The art of history taking

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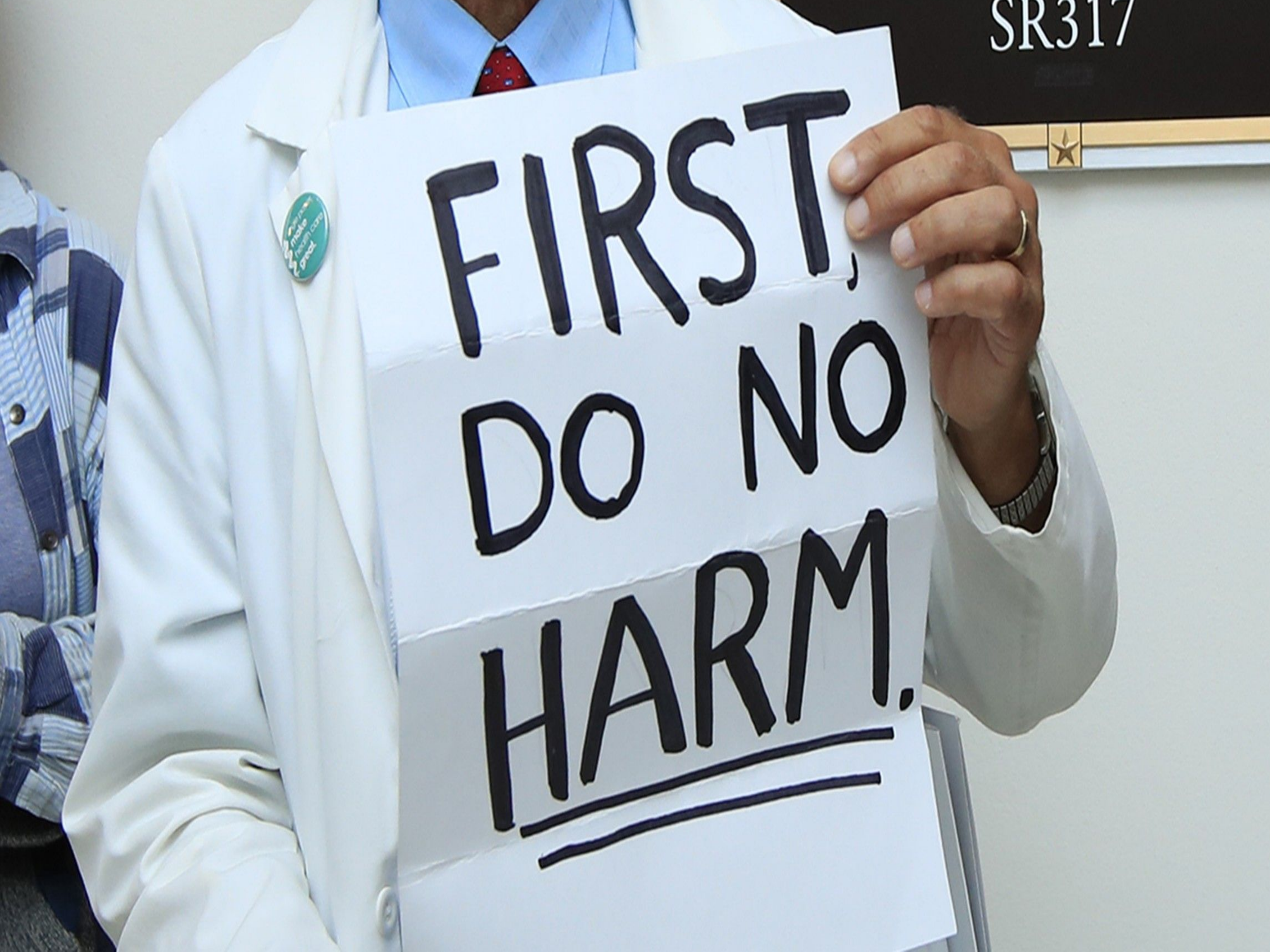

SR317
FIRST,
DO NO
HARM.

