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# Patient history example

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Preview: Medical Case ReportProvide the best health care to the people by using evidence-based care study by using this Medical Case Report template. This template contains all the information required in conducting research and report. Preview: Dental Health Record TemplateThe Dental Health Record Template is easy for patients to fill out and designed to get the doctor the most important information. Patients can fill out their information on a computer or tablet using our Dental Health Record Template. Free medical revision on history taking skills for medical student exams, finals, OSCEs and MRCP PACES Introduction (WIIPP) Wash your hands Introduce yourself: give your name and your job (e.g. Dr. Louise Gooch, ward doctor) Identity: confirm you're speaking to the correct patient (name and date of birth) Permission: confirm the reason for seeing the patient ("I'm going to ask you some questions about your cough, is that OK?") Positioning: patient sitting in chair approximately a metre away from you. Ensure you are sitting at the same level as them and ideally not behind a desk. Presenting Complaint Ask the patient to describe their problem using open questions (e.g. "What's brought you into hospital today?") The presenting complaint should be expressed in the patient's own words (e.g. "I have a tightness in my chest.") Do not interrupt the patient's first few sentences if possible Try to elicit the patient's ideas, concerns and expectations (ICE) e.g. "I'm worried I might have cancer." or "I think I need some antibiotics." History of Presenting Complaint Ask the patient further questions about the presenting complaint A useful mnemonic for pain is "SOCRATES" (Click here for further mnemonics) Site Onset Character Radiation Alleviating factors Timing Exacerbating factors Severity (1-10) Past Medical History Ask the patient about all previous medical problems. They may know these medical problems very well or they may forget some. Top ensure none are missed ask about these important conditions specifically (mnemonic: "MJTHREADS Ca") Myocardiac infarction Jaundice Tuberculosis Hypertension Rheumatic fever Epilepsy Asthma Diabetes Stroke Cancer (and treatment if so) If the patient is unsure of their medical problems, ask them further clarifying questions, for example "What do you usually visit your doctor for?". Remember you can add to past medical history if any of the medication later mentioned don't match the medical problems listed. Risk factors As part of medical history ask about specific risk factors related to their presenting complaint. For example, if the patient presents with what maybe a myocardial infarction, you should ask about associated risk factors such as: Smoking, cholesterol, diabetes, hypertension, family history of ischemic heart disease. Clarification of past medical history Some medical conditions require clarification of the severity. For example: COPD Ask about when the patient was diagnosed, their current and previous treatments, whether they have ever required non invasive ventilation ("a tight-fitting face mask"), whether they have been to intensive care Myocardial infarction Ask about angina, previous heart attacks, any previous angiograms ("a wire put into your heart from your leg or from your arm"), previous stenting Diabetes Duration of diagnosis, current management including insulin and usual control of diabetes i.e. well- or poorly-controlled Drug History All medications that they take for each medication ask them to specify: Dose, frequency, route and compliance (i.e whether they regularly take these medication). If they take medication weekly ask what day of the week they take it. If they take a medication with a variable dosing (e.g. Warfarin) ask what their current dosing regimen is Recreational drugs Intravenous drug use (current or previous) Over the counter (OTC) medications Allergies Does the patient have any allergies? If allergic to medications, clarify the type of medication and the exact reaction to that medication. Specifically ask about whether there's been a history of anaphylaxis e.g. "throat swelling, trouble breathing or puffy face" Family History Ask the patient about any family diseases relevant to the presenting complaints (e.g. if the patient has presented with chest pain, ask about family history of heart attacks). Enquire about the patient's parents and sibling and, if they were deceased below 65, the cause of death If relevant and a pattern has emerged from previous history sketch a short family tree Social History Alcohol intake Work out the number of units per week Tobacco use Quantify the number of pack years (number of packs of 20 cigarettes smoked per day multiplied by the number of years smoking) Employment history Particularly relevant with exposure to certain pathogens e.g. asbestos, where you need to ask whether they have ever been exposed to any dusts Home situation House or bungalow Any carers Activities of daily living (ability to wash, dress and cook) Mobility, and immobility aids Social/family support Do they think they're managing? Travel history Further social history maybe required depending on the type of presenting complaint for example: Respiratory presenting complaint Ask about pets, dust exposure, asbestos, exposure to the farms, exposure to birds or if there are any hobbies Infectious to disease related Ask for a full travel history including all occasions exposure to water, exposure to foreign food, tuberculosis risk factors, HIV risk factors, recent immunisations Systems Review Run through a full list of symptoms from major systems: Cardiovascular: chest pain, palpitations, peripheral oedema, paroxysmal nocturnal dyspnoea (PND), orthopnoea Respiratory: Cough, shortness of breath (and exercise tolerance), haemoptysis, sputum production, wheeze Gastrointestinal: Abdominal pain, dysphagia, heartburn, vomiting, haematemesis, diarrohea, constipation, rectal bleeding Genitourinary: Dysuria, discharge, lower urinary tract symptoms Neurological: Numbness, weakness, tingling, blackouts, visual change Psychiatric: Depression, anxiety General review: Weight loss, appetite change, lumps or bumps (nodes), rashes, joint pain Summary Provide a short summary of the history including: