Definition of History taking :

It's the information given by the patient and\or people accompaning him, medical papers or the referring practitioner detailing the patient's current and past status.

Good history taking is an important step in making a diagnosis. Medical interviews are of two basic types:

1- problem-oriented : which concerns the patients chief complaint.

2- Health promotion interview : which concerns the patients current and past health problems, assessing current health risk factors like smoking , diet , alcohol consumption ,and heritable diseases in the family

History gives the doctor an opportunity to educate the patients about the symptoms they have and even about the other symptoms which they don't have. This is called opportunistic health promotion

To take history you should first introduce yourself to the patient ,and check the patient is comfortable.
Sit beside the patient at the same level.
At first , let the patient tell his\her story in his\her own words, without interference. Be a good listener to the patient ,and conversational rather than interrogative in tone.

It's important to show that you are interested in what the patient is saying, " nodding " , saying yes or echoing what is said. And you really should be really interested in what the patient is talking about.

Avoid sudden shifts of topic as avoidance of certain issues may point to concerns that are not expressed directly. The physician's communication ability and behaviour during the interview are very important. You should be able to analyze the patient's words, accepting the significant and rejecting the insignificant.

Leading questions are best avoided. For instance, a patient present with episodic chest pain. If we use leading questions then we ask the patient "Is it worse when you are walking ?" The patient is not sure of the answer, not having thought about the influence of exercise on his pain ,but answers "*Yes*" because he remembers a day when he was walking and the pain was bad.

It's much better to ask open Questions such as :

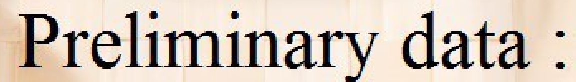
Have you noticed anything that makes the chest pain worse ?

Seek consent. If the patient declines, thank him\her and leave. You may report this to your senior doctor.

Before starting taking history , introduce yourself and gain consent.

Do you feel well enough to talk now ?

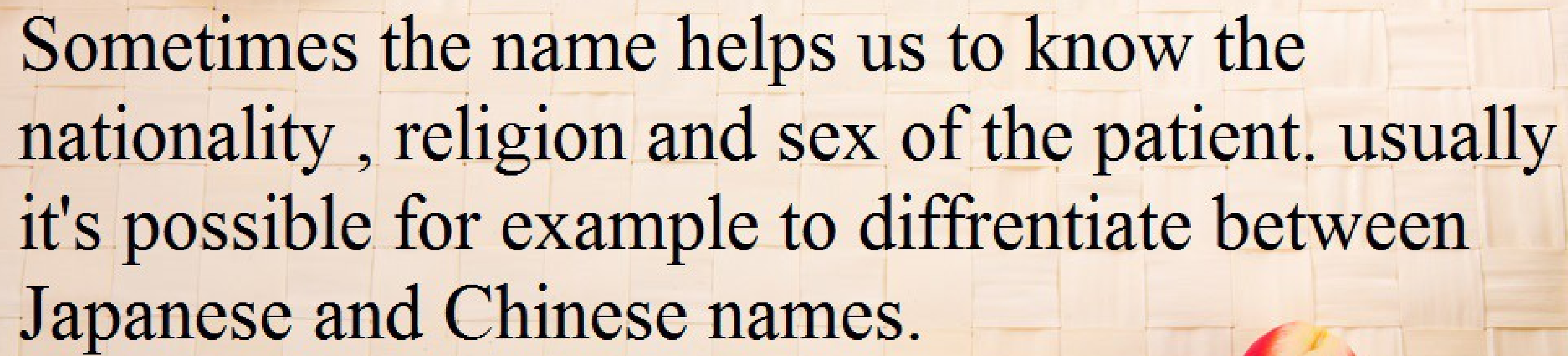
Check if there is anyone present makes the patient uncomfortable.

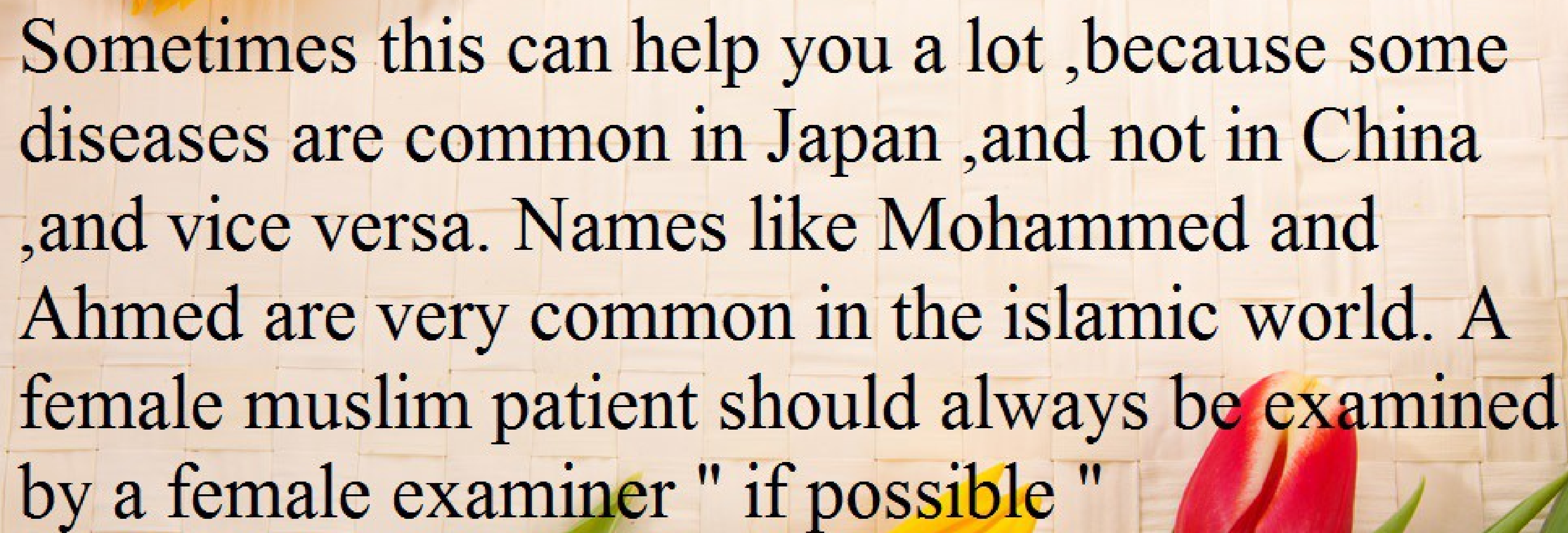


Preliminary data :

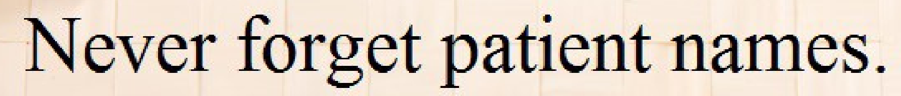
1 - Full name :

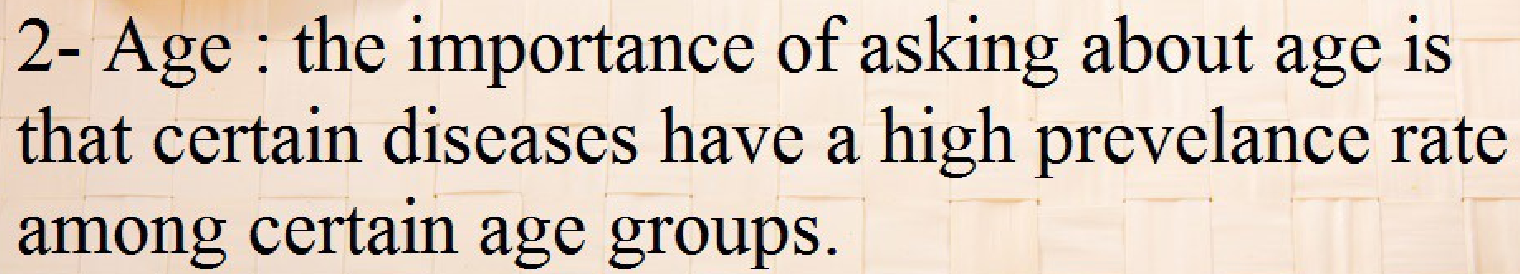
Although a simple question , it's very important to ask about the name of your patient to be familiar with. Also for identification and medical regestration.

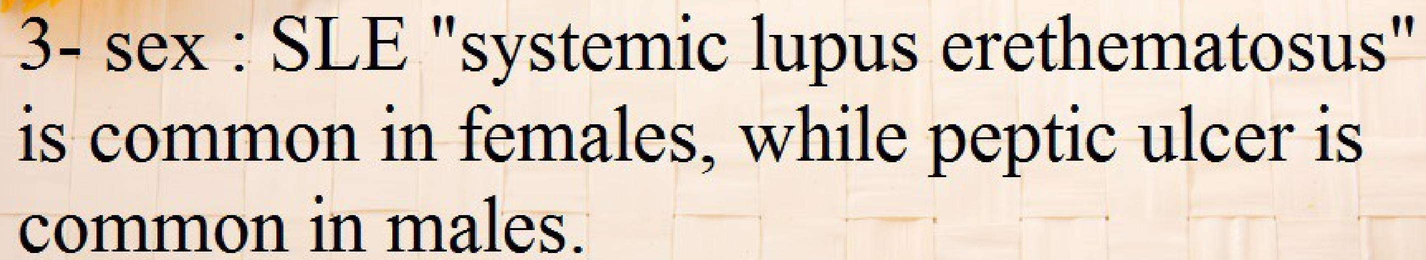

Sometimes the name helps us to know the nationality , religion and sex of the patient. usually it's possible for example to diffrentiate between Japanese and Chinese names.

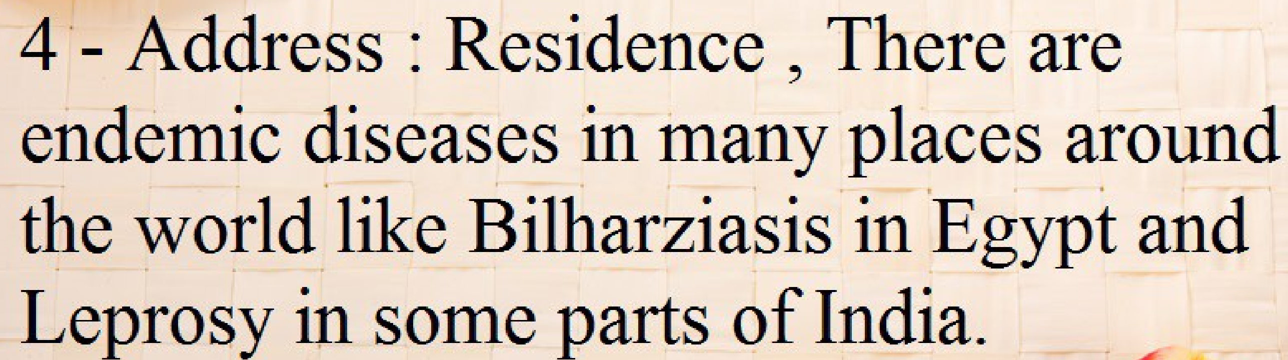


Sometimes this can help you a lot ,because some diseases are common in Japan ,and not in China ,and vice versa. Names like Mohammed and Ahmed are very common in the islamic world. A female muslim patient should always be examined by a female examiner " if possible "

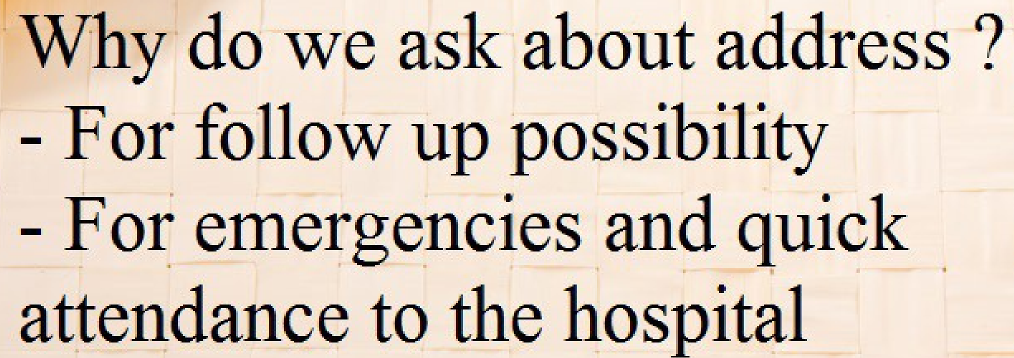

Never forget patient names.

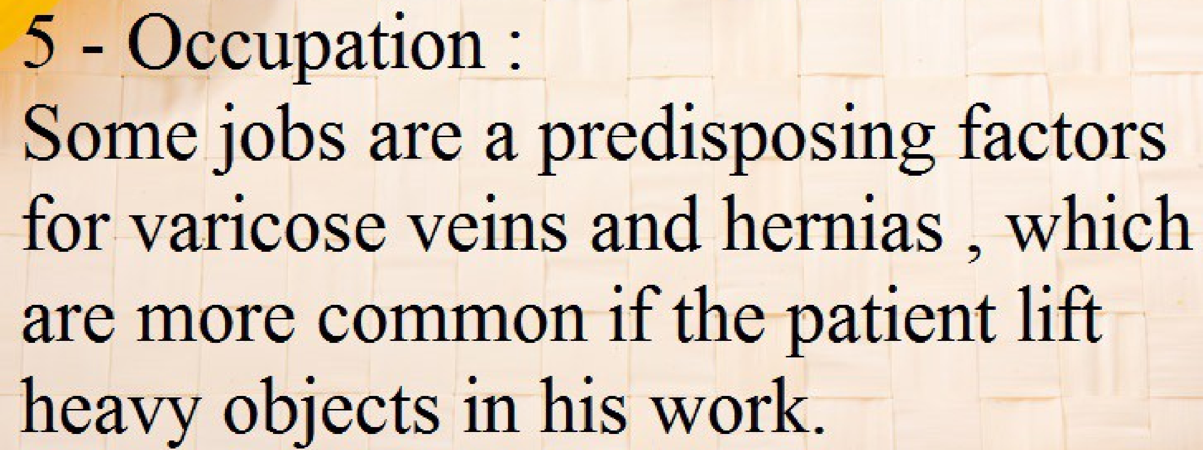

2- Age : the importance of asking about age is that certain diseases have a high prevelance rate among certain age groups.

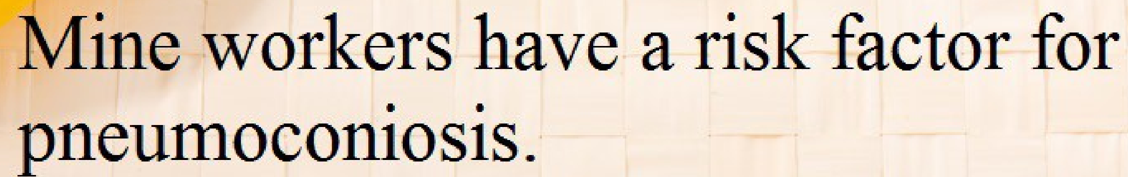

3- sex : SLE "systemic lupus erethematosus" is common in females, while peptic ulcer is common in males.



4 - Address : Residence , There are endemic diseases in many places around the world like Bilharziasis in Egypt and Leprosy in some parts of India.

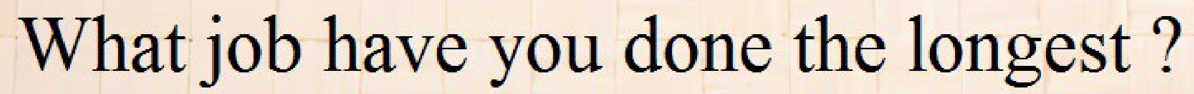

Why do we ask about address ?
- For follow up possibility
- For emergencies and quick
attendance to the hospital

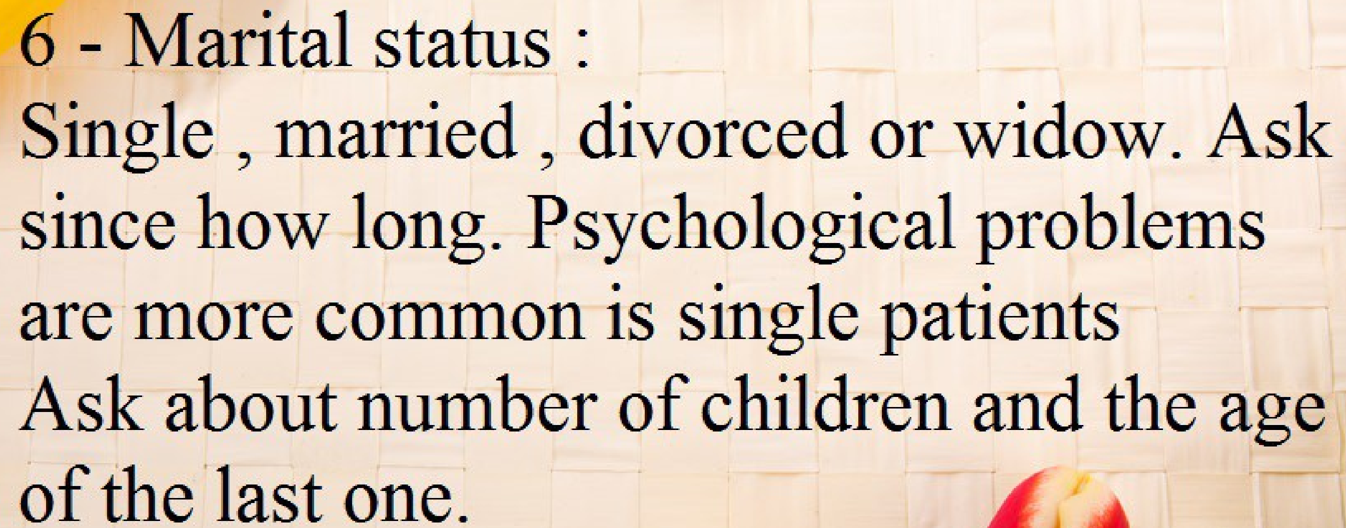

5 - Occupation :
Some jobs are a predisposing factors
for varicose veins and hernias , which
are more common if the patient lift
heavy objects in his work.

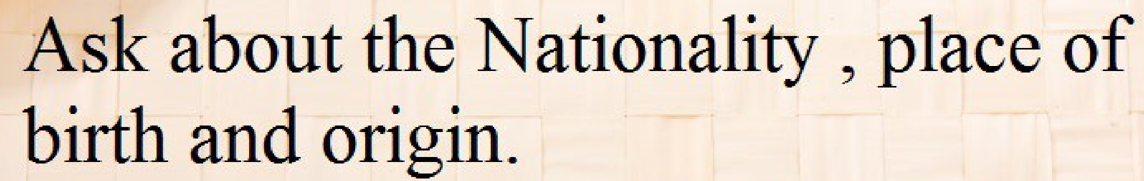


Mine workers have a risk factor for pneumoconiosis.

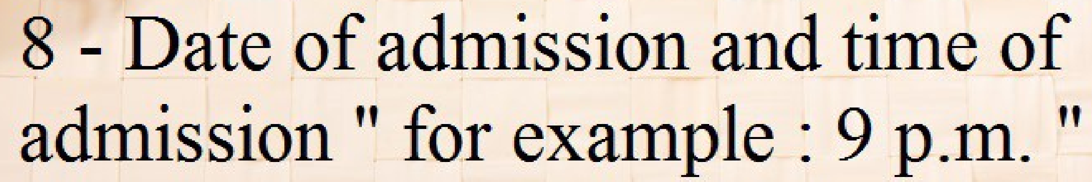
Ask the patient about any second job or previous jobs too.


