Summary of HX Taking

Partnership with the patient

- The patient and the interviewer/examiner have a partnership that should promote patient satisfaction.
- This partnership is directed toward collecting psychosocial and biologic information about the patient in order to promote health.

Factors that enhance communication

- Use approachable, professional demeanor and attire.
- Avoid reaction extremes; be sensitive to patient responses.
- Pursue patient experiences, using his or her own descriptive terms.
- Ask open-ended, not leading, questions.
- Recognize potential language differences. Listening is the art of intelligent repose.
- Be explicit without patronizing.
- Clarify information without making value judgments.
- Ask a variety of questions to help clarity and interpret information.
- Be sensitive to subtle answers. It may take time before a patient's verbal responses and nonverbal cues can be analyzed.
- Be sensitive to the patient who is anxious or depressed.

Moments of Tension

- Respond to personal inquiries without giving details. Allow moments of silence. Use time for analyzing nonverbal communication.
- Recognize patient cultural factors that may be similar to or different from your own experiences.
- Show understanding when a patient cries.
- Acknowledge anger and allow expression.
- Acknowledge a patient's anxiety and confirm with the patient the best way to handle the anxiety.
- Maintain a professional demeanor even when a patient attempts to manipulate you.
- Demonstrate compassion without seduction.
- Pursue hidden data that the patient may be reluctant to share.
- Maintain professionalism while exploring sensitive issues such as intimacy or money.

Setting for the interview

- Use a comfortable setting for data collection.
- Arrange seats to promote eye contact and attention.
- Maintain a conversational tone of voice.
- Avoid institutional or professional distractions.

Taking the History

- Conduct appropriate introduction, giving your own name and role.
- Address the patient properly. Use formal names.
- Ask questions, using a chronologic and sequential framework.
- Listen to patient's responses.

- Collect data on where, when, how, and why factors of the present problem.
- Verify the patient's understanding of circumstances and treatment.
- Individualize and humanize the patient's history.

Component of the Health History

Identifying Data

- Name
- Age
- Gender
- Marital status
- Occupation
- Location
- Religion
- Source of referral

Source and Reliability

- Source
- Cooperation
- Quality of the information
- Reliability

Date and Time

Chief Complaint (s)

- Patient's brief statement explanation or their goal instead
  (If patients use medical terms, ask to define it)

Present Illness

- Chronology is the most practical frame work for organizing the history
- Description of symptoms (OLD CARTS):
  1. Onset
  2. Location
  3. Duration
  4. Character
  5. Aggravating/Associated factors
  6. Relieving factors/Radiation
  7. Temporal factors
  8. Severity
- It is also important to include "pertinent positive" and "pertinent negative"

Past History

- *Childhood Illness*
  - Measles
  - Mumps
  - Chicken pox
  - Scarlet fever
  - Rubella
  - Whooping cough
  - Rheumatic fever
  - Polio

- *Adult Illness*
  - Medical (Diabetes, hypertension, hepatitis, asthma, HIV disease, transfusion, hospitalization, number and gender of partners)
  - Surgical (dates, indications and type of operation)
  - Obstetric/Gynecologic (relate obstetric history, menstrual history, birth control, and sexual function)
  - Psychiatric (dates, diagnosis, hospitalization, and treatments)
  - Health maintenance (Immunization)

- Screening tests (tuberculin test, pap smear, mammogram, stool exam, cholesterol tests, ...)
- Medication (past, current, and recent including name, dose, route, and frequency)

Family History

- Outline age and health, or age and cause of death, of each immediate relatives:
  - Diabetes
  - Cardiovascular disease
  - Hypercholestrolemia
  - Hypertension
  - Stroke
  - Renal disease
  - Thyroid disease
  - Lung disease
  - Arthritis
  - Headache
  - Seizure disorder
  - Mental illness
  - Suicide
  - Alcohol or drug addiction
  - Allergies

Personal and social History

- *Personal status:*
  - Birthplace
  - Position in family
  - Where raised
  - Marital status
  - Home environments as youth
  - Hobbies
  - Education
  - Sources of stress

- *Habits:*
  - Nutrition and diet
  - Patterns of eating
  - Patterns of sleeping
  - Quantity of coffee, tea, tobacco, alcohol

- *Sexual history*
- *Home condition*
- *Occupation*
- *Environments:*
  - Travel
  - Water and milk supply
  - Other exposure to contagious disease

Review of systems

- **General**
  - Usual state of health
  - Fever
  - Weakness
  - Fatigue
  - Chills
  - Sweats
  - Usual weight
  - Exposure to radiation