Name and age of the patient, presenting complaint, relevant medical history Give a differential diagnosis Explain a brief investigation and management plan Click here for how to take history of chest pain Perfect revision for medical student exams, finals, OSCEs and MRCP PACES Click here for history with patient with a cough Good history taking is a vital part of patient assessment in advanced practice, requiring a systematic and patient-centred approach. This article explains how Good history taking is a vital component of patient assessment and high-quality care. This second article in our assessment and interpretation series for advanced nurse or midwife practitioners shows how a systematic approach to taking a history, combined with asking patients about their ideas, concerns and expectations, gives a thorough understanding of patients' complaints and priorities. Citation: Butler S (2023) History taking for advanced clinical practitioners: what should you ask? Nursing Times [online]; 120: 3. Author: Sarah Butler is lecturer, University of Hull. This article has been double-blind peer reviewed Scroll down to read the article or download a print-friendly PDF here (if the PDF fails to fully download please try again using a different browser) Click here to see other articles in this series It has been suggested that between 70% and 90% of patient diagnoses are made on history taking alone (Keifenheim 2015). It is, therefore, essential as an advanced clinical practitioner that you can take a good history to facilitate diagnosis and management of health conditions. What is history taking? History taking is a logical and systematic approach to collecting personal and medical information from the patient to help assess, diagnose and manage health and wellbeing (Mosby, 2022). Using a logical and systematic approach clarifies the signs and symptoms, and allows for differential diagnoses. A good history is thorough, but also considers patients, thoughts and concerns. Communication skills Communicating effectively with your patient is essential to good history taking. The logical order of history taking can make patients feel that it is just a tick-box exercise. However, this can be avoided by ensuring that the consultation is patient-centered by using both verbal and non-verbal communication to help reassure the patient. Table 1 summarises essential communication skills that should be used for all consultations. Documentation A patient's record is another form of communication that documents the patient's healthcare journey during their lifetime (Brooks, 2021). This allows any health professional encountering the patient to understand and interpret previous healthcare information, tests and treatments. You must, therefore, be sure to complete it in an accurate and timely manner and only include factual and reliable information. Procedure There is a consensus in the nursing profession that history taking should be logical and completed in a certain order. This article follows a history-taking sequence adapted from Peart (2022) (Box 1). However, while this is a logical and systematic approach in meeting the health professional's agenda, it is not essential to adhere to it religiously or even discuss each aspect in turn. It is just as important to ensure that the consultation remains patient-centered and that you give patients enough time to answer your questions. Box 1. History-taking sequence Introduction Presenting complaint History of presenting complaint Medical history Medication Family history Social history Review of systems Summary Source: Peart (2022) Introduction Your first interaction with the patient can set the tone for the entire consultation, so it is important to make a good impression. Take the time to introduce yourself. The role of advanced nurse practitioner is one of several new and emerging roles (British Medical Association, 2022) that patients may not be familiar with, so it is beneficial to briefly explain your role (Peart, 2022). History taking is conducted in various healthcare settings. Some, such as general practice, have control over their environment, for example, by providing private consultation rooms. For others, such as emergency departments, the environment may be less than ideal; for example, taking a patient's history on a hospital trolley. However, what the environment might lack in terms of hospitality can be made up for by the practitioner adopting a warm and welcoming manner. If using a consultation room or patient bedside, arrange the chairs to allow good eye contact with the patient while still maintaining a comfortable distance, while ensuring easy access to the patient's healthcare records. Presenting complaint For patients, the presenting complaint is usually a priority as it is what has led them to seek help in the first place, either by booking a consultation or presenting at an emergency centre. However, while patients are normally quick to tell you what the complaint is about, they can still be vague. It is, therefore, important to use appropriate questioning techniques to ensure that nothing is missing when taking a patient's history. In your first contact with your patient, make your questions open-ended to allow patients to describe their symptoms and concerns in their own words (Abe et al, 2022). A useful analogy is to think of it as an essay answer as opposed to a multiple-choice response. For examples of open-ended questions, see Box 2. Box 2. Examples of open-ended questions Can you tell me what has brought you here today? How can I help you today? What health concerns do you have? An open-ended question can create a period of silence while the patient considers their response. Do not be afraid of silence. Many health professionals feel the need to fill the silence to prevent feelings of awkwardness. Exercise patience and refrain from doing this, as "intentional silence can be used to enhance the therapeutic relationship between nurse and patient" (Kemerer, 2016). For example, a moment of silence can give patients time to reflect or to summon the courage to respond. It is also an opportunity to notice how the patient presents themselves nonverbally, such as how they use their hands or facial expressions. Consider cultural differences; in some cultures, the accepted norm is for people to take their time and think about their