What job have you done the longest ?

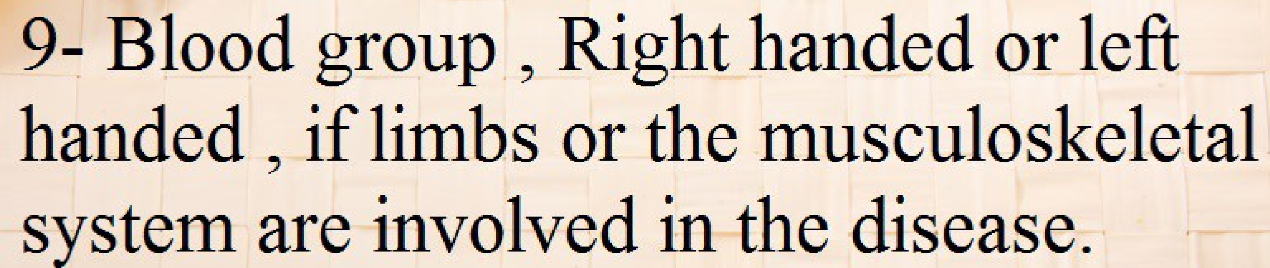

6 - Marital status :
Single , married , divorced or widow. Ask since how long. Psychological problems are more common is single patients
Ask about number of children and the age of the last one.

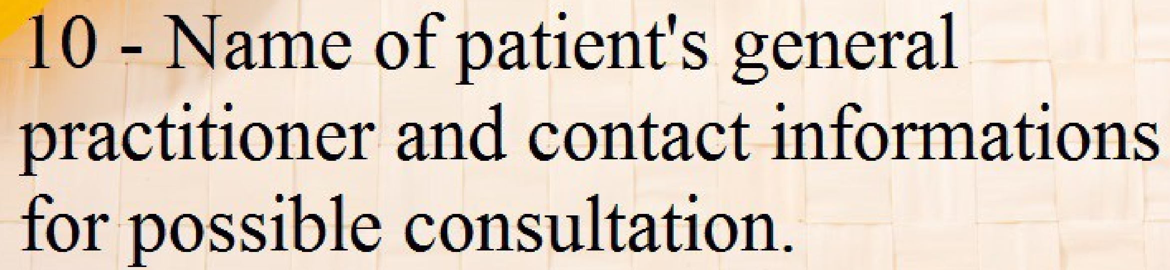


Ask about the Nationality , place of birth and origin.



8 - Date of admission and time of admission " for example : 9 p.m. "


9- Blood group , Right handed or left handed , if limbs or the musculoskeletal system are involved in the disease.



10 - Name of patient's general practitioner and contact informations for possible consultation.

Now , to tell the personal Data in one paragraph, Do not say : Name .... Age .... sex .... location ..... This is completely wrong. You should tell it like a story in harmonious flow.

For example : Mr. John Adams a 29 years old male British patient from london. He is a teacher and married since 5 years ,and father of two children , the youngest is 2 years old. His blood group is O positive. He is not a smoker. Admitted to hospital on the 3rd of June at 7 P.M. complaining of a recurrent abdominal pain. "or happening for the first time"

Chief compaint definition :

It's the problem that has prompted the patient to request the consultation.

The way of asking about the chief compalint :
First , try to encourage the patient to talk by asking him\her open-ended questions because this gives the patient the opportunity to talk about any or all problems.

Closed direct questions like yes\no questions communicate that the patient should remain silent until asked a specific question.

Open ended questions ask for narrative informations.
Closed questions ask for specific informations

Let the patient talk without interruption. A study by Beckman and Frankel showed that physicians eager to arrive at a clinical dianosis would interrupt a patient within 18 seconds of the patient begining to speak. They found that patients rarely continued to express their true concerns once they were interrupted.

Chief complaint or Present complaint :

What is wrong with you ? What brought you to see the doctor ?

The most disturbing complaint if the patient has many complaints.

Mention the complaint in the patient's own words
" No medical terms "
So don't say dyspnea , rather say breathlessness.
Vomiting up blood , not heamatemesis.

If there are more than one symptom , mention them in choronological order with duration. For example : abdominal pain since 7 days , vomiting since 4 days , fever since 2 days.

If the patient has multiple complaints , mention the last time the patient was in his\her last usual state of health

Analysis of chief complaint : Also "presenting complaint". It's a discription of the development of the illness.

In analysis of chief complaint, you should use medical terms. (but of course not when talking with the patient)

1 - Mode of onset :

- Sudden "abrupt"
- Acute
- Subacute
- Gradual

2 - Duration and frequency

3 - Site :

Mention the site exactly
Localized or diffuse
If diffuse, where is the maximum site ?
Where did it start?

4 - Aggrevating factors and relieving factors.

What makes symptoms worse ?
What makes them better ?

Let the patient talk about his aggrevating factors.

5 - Course of symptoms :

Progressive	retrogressive
constant	periodic
stationary	fluctuating

Diurnal variations : like fever in Tuberculosis which has a specific time to peak , mainly at night.

Seasonal variations : Many respiratory conditions

6- Severity \ amount :

mild, moderate, sever

if pain, let the patient describe the severity using a scale from 1 to 10

Do not describe the scale ,and do not give examples. Just let the patient give you a number

7 - Character :

character of pain, sputum, vomiting and discharge are dicussed later .

8 - Radiation

It's the extension of pain to another site, whilst the initial pain persists. e.g. the radiation of epigastric pain to the back in some patients with pancretitis.

This must be diffrentiated from "referred pain"

Example of a referred pain is the pain in umblicus from appendix.

9 - Associated symptoms :

like the following 5 constitutional symptoms :

A - Fever \ pyrexia :

ask about grade

low if < 38.5

high if = or > 38.5

ask about character of fever :

Is it continous = the same level through out the day.

remittant = fluctuant ,but not reaching the base line

intermittent = fluctuant and reaching the base line

or relapsing = with long intervals of fever free periods

B- weight changes :

Significant weight loss is > 10 % within 6 months.

Sever weight loss is called cachexia.

Does the patient measure his\her weight ?

Does the patient follow a specific diet to lose weight ?

Did the clothes become wider ?

C - Appetite :

anorexia is loss of desire to eat.

Anorexia should be differentiated from fear of eating which can happen in gastritis or gastric peptic ulcer.

D - sweating
E- fatigability

e.g. Vomiting can be associated with weight loss.

10 - Effects and impaction of symptoms on patients life :

Sleep : Does the symptoms wake the patient up from sleep ?
Daily activity : Does the patient need an assistant ?
Job or study : How many days the patient is off job\school ?

11 - Analysis and investigations done so far , and their results.

12 - Response to treatment , if any.

13 - Sitting :

Where wereyou when you first felt ill ?

What were you doing ?

Who was with you ?

Mnemonics :

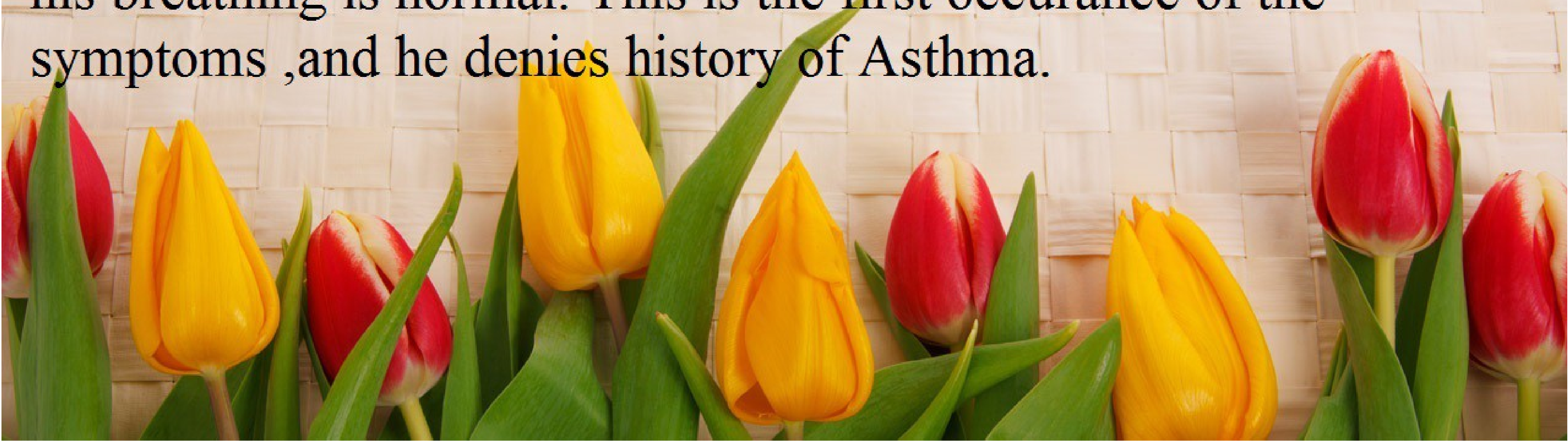
Soda scars care \ Socrates

Site - onset - duration - aggrevating factors and relieving factors - severity - character - associated symptoms - radiation - sitting - course - analysis and investigations - response to treatment - effects and impact.

You can include any important past medical, surgical, personal, social history data which are strongly related to the chief complaint in the analysis of chief complaint. For example : family history in a patient with a hereditary disease. Personal history of chronic heavy smoking in a patient presented with heamoptysis. Past surgical history of spleenectomy in a patient presented with sepsis.

Sumarizing the history of present illness "analysis of chief complaint" in front of the patient is very important. The summery gives the patient a chance to correct any mistakes in the history or any misunderstanding.

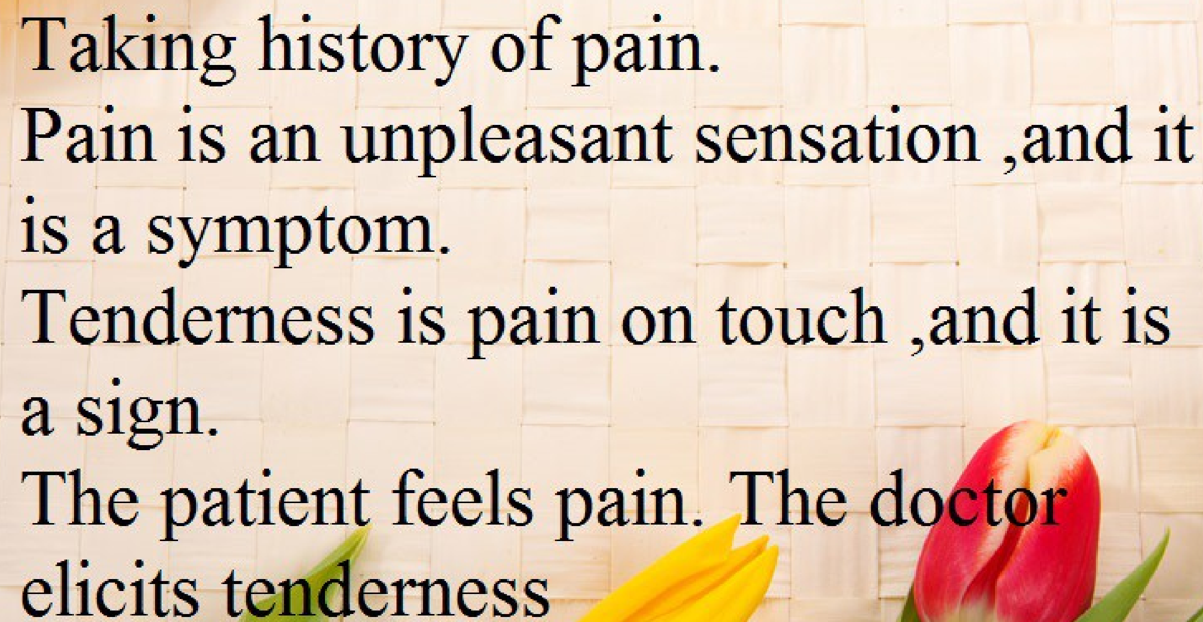
Now, let's take a quick example of the analysis of chief complaint. The patient was completely well 2 weeks back when he\she suddenly started complaining of sever breathlessness along with cough. The breathlessness is aggrevated by dust and cold weather with no obvious relieving factors. The cough is productive with green sputum and occurs approximatly every 1 hour. Otherwise his breathing is normal. This is the first occurance of the symptoms ,and he denies history of Asthma.

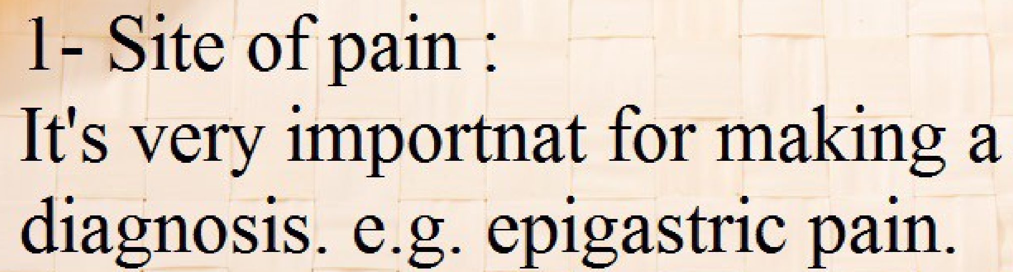


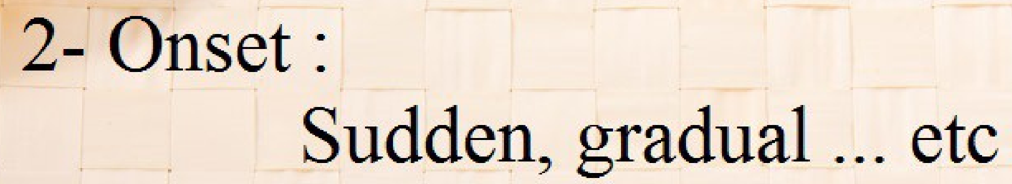
Always relay story in days before admission.

For example :

One week before admission, the patient ......


Taking history of pain.
Pain is an unpleasant sensation ,and it is a symptom.
Tenderness is pain on touch ,and it is a sign.
The patient feels pain. The doctor elicits tenderness

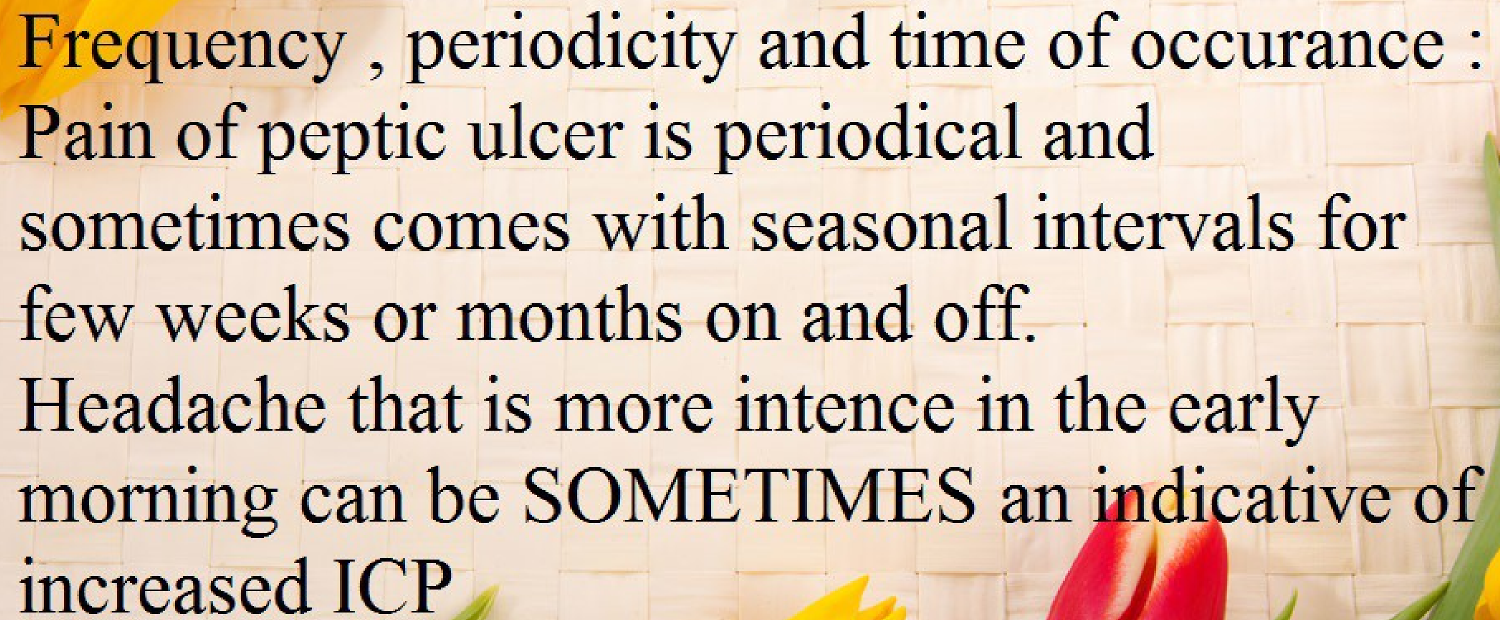

1- Site of pain :
It's very importnat for making a diagnosis. e.g. epigastric pain.

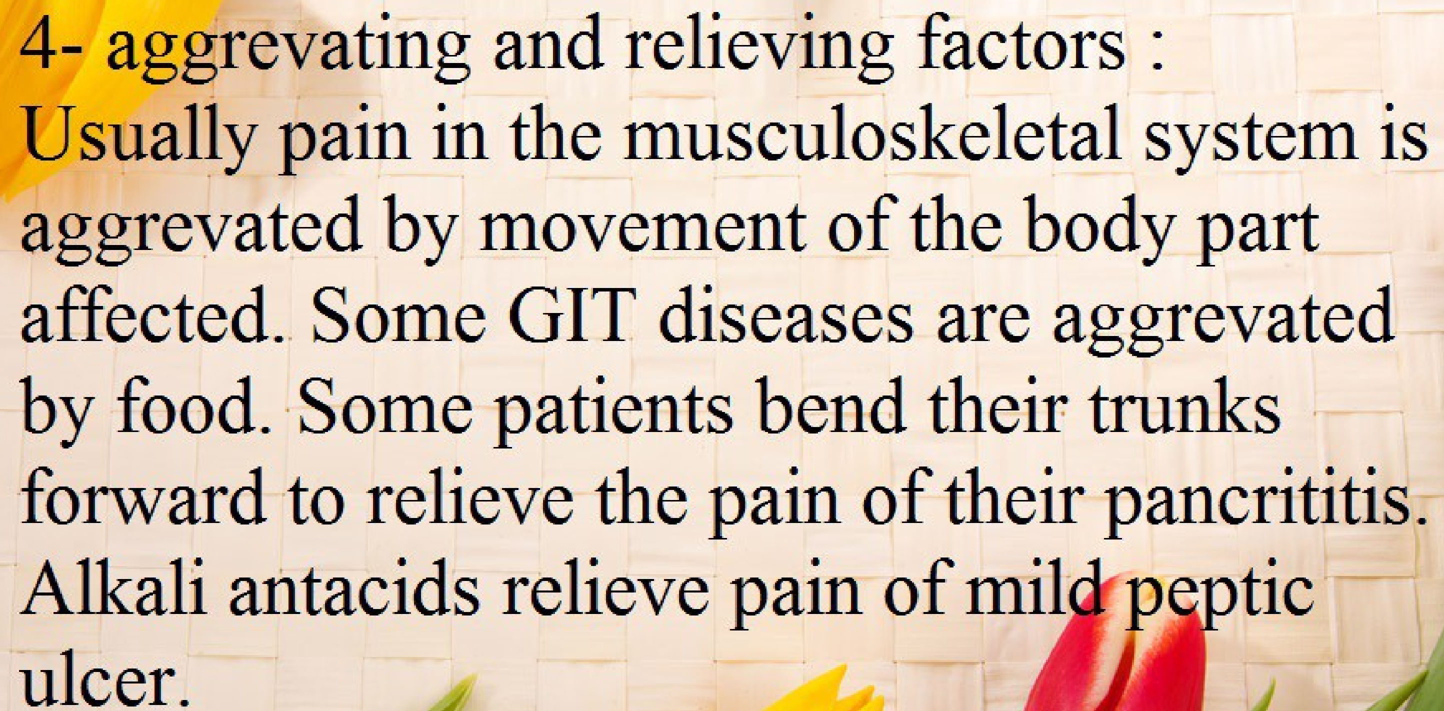

2- Onset :
Sudden, gradual ... etc

3- Duration :

Some diseases have a pain of very short duration. e.g. for seconds like in Trigeminal neuralgia.

