The Clinical Encounter And History Taking

Good Communication

Helps you:

- understand the patient as a whole.
- build trust between you and your patient.
- to agree on management goals.

Poor Communication

- Leads to patient dissatisfaction.
- Misunderstanding.
- Complaints.

Talking With Patients

Setting up:

- -choose a quite, private place.

May not be available !

Take enough time

- As a student take AT LEAST 30 minutes.

- Be professional in dress and behavior to give a good first impression.

-Introduce yourself.

-Shake hands *if culturally appropriate*.

- Ask the patient about the **MAIN** problem
- Listen **ACTIVELY**
- Observe patient's body language

- Start with OPEN questions
- Avoid leading questions

Example

- Tell me **MORE** about your chest pain **(open question).**
- Was your pain severe? **(closed question)** (yes or no questions)
- *You start with open questions, then to get the details you ask closed questions afterwards.*

- Clear & specific questions
- Try to ask one question at a time

- Have empathy understanding what your patient is going through.

Empathy ≠ Sympathy

- Sympathy is the expression of sorrow.

Sensitive Questions Guidelines

- Respect patient privacy
- Be direct and firm
- Be nonjudgmental
- Use appropriate language
- Document carefully
  - Use patient's words as possible

Confirmation

Clarifying

Ex: “What do you mean by *dizziness*?”

Confidentiality & Consent

- This information is confidential, even after a patient's death.
- There are exceptions:

1. where failure to disclose information would put the patient or someone else at risk of death or serious harm
2. where disclosure might assist in the prevention, detection or prosecution of a serious crime.

Confidentiality & Consent

- Always obtain **verbal** consent before history taking and physical examination.
- **Written** consent is needed when providing intervention or involving patients in teaching or research.

DO NOT

- Give false quick diagnosis
  - Malignancy
  - Debilitating disease

- Avoid over reassurance
  - *Unless it can be provided with confidence*

The History

What is it?

- Patient interview in systematic way to:

Record and find out the necessary medical information

Why is it important ?

- Helps in reaching the diagnosis
- Helps in formulation treatment plan
- Evaluates disease progression / regression
- Medico-Legal record

Complete History Taking

- Patient profile
- Chief complaint
- History of present illness
- Review of systems
- Past medical history
- Past surgical history
- Gynecological and obstetric hx
- Medications and allergy history
- Family history
- Social history
- Summary , Ddx , plan of care

The patient's profile:

- Name:(الاسم الثلاثي)
  - Full and accurate , ***Why ?***
  - Communicate with patient
  - Medico-legal aspects

- Age:
- Or date of birth , why ?
  - Certain diseases correlated with age
  - Management according to age

The patient's profile:

- Patient's name , age , marital status , address , job.
- Source of history : patient , relative..
- Source & time of referral/admission.
- Who took the history.
- Date & time of history taking.

Example

- Mrs. Laila Ahmad Isam is a 34 year-old married lady.
- She works as a teacher and lives in al-Zarqa city.
- She was admitted on the 2nd of July 2020 on 3:15 a.m. through the ER.
- History was taken from the patient herself by me ____ , 4th year medical student on the 4th of July 2020 at 10:00 a.m.

- **Chief complaint:**

- The **major problem** in the patient's own words plus its **duration**.**(prior to admission)**

- Use patient's words
- avoid medical terminology.

Examples

Don't use	Use
dysphagia	Difficulty in swallowing
dyspnea	Shortness of breath
Seizure	Abnormal movement
angina	Chest pain

Many complaints ??

- Use the first symptoms that caused patient to seek medical advice

- Or the most concerning symptom to the patient

History of present illness

- It is the analysis of the presenting complaint .
- The patient was doing well until.. OR
- The patient was relatively doing well until .....