The basis of a true history is good communication between doctor and patient

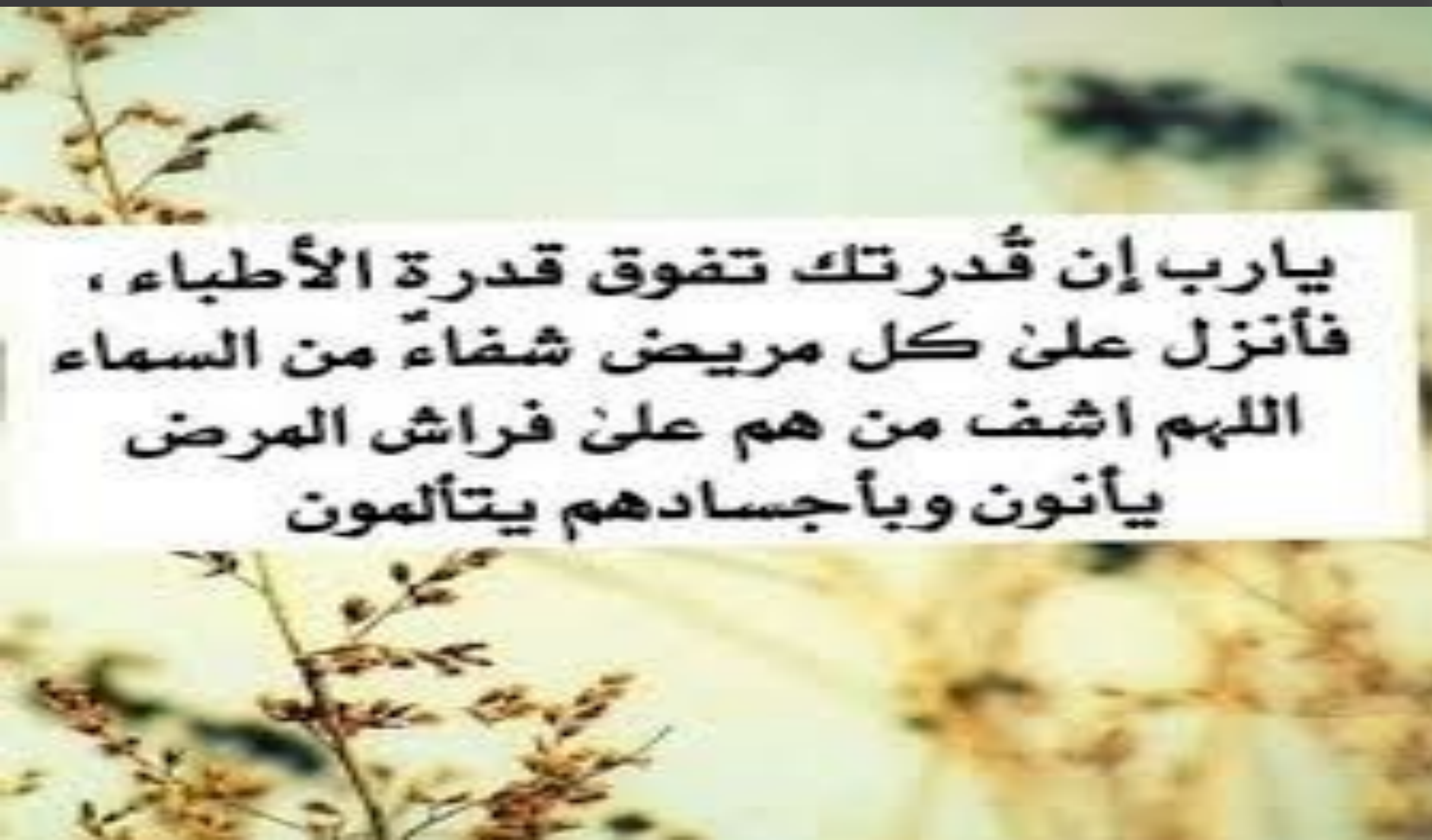
أخلاقيات الطب

- ربما يُنظر إلى الطبيب الى نفسه معتقدا بأنه أرفع منزلة من المريض لأنه لديه المعرفة وشهادات الاعتماد وغالبًا ما يكون هو الشخص الذي لديه دراية بأوضاع المريض.

- كما تتعقد العلاقة بين الطبيب والمريض بسبب معاناة المريض (مريض مشتقة من اللفظ اللاتيني patior "معاناة") وقدرته المحدودة على التعافي بالاعتماد على ذاته/ذاتها ويحتمل أن يؤدي هذا إلى حالة من اليأس والاعتماد على الطبيب.

- فأقل ما يجب على الطبيب أن يكون على وعي بهذه التفاوتات من أجل إقامة علاقة طيبة وتحسين التواصل مع المريض إلى أقصى درجة. وربما يكون من المفيد بدرجة أكبر للعلاقة بين الطبيب والمريض أن يكون بها نوعًا من الرعاية المشتركة مع تمكين المريض من تحمل قدر كبير من المسؤولية تجاه رعايته أو رعايتها.

تذكر دائما ان علمك وقدرتك قطرة في محيط



Does A Doctor’s Physical Appearance Affect Patient Perception?

Doctors are some of the most respected people in society. It can therefore be difficult to imagine that patients would judge their doctors based on their looks. However, judging the looks of people (and things) is something humans are .programmed to do

تجنب المظاهر التي تضعف ثقة المريض بك

MEDICAL
ethics

Maintaining professional boundaries

Respect people, healthy or ill, regardless of who they are. All are equal

Respect for the patient as an individual

Preparing the environment Maintenance of Privacy & Dignity

Maintenance of privacy of the layout of consulting room can .assist good consulting

Avoid taking history in crowded room,corrridors in the .presence of attendances who are observing

It is important that the environment in practical terms is accessible, appropriately equipped, free from distractions .and safe for the patient and the medical staff

Optimum environment not always by hand

Sufficient time

- Patient medical history performed in a limited time period may lead to impairment in patient and physician relationship, defective and erroneous diagnosis & inappropriate prescriptions
- It is essential to allow sufficient time to complete the history. Not allowing enough time can result in incomplete information .important feature of assessment
- It is also important not to appear rushed, as this may interfere with the patient's desire to disclose .information
- Gathering important information from the patient's medical history is needed for effective clinical decision making while empathy is .relevant for patient satisfaction

Words matter

Should avoid the use of technical terms or jargon and, whenever possible, use the patient's own words. The way you communicate with your patients can dramatically change how they think and understand their own illnesses. Don't say things .you can't commit to

حضور أشخاص آخرين

من أمثلة احتمالية تأثير حضور أشخاص آخرين في مقابلة الطبيب والمريض على تواصلهما حضور أحد الأبوين أو أكثر أثناء زيارة القاصر او فتاة للطبيب. فيمكن أن يقدموا الدعم النفسي للمريض ولكن في بعض الحالات ربما تؤثر بالسلب على الثقة بين الطبيب والمريض وتمنع المريض من الكشف عن الأمور غير المريحة أو الشخصية.

حضور أشخاص آخرين

سلوك الطبيب في وجود المريض

- إن السلوك الجيد للطبيب في وجود المريض يعتبر في العادة أمرًا يطمئن المريض ويريحه مع الحفاظ على مبدأ الصدق في التشخيص. فالنبرات الصوتية ولغة الجسد والانفتاح والحضور والكتمان في أي موقف ربما تؤثر جميعها على سلوك الطبيب في وجود المريض. أما السلوك السيء للطبيب في وجود المريض فتترك المريض وهو يشعر بعدم الرضا أو القلق أو الخوف أو الوحدة. ويصبح سلوك الطبيب في وجود المريض أمرًا صعبًا عندما يجب على أخصائي الرعاية الصحية شرح تشخيص غير محبوب للمريض، في الوقت الذي يحافظ فيه على عدم إزعاج المريض.

علاج السكر خلال

١٠ دقائق بجلسة واحدة (حجي مالك

أول معالج على مستوى العراق لمرض السكر)) بغداد المدائن

خلف أعدادية تجارة

سلوك الطبيب في وجود المريض

Be kind—kinder than you think you need to be. At the end of the day, medicine can be complex, but is also always quite simple.

Take care with the opening greeting

:The best is

- السلام عليكم ورحمة الله وبركاته
- لا تستعمل كلمات مثل هلو وخصوصا مع كبار السن.

