Consultation: Taking a patient history

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The clinical encounter usually consists of the steps shown in fig 1. A good history is very important for making a diagnosis. Examination and investigations may help to confirm or refute the diagnosis made from the history.

The history will also tell you about the illness as well as the disease. The illness is the subjective component and describes the patient’s experience of the disease.

Try to follow the sequence history, examination, investigation when you see a patient. A common mistake is to rush into investigations before considering the history or examination.

It is easy to mindlessly order a battery of tests. There are many problems with this approach:

- Investigations cannot be used in isolation—is the x ray finding or blood test result relevant or an incidental finding?
- Investigations can be inaccurate—there can be problems with technique, reagents, or interpretation of the findings
- Investigations pose risks—radiation exposure, unnecessary further procedures, and so on
- Investigations can be costly, to the patient and to society.

Always remember to treat the patient and not the investigation. And remember that although we talk about “the patient,” you should consider “the person.”

Structure

Fig 1: Steps in a clinical encounter

You should use the following as a guide until you develop your own style and one that you feel comfortable with. You are at liberty to reorganise the order. For instance, you could go to the systems review after the history of the presenting complaint. Whatever order you use, however, you need to ensure that you get all components of the history (fig 2).
Introduction and details

You should always begin by introducing yourself. This should include your status as well as the educational reason for the encounter. For example, “My name is... I am a... year medical student, and I have come to talk to you to learn how to take a medical history.”

It is then useful to obtain some background information about the patient including their name, age, marital status, and occupation.

To establish rapport, and to put the patient at ease, it often helps to continue the interview by considering issues such as:

- How they would like to be addressed (forename or surname)
- Their physical comfort
- That you will treat all information as confidential
- How the patient may end the consultation: “If at any time you wish to stop this interview then please let me know.”

Presenting complaint

Ask the patient to describe the symptom or problem that brought them to hospital by using an open ended question: “What has happened to bring you to hospital?” or “What seems to be the problem?” You should show interest to facilitate this. Clearly, you want answers but you also wish to develop a rapport with the patient as well as understand him or her (and you will not do this through a series of closed questions).

The patient’s narrative gives important clues as to the diagnosis and the patient’s perspective of their illness. You should not interrupt. Most patients’ initial response will last fewer than two minutes. So it is worth while to give this amount of time to let the patient describe in their own words the problem that has led to their present situation.

Thus, history taking involves the use of communication skills. You need to develop your skills in:

- Opening and closing a consultation
- The use of open and closed questions
- The use of non-verbal language
- Active listening
- Showing respect and courtesy
- Showing empathy
- Being culturally sensitive.

This is not just an academic exercise—management of the patient is dependent on these aspects. If you do not communicate properly you will become increasingly frustrated and the patient will get suboptimal care. So, when you are taking a history, listen to the patient. Do they know what is wrong with them? Do they understand the implications of this? What are their concerns and expectations?
Once you have determined what the presenting complaint is, it must be evaluated in detail. Some of the information required includes:

- When did the problem start (date and time)?
- Who noticed the problem (patient, relative, caregiver, health professional)?
- What initial action was taken by the patient (any self treatment)?
- When was medical help sought and why?
- What action was taken by the health professional?
- What has happened since then?
- What investigations have been undertaken and what are planned?
- What treatment has been given?
- What has the patient been told about their problem?

This is not as easy as it sounds, especially in the beginning. You need to be patient and practice taking histories. In the early years there is a tendency to concentrate on events (investigations, treatments, etc) undertaken after the patient has been admitted to hospital. Although this is useful, what you should be aiming to do is defining the problem. In other words, what history would you take if you were the first person to see the patient and had to make a differential diagnosis? To a large extent, this means making sense of the symptoms that the patient presents with.

Sometimes the patient will tell you the diagnosis: “The doctor said that I’ve got pneumonia.” Despite the presumed diagnosis, it is worthwhile to determine the symptoms or problems that led to this diagnosis: “So, what symptoms did you have?”

This is important as:

- You can then attempt to link the symptoms to the diagnosis
- The patient may have misheard or misunderstood the discussions, and the diagnosis might be incorrect or only partly correct.

This leads to the rule that you should always make your own judgment.

You will find a great variety in patients’ account of their illnesses. Some keep meticulous details and can recall dates and times without hesitation; others are vague even about details of their hospital stay. This in itself is important:

- Does the patient understand their illness?
- Have they been given sufficient information?
- Do they have dementia, delirium, or confusion?

Often, the patient will complain of pain and there are specific characteristics of pain that need to be elicited:

- Exact site or location of pain
- Nature of pain (dull, sharp, etc)
- Onset of pain (sudden, gradual, etc)
- Severity of pain (can use a scale 1-10)
- Duration of pain (seconds, minutes, hours, or days)
- Progress, including frequency and timing of the pain (constant, intermittent, etc)
- Radiation of the pain
- Aggravating and relieving factors
- Previous occurrences
- Associated symptoms (nausea, vomiting, etc)
- The patient’s notion of what is causing the pain.

An attempt should be made to link the presenting complaint with the related systems review or inquiry (see the second part in next month’s Student BMJ). For instance, a patient presenting with chest pain should be asked questions covering the cardiovascular and respiratory systems such as cough, shortness of breath, palpitations, ankle swelling, etc.

Likewise, it is worthwhile to try and determine any risk factors for the probable diagnosis. For example, a patient presenting with chest pain, and suspected of having a myocardial infarction, should be asked questions about smoking, hypertension, diabetes, family history, etc. The aim of this is to integrate your history, make a correct diagnosis, and ensure that management takes into account all the available information.

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