ANKARA UNIVERSITY FACULTY OF MEDİCİNE

COURSE INFORMATION FORM

COURSE NAME: Principals of Medical History Taking
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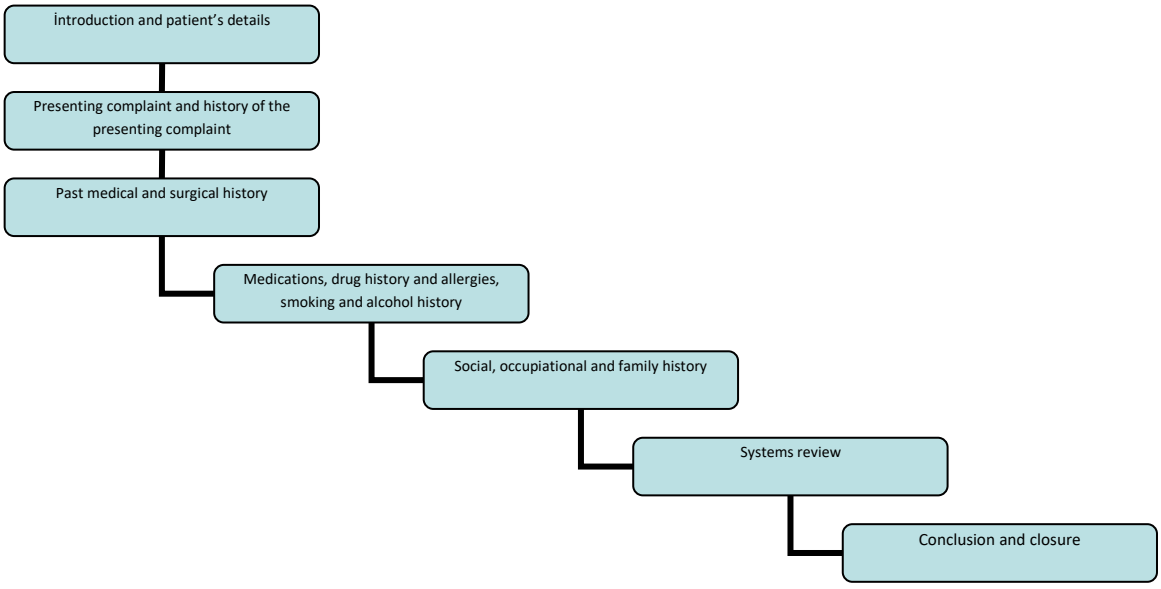
MODULE: Year 2 English

UPDATE: 27.03.2020

Introduction to medical history taking

The history will tell you about the illness as well as the disease. The illness is the subjective component and describes the patient's experience of the disease. Try to follow the sequence history, examination, investigation when you see a patient. A common mistake is to rush into investigations before considering the history or examination. Always remember to treat the patient and not the investigation. And remember that although we talk about "the patient," you should consider "the person." Figure 1 shows the components of history taking.

Figure 1. Medical History Taking Components



You should use the following as a guide until you develop your own style and one that you feel comfortable with. You are at liberty to reorganise the order. For instance, you could go to the

systems review after the history of the presenting complaint. Whatever order you use, however, you need to ensure that you get all components of the history.

Components in taking a medical history

Introduction and details

You should always begin by introducing yourself. This should include your status as well as the educational reason for the encounter. For example, “My name is… I am a… year medical student, and I have come to talk to you to learn how to take a medical history.” It is then useful to obtain some background information about the patient including their name, age, marital status, and occupation. To establish rapport, and to put the patient at ease, it often helps to continue the interview by considering issues such as:

• How they would like to be addressed (forename or surname)

• Their physical comfort

• That you will treat all information as confidential

• How the patient may end the consultation: “If at any time you wish to stop this interview then please let me know.”