Listen to your patients; they are telling you the diagnosis‘

Dr William Osler—the father of modern medicine(1849-1919)

A good history is one which reveals the patient's ideas, concerns and expectations as well as any accompanying .diagnosis

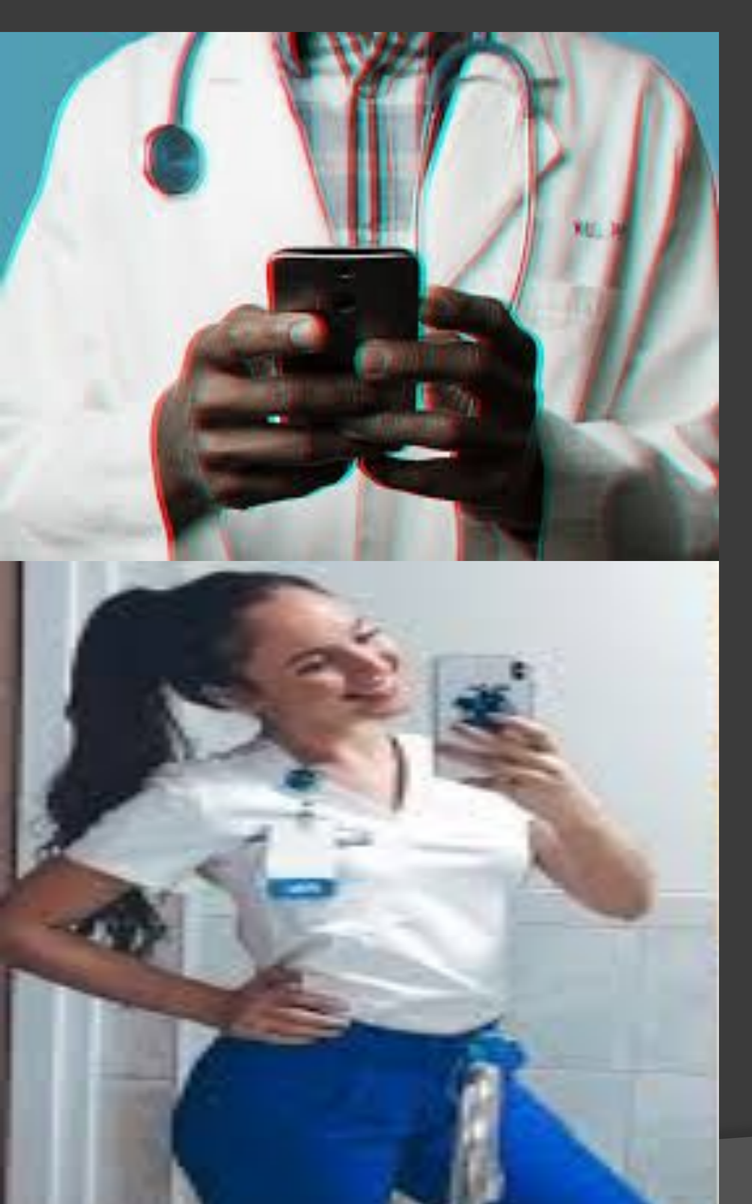
Treating the person instead of the disease

For most cases, asking the right questions and listening carefully will tell you more than any CT scan or ultrasound can. With that, make sure that you get to know your patients beyond just their chief complaint. Take a thorough social history. Ask more than just: "Do you smoke cigarettes, drink alcohol, or use drugs?" When you skip the social history, you risk treating the disease instead of the person. You also fail to understand the environment and conditions that led to their .decline in the first place

Raise your words, not your voice. It is .rain that grows flowers ,not thunder

ارتقي بمستوى كلماتك وليس صوتك.
فالمطر هو من يجعل الورود تنمو وليس صوت الرعد.

Listen first and listen second



Let the patient tell you the story they have been storing .up for you

It is important to let patients tell their story in their own words while using active .listening skills

Open questions

These are seen as the gold standard of historical inquiry. They do not suggest a 'right' answer to the patient and give them a chance to express what is on their mind. Your question should not be able to be answered with 'yes' or 'no'. A broad example is: 'What's been ‘?bothering you

Do you have another ?complaints

Questions with options (Clarification)

It is necessary to ask to clarify exactly what a .patient means by a particular statement

In this case, if the information you obtained through open questioning can not clarify the patient story ,then give the patient some options .to indicate what information you need

For instance, if a female patient complains of 'pain all over the body" and it is difficult to tell what she means, even after being given a chance to expand on the subject, you could ask: 'Is that ?in your head or your joints or backache

Leading questions

These are best avoided at beginning o
.if at all possible

These questions would help you to decide if your provisional diagnosis is true

For instance, a male patient presents with episodic chest pain. You know he is a smoker and overweight so you sta asking questions that may help you to decide if he had angina pectoris e.g. di ?.you have chest pain during exercise

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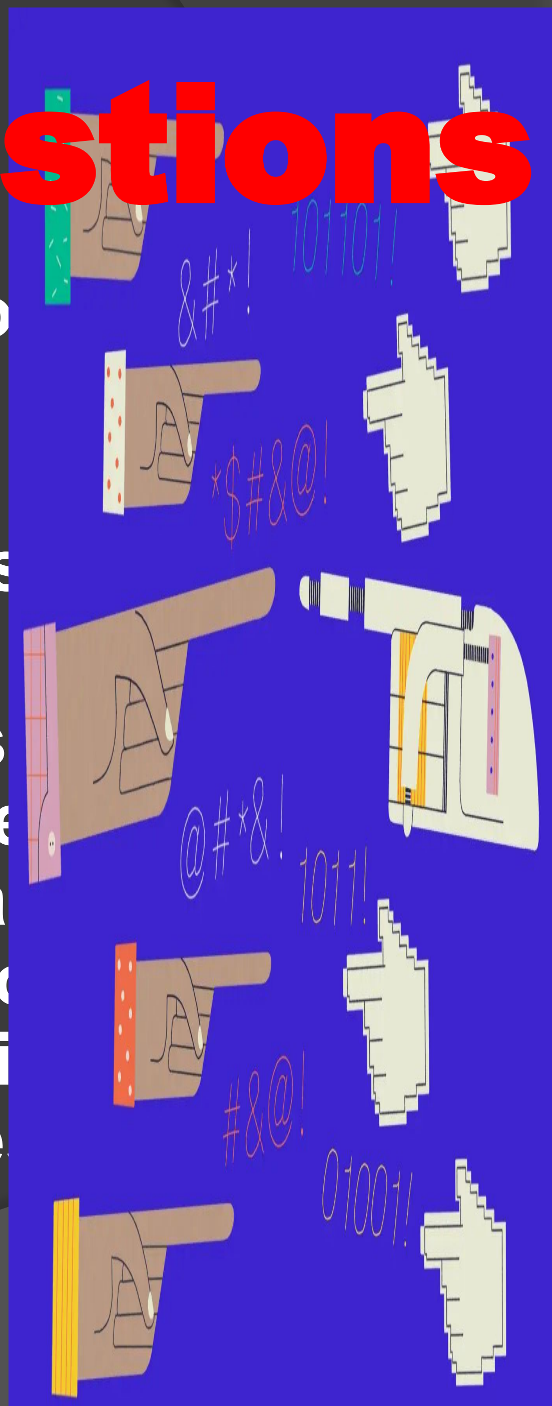


History Taking

- The content of the history required in primary care consultations is very variable and will depend on the presenting symptoms, patient concerns and the past medical, psychological and social history. However there is general .framework for history taking

Obtaining an Older Patient's Medical History

try to gather preliminary data before the-1 meeting . Request previous medical .records & all investigations

