DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE

Communication Skills Program
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The Medical History (Content)

Patient Identification
Brief description of the patient

Presenting Problem(s)
Main reason patient came to see the doctor. Record using patient's own words

Identify reason(s) for consultation
Use appropriate open-ended questions to identify problems/issues. Listen attentively without interruption to opening statement. Confirm list & screen for more problems. Negotiate agenda, including needs of patient & doctor.

History of Presenting Problem(s)
Elaboration of presenting problem(s) using general to specific questions about:
Biomedical ***disease:*** **WH** questions (where, what, when, why, who, & how) and
Paitent's lived experience of ***illness:*** **FIFE** questions (**F**eelings/concerns, **I**deas, effects on **F**unction/daily life, **E**xpectations of consultation)[1]

Past Medical History
Childhood/adult illnesses (medical/surgical/obstetrical/psychiatric/chronic), hospitalizations, accidents, injuries, allergies

Medication History
Current prescribed medications, non-prescription meds (over the counters [OTCs], vitamins and herbal medicines and supplements, recreational drugs)

Family History
Health and disease status of immediate family (partner, parents, siblings, children), inherited traits, potential increased risks

Personal & Social History
Demographics, life context, living arrangements, occupation, relationships, sexuality, ethnicity, cultural and spiritual beliefs/practices

Functional Inquiry
Review of systems, recheck for missed clues, screening beyond presenting problem(s)

FUNCTIONAL INQUIRY

This series of symptom related questions is used to elicit new information and obtain further details about the presenting problem. The process of asking these questions is flexible. Open-ended questions should be used to explore a positive response to a closed question.

Before you begin, tell the patient that you will be asking him/her a series of questions, many of which may seem unrelated to the reason s/he came to see the doctor. Explain that the purpose of asking these questions is to give a fuller picture of the patient's overall health and ensure that nothing is missed.

GENERAL

How is your energy level? Are you sleeping well?
Any changes in appetite or weight?
Do you have fever/night sweats/shaking?
Do you have any rashes/bruising?
Have you noticed any changes in your skin colour (pale, yellow, orange, blue, tanned)?
Have you experienced any flushing?

CARDIOVASCULAR

Do you have any pain or discomfort in your chest?
Are you short of breath during physical activity/when lying down – does it wake you at night?
Do you sometimes get a fluttering feeling in your chest?
Do you have any swelling of your ankles?
Do you get pain in the calves of your legs when you walk?

RESPIRATORY

Do you have pain in your chest when you breathe?
Have you any shortness of breath, wheezing?
Do you have a cough? Do you cough up anything – mucous, blood (clear, frothy, pink, green, yellow, blood stained)?
Have you had a cold recently?

GASTROINTESTINAL

Do you have discomfort when you eat, difficulty swallowing?
Do you have indigestion/heartburn?
Do you have pain in your stomach? Any bloating, gas?
Have you had any nausea or vomiting. What is the vomit – colour, food, acid, blood?
Has your skin ever turned yellow?
Has there been a change in your bowels – altered frequency or consistency of stools (colour, size, blood or mucous, floating)? What is normal for you?

GENITO-URINARY

Do you have any difficulty passing your urine? How often do you go?
Do you get up at night to go? How often? Is there any pain or burning?
Do you ever leak any urine? Do you ever not make it to the toilet when you have the urge to void?
Is there any change in the colour, amount or smell of your urine?
Have you ever had a sexually transmitted infection?
Breast history – any breast lumps, nipple discomfort, discharge?

For male – Any hesitancy, dribbling or poor stream?
Any discharge - colour, smell, consistency, blood?
Are you sexually active with women, men, or both?
Do you have any difficulty with erections, ejaculation, impotence?
Any swelling or pain in your testes?

For female – When was the first day of your last menstrual period? Do you have regular periods? How often (from first day of bleeding in one cycle to first day of bleeding in next cycle)?
How long do you bleed for? Do you have heavy flow? Any bleeding between periods?
Any pain with your periods?
Do you have any hot flashes or flushing?
Are you sexually active with men, women or both? Any pain/bleeding with intercourse? Are you using any contraception?
When was your last Pap smear? Have you ever had an abnormal Pap smear?
Have you had any change in the colour, smell or consistency of your vaginal discharge?

MUSCULOSKELETAL

Do you have any pain/swelling/stiffness in your muscles/joints/back?
Do you have muscle stiffness in the mornings?
Are you able to wash and dress without difficulty?
Can you climb up and down stairs?
Have you noticed any change in your walking?

NEUROLOGICAL/PSYCHIATRIC

Do you have headaches?
Have you had any fits/faints/loss of consciousness, funny turns?
Have you had any dizziness, lightheadedness?
Is your vision good? Any double vision, other visual disturbance (wavy lines, halos round lights)?
Any hearing problems – deafness, pounding, static, ringing?
Do you have any weakness in your body?
Any numbness/tingling "pins and needles"?
Any shakiness in your hands?
Have you noticed any loss of memory/personality change?
Do you feel sad, hopeless/have episodes of tearfulness?
Do you have any anxiety, insomnia, difficulty concentrating, memory changes?

Doctors perform approximately 200,000 consultations in their professional lifetime [2]

HAEMATOLOGICAL

Do you have night sweats?
Have you noticed any bruising, rashes, red spots?
Have you noticed that you have easy &/or prolonged bleeding?
Have you ever had a blood transfusion – any reactions?
Any swellings in your neck, armpits, groin?
Have you noticed or has anyone commented on paleness, yellowness of your skin?

ENDOCRINE

Do you have fatigue or a general feeling of not being well?
Have you noticed any change in how you cope with hot or cold rooms?
Have you noticed neck swelling/ tightness?
Any increased thirst, hunger? Increased urination?
Are you lactating – any breast discharge?
Have you had any changes in your skin (rougher, smoother) & hair condition (thicker, thinner, falling out)?

WHAT FOLLOWS THE HISTORY…

Physical Examination

Differential Diagnosis – Hypothesis

Including both disease and illness issues

Plan of Management

Investigations; treatment alternatives

Explanation and Planning with Patient

What the patient has been told
The plan of action negotiated

Clinical research has repeatedly shown that the history contributes 60-80% of the data for making a diagnosis [3]

Refrences

1. Stewart, M., Brown, J.B., Freeman, T.R. (2003) Patient-Centered Medicine Transforming the Clinical Method (2nd ed).Oxon, England: Radcliffe Medical Press

2. Silverman, J., Kurtz, S., Draper, J., (2005) Skills for Communicating with Paitents (2nd ed). Oxford, England: Radcilff Publishing.

3. Peterson, M., Holbrook, J., VonHales, D., Smith, N.L., & Staker, L. (1992). Contributions of the history, physical examination, and laboratory investigation in making medical diagnoses. West J Med. 156, 163-165.