 10 year history of hypertension”.

“Medicine is learned at the bedside and not in the classroom”.

(Sir William Osler 1849 – 1919)

Further Learning Opportunities

- *Practice, practice, practice!*
- Observe fellow health practitioners undertaking patient assessments.
- Reflect (on the practice of others and on your own abilities and experiences).
- See the suggested ‘Key Texts’ in the Module Handbook.