Practice of history taking

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.

- **How to take a Respiratory History**

Record the date and time the history was taken.

Name, Age, Occupation(s)

- **Presenting Problem/Complaint**
- There are seven main respiratory symptoms to ask about:

1. Cough (character)
2. Sputum (colour, amount)
3. Haemoptysis (colour, amount)
4. Wheeze (diurnal variation?)
5. Chest Pain (site, radiation, character)
6. Shortness of breath (exercise tolerance, orthopnoea)
7. Systematic symptoms e.g. night sweats and weight loss

- **As for any history, For each symptom describe:**

- Onset
- Duration
- Course
- Severity
- Precipitating Factors
- Relieving factors
- Associated features
- Previous episodes

- **Past Medical History**

e.g. Tuberculosis, atopy, pre-existing respiratory conditions, childhood infections.

- **Drug History**

Allergies, inhalers, nebuliser, home oxygen

Drugs that cause respiratory problems including long term amiodarone, methotrexate, nitrofurantoin, and chemotherapy agents

- **Family history**

e.g. asthma/hayfever

- **Social and Occupational History**

Smoking history-measured in pack years

Illicit drug use (including cannabis and other inhaled substances eg crack)

Contact with animals/pets (especially birds –don't forget to ask about hobbies such as pigeon racing). Presence of stairs in or leading into flat/house. Who does/how is shopping done?

Exposure asbestos, dusts, and other chemicals and organic material (hay, fungi)

Systemic Review and Summarise – does the patient have any questions?

- **How to take a Cardiovascular History**

Record the date and time the history was taken.

Name, Age, Occupation(s)

- **Presenting Problem/ Complaint**

Remember, this is the main reason for the patient's attendance to hospital/GP surgery and should be recorded in the patient's own words.

- **History of Presenting Complaint**

There are 4 main cardiovascular symptoms:

1. Chest pain (character, radiation)

2. Shortness of breath (exercise tolerance, orthopnoea, paroxysmal nocturnal dyspnoea)

3. Presence and extent of oedema (ankle, leg or sacral)

4. Palpitations (tap out rhythm, any dizziness or blackouts)

- ***Remember the 8 questions you need to ask about each symptom?***
- During the history consider (and ask about) the main risk factors for Ischaemic Heart Disease:

1. Smoking
2. Hypertension
3. Diabetes mellitus
4. Hyperlipidaemia
5. Family history

- **Past Medical History**

e.g. angina, myocardial infarction, previous coronary bypass operation, valvular disease or previous heart valve replacement surgery, rheumatic fever, stroke, intermittent claudication

- **Drug History**

Allergies, anti-hypertensive drugs, anti-hyperlipidaemic drugs, anti-arrhythmic drugs etc

- **Family History**

e.g. ischaemic heart disease, myocardial infarction (MI) - remember in particular to ask about

the age of the family member(s) first MI

- **Social History**

Smoking (pack years)

Alcohol

Exercise and diet

Presence of stairs in or leading into flat/house

- **Systemic Review Summarise – does the patient have any questions?**

- **How to take a Locomotor History**

Main points to enquire about are:

Evolution of condition

- Acute or chronic?
- Associated events
- Response to treatment

- **Current symptoms**

- Pain
- Stiffness
- Swelling
- Pattern of joint involvement

- **Involvement of other organ symptoms**
  - E.g. Skin, lung, eye or kidney symptoms
  - Any symptom of malaise, weight loss, fevers or night sweats?

- **Impact of lifestyle**
  - Patient's needs/ aspirations
  - Details of any functional impairment
  - Ability to adapt with functional loss

Chest pain

Pts profile: Age, Gender, and Chief Complaint

1. Duration
2. SOCRATES

- Site ? (Retrosternal , lateral)
- Onset (when & how) , sudden or gradual
- Character (heaviness , stabbing , dull …)
- Radiation (to left shoulder , neck , teeth ?? or maybe not)
- Timing (night , day , with exertion , at rest) & time of each episode (5, 10 ,30 min) ??
- Associated symptoms
- Exacerbating and reliving factors (increased by exertion , relieved by NTG or rest, related to position, or respiration (pleuritic chest pain)
- Severity (out of 10)