Presenting complaint

Ask the patient to describe the symptom or problem that brought them to hospital by using an open ended question: “What has happened to bring you to hospital?” or “What seems to be the problem?” You should show interest to facilitate this. Clearly, you want answers but you also wish to develop a rapport with the patient as well as understand him or her (and you will not do this through a series of closed questions). The patient's narrative gives important clues as to the diagnosis and the patient's perspective of their illness. You should not interrupt. Most patients' initial response will last fewer than two minutes. So it is worth while to give this amount of time to let the patient describe in their own words the problem that has led to their present situation. Thus, history taking involves the use of communication skills. You need to develop your skills in: • Opening and closing a consultation

• The use of open and closed questions

• The use of non-verbal language

• Active listening

• Showing respect and courtesy

• Showing empathy

• Being culturally sensitive.

If you do not communicate properly you will become increasingly frustrated and the patient will get suboptimal care. So, when you are taking a history, listen to the patient.

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This is not as easy as it sounds, especially in the beginning. You need to be patient and practice taking histories. In the early years there is a tendency to concentrate on events (investigations, treatments, etc) undertaken after the patient has been admitted to hospital. Although this is useful, what you should be aiming to do is defining the problem. In other words, what history would you take if you were the first person to see the patient and had to make a differential diagnosis? To a large extent, this means making sense of the symptoms that the patient presents with. This is important as:

• You can then attempt to link the symptoms to the diagnosis

• The patient may have misheard or misunderstood the discussions, and the diagnosis might be incorrect or only partly correct.

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incorrect or only partly correct.

An attempt should be made to link the presenting complaint with the related systems review or inquiry. For instance, a patient presenting with chest pain should be asked questions covering the cardiovascular and respiratory systems such as cough, shortness of breath, palpitations, ankle swelling, etc.

Past illness

List **childhood illnesses**, then list **adult illnesses** in each of four areas:

● Medical (e.g., diabetes, hypertension, hepatitis, asthma, HIV), with dates of onset; also information about hospitalizations with dates; number and gender of sexual partners; risky sexual practices

● Surgical (dates, indications, and types of operations)

Obstetric/gynecologic (obstetric history, menstrual history, birth control, and sexual function)

● Psychiatric (illness and time frame, diagnoses, hospitalizations, and treatments)

In addition, list ***medications***, including name, dose, route, and frequency of use; ***allergies***, including *specific reactions* to each medication; ***tobacco*** use; and ***alcohol*** and ***drug*** use. Also discuss ***Health Maintenance***, including *immunizations*, such as tetanus, pertussis, diphtheria, polio, measles, rubella, mumps, influenza, varicella, hepatitis B, *Haemophilus influenzae* type b, pneumococcal vaccine, and herpes zoster vaccine; and *screening tests*, such as tuberculin tests, Pap smears, mammograms, stool tests, for occult blood colonoscopy, and cholesterol tests, together with the results and the dates they were last performed.

Family Hıstory

Outline or diagram the age and health, or age and cause of death, of each immediate relative, including grandparents, parents, siblings, children, and grandchildren. Record the following conditions as either *present or absent* in the family: hypertension, coronary artery disease, elevated cholesterol levels, stroke, diabetes, thyroid or renal disease, cancer (specify type), arthritis, tuberculosis, asthma or lung disease, headache, seizure disorder, mental illness, suicide, alcohol or drug addiction, and allergies, as well as conditions that the patient reports.

Personal And Socıal Hıstory

Include occupation and the last year of schooling; home situation and significant others; sources of stress, both recent and long term; important life experiences, such as military service; leisure activities; religious affiliation and spiritual beliefs; and activities of daily living (ADLs). Also include lifestyle habits such as *exercise* and *diet*, *safety measures*, and *alternative health care* practices.

Review Of Systems (Ros)

These “yes/no” questions go from “head to toe” and conclude the interview. Selected sections can

also clarify the Chief Complaint; for example, the respiratory ROS helps characterize the symptom of cough. Start with a fairly general question. This allows you to shift to more specific questions about systems that may be of concern. For example, "How are your ears and hearing?" "How about your lungs and breathing?" "Any trouble with your heart?" "How is your digestion?" The *Review of Systems* questions may uncover problems that the patient overlooked. *Remember to move major health events to the Present Illness or Past History in your write-up.* Some clinicians do the *Review of Systems* during the physical examination. If the patient has only a few symptoms, this combination can be efficient but may disrupt the flow of both the history and the examination.

General. Usual weight, recent weight change, clothing that fits more tightly or loosely than before; weakness, fatigue, fever.

