HISTORY TAKING

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DEFINITION OF MEDICAL HISTORY

- A medical history is defined as a planned professional conversation that enables the patient to communicate his/her symptoms, feelings & fears to the clinician so as to obtain an insight into the nature of patient's illness in order to aid in establishing a medical diagnosis and developing a treatment plan.

The art of history taking

- It is widely taught that diagnosis is revealed in the patient's history.
- Often the history alone does reveal a diagnosis.
- Listen to your patient, they are telling you the diagnosis

General principles of history taking


Introduce yourself

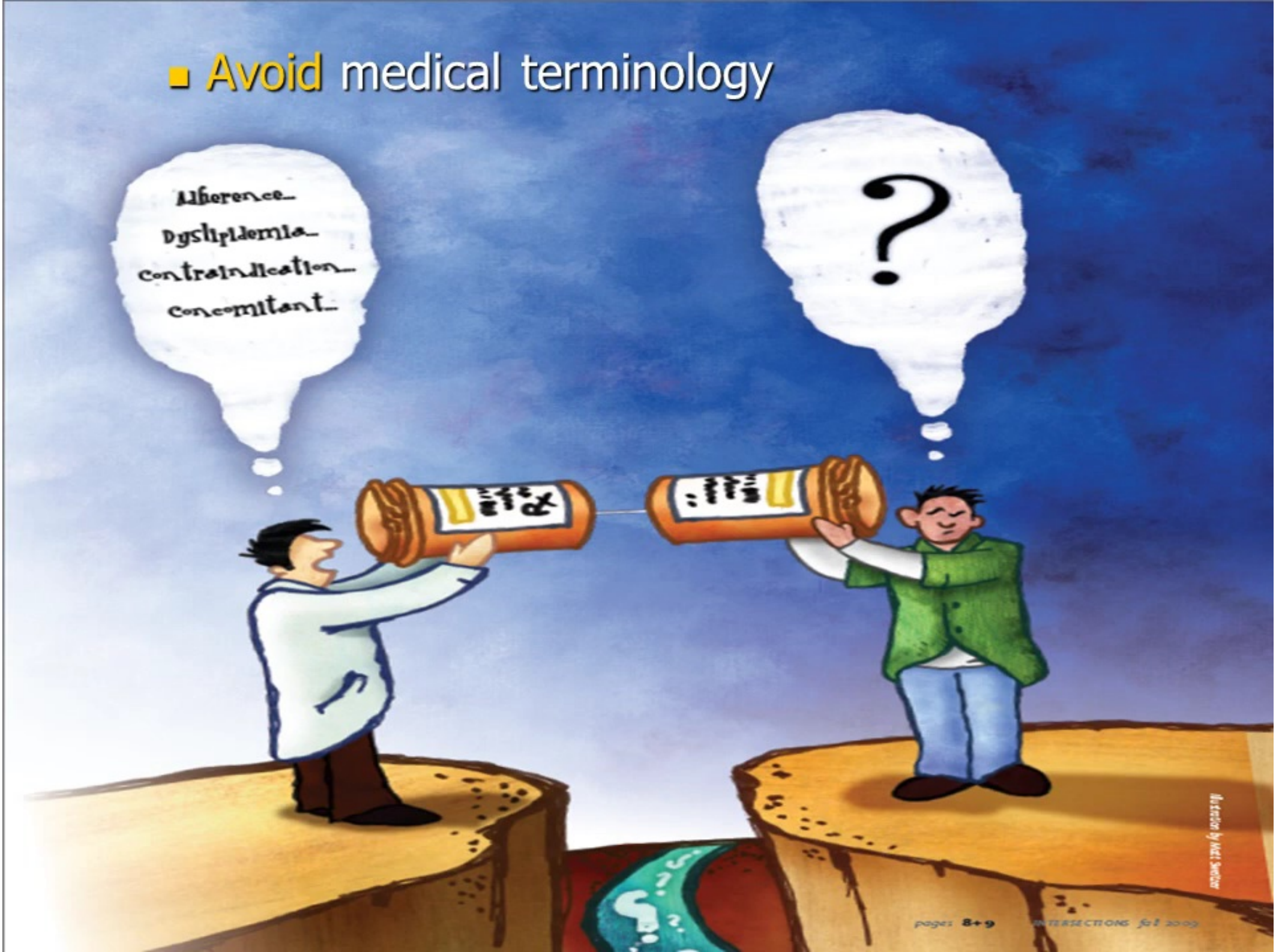

Explain what are you doing


Attention to patient


Respect patient privacy


Respect patient privacy


Respect patient privacy


Avoid medical terminology
Adherence
Dyslipidemia
Contraindication
Concomitant
?
illustration by Matt Smeltzer
page: 8+9
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TIP 3

Use words that an 8-year old would understand.