- If there is any associated symptom analyze it ..
  - SOB
  - orthopnea , Palpitations , ankle swelling
  - nausea , Sweating, VOMITING
  - Hemoptysis
  - Cough, sputum
  - Fever, rigors & chills
  - Arthritis, Skin rash (don’t forget)

- Ask about the Risk Factors for the most likely diagnosis :

If MI : age , HTN , DM , Hyperlipidemia , premature death in the family , Smoking

Family hx of IHD,HTN,DM

If PE : ask about recent travel and how long , bed rest , hypercoagulabe state

Ask about Trauma, Skin rash (don't forget)

- a quick systemic review for the other DDx (don't repeat) : wt. loss , loss of appetite, general fatigue

- **Past hx :**
- - Ask about previous attacks (very important) ,
- - previous Caths or Stents m or MI
- - Previous DVT (if PE suspected)
- - previous hospital admissions , previous surgeries
- - trauma

Drug Hx :

HTN , DM drugs and if controlled

Oral contraceptives (If PE)

Aspirin , anticoagulants , B- blockers

Allergy to drugs

Social hx :

Smoking , Alcohol

- **DDX :**
- **MI →** if it was sudden retrosternal chest pain for 1-4 hrs heavy in nature , at rest , not relieved by rest or NTG , and usually associated with sweating and vomiting (don't forget to ask about them)
- **Unstable angina →** sudden retrosternal chest pain for usually 30 min heavy in nature , at rest , not or slightly relieved by NTG or rest and usually there's not sweating and vomiting
- **Stable angina →** gradual retrosternal pain or chronic (intermittent heavy in nature) , comes only with exertion and relieved by rest or NTG

PE → sudden lateral or central pleurtic chest pain with SOB and sometimes with frank blood hemoptysis and cyanosis and don't forget to ask about DVT …

Pneumonia → gradual pleuritic chest pain (with respiration) , with cough , sputum , Fever & chills

Pericarditis → precordial stabbing pleuritic pain , increased with cough, relieved on leaning forward

Herpes Zooster -- > if there is skin rash on the chest

Trauma

Investigations :

For MI , or Angina → ECG , Cardiac enzymes

PE → D-dimer , CT angio

Pneumonia → Chest X-ray

SOB

Pts profile: Age, Gender, and Chief Complaint

- Duration

- Sudden or gradual

- Progression

- Timing

- Severity

- Exacerbating and relieving factors? comes with exertion (exertional dypsnea) or at rest

- Associated symptoms : (analyze the positive symptom)

it depends according to the DDx … read the DDx below

- COMPLETE the cardinal symptoms of the system and quick systemic review (don’t repeat) :

Past hx :

- previous attack

- chronic respiratory disease (Fibrosis , Brochiectasis , Asthma , COPD ..) or heart diseases (HF , MI …)

- DM, HTN , Hyperlipidemia , chronic renal disease , any chronic disease

- Previous surgeries

Drug Hx :

- B blockers, Calcium channel blocker , Ask about allergy for any thing

Family Hx: respiratory , cardiac , DM,HTN….

Social : **SMOKING** (its better to ask it in history of present illness) , Alcohol , occupation

DDX :

Sometimes the question is SOB with ejection fraction < 30% → HF , so this is cardiac

Sometimes dizziness/SOB/fatigue with low Hb → anemia

Sometimes only SOB and in the history there is cough, sputum and fever → pneumonia or something respiratory

SO MAKE SURE YOU KNOW WHERE YOU ARE GOIN … SO YOU SHOULD modify your history

IF there is cough , sputum , fever & chills , concentrate on the respiratory system because most likely its chest infection .

- If the SOB comes at night with dry cough and wheezes so this is most likely asthma … or if its associated with small amount of sputum and a long history of smocking so most likely its COPD.

