

The History and Interviewing Process

Interviewing is the key skill of the physician, because visiting the patient for the first time can provoke anxiety in the medical student, but motivation of becoming a physician far outweighs the fear.

Setting the stage for the interviewing:

1. Welcome the patient
2. Use the patient's name
3. Ensure patient readiness & privacy
4. Remove barriers to communication
5. Ensure comfort & put patient at ease

When you want to start taking history, you should allow the patients to describe their symptoms in their own words & should initiate the discussion with open-ended questions.

Open-ended questions do not encourage one-word answers, (yes or no) or short answers. These words elicit the patient's description in her or his own words of symptoms or personal concern. Open-ended inquiry elicits information from the patient's mind rather than from the student's or the clinician's.

The 6 skills in interviewing are silence, non-verbal encouragement, neutral utterances, reflection requests, and summarization.

Method of write up of history differs oral presentation. The purpose of write up is to record the patient's story in a concise and well organized manner at the time of admission and to demonstrate your clinical reasoning and decision making to other providers. Write up fortify your knowledge and problem solving skills.

The purpose of oral presentation is to provide other clinicians with patient information. Oral presentation must be done in such a way that tells the patient's information in a logical, clear and complete presentation should take no little as 15-30 seconds.

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.



Dear medical students:

Scientific decision making and clinical reasoning are the main axis for clinical diagnosis.

This brief guideline to history taking is designed for you; the novel medical students, who are the future doctors. To be able to take a comprehensive history, and understand the patient's problem.

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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 relative:
 - Diabetes
 - Cardiovascular disease

- Hypercholesterolemia
- Stroke
- Thyroid disease
- Arthritis
- Seizure disorder
- Suicide
- Allergies
- Hypertension
- Renal disease
- Lung disease
- Headache
- Mental illness
- Alcohol or drug addiction

Personal and social History

• Personal status:

- Birthplace
- Where raised
- Home environments as youth
- Education
- Position in family
- Marital status
- Hobbies
- 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
- Weakness
- Chills
- Usual weight
- Change in weight
- Fever
- Fatigue
- Sweats
- Exposure to radiation
- Appetite

• Skin

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

HEENT

Head

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



History Taking Guide Lines



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

• 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
- Heartburn
- Vomiting
- Abdominal pain
- Change in stool color
- Change in stool caliber
- Change in stool consistency
- Gallbladder disease
- Frequency of bowel movements
- Vomiting blood
- Rectal bleeding
- Black, tarry stools
- Laxative or antacid use
- Excessive belching
- Food intolerance
- Change in abdominal size
- 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
- History of venereal disease and treatment
- Frequency of intercourse
- Pain
- Scrotal masses
- Fertility problems
- Hernias

Female Genitalia

- Lesions on external genitalia
- Itching
- Discharge
- Last Pap smear and result
- Pain on intercourse
- Frequency of intercourse
- Birth control methods
- Duration of periods
- Amount of flow
- Date of last period
- Bleeding between periods
- Number of pregnancies
- Abortions
- Term deliveries

- Ability to enjoy sexual relations
- Complications of pregnancies
- Fertility problems
- Hernias
- Age at menarche
- Interval between periods
- Menopausal symptoms
- History of venereal disease and treatment
- Description(s) of labor
- Number of living children
- Menstrual pain
- Age at menopause
- Postmenopausal bleeding

• Musculoskeletal

- Weakness
- Paralysis
- Muscle stiffness
- Limitation of movement
- Joint pain
- Joint stiffness
- Arthritis
- Gout
- 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

References:

1. BATES Guide to Physical Examination, and History Taking, Lynn S.Bickley, Thirteenth, International Edition. Chapter 1, 2020.
2. Textbook of Physical Diagnosis. History and Examination MARK H.SWARTZ Eight Edition. Chapter 1, 2020.

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

• Neck

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

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