DOWNLOAD PDF EXAMPLE OF HISTORY TAKING IN MEDICINE

Chapter 1 : How to Take a Medical History: 10 Steps (with Pictures) - wikiHow

The links below are to actual H&Ps written by UNC students during their inpatient clerkship rotations. The students have granted permission to have these H&Ps posted on the website as examples.

The "daVinci Anatomy Icon" denotes a link to related gross anatomy pictures. A large percentage of the time, you will actually be able to make a diagnosis based on the history alone. The value of the history, of course, will depend on your ability to elicit relevant information. Your sense of what constitutes important data will grow exponentially in the coming years as you gain a greater understanding of the pathophysiology of disease through increased exposure to patients and illness. However, you are already in possession of the tools that will enable you to obtain a good history. That is, an ability to listen and ask common-sense questions that help define the nature of a particular problem. It does not take a vast, sophisticated fund of knowledge to successfully interview a patient. In fact seasoned physicians often lose site of this important point, placing too much emphasis on the use of testing while failing to take the time to listen to their patients. Successful interviewing is for the most part dependent upon your already well developed communication skills. What follows is a framework for approaching patient complaints in a problem oriented fashion. The patient initiates this process by describing a symptom. It falls to you to take that information and use it as a springboard for additional questioning that will help to identify the root cause of the problem. Note that this is different from trying to identify disease states which might exist yet do not generate overt symptoms. To uncover these issues requires an extensive "Review Of Systems" a. Generally, this consists of a list of questions grouped according to organ system and designed to identify disease within that area. For example, a review of systems for respiratory illnesses would include: Do you have a cough? If so, is it productive of sputum? Do you feel short of breath when you walk? In a practical sense, it is not necessary to memorize an extensive ROS question list. Rather, you will have an opportunity to learn the relevant questions that uncover organ dysfunction when you review the physical exam for each system individually. In this way, the ROS will be given some context, increasing the likelihood that you will actually remember the relevant questions. Always introduce yourself to the patient. Then try to make the environment as private and free of distractions as possible. This may be difficult depending on where the interview is taking place. The emergency room or a non-private patient room are notoriously difficult spots. Do the best that you can and feel free to be creative. If possible, sit down next to the patient while conducting the interview. Remove any physical barriers that stand between yourself and the interviewee e. These simple maneuvers help to put you and the patient on equal footing. Furthermore, they enhance the notion that you are completely focused on them. You can either disarm or build walls through the speech, posture and body languarge that you adopt. Recognize the power of these cues and the impact that they can have on the interview. While there is no way of creating instant intimacy and rapport, paying attention to what may seem like rather small details as well as always showing kindness and respect can go a long way towards creating an environment that will facilitate the exchange of useful information. If the interview is being conducted in an outpatient setting, it is probably better to allow the patient to wear their own clothing while you chat with them. At the conclusion of your discussion, provide them with a gown and leave the room while they undress in preparation for the physical exam. Ideally, you would like to hear the patient describe the problem in their own words. Open ended questions are a good way to get the ball rolling. How can I help you? What seems to be the problem? When this occurs, explore each one individually using the strategy described below. There is no single best way to question a patient. Successful interviewing requires that you avoid medical terminology and make use of a descriptive language that is familiar to them. There are several broad questions which are applicable to any complaint. How long has this condition lasted? Is it similar to a past problem? If so, what was done at that time? How bothersome is this problem? Does it interfere with your daily activities? Does it keep you up at night? Try to have them objectively rate the problem. If they are describing pain, ask them to rate it from 1 to 10 with 10 being the worse pain of their life, though first find out what that was so you know what they are using for comparison e. Furthermore, ask them to describe the symptom in terms with which they are already familiar. A sensation of pressure? If it affects