- Change in weight
- Appetite

- **Skin**
  - Rashes
  - Itching
  - Hives
  - Easy bruisability
  - History of eczema
  - Dryness
  - Changes in skin color
  - Changes in hair texture
  - Changes in nail texture
  - Changes in nail appearance
  - History of previous skin disorders
  - Lumps
  - Use of hair dyes

- **HEENT**

Head

- "Dizziness"
- Headache
- Pain
- Fainting
- History of head injury
- Stroke

Eyes

- Use of eyeglasses
- Current vision
- Change in vision
- Double vision
- Excessive tearing
- Pain
- Recent eye examinations
- Pain when looking at light
- Unusual sensations
- Redness
- Discharge
- Infections
- History of glaucoma
- Cataracts
- Injuries

Ears

- Hearing impairment
- Use of hearing aid
- Discharge
- "Dizziness"
- Pain
- Ringing in ears
- Infections

Nose and Sinuses

- Nosebleeds
- Infections
- Discharge
- Frequency of colds
- Nasal obstruction
- History of injury
- Sinus trouble
- Hay fever

Throat and mouth

- Condition of teeth
- Last dental appointment
- Burning of tongue
- Hoarseness

- Condition of gums
- Bleeding gums
- Frequent sore throats
- Voice changes
- Postnasal drip

- **Neck**
  - Lumps
  - Goiter
  - Pain on movement- Thyroid trouble
  - Tenderness
  - History of "swollen glands"

- **Respiratory**
  - Dyspnea
  - Cough
  - Pain
  - Shortness of breath
  - Pleurisy
  - Sputum production (quantity, appearance)
  - History of bacille Calmette-Guerin vaccination
  - Bronchitis
  - Coughing up blood
  - Wheezing
  - Last x-ray
  - Last test for tuberculosis

- *Cardiac*
  - Chest pain or discomfort
  - Dyspnea
  - Shortness of breath when lying flat
  - Shortness of breath with exertion
  - History of heart attack
  - Other tests for heart function
  - Sudden shortness of breath while sleeping
  - Edema
  - High blood pressure
  - Last electrocardiogram
  - Rheumatic fever

- **Vascular**
  - Pain in legs, calves, thighs, or hips while walking
  - Swelling of legs
  - Varicose veins
  - Thrombophlebitis
  - Ulcers
  - Coolness of extremity
  - Loss of hair on legs
  - Discoloration of extremity

- **Breasts**
  - Lumps
  - Discharge
  - Pain or Tenderness
  - Self examination

- **Gastrointestinal**
  - Appetite
  - Excessive hunger
  - Excessive thirst
  - Nausea
  - Swallowing
  - Constipation
  - Diarrhea
  - Vomiting blood
  - Rectal bleeding
  - Black, tarry stools
  - Laxative or antacid use
  - Excessive belching
  - Food intolerance
  - Change in abdominal size

- Heartburn
- Vomiting
- Abdominal pain
- Change in stool color
- Change in stool caliber
- Change in stool consistency
- Frequency of bowel movements
- Gallbladder disease
- Hemorrhoids
- infections
- Jaundice
- Rectal pain
- Previous abdominal x-rays
- Hepatitis
- Liver disease

• **Urinary**

- Frequency
- Urgency
- Incontinence
- Excessive urination
- Pain on urination
- Burning
- Blood in urine
- Urine odor
- Difficulty in starting the stream
- Flank pain
- Infections
- Stones
- Bed-wetting
- Awakening at night to urinate
- History of retention
- Urine color

Male Genitalia

- Lesions on penis
- Discharge
- Ability to enjoy sexual relations
- Impotence
- Prostate problems
- Frequency of intercourse
- Pain
- Scrotal masses
- Fertility problems
- Hernias
- History of venereal disease and treatment

Female Genitalia

- Lesions on external genitalia
- Itching
- Discharge
- Last Pap smear and result
- Pain on intercourse
- Frequency of intercourse
- Birth control methods
- Ability to enjoy sexual relations
- Fertility problems
- Hernias
- Age at menarche
- Interval between periods
- Menopausal symptoms
- Duration of periods
- Amount of flow
- Date of last period
- Bleeding between periods
- Number of pregnancies
- Abortions
- Term deliveries
- Complications of pregnancies
- Description(s) of labor
- Number of living children
- Menstrual pain
- Age at menopause
- Postmenopausal bleeding
- History of venereal disease and treatment

• **Musculoskeletal**

- Weakness
- Paralysis
- Arthritis
- Gout

- Muscle stiffness
- Limitation of movement
- Joint pain
- Joint stiffness
- Back problems
- Muscle cramps
- Deformities

