History taking

The history (or anamnesis) is the information gained by doctor with the aim of formulating a diagnosis, providing medical care.

Calgary-Cambridge model:

https://www.gp-training.net/communication-skills/calgary- cambridge-model/communication-process/

Written medical history must include:

1. Personal details

Introduce yourself, identify your patient.

Note the date of gaining information.

2. Presenting complaint

Opening questions:

‘How can I help you today?’ ‘What has brought you along to see me today?’ ‘What has brought you into hospital today?’ ‘What problems have brought you to see me today?’

Presenting complaint: This is what the patient tells you is wrong. Gain as much information you can about the specific complaint.

Each principal symptom should be well characterized. The seven attributes of a symptom:

(1) location;

(2) quality;

(3) quantity or severity;

(4) timing, including onset, duration, and frequency;

(5) the setting in which it occurs;

(6) factors that have aggravated or relieved the symptom;

(7) associated manifestations.

3. Review of systems

General: Fatigue/ malaise; Fever/rigors/night sweats; Weight/appetite; Skin: rashes/bruising; Sleep disturbances

Cardiovascular: Chest pain; Shortness of breath; Orthopnoe; Paroxysmal nocturnal dyspnoea; Palpitations; Ankle swelling

Respiratory: Chest pain; Shortness of breath/ wheeze; Cough/sputum/haemoptysis; Excersise tolerance

Gastrointestinal: Apetite/weght loss; Dysphagia; Nausea/vomitting/ haematemesis; Indigestion/heart burn; Jaundice; Abdominal pain; Bowels: change/constipation/diarrhoea/description of stool/blood/mucus/flatus

Endocrine: Menstrual abnormalities; Hirsutism/alopecia; Abnormal secondary sexual features; Polyuria/polydypsia; Amount of sweating; Quality of hair

Genitorurinary: Frequency/dysuria/nocturia/polyuria/oliguria; Haematuria; Incontinence/urgency; Prostatic symptorms; Impotence; Menstruation if appropriate; Menopause

Central nervous system: Headaches; Fits/faints/loss of consciousness; Dizziness; Vision – acuity, diplopia; Hearing; Weakness; Numbness/ tingling; Loss of memory/personality change; Anxiety/depression

Skin: Rash; Pruritus; Acne

Musculoskeletal: Pain/swelling/stiffness – muscles/joints/back; Restriction of movement or functtion; Power; Able to wash and dress without difficulty

4. Relevant past medical history and risk factors

   Lists adult illnesses with dates for events in at least four categories: medical, surgical, obstetric/gynecologic, and psychiatric

   Lists childhood illnesses

   Immunizations, screening tests.

   Ask about specific risk factors related to their complaint.

   For instance - related to myocardial infarction: smoking, cholesterol, diabetes, hypertension, family history of ischaemic heart disease.

5. Drug history

   Find out what medications the patient is taking, including dosage and how often they are taking them. Ask about compliance.

6. Allergies

   Clarify the type of mechanism, ask about rash and nausea.

   Ask about anaphylaxis – throat swelling, trouble of breathing or puffy face

7. Social history

   Note tobacco use, including the type;   Alcohol intake

   Employment history – especially relevant with exposure to certain pathogenes

Home situation (Q: What kind of house do you live in? Who shares your home with you?)

Ask about ability to wash, dress and cook

Also find out who lives with the patient

8. Family history

    Gather some information about the patients family history. Find out if there are any genetic conditions within the family,

9. Diagnosis and differential diagnosis

    Link findings to underlying pathophysiology and identify a disease from symptoms. Write ideas for possible disease.