Skin. Rashes, lumps, sores, itching, dryness, color change; changes in hair or nails; changes in size or color of moles.

Head, Eyes, Ears, Nose, Throat (HEENT). Head: Headache, head injury, dizziness, lightheadedness. ***Eyes:*** Vision, glasses or contact lenses, last examination, pain, redness, excessive tearing, double or blurred vision, spots, specks, flashing lights, glaucoma, cataracts.

Ears: Hearing, tinnitus, vertigo, earache, infection, discharge. If hearing is decreased, use or nonuse of hearing aid.

Nose and sinuses: Frequent colds, nasal stuffiness, discharge or itching, hay fever, nosebleeds, sinus trouble.

Throat (or mouth and pharynx): Condition of teeth and gums; bleeding gums; dentures, if any, and how they fit; last dental examination; sore tongue; dry mouth; frequent sore throats; hoarseness.

Neck. Lumps, "swollen glands," goiter, pain, stiffness.

Breasts. Lumps, pain or discomfort, nipple discharge, self-examination practices.

Respiratory. Cough, sputum (color, quantity), hemoptysis, dyspnea, wheezing, pleurisy, last chest x-ray. You may wish to include asthma, bronchitis, emphysema, pneumonia, and tuberculosis.

Cardiovascular. "Heart trouble," hypertension, rheumatic fever, heart murmurs, chest pain or discomfort, palpitations, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, edema, past electrocardiographic or other cardiovascular tests.

Gastrointestinal. Trouble swallowing, heartburn, appetite, nausea. Bowel movements, color and size of stools, change in bowel habits, rectal bleeding or black or tarry stools, hemorrhoids, constipation, diarrhea. Abdominal pain, food intolerance, excessive belching or passing of gas. Jaundice, liver or gallbladder trouble, hepatitis.

Peripheral Vascular. Intermittent claudication; leg cramps; varicose veins; past clots in veins; swelling in calves, legs, or feet; color change in fingertips or toes during cold weather; swelling with redness or tenderness.

Urinary. Frequency of urination, polyuria, nocturia, urgency, burning or pain on urination, hematuria, urinary infections, kidney stones, incontinence; in males, reduced caliber or force of urinary stream, hesitancy, dribbling.

Genital. Male: Hernias, discharge from or sores on penis, testicular pain or masses, history of sexually transmitted infections (STIs) or diseases (STDs) and treatments, testicular self-examination practices. Sexual habits, interest, function, satisfaction, birth control methods, condom use, problems. Concerns about HIV infection.

Female: Age at menarche; regularity, frequency, and duration of periods; amount of bleeding, bleeding between periods or after intercourse, last menstrual period; dysmenorrhea, premenstrual tension. Age at menopause, menopausal symptoms, postmenopausal bleeding. Vaginal discharge, itching, sores, lumps, STIs and treatments. Number of pregnancies, number and type of deliveries, number of abortions (spontaneous and induced), complications of pregnancy, birth control methods. Sexual preference, interest, function, satisfaction, problems (including dyspareunia). Concerns about HIV infection.

Musculoskeletal: Muscle or joint pain, stiffness, arthritis, gout, backache. If present, describe location of affected joints or muscles, any swelling, redness, pain, tenderness, stiffness, weakness, or limitation of motion or activity; include timing of symptoms (e.g., morning or evening), duration, and any history of trauma. Neck or low back pain. Joint pain with systemic features such as fever, chills, rash, anorexia, weight loss, or weakness.

Psychiatric: Nervousness; tension; mood, including depression, memory change, suicide attempts, if relevant.

Neurologic: Changes in mood, attention, or speech; changes in orientation, memory, insight, or judgment; headache, dizziness, vertigo; fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling or “pins and needles,” tremors or other involuntary movements, seizures.

Hematologic: Anemia, easy bruising or bleeding, past transfusions, transfusion reactions.

Endocrine. “Thyroid trouble,” heat or cold intolerance, excessive sweating, excessive thirst or hunger, polyuria, change in glove or shoe size.

FURTHER READİNG:
Bates Pocket Guide to Pyhsical Examination and History Taking Seventh Edition.