Many other diseases have a pain of much longer duration. If the pain is chronic and the patient was living with it, ask the patient what brought you to see the doctor ?


Frequency , periodicity and time of occurance :
Pain of peptic ulcer is periodical and sometimes comes with seasonal intervals for few weeks or months on and off.
Headache that is more intence in the early morning can be SOMETIMES an indicative of increased ICP


4- aggrevating and relieving factors :
Usually pain in the musculoskeletal system is aggrevated by movement of the body part affected. Some GIT diseases are aggrevated by food. Some patients bend their trunks forward to relieve the pain of their pancrititis. Alkali antacids relieve pain of mild peptic ulcer.

5- Severity of pain :

To know the severity of pain, ask the patient about its interferance with his\her daily life activity and sleep. Does the pain wake the patient up at night or stop him\her from going to sleep ? Does the patient try to take analgesics ? Can the patient give a rating from 1 to 10 explaining the severity of his\her pain. Do not explain the rating.

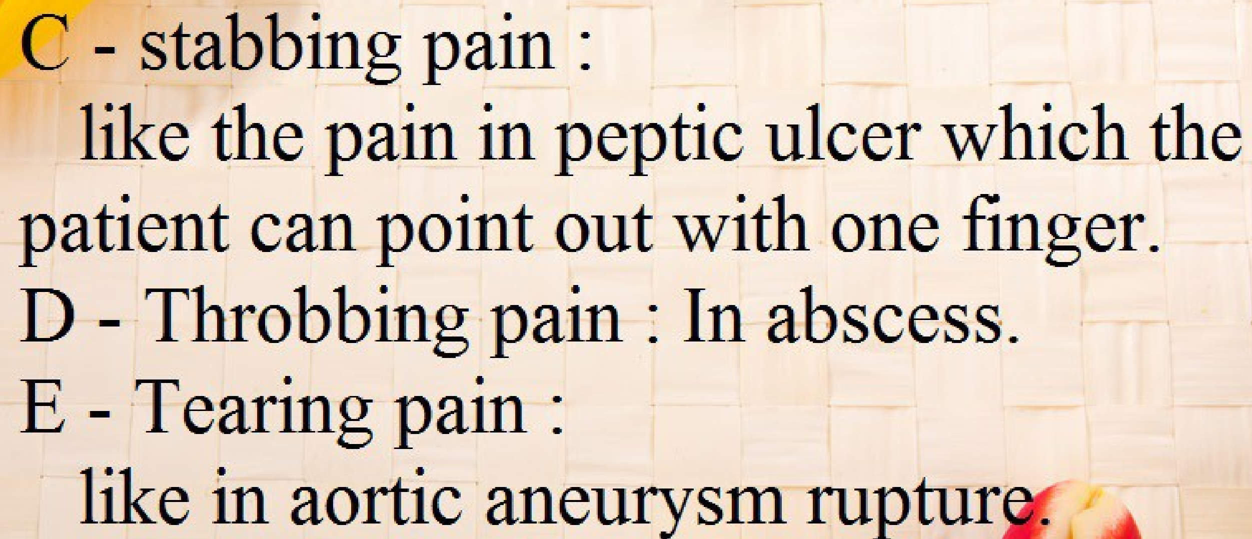
6- Character of pain :

A - Burning pain :

like in dysuria or inflammed urinary tract

B - Dragging pain :

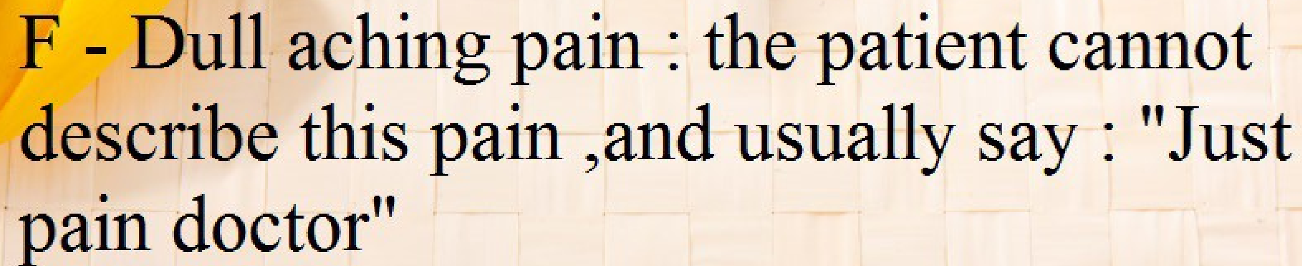
In organomegaly. like in splenomegaly or scrotal swelling.



C - stabbing pain :
like the pain in peptic ulcer which the patient can point out with one finger.

D - Throbbing pain : In abscess.

E - Tearing pain :
like in aortic aneurysm rupture.



F - Dull aching pain : the patient cannot describe this pain ,and usually say : "Just pain doctor"

G - Colicky pain : has two features :

I - comes and goes in sinusoidal way.

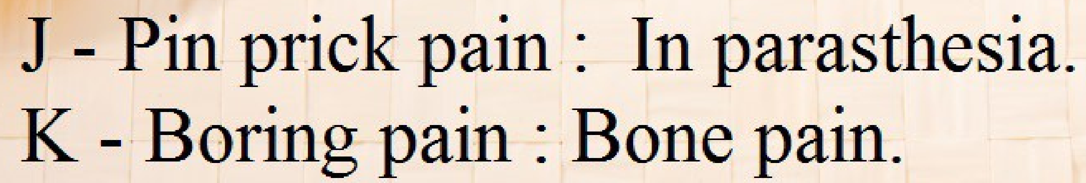
II - felt like migrating constriction in a wall of hollow tube in an attempt to push the contents forward.

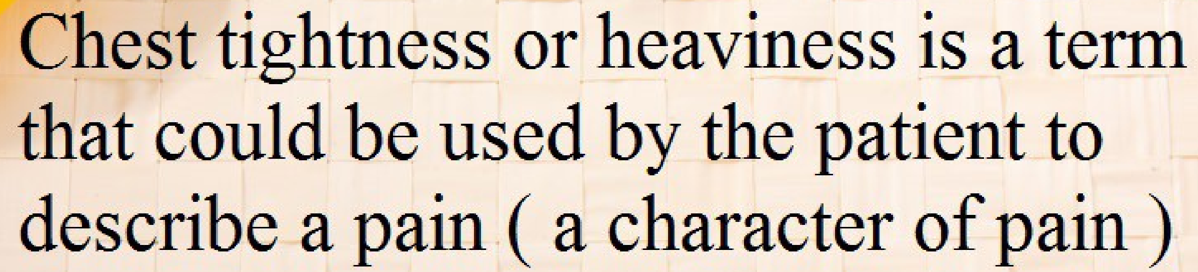
H - constricting pain :

Also called crushing tight pressing. It might happen in angina pectoris.

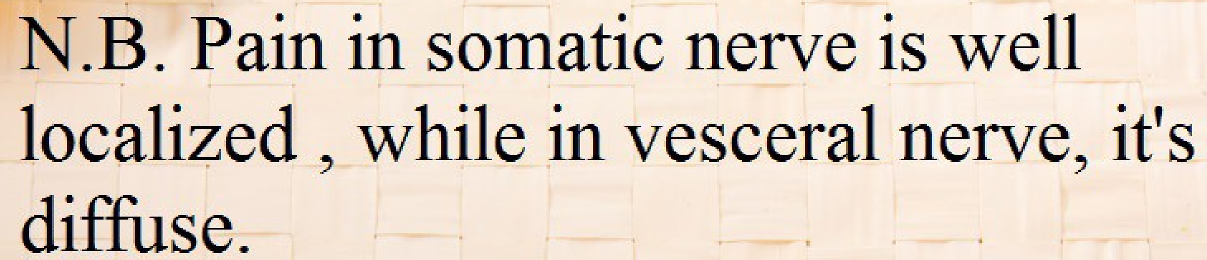
I - Distension pain :

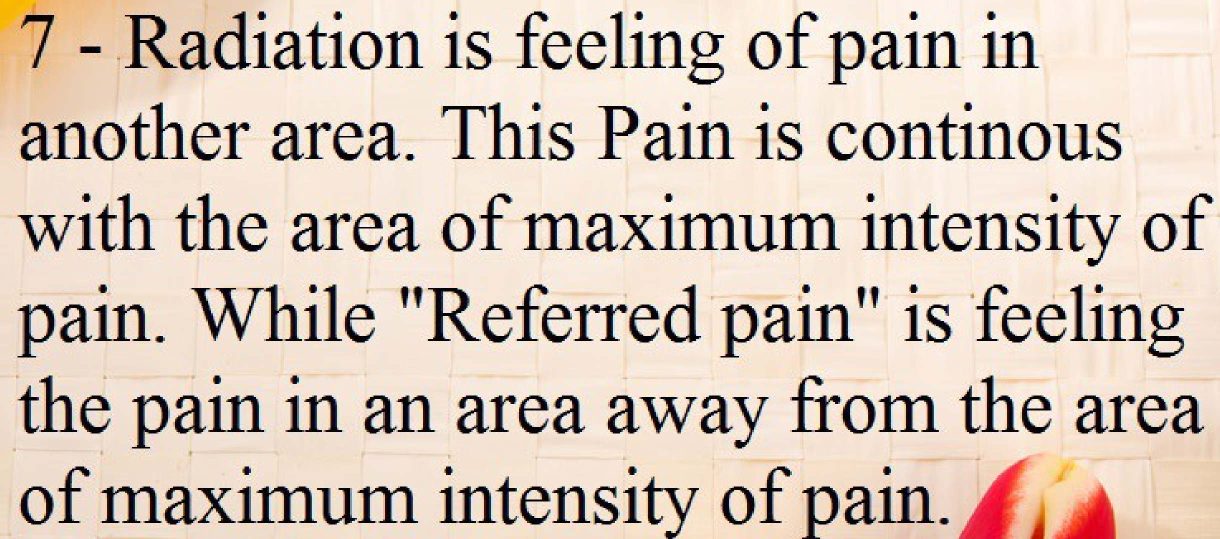
Pain from an encircled organ that has a restricting capsule or wall. e.g. bladder, bowel , encapsulated tumour.


J - Pin prick pain : In parasthesia.
K - Boring pain : Bone pain.

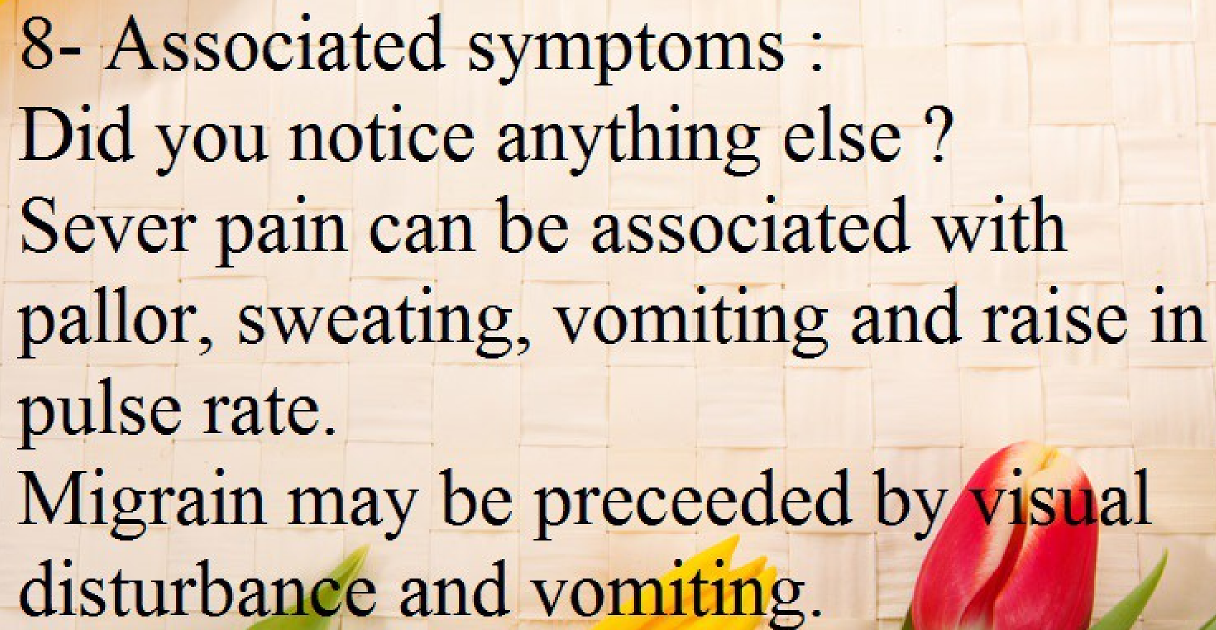


Chest tightness or heaviness is a term that could be used by the patient to describe a pain (a character of pain)

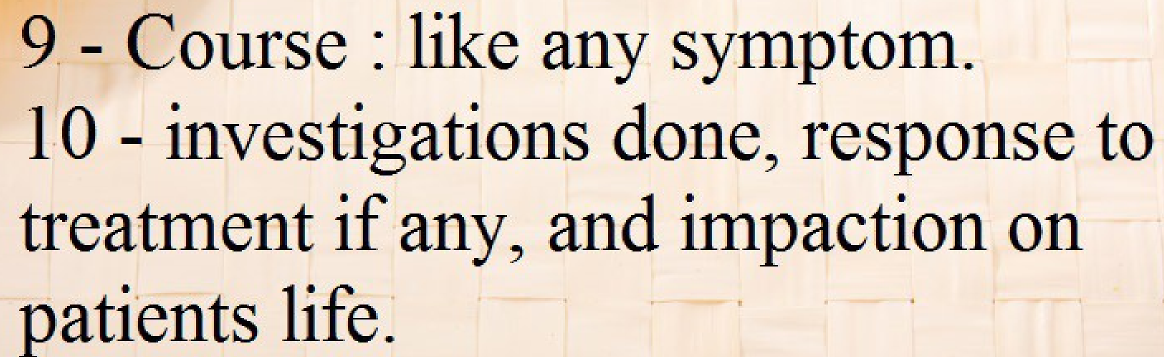

N.B. Pain in somatic nerve is well
localized , while in vesceral nerve, it's
diffuse.



7 - Radiation is feeling of pain in another area. This Pain is continous with the area of maximum intensity of pain. While "Referred pain" is feeling the pain in an area away from the area of maximum intensity of pain.



8- Associated symptoms :
Did you notice anything else ?
Sever pain can be associated with pallor, sweating, vomiting and raise in pulse rate.
Migrain may be preceeded by visual disturbance and vomiting.



9 - Course : like any symptom.
10 - investigations done, response to treatment if any, and impaction on patients life.

Transitional statements before the review of systems. Prepare your patient for the coming questions by saying : Now I'd like to ask you some questions about other parts of your body. Then begin the review of systems with an open-ended question such as : Do you have any other problems ?

By the review of systems we are aiming to :

1- look for complications of the disease on other systems.

2- Discover other symptoms which may be related to the current disease or other yet unknown diseases.

3- Knowing the presence of other symptoms can be very helpful, like anemia for anasthesia doctor.

4- To discover side effects of drugs currently used by the patient.

Start the review of systems by the most relevant system. For example if the chief complaint was breathlessness then start with the cardiovascular and respiratory systems first.

Always remember the "soda scars care \ Socrates" mnemonics when dealing with each positive symptom.

Cardiovascular and respitory systems :

1- Breathlessness or dyspnea : (soda scars care)

It's an uncomfotable awareness of rapid or difficult breathing.

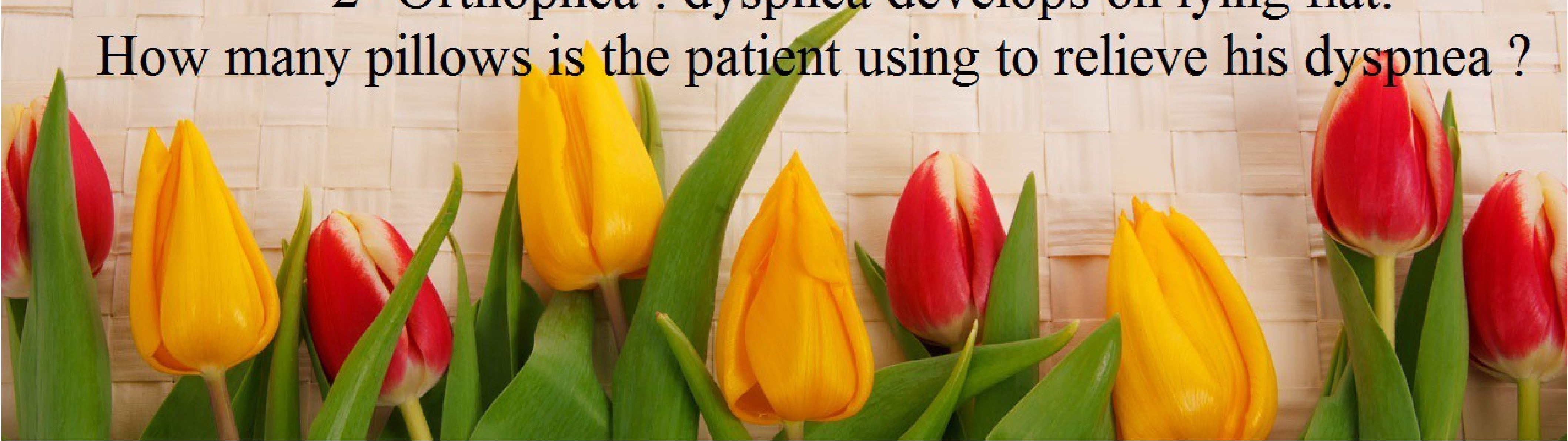
The body needs O_2 more than it is getting.

Clinical forms :

1- Exertional despnea

2- Orthopnea : dyspnea develops on lying flat.

How many pillows is the patient using to relieve his dyspnea ?



3- Dyspnea at rest : Does he become dyspnic on dressing ?

4- Paroxysmal nocturnal dyspnea : develops after 30 mins to 4 hours after getting to sleep. It does not immediately improve upon standing up, unlike Orthopnea.

5- Platypnoea : develops on sitting.

Don't forget to ask a patient of Dyspnea, Have you been recently on a long flight ?

Excercise tolerance.

2- Chest pain : (Soda scars care\Socrates)

New York heart association classification for angina\Dyspnea

Class 1 : During unusual intensive activity

Class 2 : During ordinary activity

Class 3 : With less than ordinary activity

Class 4 : At rest

3- Wheeze : is a musical sound occuring during expiration due to narrowing of the airways or due to increase in the velocity within the respiratory tree.

Difference between stridor and wheeze :

Stridor is inspiratory and in the URT

Wheeze is expiratory and in the LRT

4- Cough : is a reflex to clear the airways. It's the most common reason for visiting a primary care physician in the united states.

