**HISTORY TAKING**

It is a systematic procedure undertaken when a patient present at the hospital for proper diagnosis.

Importance of history taking is that;

* A detailed and intelligent gathered history is of vital importance in determining the presence of illness, in assessing its severity, in making a diagnostic and determining the importance of other factors which may influence the patient’s response to both the illness and its treatment.
* Gaining the patient’s confidence
* Directing your attention decisively to the area in which the patient problem lie.

**N/B**

* 90 % of patients, the diagnosis will be apparent on history alone.

 **FORMAT OF THE HISTORY**

1. **BIODATA/ PARTICULARS**

Consists of the personal information of the patient, the information include;

* Name
* Age
* Marital status
* Occupation
* Gender
* Residence
* Religion
* Address
* Date of admission
* Next of kin
1. **CHIEF COMPLAINT**

What made the patient to seek for medical attention.

At most they should be three, patient with loss of conscious can have only that as the only complaint, due to the inability to remember what took place.

Chief complaint can include, pain, swelling, loss of function, loss of conscious, bleeding etc.

**N/B**

* Pain can be described with the following approach, SOCRATES ;

**S-** site

**O-** Onset

**C-** Character

**R-** Radiation

 **A-** Associated symptoms

**T-** Timing ( duration, course, pattern)

**E-** Exacerbating and relieving factors

**S-** Severity

1. **HISTORY OF THE PRESENTING ILLNESS**

Brief examination in chronological order of the events that led to the illness/injury.

It is what the patient says and not the doctor’s view, and is recorded in patient’s language.

A history of road traffic accident (RTA) can include the following;

* What caused the accident
* Which activity was the patient involved in at the spot of accident (driving, riding or pedestrian).
* On which side was the patient knocked from.
* The name of the road also is important
* Time and date of the incidence also is included.
* What happened after the injury, I.e any first aid undertaken
1. **PAST MEDICAL HISTORY**

This is important to ascertain for any medication undertaken, underlying medical condition or if the case is a recurrent one or a fresh case.

In past medical history, the history of the following is taken;

* Past admissions
* Any case of chronic illness to the patient
* Any medication undertaken
* Blood transfusion cases
* Any case of allergic response related to drugs or food.
1. **SYSTEMIC REVIEW**

Any system involved with the affected system can be assessed for its functionality or morphological disorders.

At most two or three systems can be considered, I.e if the case involves the skeletal system; nervous, respiratory and integumentary systems can be assessed.

1. **PERSONAL, FAMILY, ECONOMIC AND SOCIAL HISTORY**

This is the patient history in depth, to understand his/her habits, family background, financial stability, and the behavior .

In personal history we consider the marital status of the patient and level of education.

In family history, for a married patient, we will talk about his family; how many children he/ she have and how many wives , if the patient is yet to marry, we will talk about; his/ her parents; if both are alive or deceased, there level of education and his/ her siblings; how many they are and what is his/ her position of birth.

Also in family history, we also need to know the residence of the patient.

In social history, we consider social habits (alcoholism and smoking) and religion.

In economic history, the occupation of the patient is discussed, how he /she will be able to pay the hospital bill ( cash or NHIF insurance).

1. **EXAMINATION**

Are assessments done to come up with the correct diagnosis and confirm patient history.

During examination, we have various categories of assessments, including;

* GENERAL EXAMINATION.

We assess general appearance of the patient, in terms of ;

1. Body posture/gait
2. General appearance of the patient, kempt or unkempt
3. Patient’s mood
4. Patient nutritional condition
* PHYSICAL EXAMINATION.

In physical examination, as the name explains, it is assessment by observing and feeling

During the assessment, we have guidelines for the examination of the patient to find out various signs and symptoms of illness.

In physical examination, the following examinations are undertaken;

* Jaundice – Is the yellowness in the body tissue due to liver dysfunction, ( good example is pregnancy and postnatal jaundice )

Jaundice can be observed at the eye sclera, tongue frenulum, foot sole and perineum ( in pediatrics )

* Pallor – Paleness due to less blood supply to the extremities, can occur as a result of blood loss.

