Principles of History Taking

Introduction

The History

The Examination

The Diagnosis: Working & Differential

Investigations

Management
Introduction

Introduce yourself to the patient

Explain who you are & what you are doing

Ask permission to carry out the history and examination
Symptoms
The History

Record the date & time of the examination

Ask patient main reason that he/she is in hospital or clinic

The reason is called the: **Presenting Complaint (PC)**

Best recorded in words spoken by the pt: usually not more than *one or two words*

**PCs** usually number: >1 & <5

List PCs: numerically, chronologically & their time course
History of Presenting Complaint 1.

Describe each separate symptom or PC in detail.

Let the patient tell story of each individual PC.

Before being recorded (written down) the account needs to be: interpreted & summarized by the student (doctor).
History of Presenting Complaint 2.

Clinical description should include:

*Nature & Character of each main symptom & why now*

For especially important comments: write & record the patients *own words*
Presenting Complaints

Nature/Character: what is it
Site/Location: where is it
Severity: how bad is it
Time course: onset, frequency, duration, progress
Aggravating & Relieving factors: worse or better
Associated symptoms: any others
Past Hist: similar symptoms, investigations & treatments
History of Presenting Complaint 3.

Incorporate relevant System Review: into the HPC

Include: current treatment & list the medications

Document informant who gave you the history: if the patient is unable to
Past Medical History

Medical illnesses, accidents, hospitalizations & operations & their: year and month of onset

Determine: active or inactive

Ask specifically re a history of: infections (HIV, TB), diabetes (DM), hypertension (BP), rheumatic fever (RF)
Family History

Record 1\textsuperscript{st} degree family relatives; \textit{parents, siblings & children}

If relevant document family tree: \textit{names, age, sex of those affected & their outcome}

If hereditary enquire if another family member is affected: \textit{e.g. Sickle cell disease, Haemophilia or DM}
Social History

Occupation & Education: ask re employment

Life Style Habits:
Smoking: pack yrs
Alcohol: amount & duration
Diet: estimated calories intake per day if indicated
Exercise: daily & amount

Marital status & household dependants
Drug History

List the drugs/medication that pt is taking

Include following:

• name of drug
• dose & duration
• frequency per day: (od= once daily, bid = 2 times daily, tid = three times daily, qid = 4 times daily)
• side effects of medication
Obstetrical & Gynaecological History

Gravida & Parity: *Number of pregnancies & live births*

Menarche & Menopause: *Year of onset*

Menstruation: *Cycle, duration etc*
Allergies

Ask if allergic & to what? *e.g. penicillin*

Name of allergy *e.g drug* must be listed & recorded in patient’s file notes

In case of a dangerous allergy: *this should be written in large red letters on front cover of pts file notes in order to avoid any mishap*
Systems Review

General
Cardiovascular
Respiratory
Gastrointestinal/Genitourinary
Reticuloendothelial
Locomotor
Nervous
General Questions

Health: How are you feeling generally

Weakness: How is your strength or are you tired

Appetite: How is your appetite or have you lost it

Weight: Have you lost any weight or have you got thin

Fevers: Any fevers or sweats at night

General well-being: How is your mood and sleep
Cardiovascular System

Dyspnoea: short of breath (SOB) at rest & on exercise

Orthopnoea: short of breath on lying flat, needs pillows

Paroxysmal Nocturnal Dyspnoea: wakes up at night

Oedema: ankle swelling

Chest Pain: in chest, neck or arm

Palpitations: an awareness of heart beat

Dizziness/Syncope: a subjective unsteadiness/LOC
Respiratory

Dyspnoea & Wheezing: shortness of breath

Cough: productive or non productive

Sputum: colour, amount, purulent, smell

Haemoptysis: blood in sputum

Chest pain: pleuritic; worse on breathing

Fevers & night sweats
Gastrointestinal

Appetite & Weight Loss: change or loss
Dysphagia: difficulty in swallowing
Flatulence/Flatus: passing air via mouth or anus
Indigestion/Heartburn: burning pain retrosternally
Vomiting and/or Haematemesis: vomiting blood
Abdominal pain/discomfort
Bowel habit: frequency & any change recently
Diarrhoea: loose bowel motion frequency >3 per day
Jaundice: eyes and/or skin yellow
Stool: bloody or melena (black)
Genitourinary System

