BASIC SKILLS IN INTERVIEWING THE PATIENT (a.k.a. HISTORY TAKING)

INTERNAL PROPAEDEUTICS

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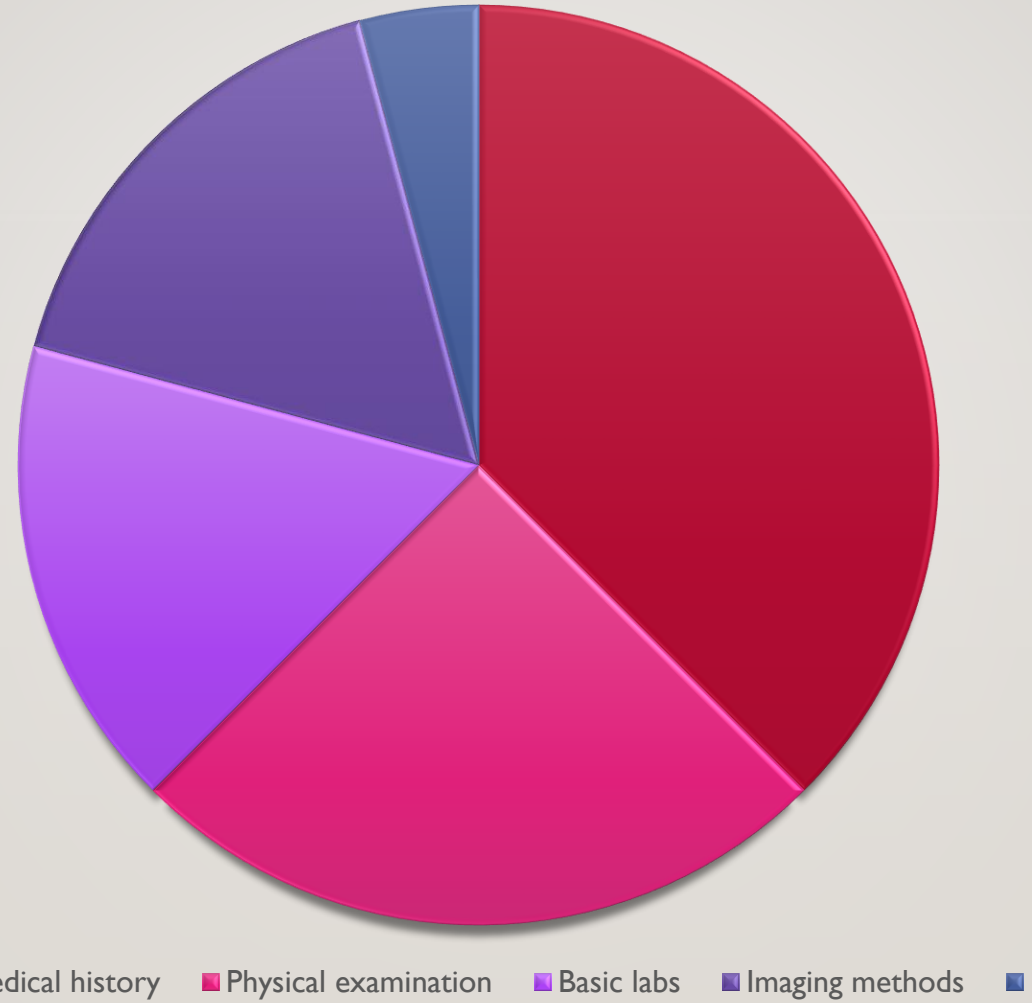
M. KOMLOSI, MD.

3RD INT. DEP.

MEDICAL HISTORY TAKING

- Critical step in determining the aetiology of patient's problem
- Many times it is possible to tell the diagnosis based on the patient's history alone
- Subtle skill to elicit **the relevant information** (this will get better with years of experience)

Diagnosis


Medical history
Physical examination
Basic labs
Imaging methods

GETTING STARTED…

- ✓ Wash your hands
- ✓ Always introduce yourself
- ✓ Identify the patient (full name, date of birth, address)
- ✓ Try to make the environment comfortable for the patient (privacy, no distractions)
- ✓ Put yourself and the patient on equal footing (do not act superiorly)
- ✓ Use the language that the patient is able to understand (avoid too many medical terms)
- ✓ PAY ATTENTION TO WHAT THE PATIENT SAYS

PRESENT ILLNESS

It is the actual problem leading the patient to seek for medical help

It usually consists of:

The chief complaint – the sign that attracts most of the patient's attention and causes the biggest discomfort (e.g. chest pain, fever, shortness of breath, etc.)