• **Neurologic**
- Fainting
- "Dizziness"
- "Blackouts"
- Paralysis
- Strokes
- "Numbness"
- Tingling
- Burning
- Tremors
- Loss of memory
- Speech disorders
- Unsteadiness of gait
- Loss of consciousness
- Disorientation

• **Hematologic**
- History of Anemia
- Easy bruising or bleeding
- Past transfusion
- Transfusion reaction

• **Endocrine**
- Thyroid trouble
- Heat or cold intolerance
- Excessive sweating
- Excessive thirst or hunger
- Polyuria
- Change in glove or shoe size

• **Psychiatric problem**
- Nervousness
- Tension
- Mood
- General behavioral change
- Depression
- Suicide attempts
- Hallucinations

Checklist for history taking

Identifying data

- Asks about:
  a. Age ☐
  b. Gender ☐
  c. Marital status ☐
  d. Occupation ☐
- Mentions and considers:
  a. Number of admissions ☐
  b. Date of hospitalization ☐
- Mentions any specific multiorgan disease

Chief complaint(s)

- Mentions the one or more symptoms or concerns causing the patient to seek care.
- Uses the patient's own words
- If patients have no overt complains, reports their goal instead.
- Mentions time of onset of chief complaint

Source of history

- Mentions the source:

  a. Patient ☐ b. Family member ☐
  c. Friend ☐ d. Letter of referral ☐ e. Other medical record ☐
- Judges the quality of information by assessing the reliability, cooperation and information at the end of interview.

Present illness

- High lights any multiorgan disease and clarifies the organs involved.
- Characterizes the principal symptoms with description of:

  a. Location ☐ b. Quality ☐
  c. Quantity or severity ☐ d. Radiation (of pain) ☐

  e. The setting in which they occur ☐
  f. Timing including onset, duration and frequency ☐
  g. Factors that have aggravated or relieved the symptoms☐
  h. Associated manifestations ☐
- Organizes the data chronologicly
- Mentions any treatment
- Includes "pertinent positives" and "pertinent negatives" from sections of the review of system related to the chief complaints.
- Considers the patient's responses to his or her symptoms and what effect the illness has had on the patient's life.

Note: Refer to *Checklist for History Taking*.

Drug history

- Asks about drugs name, dose, route and frequency of use
- Lists:

  a. Home remedies ☐ b. Nonprescription drugs ☐
  c. Vitamins ☐ d. Mineral or herbal ☐
  e. Birth control pills ☐
  f. Medicines borrowed from family members or friends ☐
- Asks the patients to bring in all of their medications
- Records allergies to:

  a. Medications ☐ b. Foods ☐
  c. Insects ☐ d. Environmental factors ☐

Past medical history

- Records childhood illnesses:

  a. Measles ☐ b. Rubella ☐
  c. Mumps ☐ d. Whooping cough ☐
  e. Chicken pox ☐ f. Fever ☐
  g. Scarlet fever ☐ h. Polio ☐

- Records adult illnesses:

1. Medical
   a. Diabetes ☐ b. Hypertension ☐
   c. Hepatitis ☐
2. Surgical
   a. Date ☐ b. Diagnosis ☐
   c. Hospitalization ☐ d. Treatment ☐

- Covers immunization
- Asks about screening tests

Family history

- Outlines the age and health, or age and cause of death of each immediate relatives including:
  a. Parents ☐ b. Grand parents ☐
  c. Siblings ☐ d. Children ☐
  e. Grand children ☐
- Reviews each of the following conditions and records if these are present or absent in the family:
  a. Hypertension ☐ b. Coronary artery disease ☐
  c. Stroke ☐ d. Elevated cholesterol level☐
  e. Diabetes ☐ f. Thyroid or renal disease ☐
  g. Cancer ☐ h. Arthritis ☐
  i. Tuberculosis ☐ j. Asthma or lung disease ☐
  k. Headache ☐ l. Seizure disorder ☐
  m. Mental illness ☐ n. Suicide ☐

Personal and social history

- Asks about tobacco use including type
- Reports cigarette use in pack-year
- Mentions alcohol use
- Asks about exercise and diet
- Mentions:
  a. Occupation ☐ b. Interests ☐
  c. Schooling ☐ d. Religion ☐
  e. Activity ☐ f. Job history ☐
  g. Financial situation ☐ h. Retirement ☐
  i. Military service ☐

Review of systems

- Starts with a fairly general question for example starts with “How are your ears and hearing?” “Any trouble with your heart?”
- Records illnesses as part of the present illness or past history, if the patient remembers them as you ask questions within the review of systems.