Dysuria: difficulty or pain passing urine

Frequency: how many times/day do you urinate

Nocturia: passing urine at night; mostly in men

Haematuria: do you pass blood in urine
Reticuloendothelial System

Anaemia: weak & tired, dizzy or short of breath

Low platelets: bleeding or bruising easily

Low white blood cells: fevers, infections, chills or shakes

Lymph node enlargement: swellings or lumps under your arms or in your groins
Locomotor System

Arthritis: painful or stiff joints

Synovitis/Effusions: joints swollen

Spinal Disorders: pain in neck or back

Disability: difficulty walking or self caring
Nervous System

Headaches, pain: pain in your head or face or limbs, trunk

Power: weakness or loss of power in your limbs

Feeling: loss of feeling or sensation in limbs or body

Dizziness: feel dizzy or unsteady

Consciousness: fit or blackout or LOC

Incontinence: loss of control of bladder & bowel

Vision or hearing: loss of hearing or vision
Key points

• Establish good communication
• Allow patient to tell the story of illness
• Ask questions in a logical order
• Listen carefully & order your questions appropriately
• Observe patient during history looking for useful clues
• Avoid overinterpretation early on in the history
• Identify likely anatomical & physiological basis for patient’s symptoms
Signs
Impression

General State of Patient

Record how patient appears/looks: **well or unwell?**

Record a short description of appearance: e.g. 

wasted, anaemic, cyanosed, breathless, dehydrated, jaundiced, abnormal stature, in pain, confused, comatose etc
The Physical Examination

Main Systems

Cardiovascular
Respiratory
Gastrointestinal & Genitourinary
Nervous
Reticuloendothelial
Locomotor
Vital Signs

Pulse rate: per minute

Respiratory rate: per minute

Blood pressure: arm in resting position

Temperature: orally
Cardiovascular System (CVS)

Pulses, Veins & Blood pressure & Heart

Examination order:

Inspection
Palpation
Auscultation
Respiratory system

Upper Airway: Nose, Sinuses & Throat
Lower Airways: Larynx, Trachea & Lungs

Examination order:
- Inspection
- Palpation
- Percussion
- Auscultation

Sputum: examination
Gastrointestinal System

Abdomen: Mouth, Oesophagus, Stomach, Intestine, Rectum, Liver & Gall Bladder

Examination order:
Inspection
Palpation
Percussion
Auscultation

Faeces & Vomitus: Examination
Genitourinary System

Kidneys, Ureters, Bladder, Urethra, Reproductive Organs & Genitalia
Abdomen, Pelvis & Breasts

Examination order:
Inspection
Palpation

Urine: Examination
Nervous System

Brain, Spinal Cord, Cranial Nerves, Peripheral Nerves, Neuromuscular Junction & Muscle

Examination order:
Level of consciousness,
Higher Cognitive Function, Speech, Cranial Nerves, Limbs: Motor & Sensory system & Gait

Cerebrospinal Fluid (CSF): Examination
Reticuloendothelial System

Haemopoietic system, Lymph Nodes, Liver & Spleen

Examination order:

Inspection
Palpation

Blood: Examination in Laboratory
The Locomotor System

Bones, Joints, Cartilages, Tendons, Muscles & Nerves & Gait

Examination order:

- Inspection
- Palpation
- Movement
The Endocrine System

Thyroid Gland, Hair distribution, Physical & Sexual development

Examination order:
Inspection
Palpation
Special Senses

Eye, Ear & Nose

Examination order:

Inspection

Specialized Testing: Vision, Hearing & Smell
Key points

- Physical examination best performed in well lit room, away from noise & distractions

- Make sure that pt is in correct position for system being examined

- Expose parts to be examined but cover parts not under examination using a bed sheet as a cover

- A physical sign should be reproducible & demonstrable
Case Summary

Using not more than one or two sentences summarise the most important clinical findings (*main symptoms and signs and their time course*)
Diagnosis

1) Differential Diagnosis

2) Working or Provisional Diagnosis

3) Final Diagnosis (*when known*)
Management

Plan of action

List of active problems which require action

List of investigations for each problem

List treatment planned for each problem
Investigations

**Bedside:** blood glucose, urine dipstick, $O_2$ saturation

**Laboratory:**
- Haematology
- Biochemistry
- Serology
- Microbiology

**Radiology**
- Chest Xray
- Abdominal Ultrasound, Cardiac Echo
- CT/MRI

**Specialized**
- Gastroscopy, Colonoscopy, Bronchoscopy

**Pathology**
- Histopathology