Acute < 3 weeks duration. Chronic > 3 weeks duration

Is it dry or wet ? Productive (when sputum is coughed up) or non-productive. Relation to posture.

When cough happens at night it's called nocturnal cough.

In cough, Don't forget to ask about any new medication.
Have you started any new medication recently ?

5- Haemoptysis and Sputum :

A- Haemoptysis is the coughing up of blood or of blood stained sputum. make sure that the blood is coming from the airways below the level of the larynx.

Pseudohaemoptysis is coughing up blood that is coming from the mouth, nose or the upper part of the throat.

B- Sputum :

Sputum is not Saliva. Actually when we take a sputum sample for analysis, it should not be contaminated with saliva ,because saliva is a good medium for the growth of oral bacteria.

Purulent sputum is sputum that contains pus.

6 - Fever : is a sign and it is an elevation of body temperature above the normal "range".

Does the patient measue his\her temperature ?

7 - Chills and Rigors : Chills is a feeling of coldness occuring during a high fever.

During a high fever the patient feels cold or chills until a new set point for thermoregulation is reached in the hypothalamus.

Rigors are episodes of shivering (profound chills) occurs as temperature rises fast from normal.

8- Night sweating : During sleep

Mederate

Drenching : the patient commonly changes nightclothes

Palpitation : unpleasant awareness of heartbeats patients can notice palpitations through abnormal or normal awareness. The difference between an abnormal awareness and normal awareness is that the former interrupts other thoughts whereas the latter is almost always caused by a concentration on the beating of one's heart.

Notice : It's not uncommon that an english native speaker doesn't know the meaning of the word palpitation.

You can ask : Did you feel your heart raising ?

In infants , Do not say there is palpitation ,because palpitation is about the awareness of the patient of his heartbeats

Are the heartbeats regular or irregular ?
Did he feel any missed beats ?
Could he tap out on the table the rate of heartbeats ?
If the patient has a prosthetic valve, ask the patient about cessation of clicks , a sign of prosthetic valve dysfunction.

10 - Symptoms of peripheral vessels :

Raynaud's phenomenon : It's an abnormal response of the fingers to cold. They turn white (blanching), then blue (cyanosis) and finally red (painful rebound hyperaemia) . It must be differentiated from Acrocyanosis which is a purple discoloration of the fingers on exposure to cold , no blanching phase is observed.

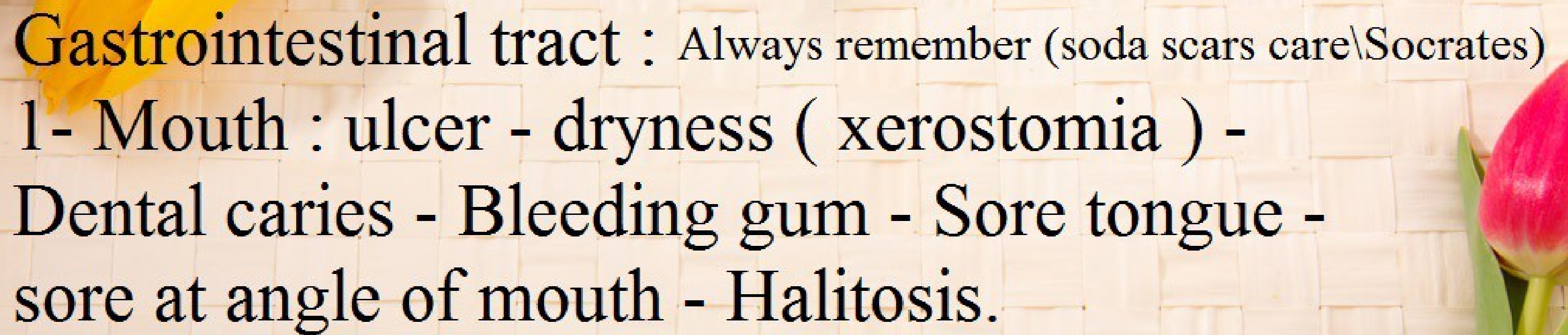
- Ankel swelling : How far is the swelling up the legs ?
- Varicose veins.
- Intermittant claudication : a muscle pain that occurs during excercise and is relieved by short period of rest.

11- Syncope : is transient loss of consciousness resulting from insufficient blood supply to the brain.

Presyncope is feeling of impending loss of consciousness.

12- Symptoms of upper respiratory tract :
Nasal discharge - sneezing - nasal obstruction - change of voice - sore throat - loud snoring - Epistaxis

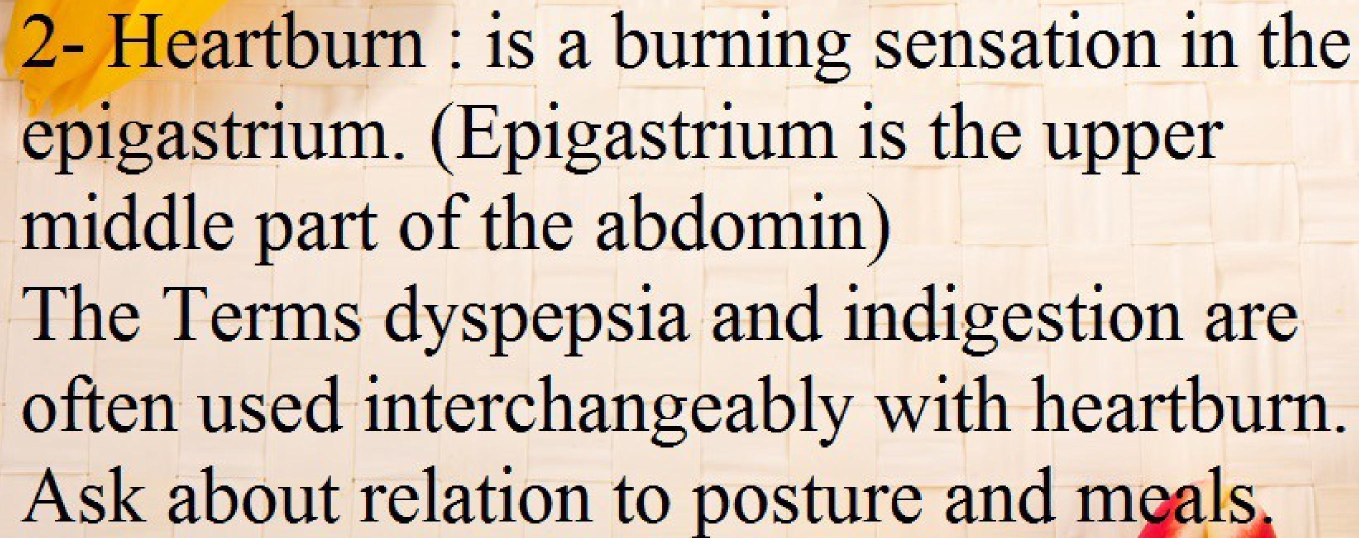
Epistaxis : Nosebleed or hemorrhage from the nose is of two types : Anterior (the most common) and posterior (less common ,but requires more attention)



Gastrointestinal tract : Always remember (soda scars care\Socrates)

1- Mouth : ulcer - dryness (xerostomia) - Dental caries - Bleeding gum - Sore tongue - sore at angle of mouth - Halitosis.

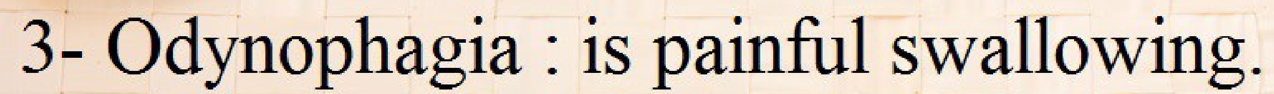
Halitosis is oral unpleasant odor.

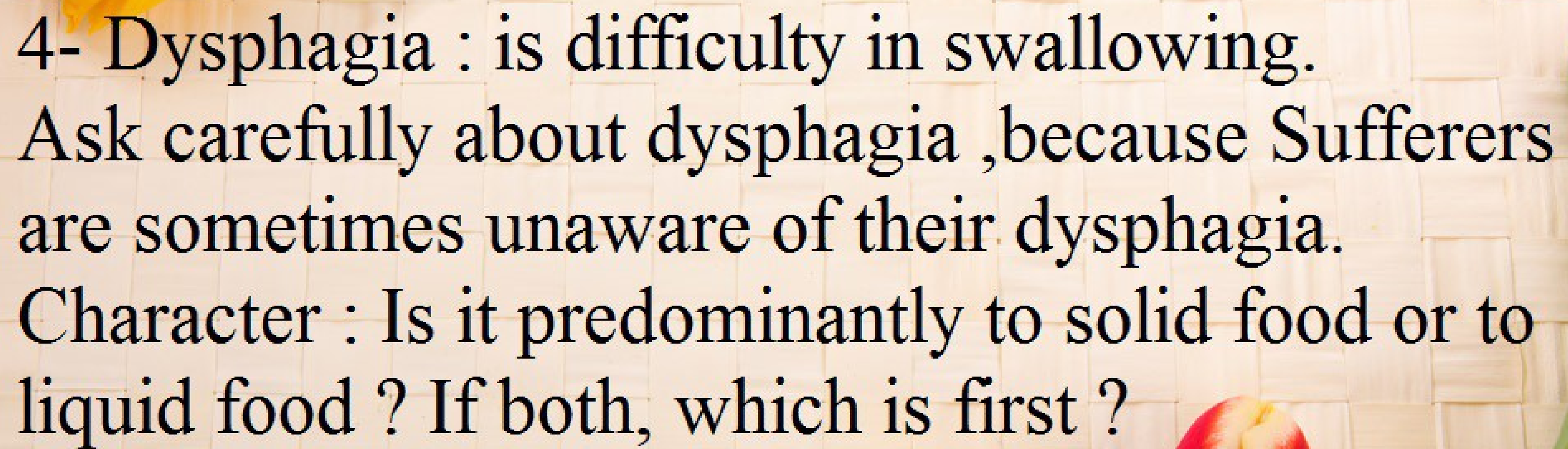


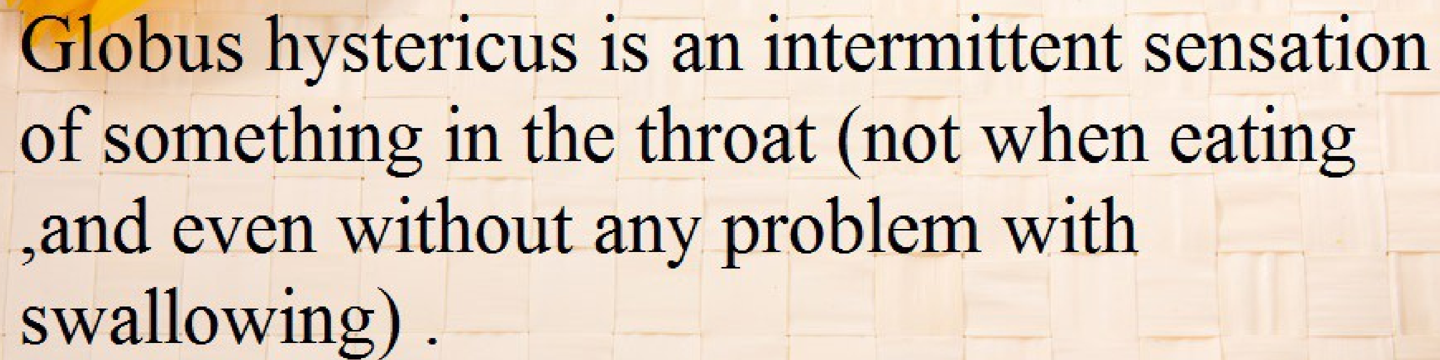
2- Heartburn : is a burning sensation in the epigastrium. (Epigastrium is the upper middle part of the abdomin)

The Terms dyspepsia and indigestion are often used interchangeably with heartburn.

Ask about relation to posture and meals.


3- Odynophagia : is painful swallowing.

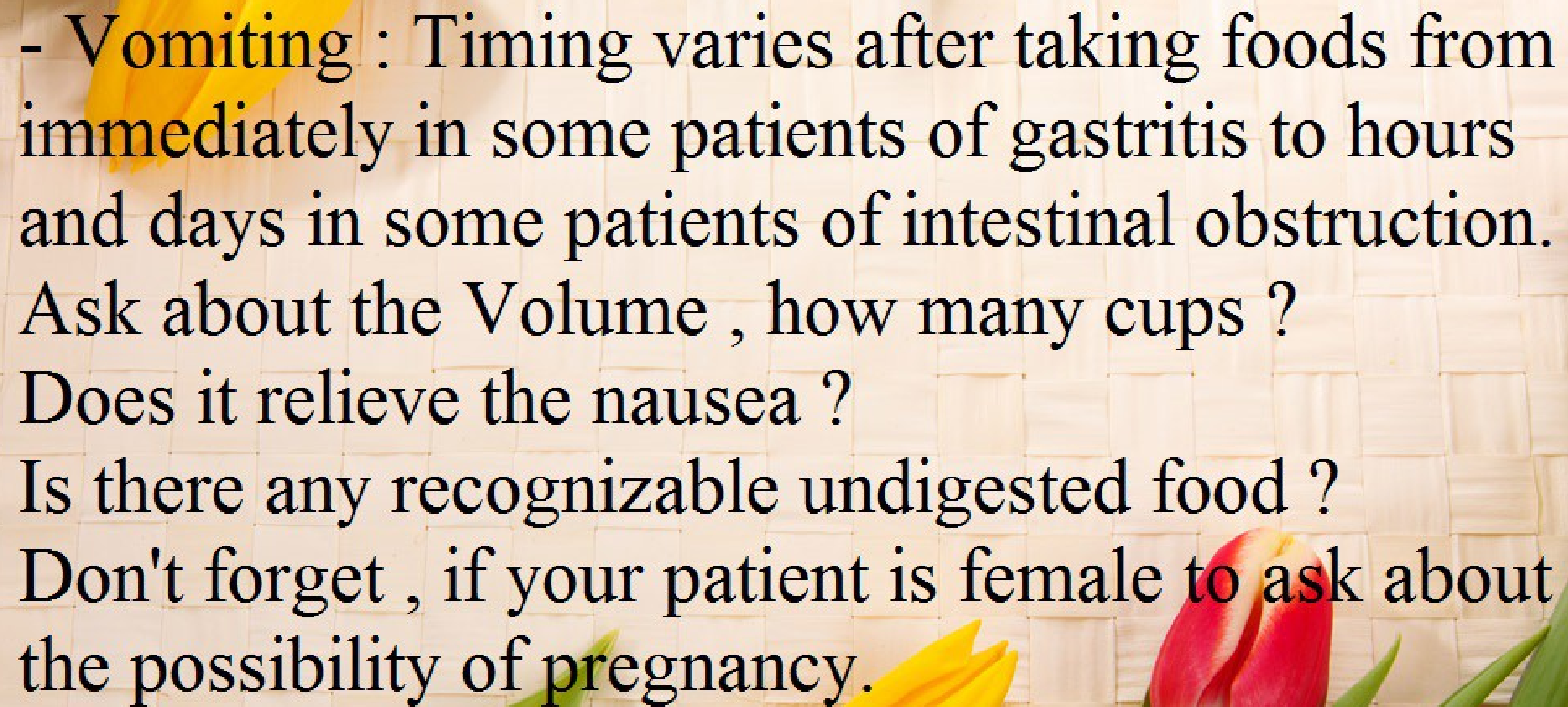

4- Dysphagia : is difficulty in swallowing.
Ask carefully about dysphagia ,because Sufferers are sometimes unaware of their dysphagia.
Character : Is it predominantly to solid food or to liquid food ? If both, which is first ?



Globus hystericus is an intermittent sensation of something in the throat (not when eating ,and even without any problem with swallowing) .

5- Nausea , vomiting and Regurgitation :

- Nausea is a sensation of unease in the upper stomach and an imminent desire to vomit.
- Retching : It's an unproductive effort to vomit or is the reverse movement (peristalsis) of the stomach and esophagus without vomiting usually caused by a bad smell or many other trigering factors.



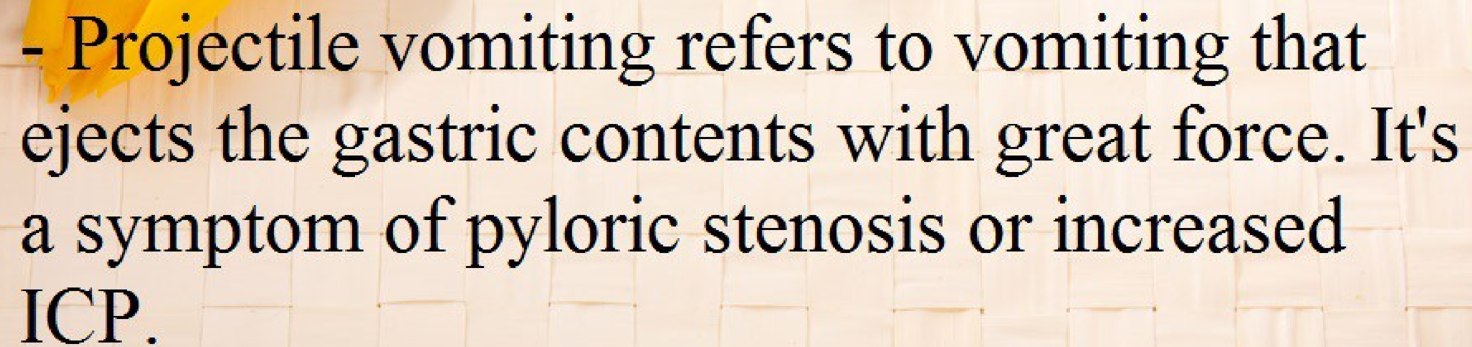
- Vomiting : Timing varies after taking foods from immediately in some patients of gastritis to hours and days in some patients of intestinal obstruction.

Ask about the Volume , how many cups ?

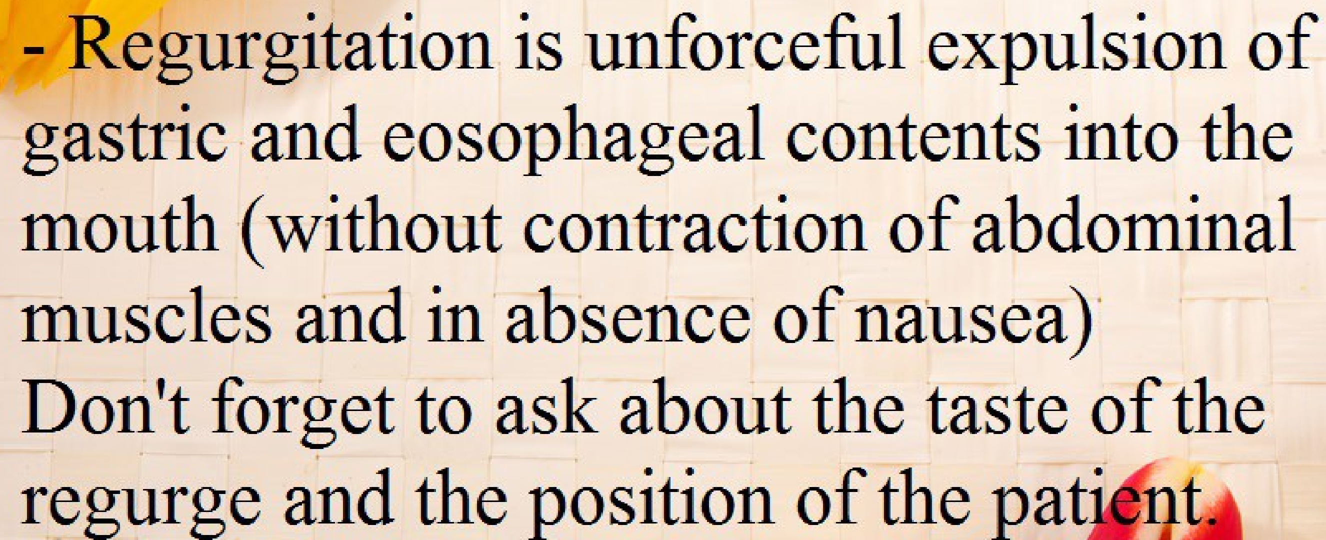
Does it relieve the nausea ?

