1. HISTORY: CENTRAL TO MEDICINE

History is central to the practice of all branches of medicine, and it requires **patience, empathy,** and **understanding.**

2. BEGINNING: GATHERING INFORMATION

1. Begin the history preparation

- Read the patient's last records if available for any referral, transfer, or discharge.

2. Allow sufficient time

- Consultation length varies.
- In UK general practice, see the same family multiple times, the appointment is short but adequate.
- A longer appointment is usually scheduled when:
  - It is a new and complex problem.
  - It is the first time you are meeting the patient.
- You need to learn the skill of managing the pace without giving the impression that you're short of time.
- Learning to communicate efficiently takes time.

3. STARTING THE CONSULTATION

- Start by introducing yourself.
- The appropriate physical greeting depends on the cultural and infection control.
  - Since COVID-19, handshaking is no longer a usual practice in the UK.
- Ask how the patient wants to be addressed.
- Use different types of questions.
- Begin with open question to encourage them to think and report their symptoms in order.
- Listen actively and look interested while making encouraging comments.
- Allow them to tell in their own words.
- Gently, shortly direct them back when they feel they're deviating away.
- Make sure you have some sort of reflection where you ask them if your interpretation is correct.
- Use open questions as general invitations and then closed questions to seek specific information or clarification (e.g., "Have you had any cough today?").

4. SHOWING EMPATHY WHEN TAKING A HISTORY

Being empathetic is important in building the relationship with the patient and it even improves their health outcomes.

5. HISTORY OF THE PRESENTING SYMPTOMS

- Start with the chief complaint or the two or three main symptoms they are describing. These are the essence of the history.
- Use a mental list of possible diagnoses, a differential diagnosis to guide you.
- Make sure you understand what they mean.

6. THINGS PATIENTS SAY AND WHAT THEY COULD MEAN

What the patient says	What it could mean		Details
Allergy	True allergy (IgE-mediated)		Rash, swelling, rapid onset.
	Intolerance of food or drug		GI symptoms.
Indigestion	Acid reflux (with esophagitis)		Retrosternal pain, burning, acid taste.
	Abdominal pain in different locations	Stomach (epigastric)	• Relieved by food → peptic ulcer. • With vomiting → gastritis.
		Upper quadrant	Abdominal pain with tenderness on the side → acute cholecystitis.
		Epigastric	Epigastric pain with tenderness → pancreatitis.
Arthritis	Joint pain		Joint swelling with tenderness.
	Muscle pain		Muscle tenderness.
	Skeletal injury causing immobility		Deformity at site.
Catarrh (احتقان)	Purulent sputum from bronchitis		Cough with yellow or green sputum.
	Infected sinus discharge		Yellow or green nasal discharge.
	Nasal blockage		Prior nasal injury or insomnia.
Fits	Epilepsy		Tonic or clonic movement with postictal amnesia.
	Transient syncope (from cardiac disease)		Pallor during the syncope (vertigo).
	Abnormal involuntary movement		No loss of consciousness.
Dizziness	Labyrinthitis		Comes and often is dyggnous, feeling of spinning without any other neurological defects.
	Syncope from hypertension		Palpitation or cardiac events.
	Cerebrovascular event		Sudden onset with other neurological defects.

7. EXAMPLE & DIFFERENTIAL DIAGNOSIS

- Advanced age + smoking + chronic cough → Possible: COPD or lung cancer.
- Pain does not exclude COPD (could have pulled a muscle).
- Pleuritic pain → think of infection or PE.
- Chronic hemoptysis (up to 2 months) + weight loss → think of lung cancer.

