HISTORY TAKING PART 1



- 1. Introduction and Describing Aim & Objectives
- 2. Chief complaint
- 3. History of present illness
- 4. Past medical history
- 5. Systemic enquiry
- 6. Family history
- 7. Drug history
- 8. Social history

Pair Group and Role Play

20 min



- Obtaining an accurate history is the critical first step in determining the etiology of a patient's problem.
- A large percentage of the time) 70%), you will actually be able make a diagnosis based on the history alone.

General Approach

- Introduce yourself.
 - Note never forget patient names
 - Creat patient appropriately in a friendly relaxed way.
 - Confidentiality and respect patient privacy.
- Try to see things from patient point of view. Understand patient underneath mental status, anxiety, irritation or depression.

Always exhibit neutral position.

- Listening
- Questioning: simple/clear/avoid medical terms/open, leading, interrupting, direct questions and summarizing.



- Always record personal details: NASEOMADR.
 - Name,
 - Age,
 - Address,
 - Sex,
 - Ethnicity
 - Occupation,
 - Religion,
 - Marital status.
 - Date of examination



- Chief complaint
- History of present illness
- Past medical /surgical history
- Systemic review
- Family history
- Drug /blood transfusion history
- Social history
- · Gyn/ob history.

Chief Complaint

- The main reason push the pt. to seek for visiting a physician or for help
- Usually a single symptoms, occasionally more than one complaints eg: chest pain, palpitation, shortness of breath, ankle swelling etc
- The patient describe the problem in their own words.
- It should be recorded in pt's own words.
- What brings your here? How can I help you?
 What seems to be the problem?

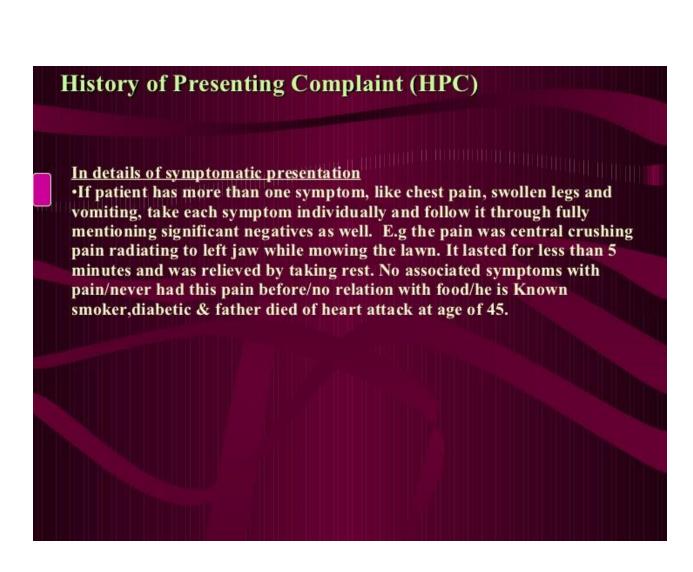
Chief Complaint

Cheif Complaint (CC):

- Short/specific in one clear sentence communicating present/major problem/issue. As:
- Timing fever for last two weeks or since Monday
- Recurrent recurring episode of abdominal pain/cough
- Any major disease important e.g. DM, asthma, HT, pregnancy, IHD:
- Note: CC should be put in patient language.



- Elaborate on the chief complaint in detail
- Ask relevant associated symptoms
- Have differential diagnosis in mind
- Lead the conversation & thoughts
- Decide & weight the importance of minor complaints



Pain (OPQRST)

- Onset of disease
- Position/site
- Quality, nature, character burning sharp, stabbing, crushing; also explain depth of pain superficial or deep.
- Relationship to anything or other bodily function/position.
 - Radiation: where moved to
 - Relieving or aggravating factors any activities or position
 - Severity how it affects daily work/physical activities. Wakes him up at night, cannot sleep/do any work.
- Timing mode of onset (abrupt or gradual), progression (continuous or intermittent if intermittent ask frequency/ nature.)

 Treatment received or/and outcome.
 - Are there any associated symptoms?.