The Manner of History Taking and Physical Examination

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During History Taking

The General Facts

- Welcome the patient - ensure comfort and privacy
- Know and use the patient's name
- Introduce and identify yourself
- Keep eye contact during conversation
- Set the Agenda for the questioning

- Use open-ended questions initially
- Negotiate a list of all issues - avoid excessive detail initially
  - Chief complaint(s) and other concerns
  - Specific requests (i.e. medication refills)
- **Show empathy**
- Clarify the patient's expectations for this visit - ask the patient "Why now?"

- Elicit the patient's story
- Return to open-ended questions directed at the major problem(s)
- Encourage with silence, nonverbal cues, and verbal cues
- Focus by paraphrasing and summarizing
- Professionally treat the difficult patients while taking history (Silent patient, talkative patient, crying patient…)

Components of the History

- Chief complaint
- Present Illness
- Past Medical/Surgical, Allergies, Medications, Hospitalizaions, Obstetrics, Sleep, Family
- Sexual, Social,

- Review of Systems

Chief Complaint

- This is why the patient is here in the emergency room or the office

- Examples:
  - Shortness of breath
  - Chest pain
  - Nausea or vomiting

Present Illness

- This is the detailed reason why the patient is here
- It is the why, when and where, etc…
- Use the OPQRSTA approach to cover all aspects of information

History of Present Illness

- OPQRSTA
  - Onset
    - When did the chief complaint occur
  - Prior occurrences of this problem
  - Progression
    - Is this problem getting worse or better
    - Is there anything that the patient does that makes it better or worse
  - Quality
    - Is there pain, and if so what type—how would the patient describe it is words

- OPQRSTA (continued)
  - Radiation
    - Do the symptoms radiate to anywhere in the body, and if so, where?
  - Scale
    - On a scale of 1 to 10, how bad are the symptoms
  - Timing
    - When do the symptoms occur?
      - At night, all the time, in the mornings, etc…
  - Associated symptoms
    - Any other info about the chief complaint that has not already been covered
    - Ask if there is anything else that the patient has to tell about the chief complaint

Past Medical History

- These are the medical conditions that the patient has chronically and that they see a doctor for.

- Examples:
  - Hypertension, GERD, Depression, Congestive heart failure, hyperlipidemia, Diabetes, Asthma, Allergies, Thyroid problems, etc…

Past Surgical History

- These are any previous operations that the patient may have had
- Make sure to put how old the patient was when they occurred
- Include even those that occurred in childhood
- Examples:
  - Tonsillectomy, Hysterectomy, Appendectomy, Hernias, Cholecystectomy

Medications

- Include all meds the patient is on—even over the counter meds and herbals
- Try to include the dosages if the patient knows them
- Include how often the patient takes them

Allergies

- Make sure to ask about medication allergies and the reaction that the patient has to them
- Ask about latex, food and seasonal allergies

Social History

- Things to include:
  - Occupation
  - Marriage status
  - Tobacco use—how much and for how long
  - Alcohol use
  - Illicit drug use
  - Immunization status
  - If pertinent, sexually transmitted disease history

Social History

- In U.S. Hospitals, The followings are Included when required:
  - Code status
    - Does the patient wish to have resuscitative measures taken in the event of cardiac arrest, including chest compressions and/or intubation.
      - **DNR—do not resuscitate**
      - **DNI—do not intubate**

Family History

- Ask if the patient's parents, grandparents, siblings or other family members had any major medical conditions
  - Examples:
    - Heart disease, heart attacks, hypertension, hyperlipidemia, diabetes, sickle cell disease

Review of Systems

- The review of systems is just that, a series of questions grouped by organ system including:
- General/Constitutional
- Skin/Breast
- Eyes/Ears/Nose/Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Neurologic/Psychiatric
- Allergic/Immunologic/Lymphatic/Endocrine

Physical Exam

Important Points:

- **Wash your hands.**
- **Asked permission to start the exam.**
- **Use respectful draping.**
- **Do not repeat painful maneuvers**
- **Explain while performing physical exam**
- **Try to be face to face during all conversations**

Physical Exam

- General
- Skin
- HEENT
- Neck
- Heart
- Lungs
- Abdomen
- Extremities
- GU if pertinent to the chief complaint

Physical Exam

- Make sure to include vital signs as part of this
- Develop a systematic approach for doing the physical exam

Assessment and Plan

- This is what you think is wrong with the patient, and what you plan to do initially during admission

- Example:
  - A/P: Chest pain.
    - Admit the patient to the chest pain protocol
    - Get EKG every 8 hours times three
    - Cardiac enzymes every eight hours times three
    - CBC, Elect, etc.…

Closure

- Discus the initial diagnostic impressions

- Discus initial management plans
- Always explain the complex medical terminology in lay language

- Health education about smoking, alcohol, elicit drugs etc

- **Ask if the patient has any other questions or concerns (Difficult Question) and answer it in a professional manner.**

Closure Continue

- **Never give false hopes to the patients.**

- Never deliver partial and non-confirmed information to the patient.

Dictating

- This will all be dictated as part of the official medical record
- Beginning parts:
  - State your name
  - Visit/Admission date
  - Attending physician
  - Resident physician

Thank You