their activity level, determine to what degree this occurs. For example, if they complain of shortness of breath with walking, how many blocks can they walk? How does this compare with 6 months ago? Is the symptom e. Has this changed over time? If the symptom is not focal, does it radiate to a specific area of the body? Have they tried any therapeutic maneuvers?: Is the problem getting better, worse, or staying the same? If it is changing, what has been the rate of change? Are there any associated symptoms? Often times the patient notices other things that have popped up around the same time as the dominant problem. These tend to be related. Does this relate to a gradual worsening of the symptom itself? Has the patient developed a new perception of its relative importance e. Do they have a specific agenda for the patient-provider encounter? The pain began 1 month ago and only occurs with activity. It rapidly goes away with rest. When it does occur, it is a steady pressure focused on the center of the chest that is roughly a 5 on a scale of 1 to Over the last week, it has happened 6 times while in the first week it happened only once. The patient has never experienced anything like this previously and has not mentioned this problem to anyone else prior to meeting with you. As yet, they have employed no specific therapy. This is quite a lot of information. However, if you were not aware that coronary-based ischemia causes a symptom complex identical to what the patient is describing, you would have no idea what further questions to ask. With additional experience, exposure, and knowledge you will learn the appropriate settings for particular lines of questioning. With each step, the list of probable diagnoses is pared down until a few likely choices are left from what was once a long list of possibilities. Perhaps an easy way to understand this would be to think of the patient problem as a Windows-Based computer program. The patient tells you a symptom. You click on this symptom and a list of general questions appears. The patient then responds to these questions. You click on these responses and As yet, you do not have the clinical knowledge base to know what questions to ask next. As such, you would ask follow-up questions that help to define a cardiac basis for this complaint e. You may then focus your exam on the search for physical signs that would lend support to your working diagnosis and help direct you in the rational use of adjuvant testing. All patient complaints merit careful consideration. Some, however, require time to play out, allowing them to either become "a something" a recognizable clinical entity or "a nothing," and simply fade away. Clinicians are constantly on the look-out for markers of underlying illness, historical points which might increase their suspicion for the existence of an underlying disease process. For example, a patient who does not usually seek medical attention yet presents with a new, specific complaint merits a particularly careful evaluation. Dealing With Your Own Discomfort: Many of you will feel uncomfortable with the patient interview. This process is, by its very nature, highly intrusive. The patient has been stripped, both literally and figuratively, of the layers that protect them from the physical and psychological probes of the outside world. Furthermore, in order to be successful, you must ask in-depth, intimate questions of a person with whom you essentially have no relationship. This is completely at odds with your normal day to day interactions. There is no way to proceed without asking questions, peering into the life of an otherwise complete stranger. In fact, at this stage of your careers, you perhaps have an advantage over more experienced providers as you are hyper-aware that this is not a natural environment.

Chapter 2 : History taking | Geeky Medics

What the candidate reads Candidate's instructions. Julia Russo, 65 years old, has come alone to your office with the following complaint: "I just can't cope.

A practitioner typically asks questions to obtain the following information about the patient: The " chief complaint CC " â€" the major health problem or concern, and its time course e. Childhood diseases â€" this is very important in pediatrics. Social history medicine â€" including living arrangements, occupation, marital status, number of children, drug use including tobacco, alcohol, other recreational drug use , recent foreign travel, and exposure to environmental pathogens through recreational activities or pets. Computerized history-taking could be an integral part of clinical decision support systems. A follow-up procedure is initiated at the onset of the illness to record details of future progress and results after treatment or discharge. This is known as a catamnesis in medical terms. Review of systems[edit] Main article: Review of systems Whatever system a specific condition may seem restricted to, all the other systems are usually reviewed in a comprehensive history. The review of systems often includes all the main systems in the body that may provide an opportunity to mention symptoms or concerns that the individual may have failed to mention in the history. Health care professionals may structure the review of systems as follows: Cardiovascular system chest pain, dyspnea, ankle swelling, palpitations are the most important symptoms and you can ask for a brief description for each of the positive symptoms. Respiratory system cough, haemoptysis, epistaxis, wheezing, pain localized to the chest that might increase with inspiration or expiration. Gastrointestinal system change in weight, flatulence and heart burn, dysphagia, odynophagia, hematemesis, melena, hematochezia, abdominal pain, vomiting, bowel habit. Genitourinary system frequency in urination, pain with micturition dysuria , urine color, any urethral discharge, altered bladder control like urgency in urination or incontinence, menstruation and sexual activity. Nervous system Headache, loss of consciousness, dizziness and vertigo, speech and related functions like reading and writing skills and memory. Cranial nerves symptoms Vision amaurosis , diplopia, facial numbness, deafness, oropharyngial dysphagia, limb motor or sensory symptoms and loss of coordination. Endocrine system weight loss, polydipsia, polyuria, increased appetite polyphagia and irritability. Musculoskeletal system any bone or joint pain accompanied by joint swelling or tenderness, aggravating and relieving factors for the pain and any positive family history for joint disease. Skin any skin rash, recent change in cosmetics and the use of sunscreen creams when exposed to sun. Inhibiting factors[edit] Factors that inhibit taking a proper medical history include a physical inability of the patient to communicate with the physician, such as unconsciousness and communication disorders. In such cases, it may be necessary to record such information that may be gained from other people who know the patient. In medical terms this is known as a heteroanamnesis in contrast to a self-reporting anamnesis. Medical history taking may also be impaired by various factors impeding a proper doctor-patient relationship , such as transitions to physicians that are unfamiliar to the patient. History taking of issues related to sexual or reproductive medicine may be inhibited by a reluctance of the patient to disclose intimate or uncomfortable information. Also an advantage is that it saves money and paper. One disadvantage of current medical history systems is that they cannot detect non-verbal communication, which may be useful for elucidating anxieties and treatment plans. Another disadvantage is that people may feel less comfortable communicating with a computer as opposed to a human. For example, as of , there are no randomized control trials comparing computer-assisted versus traditional oral-and-written family history taking to identifying patients with an elevated risk of developing type 2 diabetes mellitus.