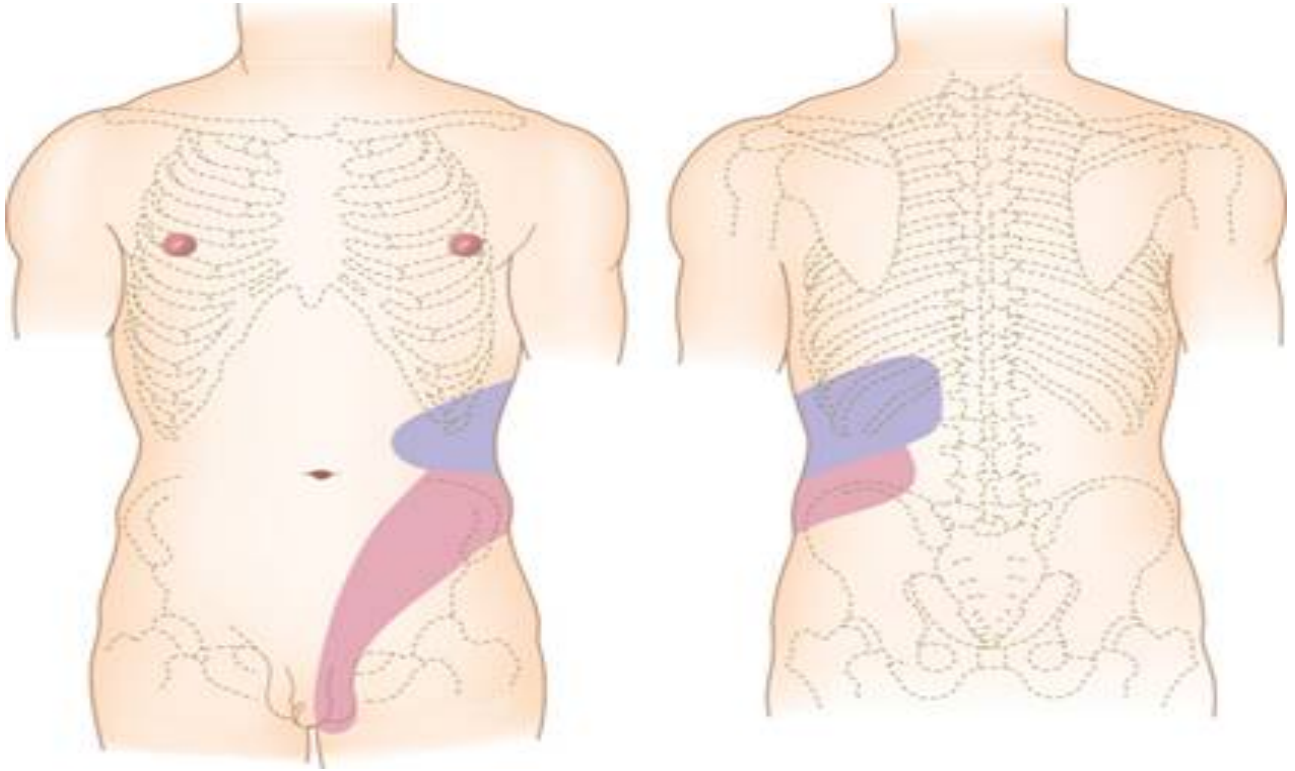
!PATIENT'S OWN WORDS

Characteristics of pain (SOCRATES)

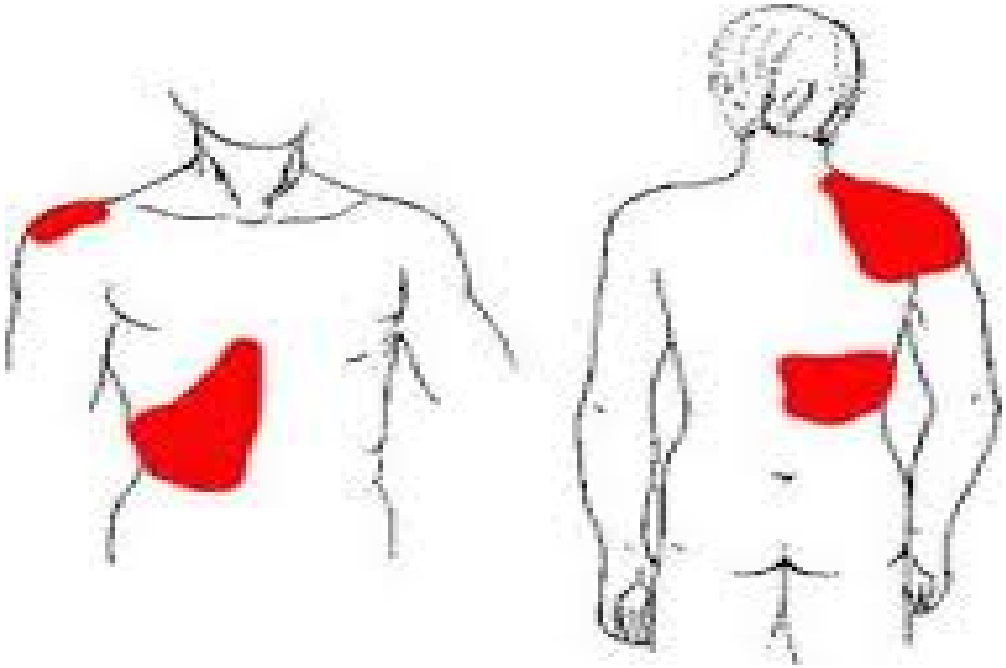
- Site
- Onset (sudden v.s. gradual)
- Character : sharp , dull , burning , stabbing, crushing
- Radiation : local extension , referred pain

