History Taking
Aims

- Basic knowledge of history taking
Learning Outcomes

- Establish the patient’s main complaint or complaints.
- Obtain a clear picture of all the main symptoms.
- Systematic approach to other relevant history
- Able to explore the patient’s views/concerns
Why do you need to take a history

- History taking contributes 60-80% of the data for diagnosis.
How do I start?

- GRIP
  - Greet
  - Rapport
  - Introduce yourself
  - Identify patient (name and DOB) and others
  - Privacy, purpose
The outline

- Presenting complaint
- Past Medical History
- Drugs
- Allergies
- Family History
- Social history
- Systemic review
Taking notes

- Write while you talk
  
  or

- Talk first, write later?
Opening lines:

- “What brings you here today?”
- “So tell me what happened”
- “When were you last well and what happened after that?”
Presenting complaint

- Consists of:
  - Narrative
  - Open questions
  - Closed questions
    - Hypothesis testing
Narrative History

Doctors interrupt their patient’s opening statements after 18 seconds

Beckmann HB, Frankell RM. Annals of Internal Medicine 1984;101:692-6
Main compliant or complaints in patients own wards
  - ‘Dr I think I have pneumonia’

Get a clear picture
  - Chronology
  - Characteristics
    - Eg Cough, Chest pain
Pain

- Site
- Onset
- Character
- Radiation
- Associated symptoms
- Time course
- Exacerbating / relieving factors
- Severity
Cough

- Dry/wet
  - Sputum-colour, amount, associations – posture...
- Pattern
- Time of the day
- Associated symptoms- wheeze
- Exacerbating/relieving factors
Am I leading the patient?

- “Describe your pain to me”

- “Was it dull, central, crushing chest pain radiating to the left arm and jaw with associated nausea and sweating?”
Hypothesis Testing

- Important positive and negative
Don’t forget to explore the patients thoughts, concerns and worries
Past medical History

- Start with open questions
  - Any illnesses / medical problems in the past
  - Any Hospital admissions- details

- Then closed/direct questions
- Diabetes
- Jaundice
- Peptic ulcer
- Hypertension
- Asthma
- Thromboembolism
- Myocardial Infarction
- Angina
- Stroke
- TB
- Epilepsy
- Rheumatic Fever
Past Surgical History

- Narrative
- What, when, where, who, why, any complications?
- Anaesthetic problems
Drug History

- Prescribed
- Over-the-counter
- Alternative
- Dose, frequency, indication

- List from GP
- Bag of drugs
Allergies

Are you allergic to anything?

What drug?

What reaction?
  - Record non-allergic adverse reactions too

Anaesthetics, dressings, latex, foods
Family History

Do any diseases run in the family?

- Enquire tactfully and empathetically about parents, siblings and children
- Ask specifics based upon your hypotheses
- Age that developed disease also important
- Bleeding diatheses, anaesthetic problems
Social History

- **Occupation**
  - Present and previous
  - Consider exposure, use of protective equipment

- **Habits**
  - Smoking, alcohol, illicit drugs

- **Domestic circumstances**
  - Anybody else at home, pets
  - ADLs, Barthel Index (Link to Barthel Index)
  - Social Services / home help
  - Type of home (esp. stairs)

- **Travel**
  - Immunisations, malaria prophylaxis
Group work

- Split into 5 groups of 4 or 5
- Think of all the symptoms you want to ask about
  - And formulate a question
  - Group 1 – Cardiovascular and musculoskeletal
  - Group 2 – Respiratory and endocrine
  - Group 3 – Gastrointestinal and skin
  - Group 4 – Genitourinary and Gynae
  - Group 5 – Neuro/mental health and haematology
Cardiovascular

- Chest pain
- Breathlessness (SOB, SOBOE, SOBAR)
- Orthopnoea
- Paroxysmal nocturnal dyspnoea (PND)
- Stairs / exercise
- Swelling of ankles (SOA)
- Intermittent claudication
- Palpitations
- Cold / blue extremities
Respiratory

- Dyspnoea
- Chest pain
- Cough
- Sputum
- Haemoptysis
- Snoring / sleep apnoea
- Wheeze
- Fever, night sweats
Gastrointestinal

- Anorexia
- Diet
- Wt loss
- Mouth ulcers
- Dysphagia
- Odynophagia
- Indigestion
- Nausea
- Vomiting
- Haematemesis
- Jaundice or hepatitis
- Pruritus
- Abdo pain
- Bloating
- Borborygmi
- Change in bowel habit
- Change in colour / consistency of stool
- Blood or mucus or black stool (melaena)
- Incontinence
- Tenesmus
- Pruritus ani
Genitourinary

- **Voiding**
  - Dysuria
  - Haematuria – where in stream, painful or painless, ?degree
  - Hesitancy
  - Strangury
  - Poor stream / stop-start
  - Post mic dribble
  - Pneumaturia
  - Urethral discharge

- **Storage**
  - Frequency (?volume)
  - Nocturia
  - Incontinence – stress, urge,
  - Enuresis

- **May need full sexual history**
  - Who, what, when, how
  - Past sexually transmitted infections
Gynaecology

- Pregnancies (Gravida)
- Children (parity)
- Miscarriages or TOPs
- Hypertension or diabetes in pregnancy
- Discharge
- Dyspareunia
- Could you be pregnant?

- Periods
  - LMP
  - Regularity
  - Cycle length
  - Heavy
  - Painful
- Intermenstrual / postmenopausal bleeding
Musculoskeletal

- Joint pain
- Joint stiffness
- Joint swelling
- Backache
- Myalgia
- Diurnal pattern of symptoms
- Effects on ADLs
Neurology/mental

- Fits
- Faints
- Funny turns
- Visual or hearing problems
- Abnormal sensation or numbness
- Weakness
- Speech difficulty
- Headache
- Memory problems
- Personality change
- Depression / anxiety
- Full mental state examination if indicated
Haematology

- Bruising
- Bleeding
- Tiredness
- Pruritus
- Fever / sweats
Endocrine

- Moans, stones, bones, abdominal groans
- Weight change
- Sleep change
- Thermoregulation
- Sweating
- Hirsutism
- Gynaecomastia
- Galactorrhoea
- Change in menstrual cycle
- Polyuria / polydipsia
- Sexual function
- Tremor
- Vision changes
- Change in appearance
- Depression
- Anxiety
- Flushing
Dermatology

- Rash
- Itch
- Skin infection
Pitfalls

- Missing cues
- Misunderstanding the patient
- Putting words into pt’s mouth
- Missing out sections or questions
- Going off on a tangent
- Upsetting the patient
- Lack of empathy
- Taking pts use of medical terms at face value
Finally..

- Give a summary
- End with your plans for the patient
Summery

- Open to close questions
- Listen to the patient
- Try to pick up non-verbal clues
- Summarise
Summery

Contents
- GRI P
- Presenting complaint/complaints
- Past medical/surgical history
- Drugs
- Family history
- Social history
- Systems review
- Patients views/concerns
Take lots of histories -