- If its sudden shortness of breath with hemoptysis and pleuritic chest pain so you should think of PE … so :

- ask about previous DVT ,

- risk factors for atherosclerosis,

- Ask about recent long travels ,

- Ask specifically for oral contraceptives ,

- bed rest or immobility ,

- pregnancy ,

- hereditary causes of hypercagulable states

- **if there is ejection fraction of less than 30 % for example so this is HF … CONCENTRATE on the cardiac symptoms ,, you can ask about:**

- Orthopnea (the most important)

- angina chest pain ,

- leg swelling , ascites , cyanosis , palpitations , previous MI , HTN , DM , Smoking **.**

if there is low Hemoglobin(HB) you should modify your history so ask anything that causes anemia :

For the most important you should ask about **bleeding** from any site

- and the most important the GIT … SO ask about ,,, Melena , bloody diarrhea or rectal bleeding , epigastric pain (PU) and ask about Aspirin Specifically , hematemisis, coffee ground blood with vomitus

- Hemoptysis of large amounts , hematuria , menstrual loss….. any bleeding

- ask specifically for **hemolytic anemias** if there's jaundice or hematuria if he has sickle cell , thalassemia , G6PD (تفول) or if there's family history of splenectomy , bleeding disorders

- Ask about anemia of chronic diseases (renal failure , liver failure , RA , SLE)

- Ask about nutrition (meat for B12 OR iron) , weight loss, or malabsorbtion syndrome , inflammatory bowel disease

- Ask about general symptoms like general fatigue , fever , lymphadenopathy , bleeding under the skin , infections → lymphoma, leukemia, collagen vascular diseses or infection

- Cold intolerance for hypothyroidism

Investigations:

- **Chest X ray** if you suspected infection or pulmonary edema or even asthma and COPD or lung fibrosis …

- **Spirometry :** for asthma COPD or fibrosis

- **D-dimer and CT angio for PE**

- **CBC** for anemia but if the hemoglobin is known you can ask for specific investigations … for GI Bleed you ask for upper and lower endoscopy … for hypothyroidisim you ask for TSH ,T3,T4 …..

EPIGASTRIC PAIN

Pts profile: Age, Gender, and Chief Complaint

SOCRATES

- Duration (acute or chronic)
- Sudden or gradual over time ?
- Continuous or intermittent (remitting- relapsing) ?
- If intermittent.. Time and frequency??
- SITE?
- Radiation
- Character
- Aggravating factors (food , position , movement)
- Relieving factors (food , position , drugs)
- Severity

Associated symptoms :

- Dyspepsia (feeling tired after the meal)
- Vomiting blood (fresh blood, coffee ground, clotted?)
- Amount, color, smell , and content of the bloody vomitus
- Melena , Hematechezia
- Nausea , Vomiting , diarrhea
- Constipation
- Dysphagia, odynophagia
- Fever and chills
- Jaundice , color of urine and stool , itching →hepatitis or cholestasis
- Chest pain , SOB , sweating → MI
- Orthopnea , PND
- Arthritis & skin rash
- Complete with a quick systemic review : early satiety, wt loss , loss of appetite , cough, sputum .....

Past hx :

- History of peptic ulcer , GERD , IHD , HTN , DM , Hyperlipidemia

- History of hepatitis B, C .. or BLOOD TRANSFUSION , sexual contact

- Hemorrhoids or bleeding from any other site

- Family history of PUD , IHD , HTN, DM

Drug Hx :

Ask about Aspirin or NSAIDS specifically .

Social history Hx :

Smoking, Alcohol, contact to anyone has Hepatitis

DDx :

Localized remitting relapsing Epigastric pain which is aggravated by food associated sometimes with bloody vomitus (coffee ground) and melena if there was any bleeding and usually there is Hx of NSAIDs use for arthritis or any chronic pain → **Gastric ulcer**

If there is heartburn, water brush regurgitation cough and hoarseness of voice it could be **GERD**

Note that it could be an **Inferior wall MI ,** or MI in DM pts could come with epigastric pain so ASK about cardiac symptoms …

Ask about jaundice, change in urine or stool color because it could be **Hepatitis** or something in the liver so ASK also about Alcohol , blood transfusion , DM

If the pain is radiated to the right hypochonrium and between the scapulea and the pain is related to fatty food then it could be acute or chronic **cholecystitis**

If the pain is relieved by bending forward it could be **Pancreatitis**

Investigations:

For peptic ulcer → Upper Endoscopy

UPPER GI BLEEDING

Pts profile: Age, Gender, and Chief Complaint

- Duration
- Amount , color , smell , content of the bloody vomitus
- Frequency
- Fresh blood, clotted or coffee ground ?
- Is it increased or decreased over time?
- Was there severe recurrent vomiting before the bleeding ?
- Alcohol abuse?
- Jaundice , change in urine , stool color ??
- **Melena** ?
- Bleeding from other sites?