8. SOCRATES: TO DESCRIBE CHARACTERISTICS OF PAIN

S	**Site**	Somatic pain is well localized (e.g., sprained ankle). Visceral pain is more diffuse (e.g., angina pectoris).
O	**Onset**	Is it acute or chronic?
C	**Character**	How do they describe it using adjectives?
R	**Radiation**	• Progression locally and is connected → radiating. • In two spots that are not connected → referred. • May be due to a shared neural pathway (e.g., diaphragmatic pain at the shoulder tip due to the phrenic nerve).
A	**Associated symptoms**	Things that come with the pain or with the main complaint.
T	**Timing**	• Duration, course, pattern. • If episodic → duration and frequency of attack. • If continuous → any changes in the severity.
E	**Exacerbating and Relieving factors**	Things that increase the pain or lower it.
S	**Severity**	Subjective: 1 to 10. 10 is the worst thing imaginable.

9. ASSOCIATED SYMPTOMS

Questions from the review of systems, but with the differential diagnosis in mind.

10. ALSO ASK ABOUT THE PATIENT

- How the symptom is affecting their daily life and functionality. (A specific symptom could affect a retired person much less than it affects someone working in construction, for example.)
- Ask about their ICE:
  - Ideas
  - Concerns
  - Expectations

11. TYPICAL PATTERNS OF SYMPTOMS RELATED TO DISEASE CAUSATION

Disease causation	Onset of symptoms	Progression of symptoms	Associated symptoms/pattern of symptoms
Infection	Usually hours, unheralded	Usually fairly rapid over hours or days	Fevers, rigors, localising symptoms (e.g. pleuritic pain and cough)
Inflammation	May appear acutely	Coming and going over weeks to months	Symptoms may be multifocal, often with local tenderness
Metabolic	Variable, hours to months	Steady progression in severity with no remission	Variable, weakness, altered weight
Malignant	Gradual and insidious	Steady progression over weeks to months	Weight loss, fatigue
Toxic	Abrupt	Rapid	Dramatic onset of symptoms; vomiting often a feature
Trauma	Abrupt	Little change from onset	Diagnosis usually clear from history
Vascular	Sudden	Stepwise progression with acute episodes	Rapid development of associated physical signs
Degenerative	Gradual	Months to years	Gradual worsening with periods of more acute deterioration

1. PAST MEDICAL HISTORY

- The past medical history may be relevant to the presenting symptoms, e.g.:
  - Previous migraine in a patient with headache.
  - Hematuria and multiple minor injuries in a patient with excess alcohol intake.
- It would also reveal a predisposing past underlying disease/illness, e.g.:
  - Diabetes in a patient with cerebrovascular disease.
  - Childhood wheezing in bronchiectasis.

2. REFERRAL LETTER & CASE RECORDS

- Read the referral letter and case records if they are available.

3. THE PATIENT IS THE BEST SOURCE

Ask about:

- How many times they've seen a doctor.
- If they've been admitted in a hospital.
- Any operations.
- Any medications they take regularly.

4. DRUG HISTORY

- The drug list on the referral letter, the hospital record, and the patient's own recollection of what they take.
- Include inhalers and topical medications, not only oral.
- Include: doses, dosage regimen, duration of treatment, and any significant adverse effects.
- Some medications (e.g. methadone) prescribed for addiction — ask the community pharmacy to confirm the dosage.
- Do not forget: recreational drugs, over-the-counter remedies, and herbal and homeopathic remedies such as vitamins or mineral supplements.
- 30% of people in Britain use illegal recreational drugs (e.g. cannabis).

5. CONCORDANCE & ADHERENCE

- Adherence: patients who take their medication as directed.
- Concordance: patient and doctor have negotiated and settled on treatment, compliance is likely but not guaranteed.

6. DRUG ALLERGIES / REACTIONS

- Ask if the patient has any drug reactions to a medication or vaccine.
- Clarify what patients mean by "allergy" – it could be an intolerance (e.g. nausea), which is more common than a true allergy.
- Drug allergies are often over-reported.
  - 1 in 7 who report a rash with penicillin actually have a positive penicillin skin test.
- Note other allergies (e.g. food, pollen).
- Record only true allergies.