Questioning : simple , clear


Talk to companion ?

Don't write & talk at the same time

COMPONENTS OF MEDICAL HISTORY

1. Personal History

* Name
* Age
* Address
* Occupation
* Sex
* Marital Status
* Ethnic group

Date of the examination

2. The present complaint

- Record the patient own words
- **Ask**
  - How can I help you?
  - What brings you here?
  - * Don't ask what is the mater ?
  - * In Case of many complaints: list them in order of severity

3. History of Present complaint

- Full details of the Hx. of the main complaint
- ? Similar attacks in the past should be included in the present complaint

3. History of Present complaint *cont…*

Example I : Epigastric pain

- Onset , timing, course , type of pain , severity radiation , relieving factors & aggravating factors, ? treatment received…
- Continue asking about alimentary system

3. History of Present complaint *cont…*

Example II: Lump/Mass/Ulcer

- ? Location
- When/how did you notice it ?
- Change in color of skin/ size ?
- ? Pain
- Discharge / bleeding ?
- ? Trauma
- ? Affecting daily activity
- ? Any other ones

4. Systemic Direct Question

Alimentary system

- Appetite - Diet - Wt. - Swallowing
- Regurgitation - Flatulence - Heartburn
– Vomiting - Haematemisis – Distension – Change in bowel habits ,Defecation , Color of stool .....

4. Systemic Direct Questions (cont.)

Respiratory system

- Cough – Wheezes - Sputum ? color - Haemoptysis - Dyspnea - Orthopnea - Chest pain

4. Systemic Direct Questions (cont.)

Cardio Vascular & PV system

- Palpitation - Dizziness - Headache
- Dyspnea - Orthopnea - PND
- Intermittent claudications - Rest Pain
- Lower Limb edema

4. Systemic Direct Questions (cont.)

Urinary System

- Hesitancy passing urine - Frequency of micturition – Incontinence - Urethral discharge - Haematuria - Pain - Thirst - Oedema

4. Systemic Direct Questions (cont.)

Genital Tract

- Scrotum - Urethra - Menstruation
- Pregnancies - Dyspareunia - Breast
- Secondary Sexual Characters

4. Systemic Direct Questions (cont.)

The Nervous System

- Mental Status
- Brain and Cranial Nerves
- Peripheral Nerves

4. Systemic Direct Questions (cont.)

Musculoskeletal System

- Pain – Swelling - Decrease Joint Movement
- Weakness of Muscles
- Walking
- Congenital Abnormalities

4. Systemic Direct Questions (cont.)

Metabolism

- Weight
- Appetite
- Growth

5. Past History

Not related to present complaint

- **Operations**: type ,When, ? Wound infection ? Recurrence ? blood transfusion,
- Accidents / illness
- Gyne / obstetric history
- Previous hospital admission
- Ask About B. asthma
  DM
  HTN

6. Drug History

- Steroids
- MAO inhibitors
- Anticoagulants (Coumadin)
- Aspirin
- Insulin
- Oral Contraceptive pills

? **Allergies**

7. Immunization

- DPT.
- Polio
- BCG
- Typhoid

8. Family History

- Cause of Death in relatives
- Similar Problem
- Cancer: Breast & colon cancer

9. Social History

- Occupation, education..
- Living Conditions: water, ? Animals / birds at home,
- Payment
- Traveling Abroad

10. Habits

- Smoking : amount , duration type…
- Drink ……
- Unusual eating Habits

Summarizing

- After taking the history, it's useful to give the patient a run-down of what they've told you as you understand it. For example:
- ***'So, Mohammed , from what I understand you've been losing weight, feeling sick, had trouble swallowing - particularly meat - and the whole thing's been getting you down. Is that right?'.***
- If there is a nod of approval or expressed agreement with the story then it's fairly certain you're getting what the patient wanted to tell you.
- If not, then you may need to try another approach.
- This technique can avoid incorrect assumptions by the doctor.

Conclusion

- Try to let patients tell you their story freely.
- When you use questions, try to keep them as open as possible.
- Use all your senses to 'listen'..
- Keep an open mind and always ask yourself if you're making assumptions.
- Be prepared to reconsider the causes of symptoms that you or a colleague have decided upon.

Thank You