Is there any recognizable undigested food ?

Don't forget , if your patient is female to ask about the possibility of pregnancy.

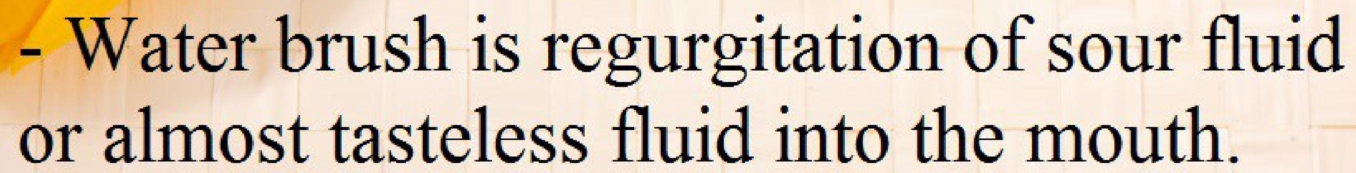


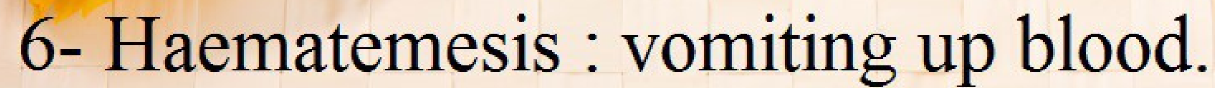
- Projectile vomiting refers to vomiting that ejects the gastric contents with great force. It's a symptom of pyloric stenosis or increased ICP.



- Regurgitation is unforceful expulsion of gastric and eosophageal contents into the mouth (without contraction of abdominal muscles and in absence of nausea)

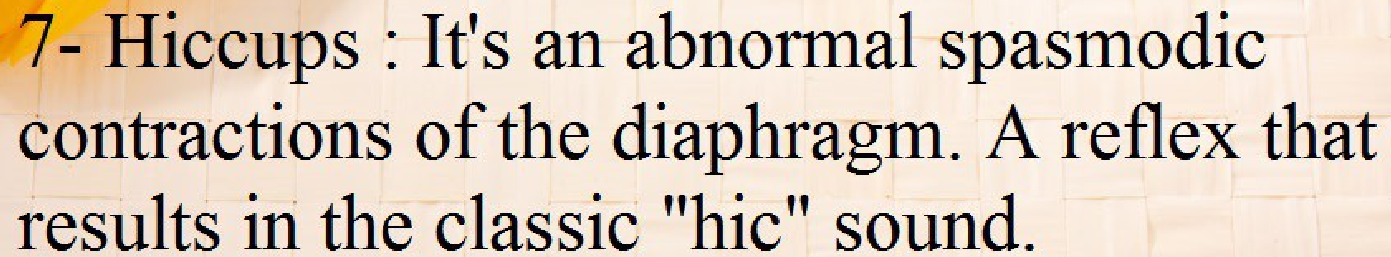
Don't forget to ask about the taste of the regurge and the position of the patient.


- Water brush is regurgitation of sour fluid
or almost tasteless fluid into the mouth.



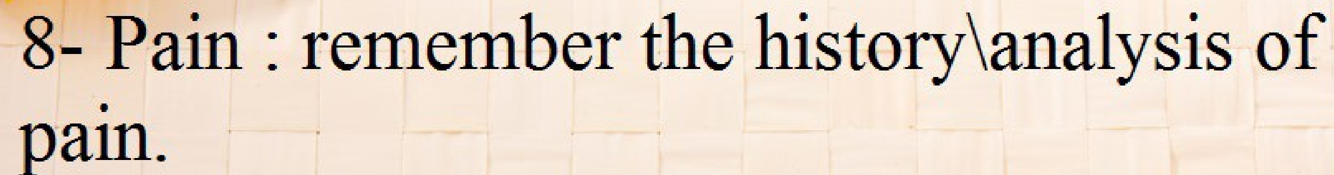
6- Haematemesis : vomiting up blood.

The blood can be red or dark in color because of degradation by pepsin (if dark it is called coffee ground vomiting) .



7- Hiccups : It's an abnormal spasmodic contractions of the diaphragm. A reflex that results in the classic "hic" sound.

8- Eructation (Belching) is release of gas from stomach or eosophagus through the mouth.



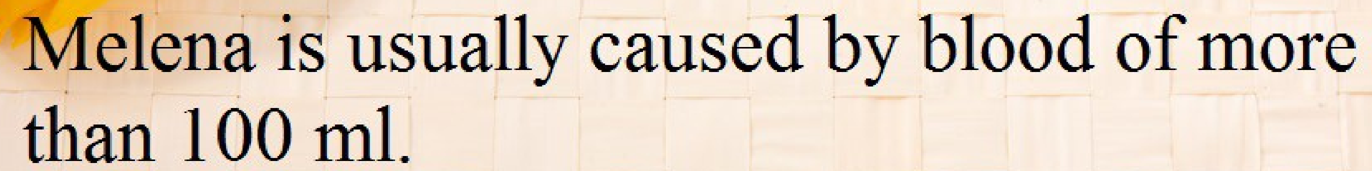
8- Pain : remember the history\analysis of pain.

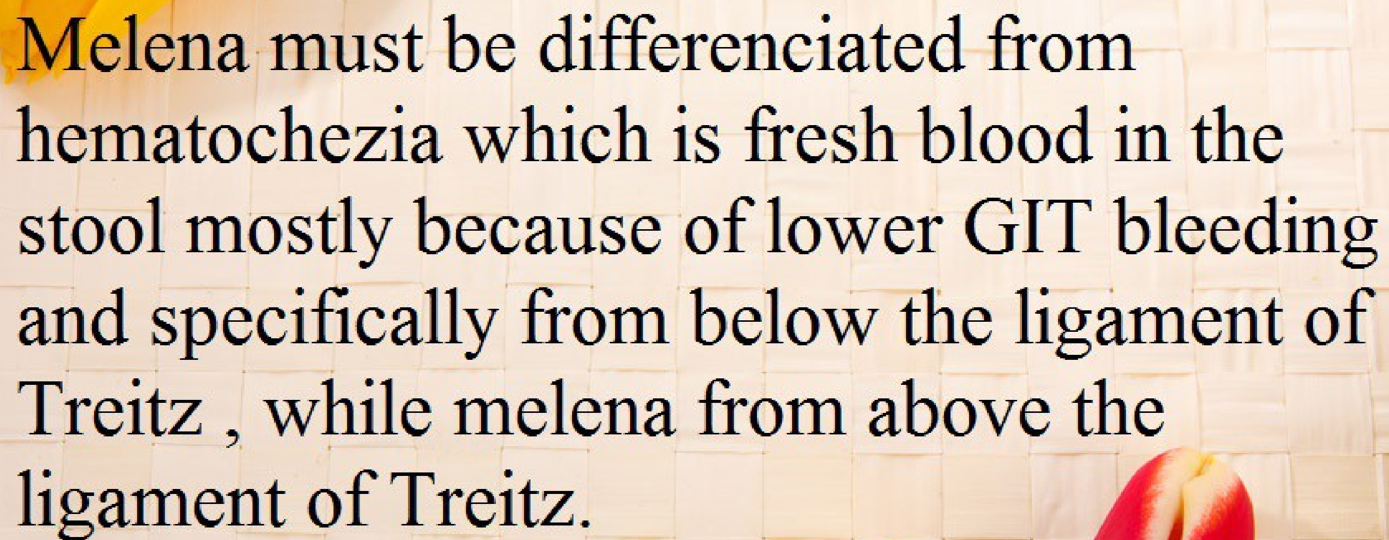
Radiation : usually a biliary pain radiates to the right shoulder, splenic to the left shoulder, pancreatic to the midback, kidney to loin\flank, ureter to groin.

9- Bowel habit :

Consistency and shape of stool ,bulky , pellet or tape like. Specific gravity sink or float (float if there is much fat)

Melena is a black tarry stool associated with GIT bleeding. The black color is caused by the oxidation of iron in heamoglobin.

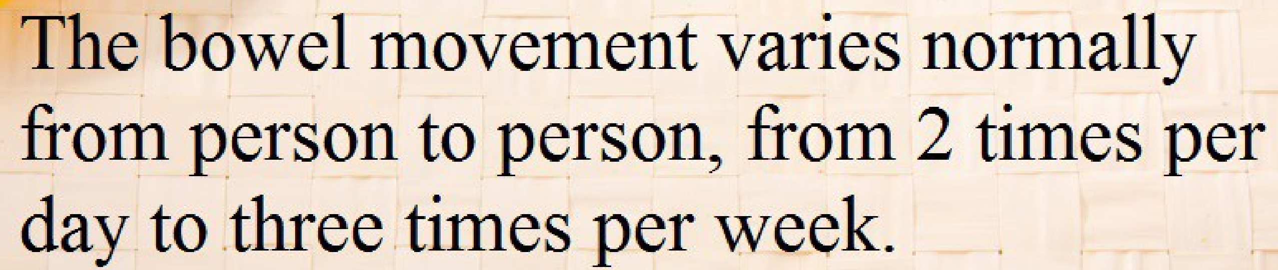

Melena is usually caused by blood of more than 100 ml.

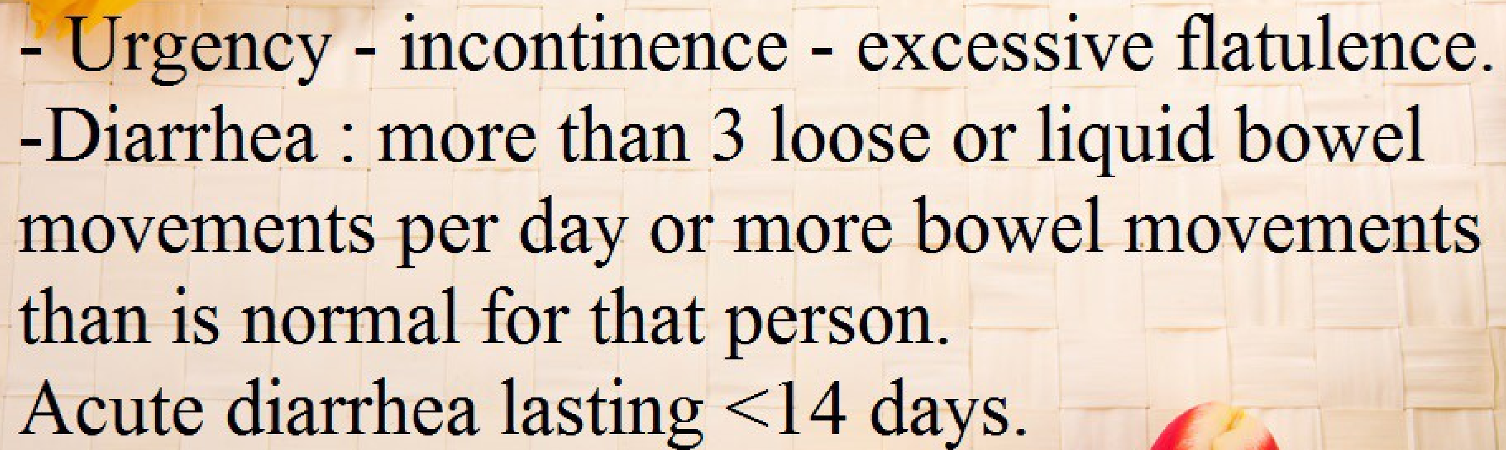


Melena must be differenciated from hematochezia which is fresh blood in the stool mostly because of lower GIT bleeding and specifically from below the ligament of Treitz , while melena from above the ligament of Treitz.

Rectorrhagia is the expulsion of fresh red blood without stools.

Also, Is there any pus , mucus or undigested food in the stool ?


The bowel movement varies normally
from person to person, from 2 times per
day to three times per week.


- Urgency - incontinence - excessive flatulence.
-Diarrhea : more than 3 loose or liquid bowel movements per day or more bowel movements than is normal for that person.
Acute diarrhea lasting <14 days.

Types of diarrhea :

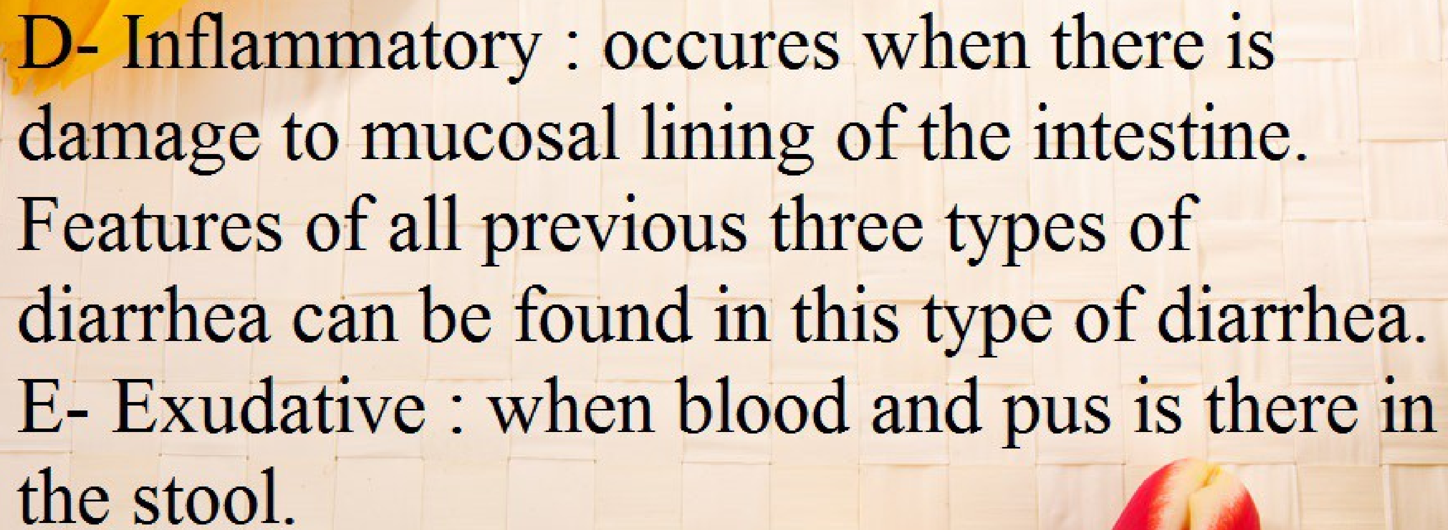
A- secretory : the body actively secretes fluids into the gut lumen.

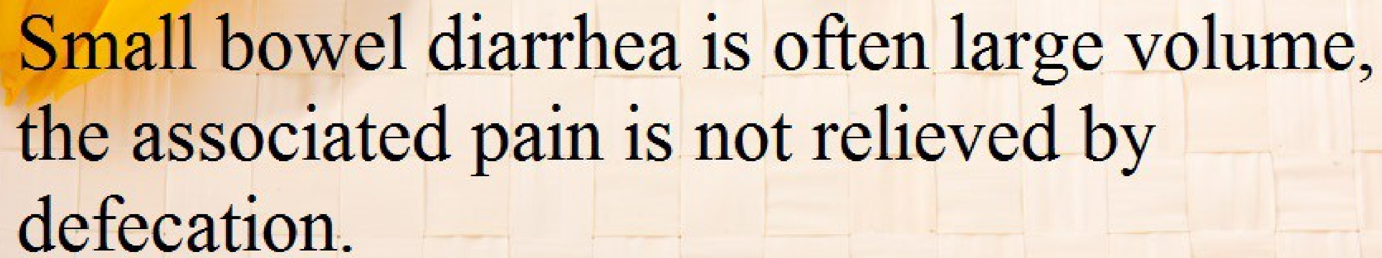
B- Osmotic : when too much water is drawn into the bowel.

C- Motility related : due to rapid movement of food through the intestine.

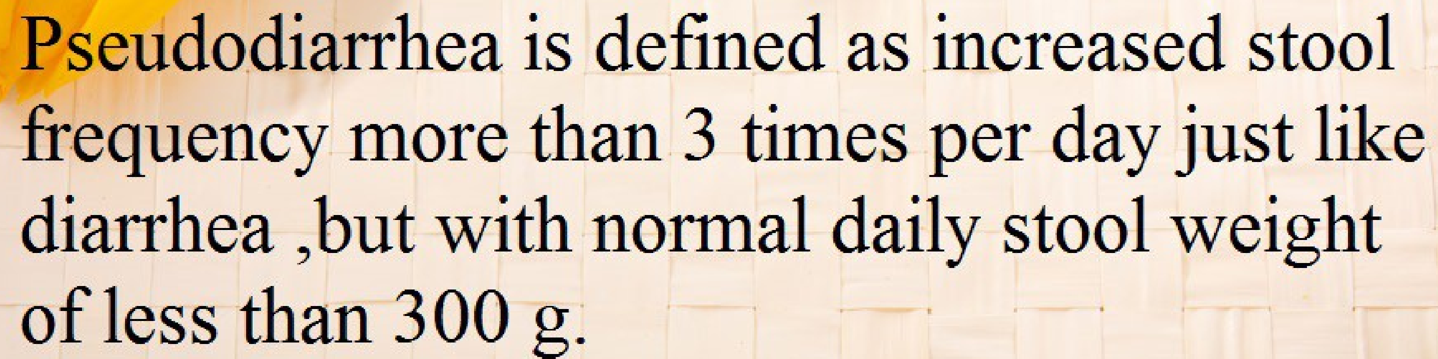
D- Inflammatory : occures when there is damage to mucosal lining of the intestine. Features of all previous three types of diarrhea can be found in this type of diarrhea.

E- Exudative : when blood and pus is there in the stool.

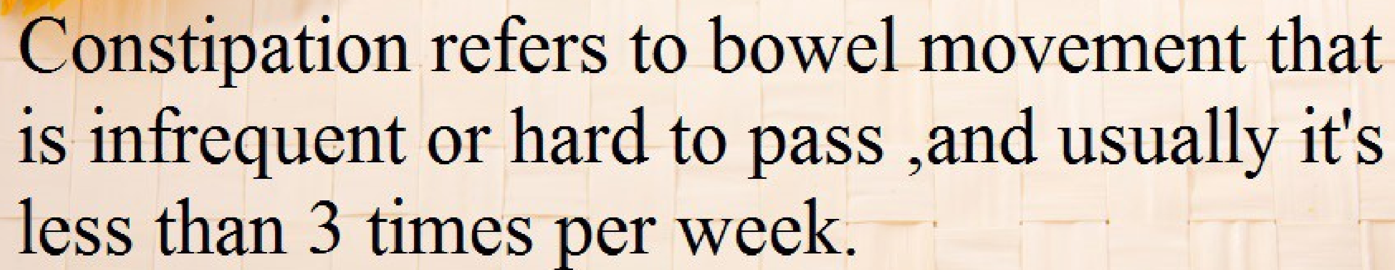




Small bowel diarrhea is often large volume, the associated pain is not relieved by defecation.
Large bowel diarrhea is often smaller volume , the associated pain is relieved by defecation.