Accompanying symptoms – other associated signs of less importance to the patient, but still of high importance for differential diagnosis

E.g.: Dyspnoe + fever + cough = susp. from bronchopneumonia

Dyspnoe + unilateral leg oedema = susp. from thromboembolism

Dyspnoe + intolerance of horizontal position = susp. from decompensated cardiac failure

WHAT WE SHOULD KNOW ABOUT OUR PATIENT…

1. Present illness
2. Past medical history
3. Medication review
4. Allergy review
5. Family health history
6. Social history
7. Abuses
8. Epidemiologic history / travel history / vaccination
9. Obstetric / gynaecologic history
10. Physiologic functions

HISTORY OF PRESENT ILLNESS

First question should be neutral, encouraging the patient to talk about the problem from his own perspective (e.g. "What brings you here?", "What seems to be the problem?"). After the doctor has some idea of what is going on he/she moderates the discussion.

Some important follow up questions considering the chief and accompanying complaints:

Duration ? Onset circumstances ?

Severity/Character ?

Location/Radiation ?

What is the cause according to the patient ?

Any provoking manoeuvre / situation ?

Any therapeutic manoeuvres ?

Pace of illness, ever before ?

Associated symptoms ?

Why today ?

HISTORY OF PRESENT ILLNESS

SOCRATES

- **S**ite
- **O**nset
- **C**haracter
- **R**adiation
- **A**lleviating factors
- **T**iming
- **E**xacerbating factors
- **S**everity (1-10/10)

EXAMPLE 1 – MALE WITH COUGH

45-year old man comes to consultation because of cough:

Since when do you experience this cough? – Since yesterday afternoon. (duration)

Is the cough dry or productive? - It is a dry cough (character)

Has it become any worse or better since the onset? – It is progressively getting worse (pace)

Do you experience any other symptoms? Fever, chills, sorethroat, shortness of breath, chest pain, muscle pain…? - Yes, I had a fever of 38,5 °C in the morning and I feel like I can't get enough of air into my lungs. There is no particular chest pain, but I can feel that my back and shoulders hurt (associated symptoms)

Have you tried any medications? – I took one pill of ibuprofen in the morning and I try to eat more fruits. (therapeutic manoeuvres)

Do you have any idea what might have caused your trouble? – My wife is having similar problem and she was diagnosed with COVID-19. (patient's idea of source of trouble)

EXAMPLE 2 – FEMALE WITH LEG OEDEMA

65-year old female presents to ER with right leg oedema:

Since when have you notices the oedema? – It is progressively growing since 3 days.

Is the swelling painful? – Yes, it is very tender on touch.

On the scale from 1 to 10, how severe is the pain? – It is about 6 to 7 out of 10.

Is it the first time that you have such a problem? – No, it is much worse, that's why I decided to come today.

Do you experience some other symptoms? – I think I had increased temperature yesterday, but I have no other problem.

Have you tried anything to ease the pain? – I put some analgesic cream but it did not really help.

Do you have any explanation for your problem? – It started after I came back from my holiday in Australia, I think it may be connected with the long flight.

PREVIOUS ILLNESSES / PAST MEDICAL HISTORY

This part makes an image of what kind of patient are you actually dealing with (young otherwise healthy, elderly with comorbidities, the patient in end-stage oncological disease…)

- Older the patient is, more the diseases he/she has (esp. chronic ones)
- It is no exemption that the patient of 75+ is treated for >5 different chronic diseases

The more precisely you take the past medical history, the easier would be the management of present complaint

PREVIOUS ILLNESSES / PAST MEDICAL HISTORY

I. Chronic diseases (hypertension, diabetes, osteoporosis, bronchial asthma, liver cirrhosis…)

if the patient cannot tell precisely, ask, whether he/she visits any specialist (this will give you at least some idea whether any organ / system is monitored regularly)