Try to have the patient tell his or her-2 story only once, not to another staff member and then again to you. For older patients who are ill, this process can be .very tiring

Sit and face the patient at eye level. Use-3 active listening skills, responding with brie encouraging comments such as “very .good " and "okay.“ & yes, your are right

You may need support from family-4 .members or closed friends

A history can and should always be obtained concerning an unconscious patient

Unconsciousness is a time-sensitive medical emergency where early physiological stability and diagnosis are vital in .optimizing patient outcomes

An initial assessment of airway, breathing, and circulation must be performed to identify and manage the most .immediate threats to life

All steps of care, history, examination, investigation and treatment/management should be delivered in parallel by a .team working in a systematic way

History from relatives or other witnesses of unconscious patient

A collateral history from relatives or other witnesses, including paramedics, is vital. The patient's recent health, functional status and previous medical history may provide diagnostic clues as well as guiding decisions regarding ongoing care

communication can be enhanced if the medical staff is closely involved with the unconscious patient’s family. Gaining an insight into the patient’s background and personality also allows the doctor to communicate more effectively

general framework for history

Step 01 - Initiating the session (WIIPP)

... Step 02 - Presenting Complaint (PC)

... Step 03 - History of Presenting Complaint (HPC)

... Step 04 - Past Medical History (PMH)

... Step 05 - Drug History (DH)

... Step 06 - Family History (FH)

Step 07 - Social History (SH)

…Step 08 - Obstetrical & Gynecological History

Step 09 – Systemic review

Step 01(Initiating the session)

To start with: WIIPP

Wash your hands

Introduce yourself, identify your patient (give your name and your .job)

Identity the patient: confirm the patient name,sex, date of birth ,adress,occupation,marital status , blood group, bed number& date of .admission

Permission: gain consent to speak with the patient or other witnesses ,confirm the reason for seeing the patient ("I'm going to ask you some questions about your condition, is that OK?")

Positioning: patient sitting in chair or on bed approximately a meter away from you, ensure you are sitting at the same level as them and .ideally not behind a desk

.

Presenting(Chief) Complaint

Ask the patient to describe their problem using open questions (e.g. "What's brought you into ?hospital today?"),What is the new complaint

The presenting complaint should be expressed in the patient's own words (e.g. "I have a tightness in my chest.")

Do not interrupt the patient's first few sentences .if possible

Try to elicit the patient's ideas, concerns and expectations (ICE)

e.g. "I'm worried I might have cancer." or "I think ".I need some antibiotics

History of Presenting Complaint

Ask the patient further questions about the presenting complaint

“A useful mnemonic for pain is “SOCRATES

Onset

Character

Radiation

Alleviating factors

Timing

Exacerbating factors

Severity(No one particular pain scale is considered .ideal or better than the others for every situation)

Chronicity. Different definitions of chronic pain are in use. It defined as a period of at least 3 months with .persisting pain

Present illness

?Onset – was it sudden, or has it developed gradually

Duration – how long does it last, such as minutes, days ?or weeks

Site and radiation – where does it occur? Does it occur ?anywhere else

Aggravating and relieving features – is there anything ?that makes it better or worse

Associated symptoms – when this happens, does anything else happen with it, such as nausea, vomiting or ?headache

?Fluctuating – is it always the same

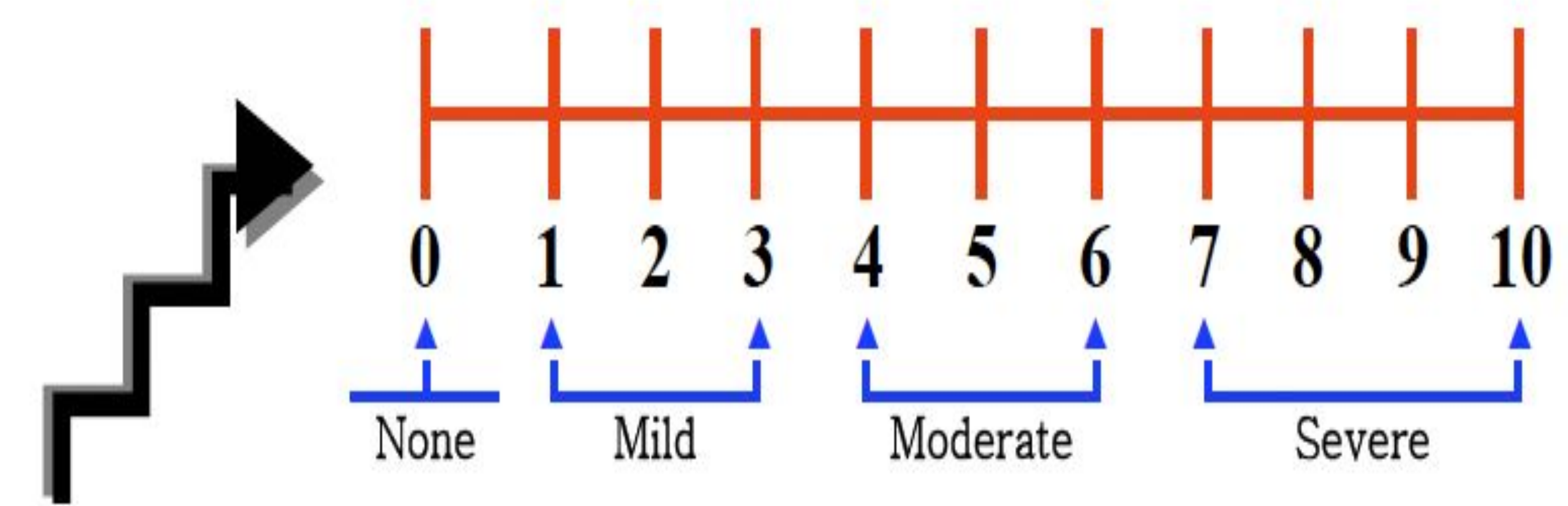
?Frequency – have you had it before

Severity scale (1-10)

