During History Taking

The General Facts

- Welcome the patient - ensure comfort and privacy
- Know and use the patient's name
- Introduce and identify yourself
- Keep eye contact during conversation
- Set the Agenda for the questioning
• Use open-ended questions initially

• Negotiate a list of all issues - avoid excessive detail initially
  – Chief complaint(s) and other concerns
  – Specific requests (i.e. medication refills)

• Show empathy

• Clarify the patient's expectations for this visit - ask the patient "Why now?"
• Elicit the patient's story
• Return to open-ended questions directed at the major problem(s)
• Encourage with silence, nonverbal cues, and verbal cues
• Focus by paraphrasing and summarizing
• Professionally treat the difficult patients while taking history (Silent patient, talkative patient, crying patient... )
Components of the History

• Chief complaint
• Present Illness
• Past Medical/Surgical, Allergies, Medications, Hospitalizations, Obstetrics, Sleep, Family
• Sexual, Social,

• Review of Systems
Chief Complaint

• This is why the patient is here in the emergency room or the office

• Examples:
  – Shortness of breath
  – Chest pain
  – Nausea or vomiting
Present Illness

• This is the detailed reason why the patient is here

• It is the why, when and where, etc…

• Use the OPQRSTA approach to cover all aspects of information
History of Present Illness

• OPQRSTA

  – Onset
    • When did the chief complaint occur

  – Prior occurrences of this problem

  – Progression
    • Is this problem getting worse or better
    • Is there anything that the patient does that makes it better or worse

  – Quality
    • Is there pain, and if so what type—how would the patient describe it in words
• **OPQRSTA (continued)**
  
  – **Radiation**
    
    • Do the symptoms radiate to anywhere in the body, and if so, where?

  – **Scale**
    
    • On a scale of 1 to 10, how bad are the symptoms

  – **Timing**
    
    • When do the symptoms occur?
      
      – At night, all the time, in the mornings, etc…

  – **Associated symptoms**
    
    • Any other info about the chief complaint that has not already been covered
    
    • Ask if there is anything else that the patient has to tell about the chief complaint
Past Medical History

• These are the medical conditions that the patient has chronically and that they see a doctor for.

• Examples:
  – Hypertension, GERD, Depression, Congestive heart failure, hyperlipidemia, Diabetes, Asthma, Allergies, Thyroid problems, etc…
Past Surgical History

- These are any previous operations that the patient may have had
- Make sure to put how old the patient was when they occurred
- Include even those that occurred in childhood

- Examples:
  - Tonsillectomy, Hysterectomy, Appendectomy, Hernias, Cholecystectomy
Medications

- Include all meds the patient is on—even over the counter meds and herbals
- Try to include the dosages if the patient knows them
- Include how often the patient takes them
Allergies

- Make sure to ask about medication allergies and the reaction that the patient has to them
- Ask about latex, food and seasonal allergies
Social History

• Things to include:
  – Occupation
  – Marriage status
  – Tobacco use—how much and for how long
  – Alcohol use
  – Illicit drug use
  – Immunization status
  – If pertinent, sexually transmitted disease history
Social History

• In U.S. Hospitals, The followings are Included when required:
  – Code status
    • Does the patient wish to have resuscitative measures taken in the event of cardiac arrest, including chest compressions and/or intubation.
      – DNR—do not resuscitate
      – DNI—do not intubate
Family History

• Ask if the patient’s parents, grandparents, siblings or other family members had any major medical conditions
  – Examples:
    • Heart disease, heart attacks, hypertension, hyperlipidemia, diabetes, sickle cell disease
Review of Systems

• The review of systems is just that, a series of questions grouped by organ system including:
  • General/Constitutional
  • Skin/Breast
  • Eyes/Ears/Nose/Mouth/Throat
  • Cardiovascular
  • Respiratory
  • Gastrointestinal
  • Genitourinary
  • Musculoskeletal
  • Neurologic/Psychiatric
  • Allergic/Immunologic/Lymphatic/Endocrine
Physical Exam

Important Points:

– Wash your hands.

– Asked permission to start the exam.

– Use respectful draping.

– Do not repeat painful maneuvers

– Explain while performing physical exam

– Try to be face to face during all conversations
Physical Exam

- General
- Skin
- HEENT
- Neck
- Heart
- Lungs
- Abdomen
- Extremities
- GU if pertinent to the chief complaint
Physical Exam

- Make sure to include vital signs as part of this

- Develop a systematic approach for doing the physical exam
Assessment and Plan

• This is what you think is wrong with the patient, and what you plan to do initially during admission

• Example:
  – A/P: Chest pain.
    • Admit the patient to the chest pain protocol
    • Get EKG every 8 hours times three
    • Cardiac enzymes every eight hours times three
    • CBC, Elect, etc....
Closure

• Discuss the initial diagnostic impressions

• Discuss initial management plans

• Always explain the complex medical terminology in lay language

• Health education about smoking, alcohol, illicit drugs etc

• Ask if the patient has any other questions or concerns (Difficult Question) and answer it in a professional manner.
Closure Continue

• Never give false hopes to the patients.

• Never deliver partial and non-confirmed information to the patient.
Dictating

- This will all be dictated as part of the official medical record
- Beginning parts:
  - State your name
  - Visit/Admission date
  - Attending physician
  - Resident physician
Thank You