- Rferred pain : pain perceived at a location other than the site of the painful stimulus . It is a result of interconnecting sensory nerves that supplies many different tissues.
  Ex: diaphragmatic pain at the shoulder tip via the phrenic nerve(c3 ,c4)

Radiating pain



Referred pain



- Associated symptoms(A at the last)

- Timing : duration , course , pattern
  -Duration: of each attack
  - Course: evolution of pain during the attack
    (progression vs regression)
  -Pattern: episodic vs continuous

    If episodic , duration and frequency of attack
    If continuous , any change in severity
  - Relation to time of day/night.

(e.g. every 15 minutes then none at night)

- Exacerbating & relieving factors :
  exertion , rest , posture , food , medications.

- Severity (grade 0-10).

- For any complaint ask about previous history of the same complaint.
- Effects on lifestyle : work , money, relationships.

- ***Negative information should be included if they contribute to the diagnosis or help exclude other possibilities***

Review of Systems

General health :

- Well being , appetite , weight change , energy , sleep, mood.

Cardiovascular system:

- Chest pain on exertion (angina)
- Shortness of breath :
- -Lying flat (orthopnoea)
- - At night (PND) paroxysmal nocturnal dyspnea.
- Palpitations
- Pain in legs on walking (claudication)
- Lower limb swelling

Respiratory

- Shortness of breath
- Cough
- Wheezing
- Sputum production
- Blood in sputum (hemoptysis)
- Chest pain

GI

- Mouth (oral ulcers)
- Difficulty swallowing (dysphagia)
- Painful swallowing (odynophagia)
- Nausea & vomiting
- Vomiting blood (hematemesis)
- Heart burn
- abdominal pain
- Change in bowel habits

Genitourinary

- Pain passing urine (dysuria)
- Polyuria (passing large amounts)
- Frequency passing urine (at night called nocturia)
- Blood in urine (hematuria)
- Incontinence
- Poor stream
- Erectile dysfunction (in men)

Nervous System

- Headache
- Dizziness(vertigo , lightheadness)
- Faints ((اغماء
- Fits
- Altered sensation
- Weakness
- Visual & hearing disturbance
- Memory & concentration changes

Musculoskeletal

- Joint pain , stiffness & swelling
- Mobility
- falls

Endocrine

- Heat or cold intolerance
- Sweating
- Excessive thirst (polydepsia)

Past History

Past medical history:

- Chronic illness
- Previous hospital admissions
- History of blood transfusions
- Past procedures (endoscopies, bronchoscopies, cath)
- Vaccination

Past surgical history:

(date, hospital, emergent or elective, complications)

Past gynecological & obstetric history:(5th year)

- Number of pregnancies & complications , types of deliveries & complications .
- Menstrual cycle (Last menstrual period, age of menarche, regularity , length , amount , pain)
- contraception.

Drug History

- Ask about prescribed medications
- (indication),illegal drugs and over the counter drugs (analgesics , vitamins, laxatives, herbs).
- Write the generic name.
- Dose, frequency & duration of treatment.
- Side-effects.
- Compliance.

Side effects	Indication	duration	dose	drug
none	After myocardial infarction	years 5	mg daily 75	Clopidogrel

- Adherent(taking drugs but not necessarily understanding why)
  vs.
  Concordant (taking the drug and understanding why)

**Allergy

- Drugs
- Foods
- Seasonal

Family History

- Document familial diseases (cancer , IHD , asthma, syndromes)
- age of death in first degree relatives (parents , siblings & children)
- pedigree chart has to be included