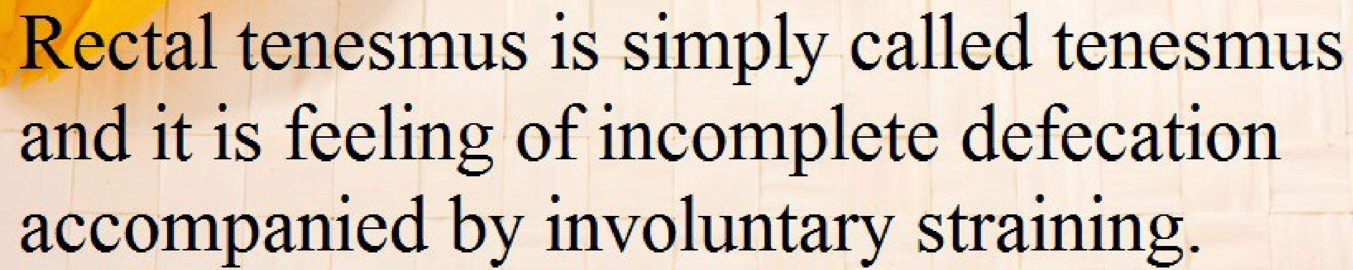


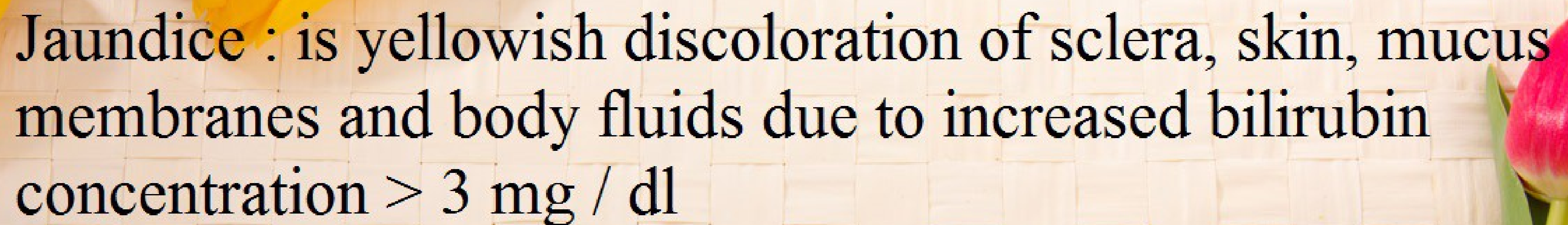
Pseudodiarrhea is defined as increased stool frequency more than 3 times per day just like diarrhea ,but with normal daily stool weight of less than 300 g.


Constipation refers to bowel movement that is infrequent or hard to pass ,and usually it's less than 3 times per week.

Abdominal distension (6 F)

Fluid as in ascites
Fat as in obesity
Flatus as in intestinal obstruction
Faces as in constipation and obstruction
Foetus in females
and Fibroid (tumour)

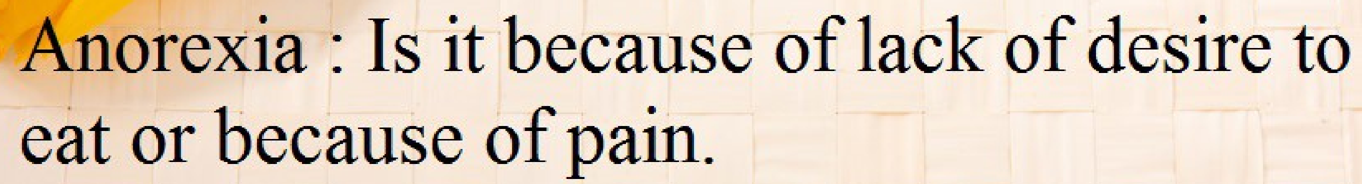

Rectal tenesmus is simply called tenesmus
and it is feeling of incomplete defecation
accompanied by involuntary straining.

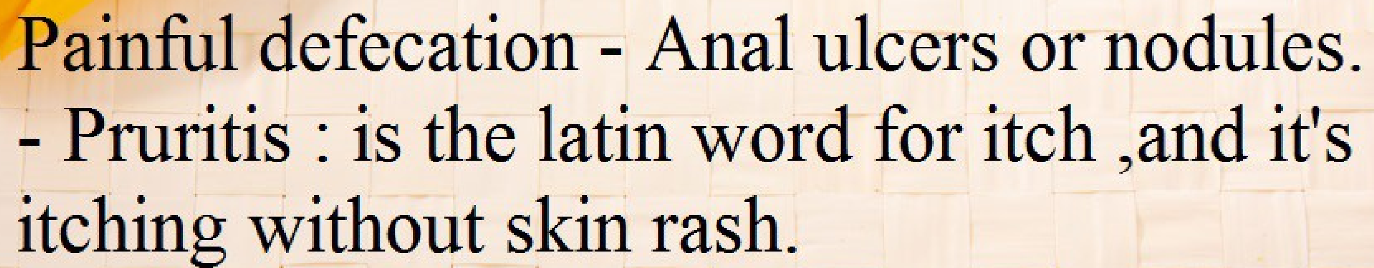


Jaundice : is yellowish discoloration of sclera, skin, mucus membranes and body fluids due to increased bilirubin concentration > 3 mg / dl

If bilirubin level is above normal ,but is not detectable clinically, it's called Subclinical Jaundice (1.2 : 1.9 mg/dl)

In jaudice, ask about pruritis , clay coloured stool and dark urine.


Anorexia : Is it because of lack of desire to eat or because of pain.


Painful defecation - Anal ulcers or nodules.
- Pruritis : is the latin word for itch ,and it's
itching without skin rash.

3- Urinary tract :

1- Pain : Loin pain, Suprapubic pain, Deep perineum pain ... etc

2- Symptoms of lower urinary tract inflammation.

A -Dysuria : pain passing urine

B- Frequency : passing urine more often. (without increase in urine volume.)

C- Precipitancy = urgency , it's inability to hold urine.
It's not necessarily associated with urinary incontenence.
D- Supra pubic pain.

E- Urethral discharge

Obstructive urinary symptoms :

- Hesitancy , it's a delay to start passing urine.
- Strangury, inability to pass urine.
- Small caliber stream, it's a narrow and thinned stream.
- Intermittency, it's interrupted micturation.
- Straining, it's using abdominal muscles to urinate.
- Urinary tenesmus. - Dribbling. - Weak stream.
- Incontinence (overflow incontinence)

Strangury is painful frequent urination of small volumes with straining.

Symptoms of urethral sphincter dysfunction :

- Retention
- Incontinence , it's involuntary passing of urine.
- Urgency

Changes in color of urine :

1- Blood : It's better to say red urine and not heamaturia.

Is it at the beginning of the urine stream = suggests bleeding from the urethra.

Is it at the end of the stream = suggests a bleeding from the bladder base or the prostate.

Is it throughout the stream = suggests bleeding from the bladder or above.

other colors :

2- red to brown

3- orange to brown

4- brown to black

5- Tubid or cloudy

Urine volume :

- Polyuria , it's passing larger volumes of urine than normal. More than 3L/24h
- Nocturia , passing urine during night.
- Oliguria is urine output of less than 500 ml/day or 20ml/h.
- Anuria is urine output of less than 100 ml/day or 4ml/h

Polyuria can be mentioned in more than one system review. When presenting the history mention it at the first system you talk about in your history.
You can repeat its mentioning if it was too important to do that.

Types of incontinence:

1- Stress incontinence, due to increased abdominal pressure more than urethral pressure like in coughing.

2- Urge incontinence, due to detrusor muscle overactivity

3- Overflow, when there is urine retention.

4- continual incontinence , when there is continous leak all times.

Genital :

- Male : priapism (prolonged painful erection) pain , ulcer , rash, scrotal swelling.
- Female : age at menarche, date of last mestrual period, amount of bleeding, period irregularity, discharge, ulcer rash, pain , ask lactating or not, contraceptive use , type of contraception, age of menopause. when was the last delivery, type of delivery. Gravida (number of pregnancies) , Parity (number of delivery) , miscarriage.

Last mestrual period , ask when was first day ?

If menopausal woman , assess for associated symptoms like hot flushes, night sweats, history of post menopausal bleeding.

Nervous system :

1- Disturbance of higher cortical functions :

Change in mood (fear, depressed)

Change in behaviour (hyperactive, quietness)

Memory - disorientation of time and place.

2 - Speech : difficulties in understanding written or spoken language. Difficulties in expression.

3 - Headache : (Soda scars care\Socrates)

Triggering factors e.g. migraine by cheese, chocolate, caffeine.

Character of headache:
Tight band or pressure , in tension headache.
Dull aching or throbbing, in migraine.

In headache ask about straining and cough.

4 - Vertigo : (spinning movement ?)

Vertigo is a subtype of dizziness.

There are three types of vertigo :

A - Objective :

It's when the patient has a sensation that objects around him\her are moving.

B- Subjective : it's when the patient feels as if he or she is moving.

C- Pseudovertigo : It's a sensation of rotation inside the patient's head.

Classification of vertigo :

1- Peripheral : caused by problems with the inner ear or vestibular system.

2- Central : caused by problems with the CNS

-Loss of consciousness

Syncope : How long does the attack last ?

Does he have presyncopal symptoms ?

Did he injure himself ?

-Loss of balance

-Ataxia and unsteady gait

-Sphincter disturbances

In syncope : Ask the following questions :

Do you have any black, tarry bowl movements after the fainting episode?
Do you have heavy periods?

- Fits and seizures : History should be taken from a witness as well as the patient.

Ask about prodromal symptoms (not part of seizure) e.g. change in mood or behaviour.

Ask about Aura symptoms (part of seizure) e.g. strange smell, deja vu ...etc

Ask about ictal (during fit) and post ictal (after fit) symptoms.

Definition of Seizures : Seizures are paroxysmal, time limited, involuntary change of motor activity and\or behavior due to abnormal electric activity of the brain.

Definition of convulsions : Excessive abnormal muscle contractions usually bilateral, which may be sustained or interrupted (motor seizures)

From the two previous definitions we conclude that there are :

convulsion seizures

And aconvulsion seizures.

5- Problems with vision :

Visual acuity, dropping of the eyelids, diplopia, photophobia.

Loss of vision , is it sudden or gradual ? monocular or binocular ? painful or painless ? IS it both in day time and night time or night time only ?

6- problems with hearing :

-Deafness

-Intolerance to high-pitched sounds = hyperacusis

-Tinnitus : ringing or buzzing in the ears. It's not a real sound ,but a perception. Usually it's not reported in children. It's intensity varies from time to time.

Any abnormalities in smell and taste.
Any problems with mastication (chewing)
Any problems with swallowing.
Any emotional liability.

Movement and balance disturbances :

- weakness
- Excess fatigue
- muscle cramp (painful spasm)
- Neurogenic claudication
- abnormal movements
- falling down.
- tremor

Tremors are involuntary repetitive movements of a part of the body and they are classified into :

1- tremor at rest

2- contraction tremor : like a tremor of a tight fist

3- posture tremor : e.g. when arms elevated

4- Intension tremors : when the fingers approach a target.

What is essential tremor ?

The term 'essential' means that there is no associated disease that causes the tremor.

Essential tremor is a familial condition, that runs in families.

Ask if there is any tremor of the head (titubation) or tremor of eyelids (blepharoclonus) .

In difficulties maintaining balance don't forget to ask, Is it more in dark or when patient closes his eyes ?

Sensory disturbances :

- Tingling = pins and needles
- Numbness = sensory loss
- Pain
- Difficulaties handling small objects

Symptoms of autonomic neuropathy :

Fainting, decreased sweating, constipation , urine retention, nocturnal diarrhea.

Haematology :

1- Symptoms of anemia : tiredness, weakness, palpitation, breathlessness, tinnitus, dizziness, headache , parasthesiae.

2- recurrent infection due to leucopenia.

3- lymph node enlargement.

4- symptoms of thrombocytopenia and defective coagulation : bleeding, easy bruising.

5- Blurring of vision, headache and coma due to hyperviscosity.

6- bleeding from any orifice.

Locomotor system :

1- Joints : Ask about pain, stiffness (It can be a symptom and\or a sign) Duration of stiffness, swelling, redness, increase in tepreture over the joint. Any joint deformity. Is the joint problems persistant or migratory (one joint subsides ,another is attacked)

2- Jaw claudication : pain on chewing.
3- Muscles : pain, swelling, weakness.
cramp (is an involuntary temporary strong muscle contraction)

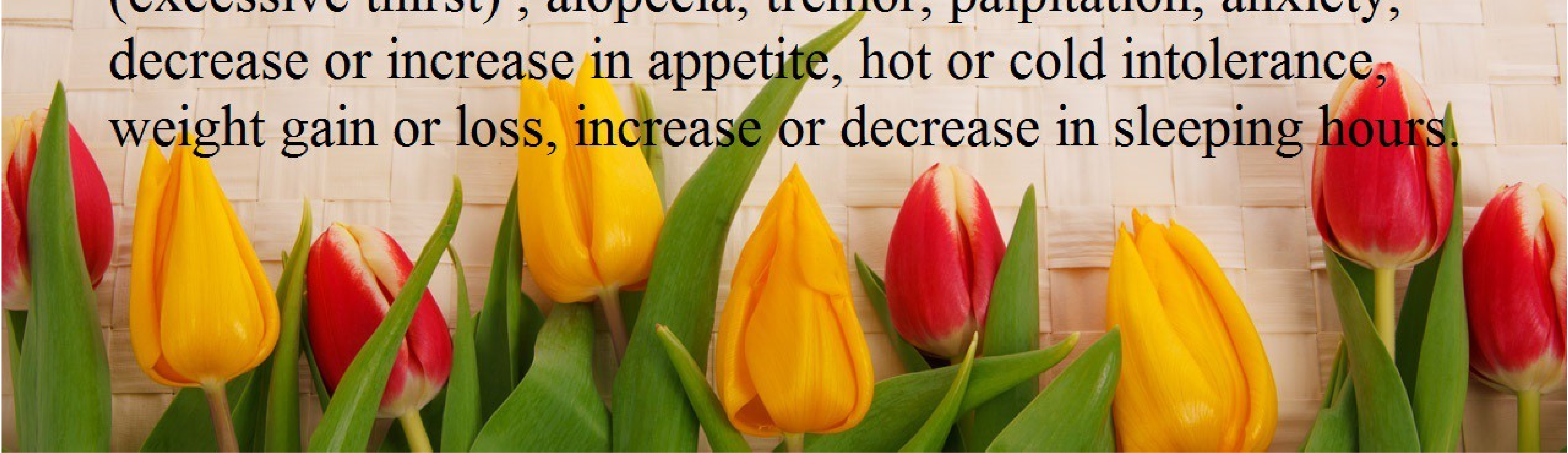
4- Back pain : it's one of the most common symptoms in medical outpatients.
5- Sole pain on walking or standing.

Impaction on daily living is important. Is the patient able to wash and dress without difficulty ? IS the patient able to climb up and down the stairs ? Does he use joint splints to assist him ?

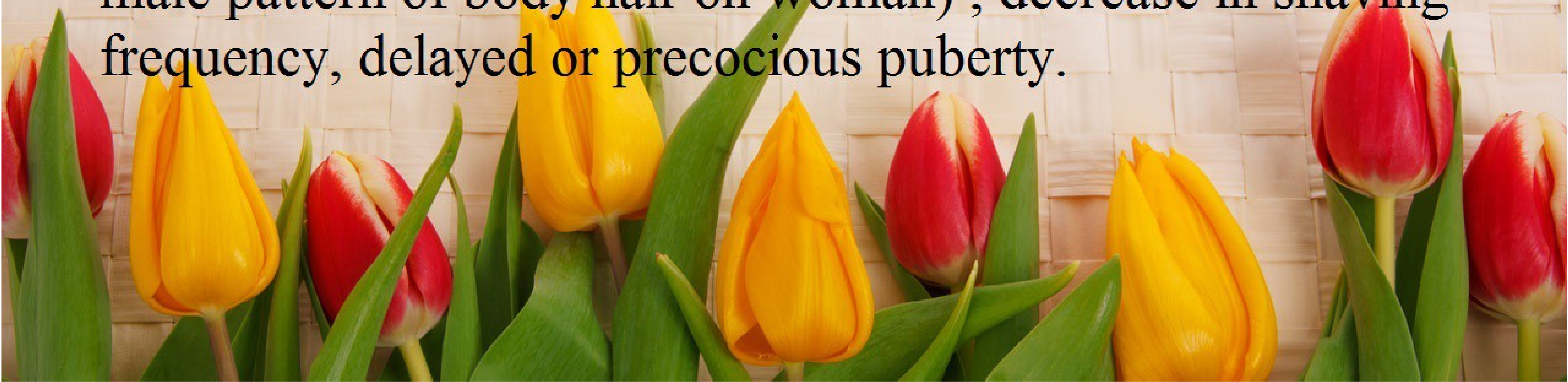
Ask about any important activity the patient is unable to do, that he wants to do.

Endocrine:

- Body size and shape : size of shoes, gloves, rings, truncal obesity, eye protrusion, neck (thyroid) swelling.
- symptoms due to swelling : dysphagia, loss of visual fields.
- Metabolic effects : weakness, muscle pain, polydipsia (excessive thirst) , alopecia, tremor, palpitation, anxiety, decrease or increase in appetite, hot or cold intolerance, weight gain or loss, increase or decrease in sleeping hours.



Endocrine reproduction symptoms : amenorrhoea\oligomenorrhoea, menorrhagia (blood loss > 80ml and\or of duration longer than 7 or 8 days) Menometrorrhagia = menorrhagia + irregularity in time. Impotence, Gynaecomastia (is benign enlargement of breast tissue in males) , Galactorrhoea (is milk flow from the breast but not in a nursing woman) , Body hair loss , Hrisutism (is male pattern of body hair on woman) , decrease in shaving frequency, delayed or precocious puberty.

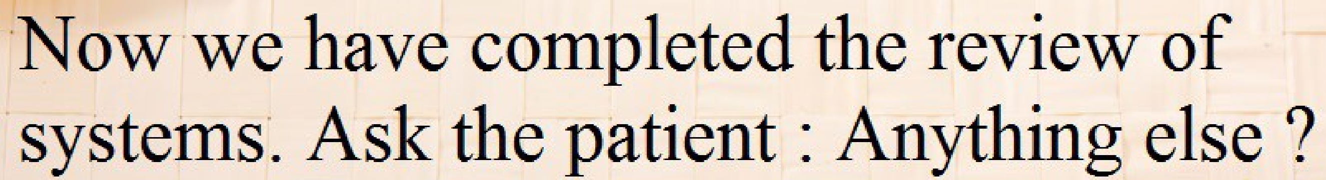


Skin endocrine symptoms :
Increase or decrease in pigmentation, dry rough skin, increase sweating, flushing.

Skin :

Change in color, rash, flushes , dryness, itching, callosities, easy bruising, easy bleeding, loss of hair, premature graying, hair thinning, nail changes , acne.

In rash, ask is it flat or raised above the skin ? Is it painful ? Is there any history of insect bites ? Contact with people with skin disorders ? Does the itching involve the eyes ?


Now we have completed the review of
systems. Ask the patient : Anything else ?

Past medical history :

- Major illness : record any significant illness. List more recent diseases first. Is it the first attack of the disease or not ? (some doctors preferr that you mention this in the analysis of chief complaint) . Ask about treatment with dosage.

- Previous admissions : Why ? When ?
Mention the name doctor.

-Follow up in the clinic : When was the last visit ? regular or iiregular visits ?

-Health maintainance like regular self examination or rotine pap smear.

- Any previous investigations.

- Immunization history.

Obstatric history :

Gender of children and their birth weight. Type of delivey. Any pregnancy complications. Did she breast feed her baby ? Miscarriages (In what month they occured ?) spontanious or induced ?