Numerical Rating Pain Scale

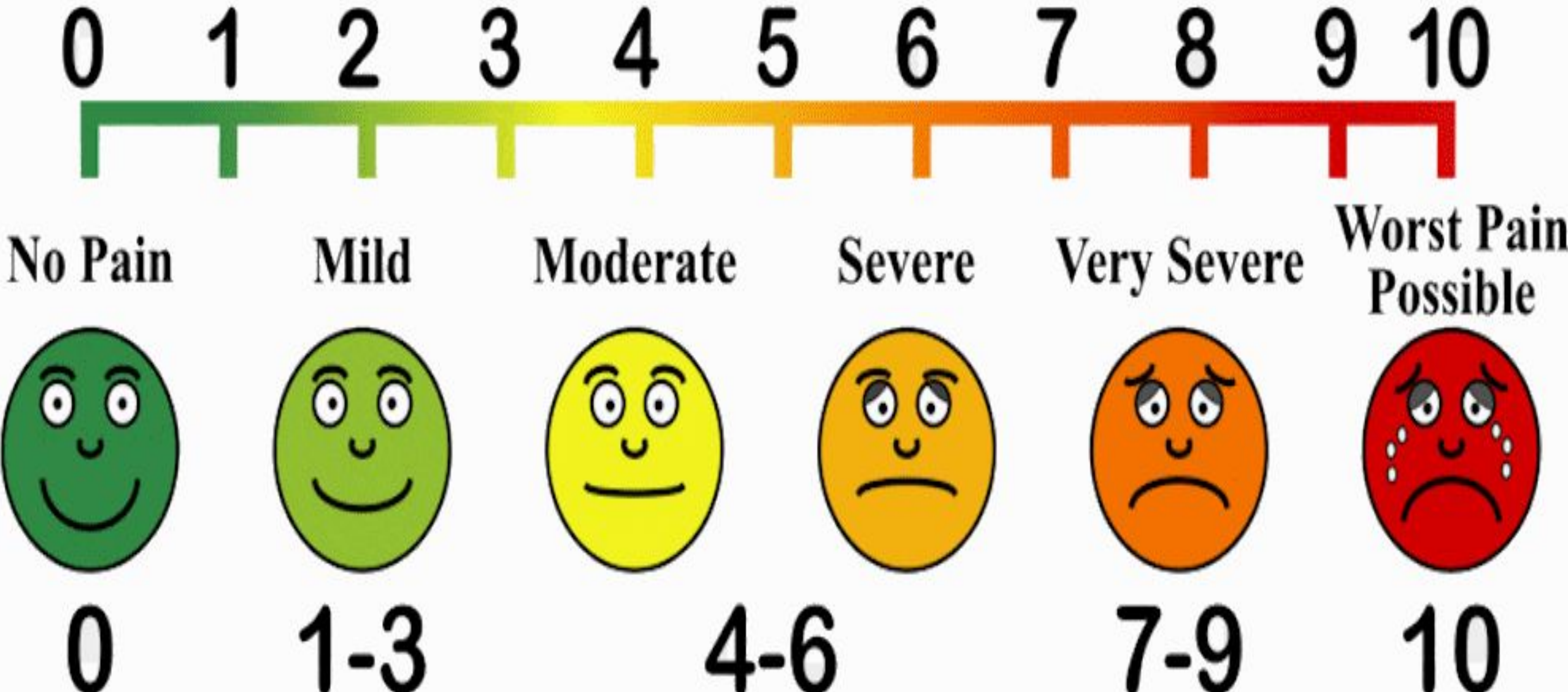
.A Pain Assessment Tool for the Person in Pain

This scale most commonly used in developed .countries but it is not suitable for our patients



Descriptor Differential Scale of Pain Intensity

A pain scale measures a persons pain intensity, and are based on self-report, observational (behavioral), or physiological data. Various pain scales are available for neonates, infants, children, adolescents, adults, seniors, and persons whose communication is impaired. Pain assessments are often ".regarded as "the 5th Vital Sign



Risk factors

As part of medical history ask about specific risk .factors related to their presenting complaint

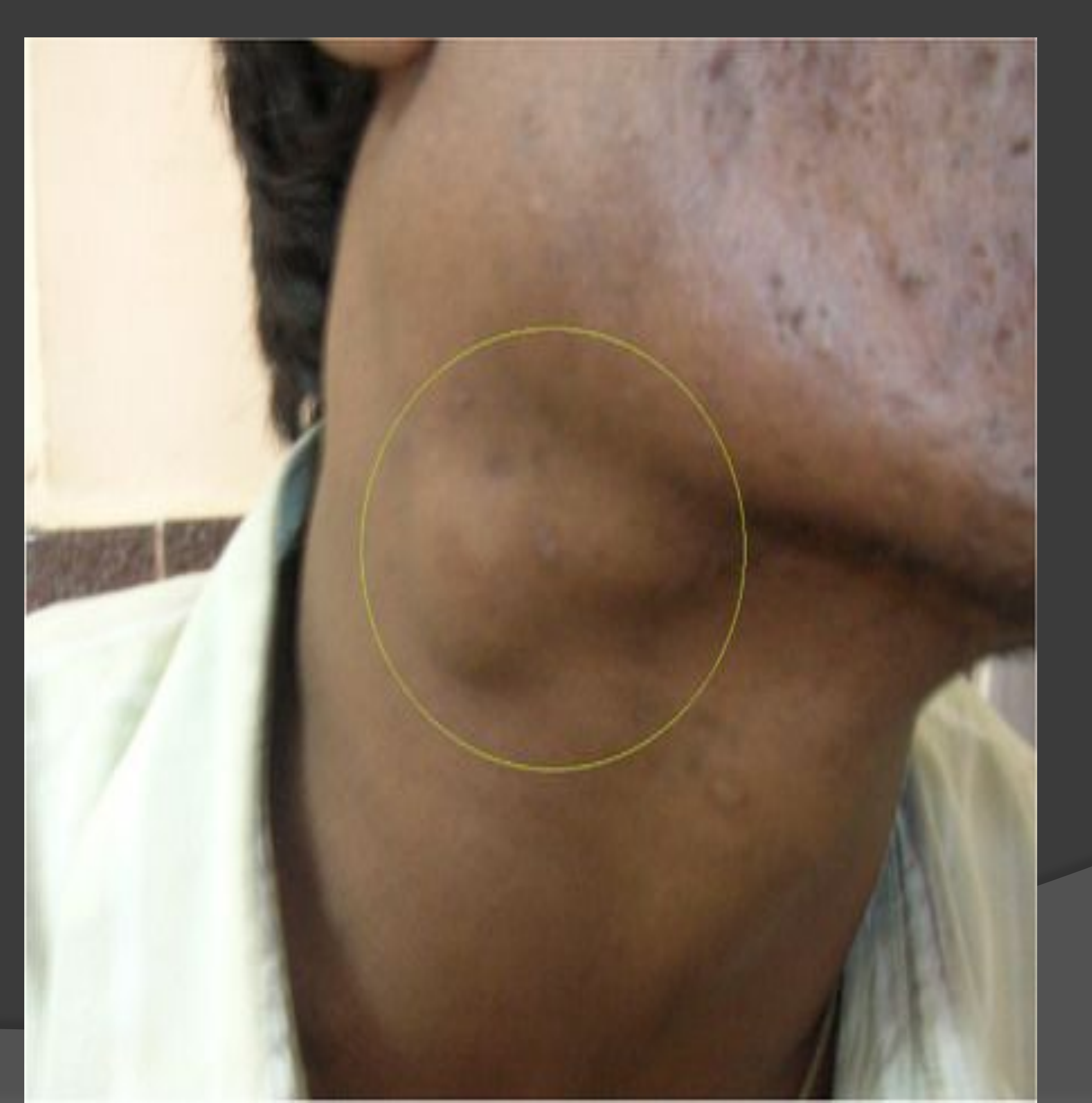
For example, if the patient presents with what maybe a myocardial infarction, you should ask about :associated risk factors such as

