HISTORY TAKING PART 1

Session Structure

1.	**Introduction and Describing Aim &Objectives**		**20 min**
2.	Chief complaint	**Pair Group and Role Play**	**10min**
3.	History of present illness		**10min**
4.	Past medical history		**10min**
5.	Systemic enquiry		**10min**
6.	Family history		**10min**
7.	Drug history		**10min**
8.	Social history		**10min**

Importance of History Taking

- 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.

Taking the history & Recording:

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

Complete History Taking

- **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.**

History of Present Illness - Tips

- 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

History of Presenting Complaint (HPC)

In details of symptomatic presentation

•If patient has more than one symptom, like chest pain, swollen legs and vomiting, take each symptom individually and follow it through fully mentioning significant negatives as well. E.g the pain was central crushing pain radiating to left jaw while mowing the lawn. It lasted for less than 5 minutes and was relieved by taking rest. No associated symptoms with pain/never had this pain before/no relation with food/he is Known smoker,diabetic & father died of heart attack at age of 45.

Pain (OPQRST)

- **O**nset of disease
- **P**osition/site
- **Q**uality, nature, character – burning sharp, stabbing, crushing; also explain depth of pain – superficial or deep.
- **R**elationship to anything or other bodily function/position.
  Radiation: where moved to
  Relieving or aggravating factors – any activities or position
  - **S**everity – how it affects daily work/physical activities. Wakes him up at night, cannot sleep/do any work.
- **T**iming – 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? .