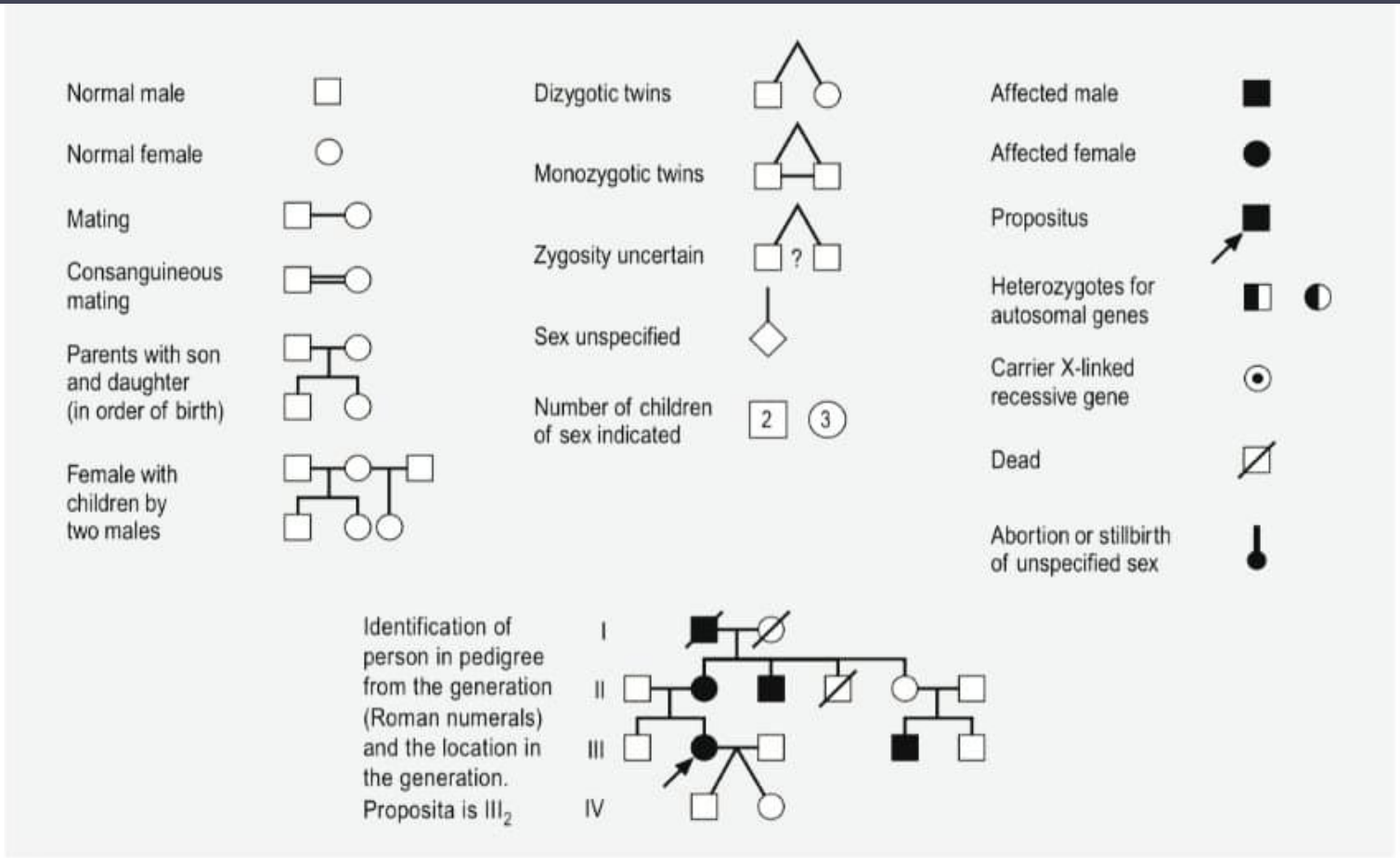


Fig. 2.1 Symbols used in constructing a pedigree chart, with an example. The terms 'propositus' and 'proposita' indicate the man or woman identified as the index case, around whom the pedigree chart is constructed.

Social History

- Occupation ; current & previous (exposure to hazards : chemicals , dust , asbestos)
- Marital status , relationships , sexual history
- Type of home , stairs
- Pets
- Smoking (cigarettes , cigars , pipe) duration & amount expressed by pack years , passive smoking
- Alcohol
- Travel history

Calculating pack years

- 1 pack of cigarettes = 20 cigarettes

$$\frac{\text{\# of cigarettes smoked X per day \# of years smoking}}{20}$$

Example: (30 cigarettes X 10 years)/20 = 15 pack years.

- Report alcohol consumption in units.
- 1 unit of alcohol = 10 ml of pure ethanol.

- %Ethanol in beer = 4%.
- % Ethanol in wine = 12 %.
- %Ethanol in spirit = 40 %.

- Calculate units based on the ethanol concentration.
- E.g., 500 ml of 4% beer alcohol
  = 20 ml pure ethanol
  = 2 units

- E.g., 300 ml of wine alcohol
  = 12% *300
  = 36 ml pure ethanol
  = 3.6 units

Ending

- Summarize the findings
- Examine the patient
- Find a diagnosis or list differential diagnoses.

"يجب أن يكون في داخل كل طبيب
عالم صغير يفكر ويحلل و يستنتج "

Thank You