II. Recently treated conditions (e.g. ATB treatment, asthmatic attack, heart attack…)

III. Past surgeries (e.g. appendectomy, hysterectomy, cholecystectomy…)

IV. Past traumas (e.g. hip fracture with endoprothesis)

V. Other (e.g. pacemaker implant, post-transplantation…)

MEDICATION REVIEW

All the medicaments the patient takes should be listed here (inclusive of over-the-counter drugs, nutritional supplements, etc.):

Name of drug (or generic): Perindopril

Dose: 5mg

Route of application: i.v. – intravenously, i.m. – intramuscularly, s.c. - subcutaneously, i.r. – intrarectally, p.o. – perorally, inh. – inhalatory…

Regimen: q.d. (once a day), b.i.d. (twice a day), t.i.d. (three times a day), q.i.d. (four times a day)

1-0-0 (one tbl. in the morning)

0-0-2 (2 tbl. In the evening)

1-1-1/2 (1 tbl in the morning, 1 tbl in the afternoon, half a tbl. in the evening)

0-0-0-1 (1 tbl. before sleep)

Compliance to the treatment: Does the patient take his/her drugs regularly?

Name of drug	Dose	Route of admin.	Regimen
Insulin Lantus		s.c.	0-0-0-24 units
Insulin Rapid		s.c.	6-8-6 units
Metformin	850mg	p.o. / tbl.	1-0-1
Furosemid	40mg	p.o. / tbl.	1-1/2-0
Aspirin	100mg	p.o. / tbl.	1-0-0
Salbutamol	2 puffs	inh.	1-1-1
Vit. B12	1,000 mcg	i.m.	Every month

ALLERGY REVIEW

List of allergies:

- Drug allergies (penicillins, lidocaine…)
- Food allergies (tomatoes, lactose intolerance, citrus…)
- Substances allergies (iodine contrast substances, alcohol disinfectants, plasters…)
- Drug side effects (e.g. oedema of the feet after amlodipine, cough after ACE-inhibtors…)

And their reactions:

- rash, tongue/throat oedema, anaphylactic shock

FAMILY HEALTH HISTORY

As some diseases may have a family occurrence, we investigate about the closest (and sometimes also distant) relatives

- Parents, grandparents, siblings, children
- Diseases they are (were) treated for, age of death, cause of death

E.g. Cardiovascular diseases, diabetes, cancer, rheumatologic diseases…

SOCIAL HISTORY

- Marrital status
- Household conditions (Live alone? Taking care of someone else? Low socioeconomic status?)
- Occupation (present + past); Exposure to toxins? Stressful job?
- Retirement

ABUSES

Smoking – yes or no? How many cigarettes per day? For how many years?

Alcohol – yes or no? Intensity? Frequency? Type of alcohol? Signs of addiction?

Drug abuse – yes or no? Which drugs? i.v. use? Signs of addiction?

Medication? – abuse of analgesics? Anxiolytics?

Other risky behaviour – risky sexual behaviour (many partners, use of preservatives, HIV status…)

EPIDEMIOLOGIC HISTORY

- Contact with infectious person? In quarantine?
- Recent travel history
- Vaccination history
- Recent hospitalizations – where? (risk of acquisition of nosocomial infection)

OBSTETRIC (GYNAECOLOGIC) HISTORY

- Details on number of gravidities, births (spontaneous, provoked, vaginal, C-section), miscarriages, interruptions
  - G3 P2 Ab1 (1x C-section)
- Details on menstrual cycle: Last period? Duration? Intensity of bleeding? Bleeding out of the cycle?
- Contraception?

PHYSIOLOGIC FUNCTIONS

- Urination – pain? burning sensation? frequency? amount? colour of urine? smelly? blood? pus? nocturnal urination – how many times? incontinency?
- Stool – consistency? colour? frequency? flatulency? blood? mucus? abdominal pain? incontinency?
- Weight – weight loss/gain? how many kg? in what time? on diet? (e.g. weight loss of 12 kgs in 3 months involuntarily)
- Sleep – insomnia? problem to fall asleep? waking up at night? why?
- Appetite – loss of appetite? certain meals? dysphagia? diet? fluid intake? thirst?
- Mobility – full or limited mobility? uses cane? wheelchair? worsened mobility lately? enough of physical activity? doing sport?