7. FAMILY HISTORY

- Single gene inherited diseases are relatively uncommon.
- Even when present, autosomal recessive diseases (e.g. cystic fibrosis) arise in patients with healthy parents or unaffected carriers.
- Many illnesses are associated with a positive family history but are not due to a single gene disorder.
  - e.g. A family history of ischaemic heart disease may increase the likelihood of the same or other ischaemic heart disease in the patient.
- Some illnesses are so common (e.g. asthma, eczema in the UK) that their presence in family members may not greatly influence the patient's risk.
- Document first-degree relatives (parents, siblings, and children).
- For inherited disorders (e.g. haemophilia), construct a pedigree chart, noting whether any individual is adopted.

PEDIGREE CHART SYMBOLS (used in family history)

	Consanguinous mating
	Monozygotic twins
	Dizygotic twins
	Sex unspecified
	Carrier (X-linked disease genes)
	Person of specified sex (male)
	Person of specified sex (female)

8. SOCIAL HISTORY & LIFESTYLE

- This may be relevant to the causes of the illness or influences the management and outcome.
- Social deprivation is a powerful predictor of many forms of illness.
- Who is there to support the patient?
  - Who is at home with you?
  - Who visits you regularly?
  - Who is your next of kin?
- Check if the patient themselves, is a carer to another vulnerable person.
- Establish the type and condition of the patient's housing.
  - e.g. Apartment without elevator → a patient with severe arthritis would struggle with stairs.

Smoking

- Tobacco use increases risk of:
  - Obstructive lung disease
  - Cardiac & vascular disease
  - Peptic ulcers
  - Intrauterine growth restriction
  - Erectile dysfunction
  - A range of cancers
- Determine type: cigarets, cigarettes, pipe, chew, etc.
- Calculate pack years:
  Pack years = (number of cigarettes smoked per day + 20) × number of years smoked
- Note if the patient is a passive smoker.

Alcohol

- Alcohol can cause:
  - Hepatic cirrhosis
  - Encephalopathy
  - Peripheral neuropathy
  - Pancreatitis
  - Cardiomyopathy
  - Erectile dysfunction
  - Injury from accidents
- Ask how much and what type of alcohol they drink.
- Calculate quantity using units:
  - 1 unit = 10 ml ethanol
  - Usually, 14 units per week for both men and women is considered hazardous in the UK department.
- Binge drinking (large amount of alcohol in a short time) causes acute intoxication.

Occupational History

- Any chemical or dust exposure?
- Worked with harmful materials?
- Consider how the disease will affect their lifestyle and livelihood.
  - e.g. Arthritis in a manual labourer or obstructive sleep apnoea in a professional driver.

Travel History

- Risk of unusual tropical infections, middle ear problems, deep vein thrombosis.
- Some diseases (e.g. vivax malaria, HIV) may present a year or more after travel.
- List locations visited and dates.
- Note any travel vaccinations and anti-malaria prophylaxis.

9. EXAMPLES OF OCCUPATIONAL DISORDERS

Occupation	Factor	Disorder	Presents
Shipyard workers, marine engineers, plumbers and heating engineers, demolition workers, joiners	Asbestos dust	Pleural plaques Asbestosis Mesothelioma Lung cancer	>15 years later
Stonemasons	Silica dust	Silicosis	After years
Farmers	Fungus spores on mouldy hay	Farmer's lung (hypersensitivity pneumonitis)	After 4–18 hours
Divers	Surfacing from depth too quickly	Decompression sickness Central nervous system, skin, bone and joint symptoms	Immediately, up to 1 week
Industrial workers	Chemicals (e.g. chromium) Excessive noise Vibrating tools	Dermatitis on hands Sensorineural hearing loss Vibration white finger	Variable Over months Over months
Bakery workers	Flour dust	Occupational asthma	Variable
Healthcare workers	Cuts, needlestick injuries	Human immunodeficiency virus, hepatitis B and C	Incubation period >3 months

See also Chapter 5, p. 91

10. CLOSING THE INTERVIEW: DIFFICULT SITUATIONS

General approach

- Use simple language.
- Explain briefly your interpretation of the symptoms.
- Be sensitive to any previously expressed concerns and body language.
- Make sure the patients are involved in their decision by suggesting possible actions and allowing them to contribute to their thoughts.

