History & Physical Examination Overview

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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, progess

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 1st degree family relatives; *parents, siblings & children*

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

If hereditary enquire if another family member is affected: 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 postion 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