Chapter 3 : Teaching history taking to medical students: a systematic review

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.

History Taking Foreword Taking a history from a patient is a skill necessary for examinations and afterwards as a practicing doctor, no matter which area you specialise in. It tests both your communication skills as well as your knowledge about what to ask. Specific questions vary depending on what type of history you are taking but if you follow the general framework below you should gain good marks in these stations. This is also a good way to present your history. In practice you may sometimes need to gather a collateral history from a relative, friend or carer. This may be with a child or an adult with impaired mental state. Procedure Steps Step 01 Introduce yourself, identify your patient and gain consent to speak with them. Should you wish to take notes as you proceed, ask the patients permission to do so. Sticking with chest pain as an example you should ask: Where exactly is the pain? What is the pain like e. Is there anything else associated with the pain, e. Does it follow any time pattern, how long did it last? Does anything make it better or worse? How severe is the pain, consider using the scale? Step 05 - Drug History DH Find out what medications the patient is taking, including dosage and how often they are taking them, for example: At this point it is a good idea to find out if the patient has any allergies. Find out if there are any genetic conditions within the family, for example: Remember to ask about smoking and alcohol. Depending on the PC it may also be pertinent to find out whether the patient drives, e. You should also ask the patient if they use any illegal substances, for example: Also find out who lives with the patient. The above example involves the CVS so you would focus on the others. These are the main systems you should cover:

Chapter 4 : Clinical History Taking Format in Medicine: Physical, Systemic Examination

Taking a history from a patient is a skill necessary for examinations and afterwards as a practicing doctor, no matter which area you specialise in. It tests both your communication skills as well as your knowledge about what to ask.