Communication difficulties

- Patients not speaking their first language need an interpreter.
- Use a professional interpreter, not a family member.
- Do not converse with the interpreter while asking questions to the patient.
- Make sure the interpreter understands your questions.
- Non-verbal cues are harder – observe the patient when the interpreter is speaking.

Hearing or speaking difficulties

- e.g. Dysphasia, dysarthria.
- Write down your queries if the patient cannot read; call someone who is used to communicating.
- Use a sign language interpreter for deaf patients.

Patients with cognitive difficulties

- Be alert for any early sign of dementia.
- Inconsistent or hesitant responses should promote suspicion of memory difficulties.
- Ask if they have any difficulties with memory.
- Make a formative assessment using a relative rating scale.

Sensitive situations

- Ask personal sensitive questions and examine intimate parts sensitively (e.g. sexual dysfunction, abuse, STDs).
- Ensure complete privacy.

Emotional or angry patients

- Stay calm, explore the reasons for the anger, and diffuse the situation.
- Never respond with anger, agitation, or passing comments.
- If upset, show empathy and try to ask why.
- If anger escalates, set boundaries, withdraw calmly, and seek assistance of another healthcare worker.

Talkative patients

- Want to deal with many things at once.
- Redirect towards the main complaint.
- If overly familiar, set professional boundaries.

2.10 Systematic enquiry: cardinal symptoms

General health

- Wellbeing
- Appetite
- Weight change
- Energy
- Sleep
- Mood

Cardiovascular system

- Chest pain on exertion (angina)
- Breathlessness:
  - Lying flat (orthopnoea)
  - At night (paroxysmal nocturnal dyspnoea)
  - On minimal exertion – record how much
- Palpitation
- Pain in legs on walking (claudication)
- Ankle swelling

Respiratory system

- Shortness of breath (exercise tolerance)
- Cough
- Wheeze
- Sputum production (colour, amount)
- Blood in sputum (haemoptysis)
- Chest pain (pleuritic or constant)

Gastrointestinal system

- Mouth (oral ulcers, dental problems)
- Difficulty swallowing (dysphagia – distinguish from pain on swallowing (i.e. odynophagia)
- Nausea and vomiting
- Vomiting blood (haematemesis)
- Indigestion
- Heartburn
- Abdominal pain
- Change in bowel habit
- Change in colour of stools (pale, dark, tarry black, fresh blood)

Genitourinary system

- Pain passing urine (dysuria)
- Frequency passing urine (at night: nocturia)
- Blood in urine (haematuria)
- Libido
- Incontinence (stress and urge)
- If appropriate: Sexual partners – unprotected intercourse

Men

If appropriate:

- Prostatic symptoms, including difficulty starting (hesitancy):
- Poor stream or flow
- Terminal dribbling
- Urethral discharge
- Erectile difficulties

Women

- Last menstrual period (consider pregnancy)
- Timing and regularity of periods
- Length of periods
- Abnormal bleeding
- Vaginal discharge
- Contraception

  If appropriate:
- Pain during intercourse (dyspareunia)

Nervous system

- Headaches
- Dizziness (vertigo or lightheadedness)
- Faints
- Fits
- Altered sensation
- Weakness
- Visual disturbance
- Hearing problems (deafness, tinnitus)
- Memory and concentration changes

Musculoskeletal system

- Joint pain, stiffness or swelling
- Mobility
- Falls

Endocrine system

- Heat or cold intolerance
- Change in sweating
- Excessive thirst (polydipsia)

Other

- Bleeding or bruising
- Skin rash