Pallor can be ascertained at the palms, finger and toe nails, upper tongues surface, eye conjunctiva.

* Cyanosis – Bluishness/ purplish color in the body tissues due to poor supply of oxygen to body tissue.

The color can be observed Incase of ischemia at ; tongue tip, nose tip also at the extremities in case of peripheral cyanosis.

* Edema – Swelling of the body tissues due to the accumulation of body fluids in the tissues.

Edema can either be pitting or non pitting (hard on pressure application).

We have various sites where fluids tend to accumulate in the body and they include; face ( post-orbital and general),sacral, abdomen and at the ankle

* Lymphadenopathy (glands) – is the swelling of the lymph nodes due to body immune reaction to illness.

On assessment of glands various b lymph nodes can be felt and they are; pre otic, sub mandibular, axillary, inguinal, popliteal among others.

* Dehydration – Is the state by which body tissue loss excess fluids to the environment.

Various conditions like burns can lead to dehydration.

Dehydration can be observed at the, lips, mouth mucosa, sunken eyes and pinching the abdomen (loss of turgor) in case of severe dehydration and dysuria.

* LOCAL EXAMINATION

In local examination, we narrow down to the site of injury, assessment is done specifically where we have the illness.

During assessment of the point of illness, we follow a systematic order;

1. Full exposure of the patient for adequate assessment
2. Inspection – inspection is done by observation and feeling the site of injury.

Massive swelling, deformity, ecchymosis( internal bleeding) and skin damage (abrasion or cuts ) can be seen on investigation

1. Palpation – can either be light or deep palpation.

Light palpation is done using the fingers to ascertain for swelling, temperature, circulation, sensitivity and deformities, also fluid accumulation.

Deep palpation is done using the palm for lump swelling, lymphadenopathy tenderness, and while palpating for tenderness, you observe the patient’s face to ascertain to pain on palpation.

1. Movement - Patient is asked to perform various movement to check for soft tissue injuries and pain at the fracture site.

Due to loss of function most patient tend not to have the strength to perform much movement on assessment, thus muscle power grading can be applied.

In normal circumstances only active movements can be performed, but in traumatic incidence patient aren’t able to perform any movement thus passive movement with the aid of the doctor.

1. Measurement – it is done to confirm for shortening or swelling.

This assessment can be performed using tape measure or comparison with the sound limb.

1. **DIFFERENCIAL DIAGNOSIS**

This is the findings from the patient history and examination.

It’s what the doctor thinks of before investigation.

Are conditions, having the same signs and symptoms with that of the incurred one.

1. **INVESTIGATION**

Further examination to come up with the correct diagnosis.

There are two types of investigation

* Radiological investigation

Involves radiographic images.

Various modes of imaging are used in diagnosis, including; x-rays, CT- scans, MRI, among others

* Lab investigation

Assessment carried out in the laboratory using body fluids (blood test, pus swabs, synovial test, csf test) and body tissues (biopsy).

1. **DIAGNOSIS**

Correct results after evaluation of the history, examination and investigation.

It is what the patient suffer from

Diagnosis opens way for correct management of the patient

1. **MANAGEMENT**

Treatment process of the patient, to counteract the illness, reduce pain, restores functionality, save life

There are three modes of treatment;

* No treatment, only assurance
* Conservative, non operative management
* Definitive, Operative management
1. **PLAN/ FOLLOWUP**

This is what should be done to the patient after management I.e the patient can be awaiting definitive management after conservative management.

1. **SUMMARY**

It is a short composure of the history, consisting of;

* Patient name, age, sex and few vital information
* Past admissions, and illness that may be associated with recent illness
* Current illness, presentation and complaint
* What has been done to the patient currently (management done).
* What’s the plan for the patient ( definitive management).

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