- Associated symptoms :
- Abdominal pain (Analysis)
- Dysphagia , Odynophagia
- - Retching , regurgitation , waterbrush , cough, hoarseness of voice
- heartburn
- **Past Hx :**
- Previous similar attacks
- PUD , Hepatitis , Cirrhosis
- Family hx of gastric CA , PUD
- History of blood transfusions or previous surgeries or admissions

Drug Hx :

- Aspirin , NSAIDS , PPI , Antacids

Social Hx :

Smoking , Alcohol Abuse , sexual contact

DDx :

Mallory weiss tears as a complication of recurrent vomiting usually in binge alcohol drinkers

Esophageal Varices if there is large fresh bloody vomitus and usually comes with liver cirrhosis

As a complication of **PUD** if there is epigastric pain and a good history suggesting it .

Gastric CA , eosophageal CA

Investigations :

Upper endoscopy

Joint pain

Pts profile: Age, Gender, and Chief Complaint

How many & what joint(s) are involved? Small or large joints? (Ex: shoulders, knees, MCP, PIP, DIP …??

- Is it symmetrical on both sides? Left and right hands or feet?

- Duration? The first attack?

- Sudden or gradual?

- Continuous or intermittent?

- What time does it get worse? At night? Or morning

- Morning stiffness? Wake up like ((مخشبthen improvers after an hour?

- Aggregated by movement or cold weather?

- Relieved by rest or movement or any drugs?

- How severe is it? Does it affect the movement?

- Redness? Swelling? Deformities?

- Is it migratory? The pain moves from one joint to another?

→ Rheumatic fever

Associated symptoms :

- Fatigue, anorexia, wt loss ,Fever, nausea, vomiting
- Skin rash, butterfly rash, photosensitivity
- Cough, chest or abdominal pain , SOB , Hemoptysis
- Oral or genital ulcers
- Headache, convulsions
-- Dysphagia, odynophagia.
- Bloody diarrhea , RLQ pain
- Urethral Discharge →gonnorheal infection
- A quick Systemic review : cough, hemoptysis,

Past Hx:

- Previous attack

- Hx of RA, SLE, Gout or any chronic disease

- Family Hx of RA,SLE, Previous surgeries

Drug Hx:

- NSAIDS, Hydralazine, diuretic

Social Hx :

- Smoking, Alcohol, sexual conact

- **DDx :**
- **Rheumatoid Arthritis (RA)→** usually a female over 40 yrs, small hands and feet joints pain and swelling with symmetrical involvement, usually the DIP and lower joints are spared, BUT the arthritis is usually destructive so there is some deformities of the hands like ulnar deviation or swan neck . There may be some extra articular manifestations like rheumatoid nodules .
- - Investigations : Rheumatoid factor (RF), anti CCP, CBC , ESR, Xray
- **SLE →** non destructive arthritis, malar rash, photosensitivity , discoid rash, serositis (inflammation of the pleura or peritoneum) , renal involvement, oral ulcers, neurologic (sezures, psychosis), hematologic (hemolytic anemia , leucopenia, thrompocytopenia).
- - Investigations : ANA, anti-smith Ab , Anti-ds DNA ab

- **Ankylosing Sponylitis** : affects usually the lower back joints, the pt usually complains of lower back pain that improves after movement (morning stiffness), also there is peripheral joint involvement but is asymmetrical unlike RA ans SLE , extraarticular manifestations usually include anterior uvietis, aortitis, aortic regurg, pulmonary fibrosis

- **Enteropathic** : comes with Ulcerative colitis and Crohn's Disease.

Gout : usually Monoarthritis, affects the 1st MTP joint (podegra), but can affect other joints, pain comes at night with warmth swelling and redness, the pain goes away spontaneously after 3-4 weeks.

Septic Arthritis : after a gonnorheal infection or staph in elderly.

FMF (Familial Mediterranean Fever) : fever, Abdominal pain, Mono arthritis, Chest pain, pericarditis.

Behcet's Disease: recurrent oral ulcers, genital ulcer, anterior/posterior Uvietis.