Past surgical history :

Any previous surgery including dental procedures.

Complications of anasthesia or surgery e.g. DVT , bedsores. How many days the patient stayed in hospital ?

Ask about wound healing.

Time and place accident

Previous bone marrow aspiration

Drug history : Native English speakers use the word 'medicines'. Please do not ask "Do you take drugs ?" as this ask about drug abuse. Ask the patient "Do you take any regular medicines? "

Medical jargon

Drug history :

In medicine , the inquiry about all drugs is important.

In sugery there are some types of drugs that are important. And they are :

1- Antiepileptics : you should inform the anasthetic about the dose taken by the patient.

2- Antihypertensive agents

3- Oral contraceptive pills : They should be stopped 6-8 weeks before elective surgery. In emergency surgery, measures to prevent DVT should be taken.

4- Antidiabetic drugs : They might be changed to insulin before surgery. Appropriate dosage should be calculated.

5- Corticosteroids : You should ask about them even if they were stopped more than 6-12 months back ,becasue of risk of adrenal crisis. Specific measures should be taken if corticosteroids were taken recently.

Complications of corticosteroids in surgery :

- they increase the risk of infection
- they delay wound healing.

6- Anticoagulants :

Warfarin : It's antidote in acute bleeding is FFP

And It s antidote in elective case is vitamin K

Heparin : Antidote is protamin sulfate. It should be given slowly because each 1 molecule of protamin sulfate binds to approximately 90 molecules of heparin, therefore if given rapidly it gives an anticoagulant effect which exacerbate bleeding.

Aspirin should be stopped 7 days before surgery ,becasue 7 days is the normal lifespan of platelets.

Ask about allergies.It's important because it concerns the patient's safety.

Some patients may describe a side effect of a drug incorrectly as a drug allergy.

Names of drugs should be mentioned in pharmacological names and not in trade names.
If using inhalers, is there any embarrassment useing them, especially in public.

Radiotherapy, blood transfusion and laser photocoagulation should be mentioned

Patients with chronic diseases :

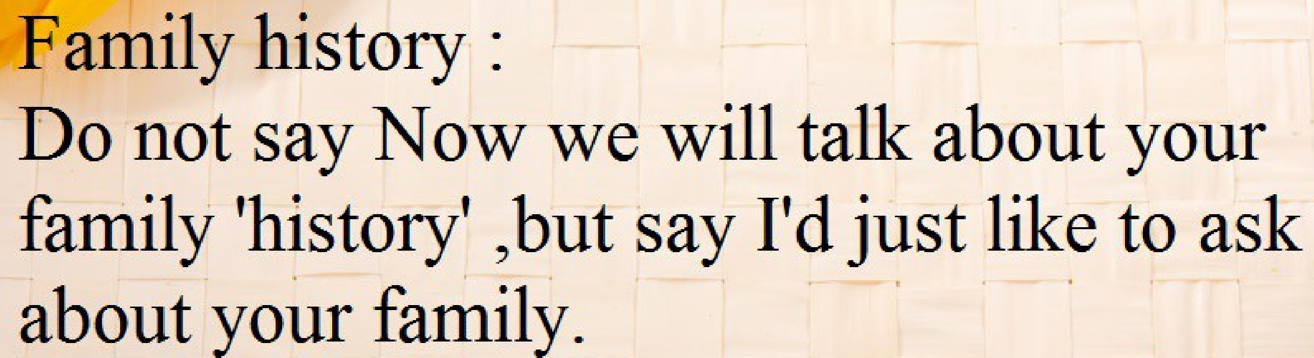
Is the patient afraid from the side effects ?

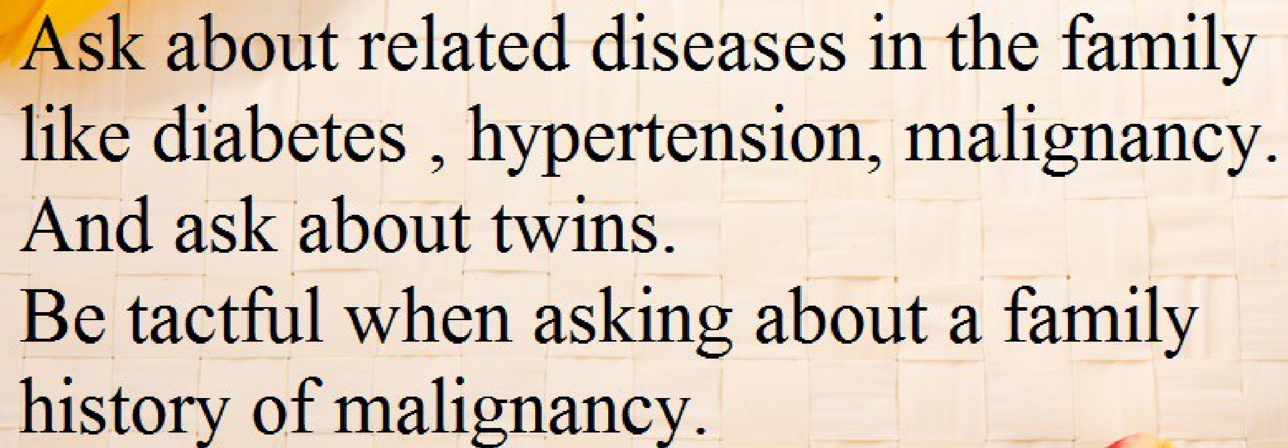
Is he able to get the drug regularly ?

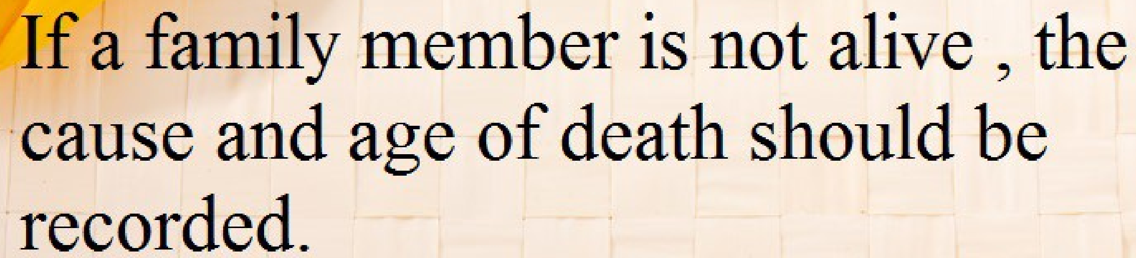
Poor choice of words :

For how many years have you been taking these B-blockers ?

The patient might not understand what B-blockers means.

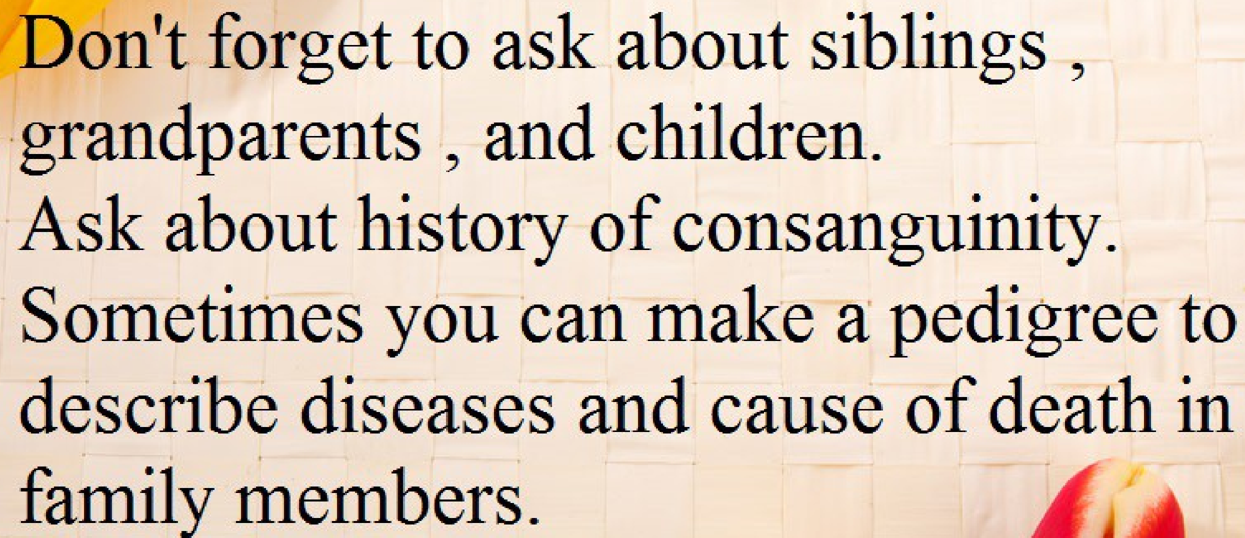

Family history :
Do not say Now we will talk about your family 'history' ,but say I'd just like to ask about your family.

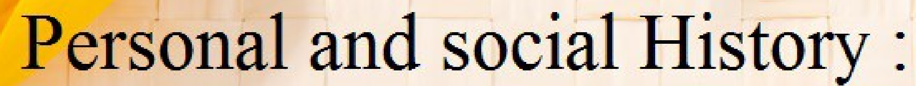

Ask about related diseases in the family
like diabetes , hypertension, malignancy.
And ask about twins.
Be tactful when asking about a family
history of malignancy.



If a family member is not alive , the cause and age of death should be recorded.

Who takes care of a disabled member in the family ?


Don't forget to ask about siblings , grandparents , and children.
Ask about history of consanguinity.
Sometimes you can make a pedigree to describe diseases and cause of death in family members.

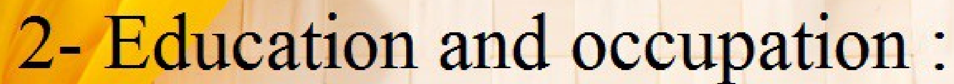


Personal and social History :

1- Marital status :

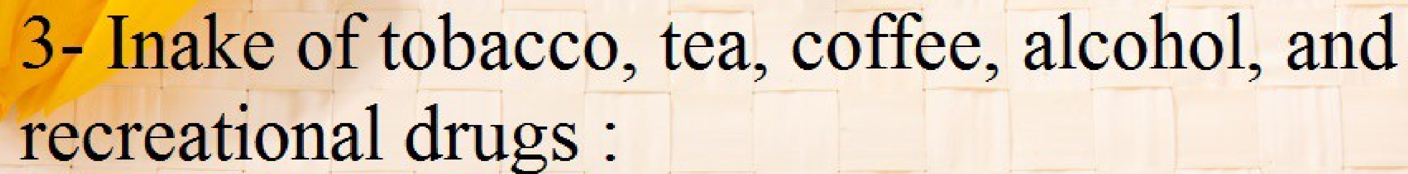
single , devorced, married

number, age and sex of all children.



2- Education and occupation :

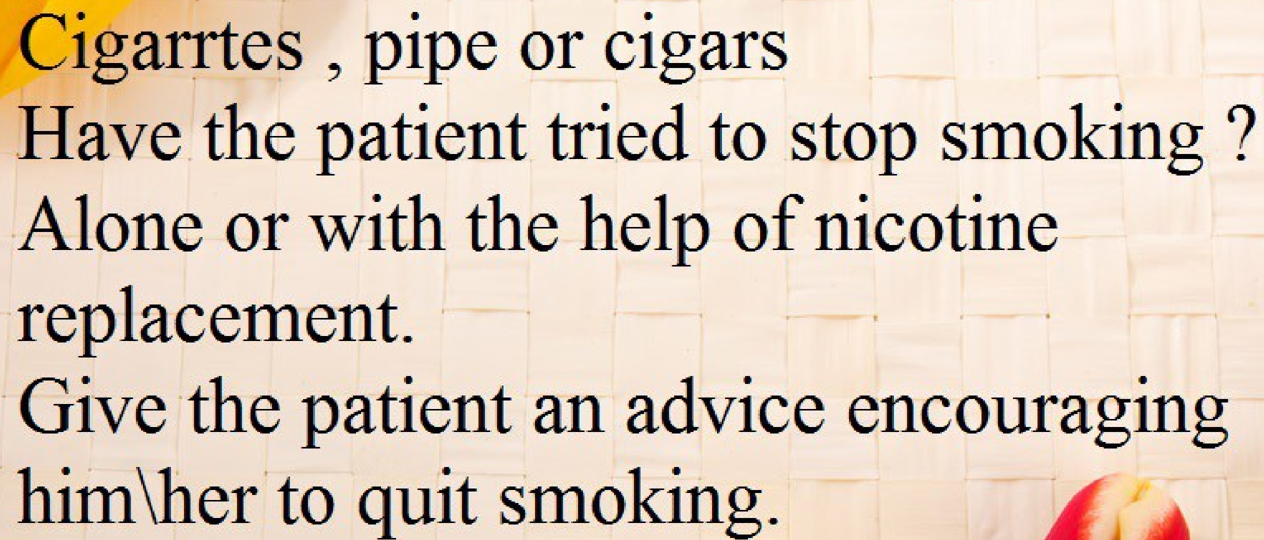
All previous occupations are important ,not just the current one. Occupation of wife\husband. Degree of work satisfaction and income adequacy. Does it cover the costs of investigations and treatment.
effects of work on illness and illness on work.

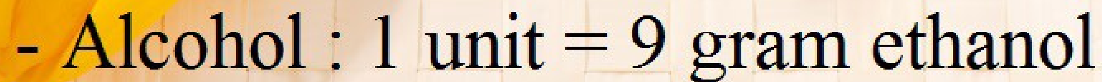


3- Inake of tobacco, tea, coffee, alcohol, and recreational drugs :

-Tobacco : (Number of cigarette per day/20 * number of years smoking)

History of passive smoking.


Cigarrtes , pipe or cigars
Have the patient tried to stop smoking ?
Alone or with the help of nicotine
replacement.
Give the patient an advice encouraging
him\her to quit smoking.

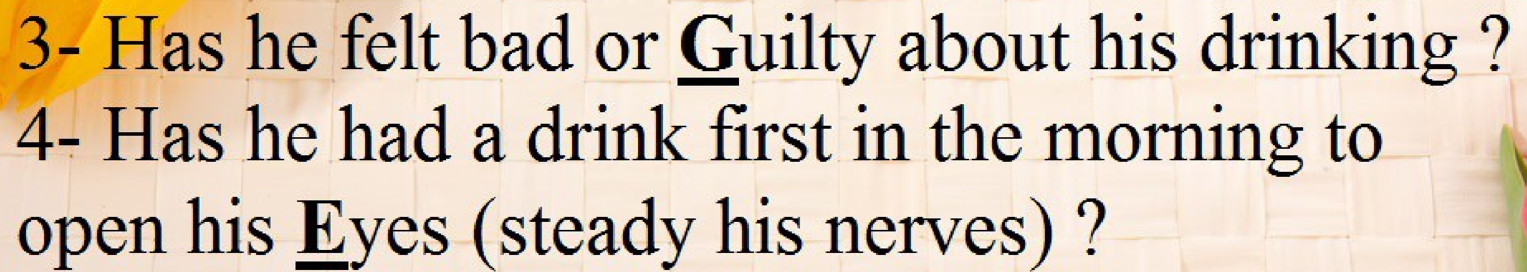


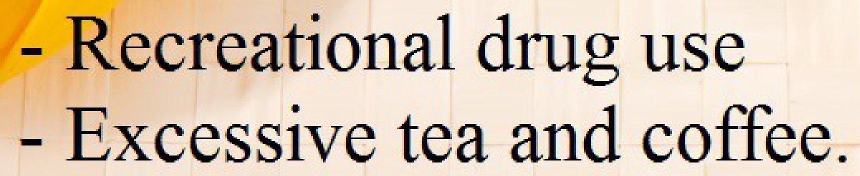
- Alcohol : 1 unit = 9 gram ethanol

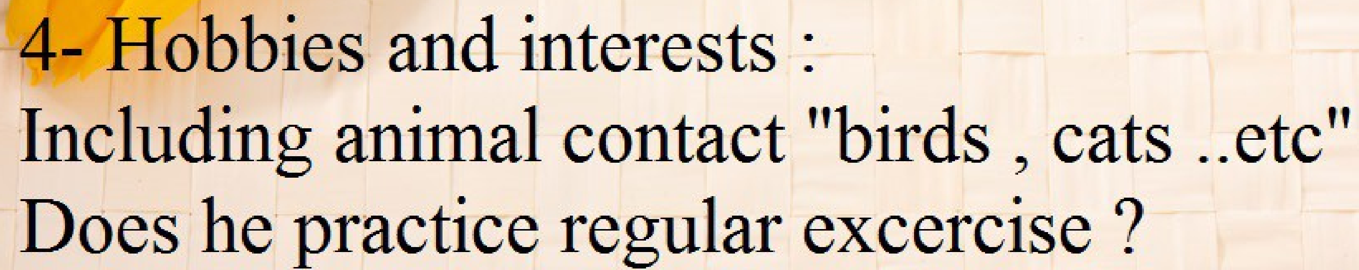
<u>CAGE</u> (mnemonic) questionaire to know heavy alcoholic :

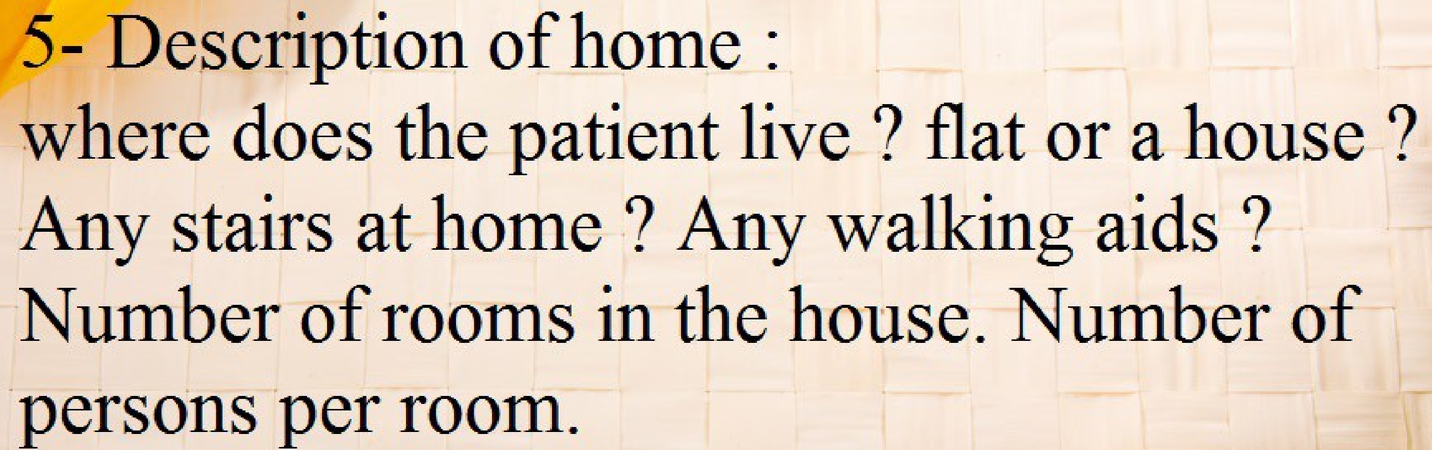
1- Has he felt that he should **<u>C</u>**ut down drinking ?

2- Have people **<u>A</u>**nnoyed him by criticizing his drinking?


3- Has he felt bad or Guilty about his drinking ?
4- Has he had a drink first in the morning to
open his Eyes (steady his nerves) ?