Smoking, cholesterol, diabetes, hypertension, family history of ischemic heart disease & previous history .of heart attacks or coronary catheterization

Drug History

- All medications that they take for each medication ask them to :specify
- Dose, frequency, route and compliance (i.e whether they regularly .take these medication)
- If they take medication weekly ask what day of the week they take .it
- If they take a medication with a variable dosing (e.g. Warfarin) ask ?what their current dosing regimen is
- Recreational drugs(psychoactive drugs which induce an altered level of consciousness for pleasure) e.g. opiate ,benzodiazepines .even alcohol
- Intravenous drug use (current or previous)
- .Over the counter (OTC) medications(without medical prescription)
- .Ask about steroids. Viagra
- If allergic to medications, clarify the type of medication and the .exact reaction to that medication
- Specifically ask about whether there's been a history of ”anaphylaxis e.g. “throat swelling, trouble breathing or puffy face

The following are possible causes for :this condition, except



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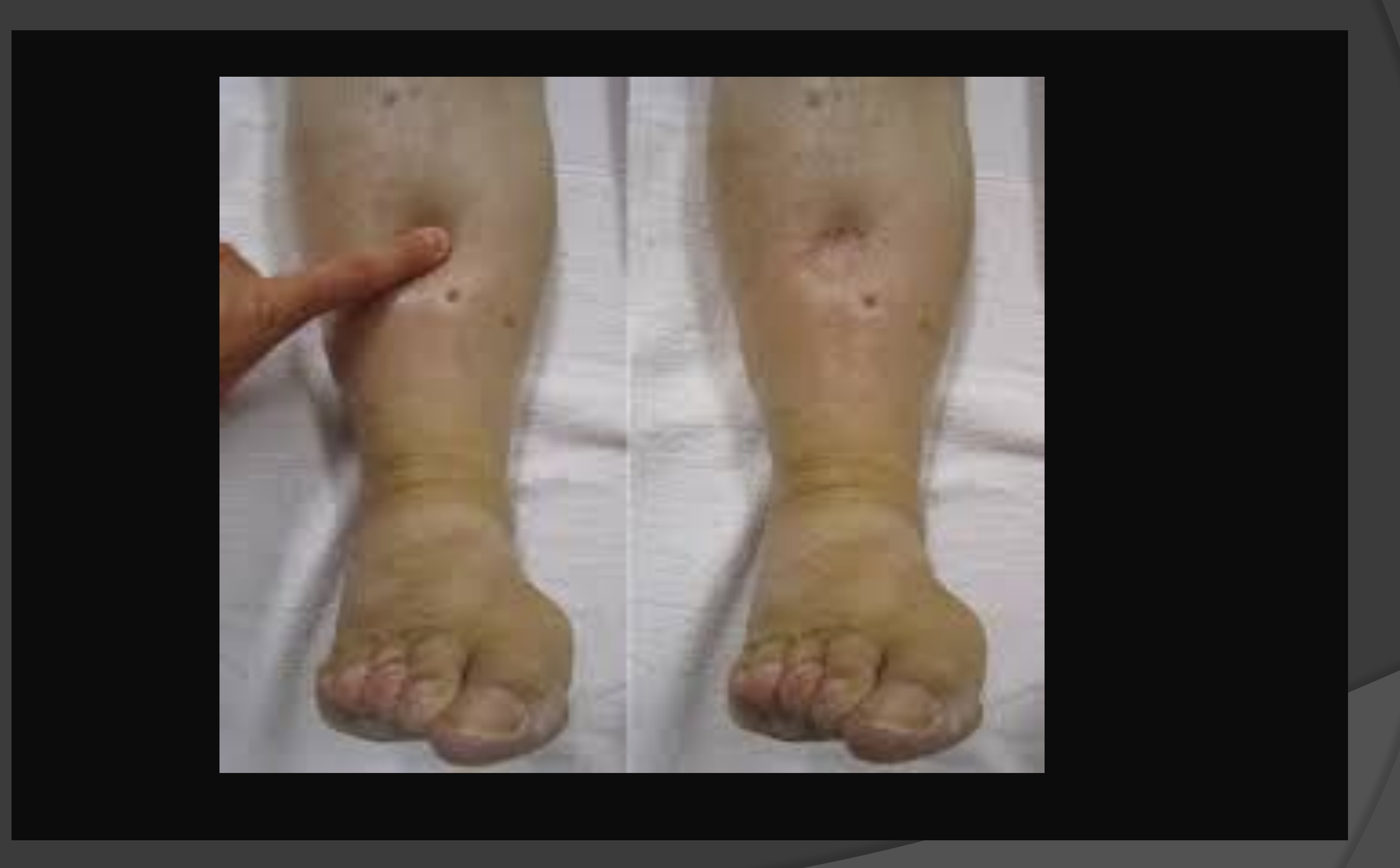
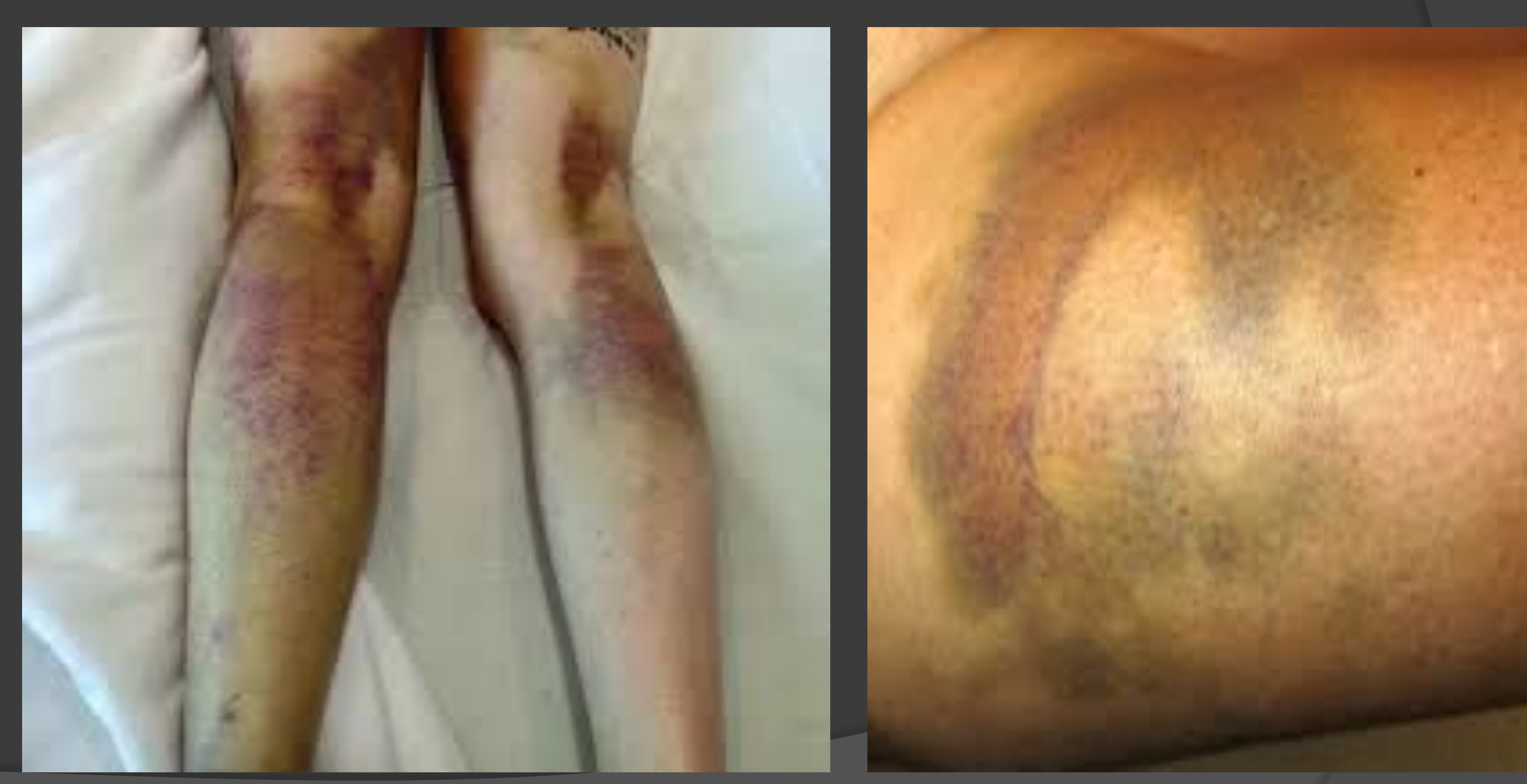
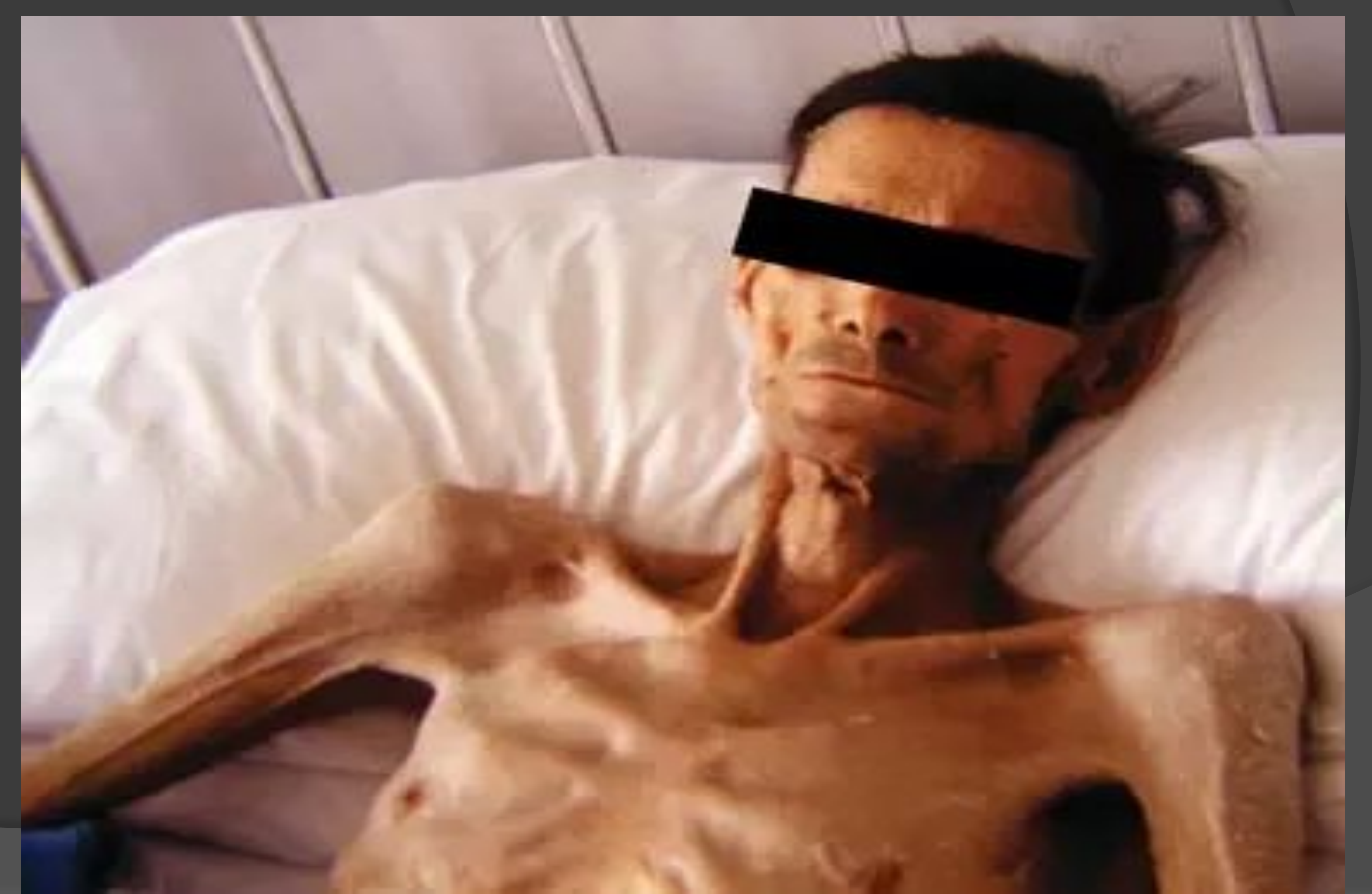