Sections of case presentation:

1. Introduction (I'd like to present...)
2. Patient's age and occupation
3. Presenting symptoms and duration
4. Associated symptoms
5. Past medical history
6. Social history
7. Family history
8. Findings on examination
9. Investigation results
10. Diagnosis
11. Treatment
12. Outcome – what happened

AIMS of taking history

1. Identify relevant physical signs
2. Main role in decision making
3. Formulate a diagnosis and differential diagnosis
4. Management plan, including necessary investigations and treatment
5. Asses mental state
6. Asses attitude towards health care

Physical examination

Techniques

1. Inspection
2. Palpation
3. Percussion
4. Auscultation

Order:
General appearance: this gives us a general idea about the patients illness and problem.
ECOG Scale of Performance Status

Appearance should be consistent with age. Too short/too tall, fat/ thin, muscular or wasted?

Assess atrophy of muscles, loss of power, loss of subcutaneous fat, lose skin,

Generalized swelling

Inspection: assess posture and patient's gait

Skin

- skin moisture or dryness; temperature; color
- lesions (location, distribution, arrangement, type, color)
- Inspect and palpate the hair, nails
- Study both surfaces of the hands
- Continue skin assessment while examining other body regions

Vital signs : blood pressure, the pulse and respiratory rate. Body temperature, oxygene saturation.

Head – Face
Facial Expression; Inspection: shape, symmetry

Normal findings: Symmetrical features, Palpebral fissures equal, Nasolabial folds present bilaterally Shape can be oval, round, or slightly square.

Abnormal findings: Deformed or absent structures Asymmetry More or less pronounced facial features

Assessment of the head
Inspection: Shape; Symmetry

Palpation: Contour; Masses; Depression; Tenderness

Inspection and palpation of the scalp

Inspect: Lesions or masses

Normal findings: Scalp is shiny, intact, without lesions or masses

Abnormal findings: Bleeding, lesions, masses, hematomas

Hair - inspection, palpation

Quantity; Distribution; Texture; Pattern of loss; Nits, dandruff

Localized area of loss of hair

Eyes

- Check visual acuity, screen the visual fields; assess movements
- Observe eyelids and inspect the sclera, conjunctiva
- Compare the pupils, test reactions to light

Ears, nose

Inspect the auricles, canals; Check auditory acuity; Examine external nose

Palpate for tenderness of the frontal and maxillary sinuses

Throat: inspect the lips, oral mucosa, gums, teeth, tongue, palate, tonsils, pharynx

Neck

Inspect and palpate the cervical lymph nodes

Note any masses or unusual pulsations in the neck

Feel for any deviation of the trachea

Observe the sounds and effort of breathing

Inspect and palpate thyroid gland

Musculoskeletal

Examine the hands, arms, shoulders, neck, joints; Check the range of motion

Breast, axillae

Inspect the breasts with arms relaxed, then elevated, then hands pressed on her hips

Inspect axillae and feel the axillary nodes

Palpate for epitrochlear nodes

Thorax and lungs

Inspect , palpate, percuss the chest

Including inspiration and expiration

Listen to the breath sounds, any added sounds

Note for: Frequency, Difficulties in breathing; Patter; Odour

Posterior thorax and lungs

Inspect, palpate, percuss the chest

Identify the level of diaphragmatic dullnes on each side

Listen to breath sounds, identify any added sounds

Back

Inspect and palpate the spine and muscules of the back

Observe shoulder height for symmetry

Cardiovascular system

Observe the jugular venous pulsations

Inspect and palpate the carotid pulsations; Listen to carotid bruits

Inspect and palpate the precordium (apical impulse)

Auscultation: listen for the first and second heart sounds, any abnormal heart sounds or murmurs

Abdomen

Inspect, auscultate and percuss the abdomen

Palpate lightly, then deeply

Assess the liver and spleen by percussion and then palpation

Try to palpate the kidneys

Palpate the aorta and its pulsations

Examine the penis

Check for hernias

Lower extremities

Examine the legs: note any deformations, enlarged joints, check the range of motion

Palpate femoral pulses and popliteal pulses

Palpate inguinal lymph nodes, pitting edema

Inspect for edema, ulcers, colour

Inspect for varicose veins

While standing: Examine the alignment of the spine and its range of motion, alignment of legs