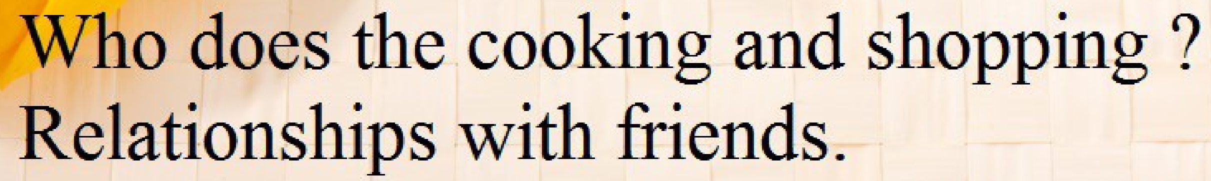

- Recreational drug use
- Excessive tea and coffee.

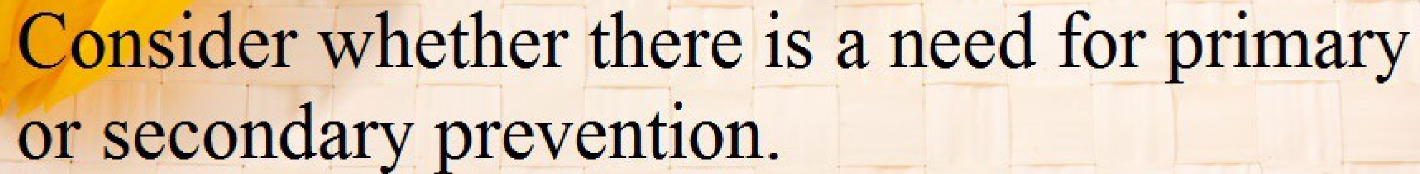

4- Hobbies and interests :
Including animal contact "birds , cats ..etc"
Does he practice regular excercise ?


5- Description of home :
where does the patient live ? flat or a house ?
Any stairs at home ? Any walking aids ?
Number of rooms in the house. Number of
persons per room.

6- Travel abroad.

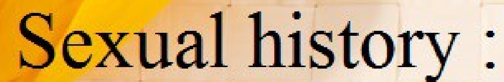
Did he take immunization before traveling abroad ?


Who does the cooking and shopping ?
Relationships with friends.



Consider whether there is a need for primary or secondary prevention.

- Primary prevention is prevention of disease, e.g. immunization.
- Secondary prevention is about prevention of worsoning of disease . for example by stopping smoking.



Sexual history :

Is the patient sexually active ?

Does the patient know the viral status of his partner ? or any sexually transmitted disease ?If the case is a case of sexual trauma (e.g. rape) refer to your consultant.

Closing the interview :

Ask the patient if there is anything else he or she would like to discuss.

Examination of a specific body region may remind the patient of previously forgotten details. So be ready to add any important details to your history even after starting the examination. Some patients become more talkative during examination , so you should remove the stethoscope from your ears if you are wearing them to hear what they say.

Establish a habit of updating historical informations during follow up visits.

Don't forget to say the prayer when visiting a sick person. When the Prophet would enter upon a sick person, he would say to that person : 'Never mind, may it (the sickness) be a purification, if Allah wills.'
or you can say : with the name of Allah. I recite over you (to cleanse you) from all that troubles you, Allah will cure you.

Summary :

After finishing the history , you can summarize your case in one paragraph by collecting the positive data in the history. You can edit and organize your report into a formal presentation.

Example of a summary :

43 years old male Indian patient from New Delhi, a farmar , a known case of hypertension and DM. Presented with history of chest pain which is most likely ischeamic in nature. He has a positive family history of the same illness. And he is a heavy smoker.

Before taking examples of focused history taking in the OSCE, we will take complete history taking.

N.B Just like in any example mentioned in this series, the names of the patients are not real.

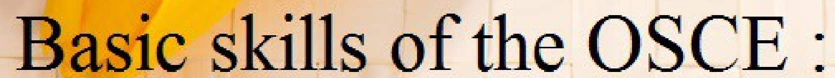
Today I saw Mr. Eduardo ...... a 34 years old single male mexican patient from mexico city. He is a merchant with blood group A+ Admitted to hospital 2 days back complaining of headache started 1 month back and vomiting which started 2 days back.

On analysis of chief complaint the patient was in his last usual state of health 1 month back when he started complaining of very sever frontal headache at early morning that awakens the patient from sleep. His headache is aggrevated by laying down and relieved by paracetamol tablets. The patient described the headache as a tight band around his head and it increases in severity and frequency.

The patient also reports a 2 days history of vomiting. This projectile vomiting is proceeded by nasea and happened twice daily. Its content is undigested food particles with no characteristic color or odor.

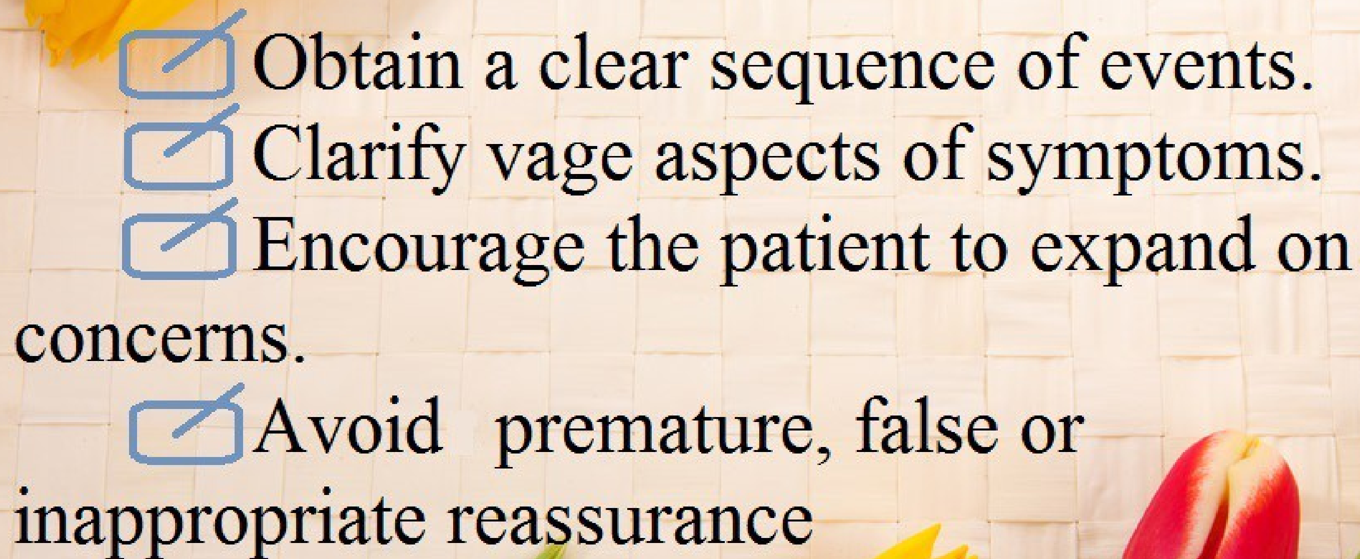
Important negatives : His vomiting is not associated with abdominal pain nor diarrhea. There is no history of fever and no history of blurred vision.

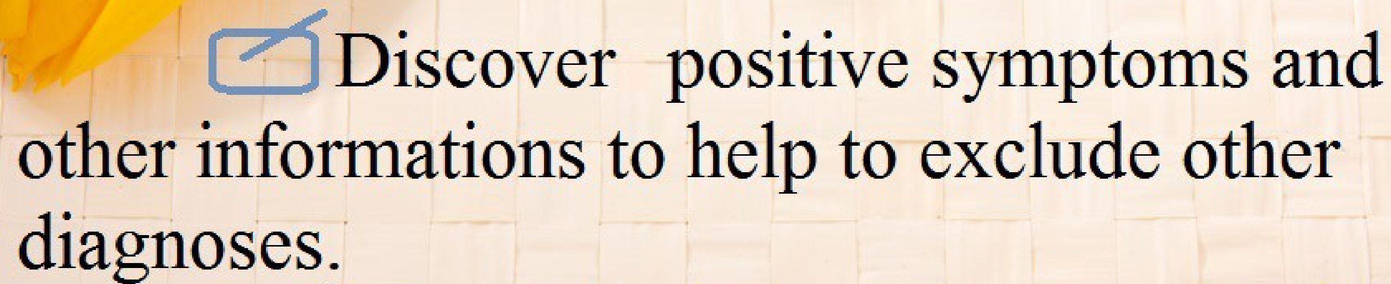
There is no family history of the same illness.



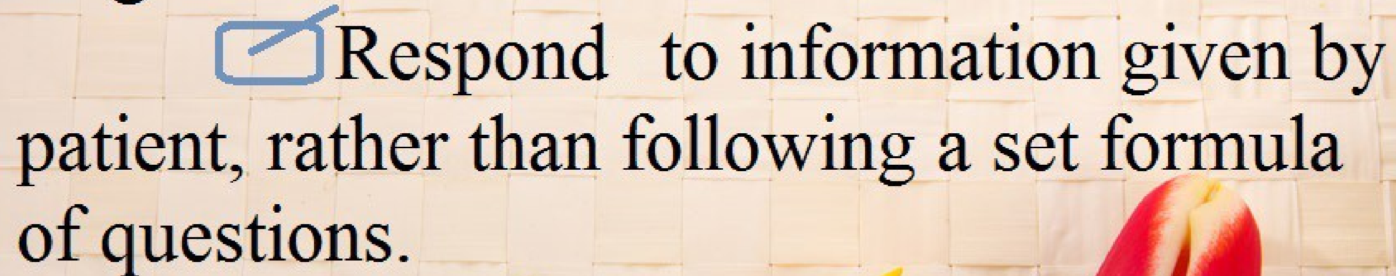
Basic skills of the OSCE :

- ☑ Use the patient's name.
- ☑ Obtain permission for interview and explain purpose.
- ☑ Do not interrupt the patient.

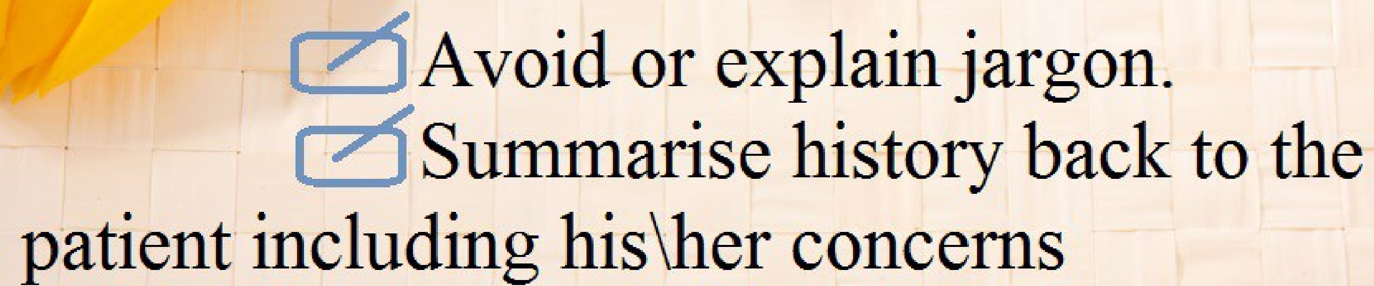

Obtain a clear sequence of events.
Clarify vage aspects of symptoms.
Encourage the patient to expand on concerns.
Avoid premature, false or inappropriate reassurance



Discover positive symptoms and other informations to help to exclude other diagnoses.



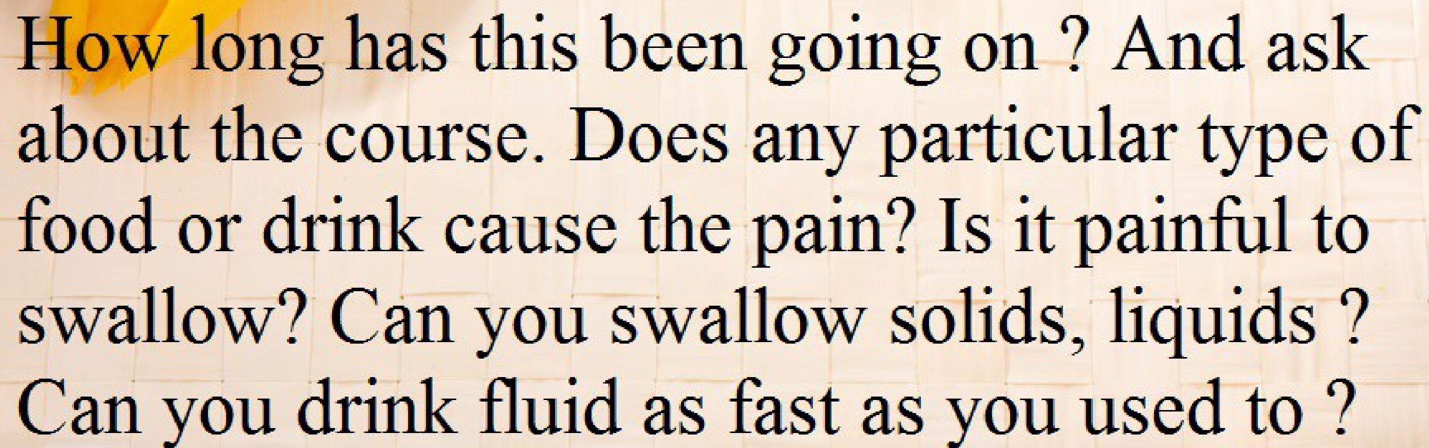
Respond to information given by patient, rather than following a set formula of questions.

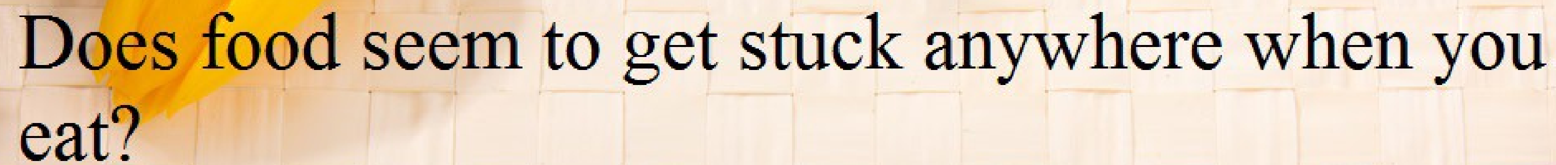

Avoid or explain jargon.
Summarise history back to the patient including his\her concerns

OSCE Focused history taking :

Dysphagia case :

- Introduce yourself and obtain patient's name and take permission.
- Ask about demographics (age, occupation)
- Ask about the presenting complaint with an open question.


How long has this been going on ? And ask about the course. Does any particular type of food or drink cause the pain? Is it painful to swallow? Can you swallow solids, liquids ? Can you drink fluid as fast as you used to ?



Does food seem to get stuck anywhere when you eat?

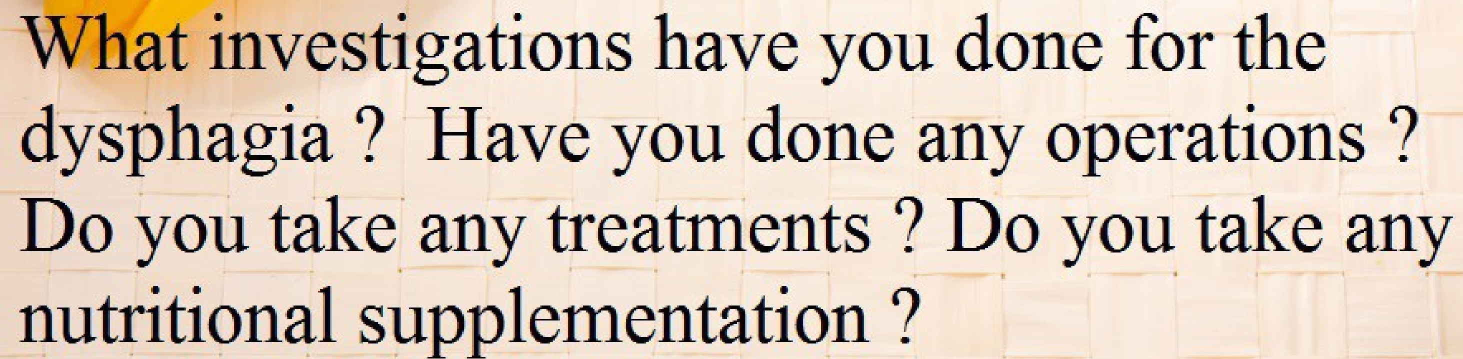
Do you ever bring food back up ?

Have you ever noticed a lump on your neck ?

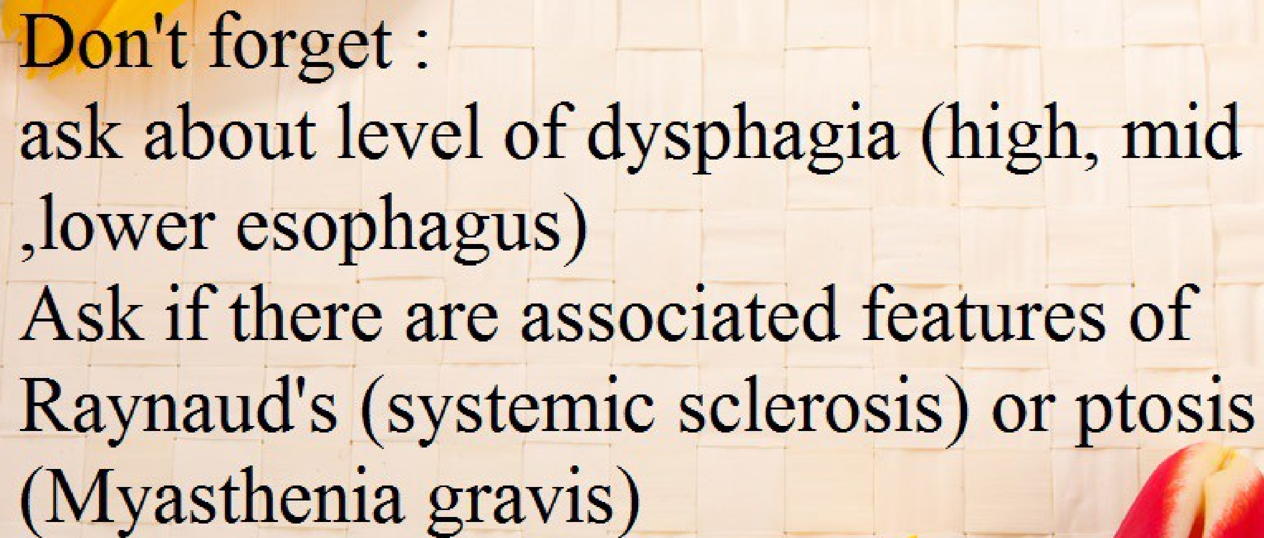
Have you noticed a change in your voice ?

Is there any cough ?

Is there any weight loss ?


What investigations have you done for the dysphagia ? Have you done any operations ? Do you take any treatments ? Do you take any nutritional supplementation ?

Do you take any medication for GERD ?
Do you have any allergies?


Don't forget :
ask about level of dysphagia (high, mid ,lower esophagus)
Ask if there are associated features of Raynaud's (systemic sclerosis) or ptosis (Myasthenia gravis)

Focused history taking Case 2 : chest pain :

-Introduce yourself , obtain patient's name and take permission.
-Ask about demographics (age , occupation)
-Ask about the presenting complaint with an open Question.

Obtains history of chest pain

Onset , Location , Precipitating factors , Relieving factors , Associated symptoms , Character , Radiation , Severity , duration

Identify risk factors for heart disease

- Ask about Past medical history and family history of heart disease or risk factors
- Smoking history
- Drug use (especially cocaine)
- Hypertension
- Exercise tolerance

Focused review of systems

Heartburn or GERD symptoms . Any palpation.

Medications and allergies

Check for any other missed informations