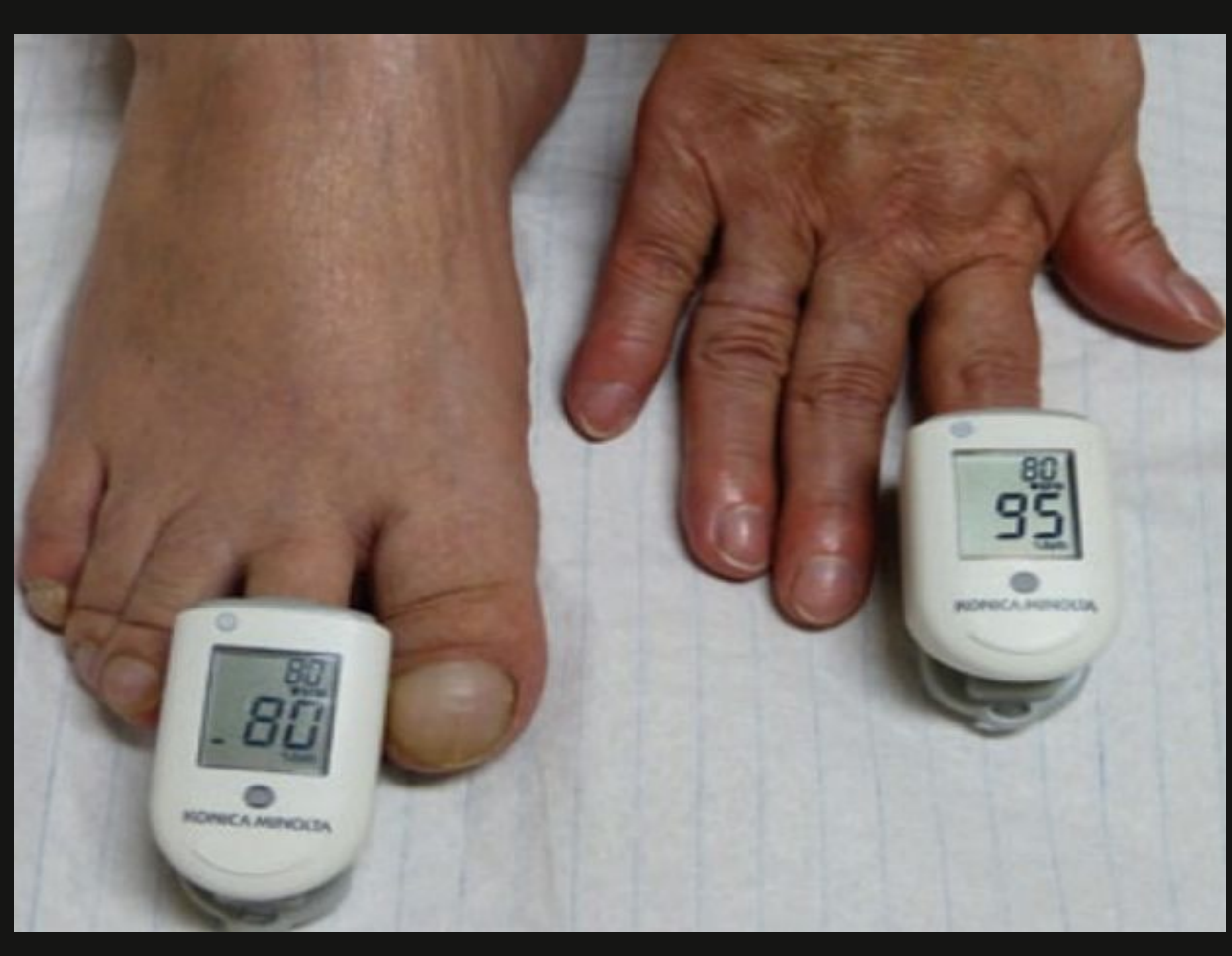
The following are possible causes of this :physical sign, except



The following may cause this condition, :except



What is the specific cause for this ?patient clubbing



Family History

- Ask the patient about any family diseases relevant to-1 the presenting complaints (e.g. if the patient has presented with chest pain, ask about family history of .heart attacks specially in youngs)
- Ask about family history of common familial -2 diseases like diabetes mellitus. HTN & asthma
- Enquire about the patient's parents and sibling and,-3 .if they were died below 65, the cause of death
- If there is hereditary disease ,ask about pattern of-4 the disease between relatives,& may includes a short .family tree
- Admission to hospital(medical.obstetrical,surgical)-6
- Trauma-7
- Immunizations-8

Social History

When you skip the social history, you risk treating the disease instead of the person

- Alcohol intake
- Tobacco use : ask about current smoking. ex smoker, passive smoking
- Employment history
- Particularly relevant with exposure to certain pathogens e.g. asbestos, where you need to ask whether they have ever been exposed to any dusts

Home situation

.Socioeconomic status: water supply,nutritions,crowded house

- Ask about pets, dust exposure, asbestos, exposure to the .farms, exposure to birds or if there are any hobbies
- Ask for a full travel history including all occasions exposure to water, exposure to foreign food, tuberculosis risk factors, .HIV risk factors

Smoking index

: Smoking index ◉

number of cigarette per day × years .of smoking

Non smoker ◉

400> ◉

400-799 ◉

800≤ ◉

Obstetrical & gynecological history

Onset of menstruation
Last menstrual period
Timing and regularity of periods
Length of periods
Heaviness of period
Vaginal discharge
Post menopausal bleeding
Current & previous pregnancies, stillbirth &
.abortions

Review of Systems

- Gather a short amount of information regarding the other systems in the body that are not covered in your History of present illness
- These are the main systems you should cover:
- CVS
- Respiratory system
- GI
- Neurology
- Genitourinary/renal
- Musculoskeletal
- Psychiatry
- General

Review of Systems

- :Run through a full list of symptoms from major systems
- Cardiovascular: chest pain, palpitations, peripheral oedema, paroxysmal nocturnal dyspnoea (PND), orthopnoea
- Respiratory: Cough, shortness of breath (and exercise tolerance), haemoptysis, sputum production, wheeze
- Gastrointestinal: Abdominal pain, dysphagia, heartburn, vomiting, haematemesis, diarrhoea, constipation, rectal bleeding
- Genitourinary: Dysuria, discharge, lower urinary tract symptoms
- Neurological: Numbness, weakness, tingling, blackouts, visual change
- Psychiatric: Depression, anxiety
- General review: Weight loss, appetite change, lumps or bumps (nodes), rashes, joint pain

Summary of History

- Provide a short summary of the history :including
- Name and age of the patient, presenting complaint, relevant medical history
- Give a differential diagnosis
- Explain a brief investigation and management plan

Teach thy tongue to say I don’t know and thou shalt“ progress”.

Maimonides, 12th century physician and philosopher