Received Apr 20; Accepted Sep This article has been cited by other articles in PMC. Abstract Background This paper is an up-to-date systematic review on educational interventions addressing history taking. Included studies had to evaluate learning progress. Results Seventy-eight full-text articles were identified and reviewed; of these, 23 studies met the final inclusion criteria. Three studies applied an instructional approach using scripts, lectures, demonstrations and an online course. Seventeen studies applied a more experiential approach by implementing small group workshops including role-play, interviews with patients and feedback. Three studies applied a creative approach. Conclusions These findings suggest that several different educational interventions are effective in teaching history taking skills to medical students. Small group workshops including role-play and interviews with real patients, followed by feedback and discussion, are widespread and best investigated. Feedback using videotape review was also reported as particularly instructive. Students in the early preclinical state might profit from approaches helping them to focus on interview skills and not being distracted by thinking about differential diagnoses or clinical management. The heterogeneity of outcome data and the varied ways of assessment strongly suggest the need for further research as many studies did not meet basic methodological criteria. Randomized controlled trials using external assessment methods, standardized measurement tools and reporting long-term data are recommended to evaluate the efficacy of courses on history taking. Undergraduate medical education, Medical students, History taking, Medical history, Medical interview, Interview skills Background In the course of his or her professional life, a clinician will conduct between , and , patient interviews [1 , 2]. The medical interview is the most common task performed by physicians. Scientific discoveries and technological innovations of the last decades fundamentally changed diagnostics and treatment of diseases. Imaging studies and laboratory tests seem crucial for an accurate diagnosis, all the more in times of multidisciplinary treatments and overall availability of instrument-based examinations. Interview skills contribute significantly to problem detection, diagnostic accuracy, patient and physician satisfaction, patient adjustment to stress and illness, patient recall of information, patient adherence to therapy and patient health outcomes [7 â€” 11]. Accuracy of diagnoses and the establishment of a good physician-patient relationship depend on effective communication within the medical interview [12 , 13]. There are different definitions and models of history taking in the international literature, suggesting a limited shared understanding of the medical interview. One reason might be that history taking is highly contextual, depending on situation, patient and physician attributes, cultural characteristics and other factors. Each function is served by a separate set of skills. Other models emphasise patient-centeredness even more, describing an equal exchange of information and shared decision-making [21 , 22]. However, some researchers described that basic communication skills deteriorate during medical education if they are not particularly activated and practised [24 , 25]. On the other hand, many studies have shown that students, having passed specialized history taking skills training, ask relevant questions and structure their interviews well. National accreditations and expert panel consensus guidelines have stressed the importance of educational interventions addressing history taking [31 , 32]. Today, it is a proven fact that interview skills can be taught if effective methods are used. Since then, many studies investigated the effectiveness of a multitude of different educational methods for teaching history taking. But there is still an uncertainty about: In view of this uncertainty, the present systematic review of the literature has been undertaken to collect the currently reported knowledge in the field of teaching history taking in order to make recommendations for curriculum planners, medical teachers and future investigators. Review objectives This review aims to answer the following questions: Hand searches were performed in the reference lists of the search results. Search terms were related to history taking and medical education, using combinations of the following: It was ensured that the search terms captured the previously published reviews [37 , 38] and all relevant studies included in these reviews. The medical interview is seen as an encounter between physician and patient, both

contributing to the results. Inclusion criteria Articles were included if the following criteria were met: Description of an educational intervention concerning history taking: This review investigates introductory workshops teaching history-taking in general, considering content, completeness, verbal and non-verbal interviewing techniques and rapport. Evaluation of learning progress at least a self-evaluation of students Reporting on undergraduate medical education i. Exclusion criteria The following results were excluded in this review: Teaching units concerning only specific aspects of the medical history e. Specific aspects of the medical interview are usually taught later in medical education and after an introductory course in medical interviewing has taken place, which is why interventions with regard to these specific aspects were excluded in this review. Teaching units addressing communication skills in general, patient-centred behaviour or empathy without regard to history taking Articles describing only the assessment of interview skills without describing a teaching unit Articles with no measured outcome at all, e. Following an initial review for relevancy by title and abstract KEK and NS and removal of duplicate results, 78 studies were left for full-text review, of these, 23 studies finally met the inclusion criteria. In case of differing judgement, EJL was consulted as independent evaluator.

Chapter 5 : A Practical Guide to Clinical Medicine

Medical history taking may also be impaired by various factors impeding a proper doctor-patient relationship, such as transitions to physicians that are unfamiliar to the patient. History taking of issues related to sexual or reproductive medicine may be inhibited by a reluctance of the patient to disclose intimate or uncomfortable information.

Chapter 6 : Ten-minute history-taking and physical examination station example | Medical Council of Cana

Senior Lecturer Gemma Hurley uses a mock patient to take you through the principles of obtaining a clinical history for www.nxgvision.com

Chapter 7 : Ten-minute history-taking station example | Medical Council of Canada

A comprehensive guide to taking a dermatological history in an OSCE setting. The guide covers taking a history of a rash, a pigmented lesion and more. Exploring first rank symptoms in a psychiatric history - OSCE guide.

Chapter 8 : History Taking. Information about History Taking | Patient

Family History Ask the patient about any family diseases relevant to the presenting complaints (e.g. if the patient has presented with chest pain, ask about family history of heart attacks). Enquire about the patient's parents and sibling and, if they were deceased below 65, the cause of death.

Chapter 9 : SAMPLE history - Wikipedia

An Example of a History, Physical Examination, Presentation and Problem Solving Practical Examination Station (Department of Internal Medicine, The University of Texas Medical Branch).