answers, responding when they are ready. While it is necessary to adhere to reasonable time limits, it is important not to press too hard and to be comfortable with silence (Ball et al, 2019). History of presenting complaint Once the patient has outlined their complaint, the next step is to explore its history. This requires information on each symptom (Box 3). Such information can be obtained by asking specific questions or following the SOCRATES framework (Curr and Fordham-Clarke, 2022) (Table 2). Although this mnemonic was originally used to assess pain (Gregory, 2019), it can be applied to other symptoms. Box 3. Specific information required for symptoms Location of the presenting complaint and when or how it started Severity of the symptoms and how this affects quality of life What improves/aggravates symptoms Whether the person has experienced something like this before, what it was and how it was dealt with Whether the person has done anything on their own to try to improve symptoms Ideas, concerns and expectations The patient's ideas, concerns and expectations (ICE) can provide additional information during a consultation (Freilich et al, 2019). Exploring ICE gives a greater understanding of what the patient thinks is important and what treatment they think they need. History taking that includes the patient's perspective is likely to be more revealing and, therefore, valuable when making a diagnosis. However, this approach may have its drawbacks, as for some patients the nature of the questions can lead to feelings of discomfort, prevent the construction of a therapeutic relationship and stop the flow of history (Snow, 2016). Ideas are the first stage of ICE, where the practitioner asks the patient to say what they think the problem is or what is causing the symptoms (Freilich et al, 2019). These questions allow the health professional to see what is on the patient's mind and can provide a starting point for diagnosis. The next logical step is to ask patients about their concerns. Patients can be complex with multiple health problems, so do not assume that their concern is straight forward or matches their ideas. For example, a patient who thinks they might have irritable bowel syndrome (IBS) may be more worried about bowel cancer. It is the practitioner's role to set the patient at ease, so they feel able to speak openly. This is where good communication skills come in, as clear communication and showing empathy can reduce a patient's anxiety about the consultation and presenting complaint (Allen, 2021). The third and final step is to ask patients about their expectations to highlight what they want from the consultation (Freilich et al, 2019). For example, are they expecting blood tests, scans or medication? Although using the ICE framework may sometimes feel like you are going off on a tangent, understanding what the patient expects can help with diagnosis and management, as well as make planning easier. Medical history Once ICE is complete, resume the sequence with a general medical history. This can sometimes be difficult to obtain, as patients often forget or do not consider it relevant to their current complaint (Fisher, 2016). In this case, closed questions can be helpful (Box 4). Where patients cannot answer some of your questions, you can check their medical history by accessing their healthcare records (Abdelrahman and Abdelmageed, 2014). Box 4. Taking a medical history: example of closed questions General Have you ever been admitted to hospital? Have you got anything inside your body you were not born with? Specific Do you have diabetes? Do you have high/low blood pressure? Medications Another part of taking an effective history is to establish what medications patients are already taking. This requires a comprehensive list of prescribed medicines and doses to be identified and discussed. Remember, just because the patient has been prescribed a drug does not mean they are taking it. Likewise, do not assume a patient who collects a prescription every month is complying with the prescribed dosage. Ask the patient directly about this, as it reduces the risk of false information clouding your diagnosis. As well as prescription drugs, ask the patient what over-the-counter medications they might be taking and at what dose (Knott, 2021). Do not forget to enquire about vitamins or herbal supplements, as these may also have potential side-effects or contraindications with prescribed medications (Tatum, 2021). It may also be appropriate to ask about illicit drugs, but make sure you do this in a non-judgmental way. The next step is to ask about allergies. Do not limit this to drug allergies, as all potential allergens need documenting. It is important the patient understands the difference between allergies and intolerance, as normal side-effects to a medicine can sometimes be mistaken for an allergy when it is an intolerance. "Many health professionals feel the need to fill the silence to prevent feelings of awkwardness. Exercise patience and refrain from doing this, as 'intentional silence can be used to enhance the therapeutic relationship between nurse and patient'" Family history Family history is not always needed, but it is good practice to ask about it in case it could be relevant to the presenting complaint. Some patients may have no idea of their family history; for example, if they are adopted or estranged from their biological parents. Social history Social history includes lifestyle or environmental factors that may increase a patient's risk of disease or affect an existing diagnosis. Box 5 shows factors to consider when asking about social history. Which are relevant depends on the patient and the presenting complaint, so use your clinical judgement. An obvious example is the question of whether it is appropriate to ask a child about alcohol and smoking – this will largely depend on their age. Certain questions may be distressing for some patients, so be sure to convey to patients why you are asking them and how it will help your assessment and diagnosis. Box 5. Lifestyle factors Alcohol consumption Smoking Support – family/friends Occupation Recent travel history Review systems After reviewing the patient's history, the final part of the sequence before the summary is to review bodily systems not covered in the first presenting complaint. Table 3 shows a list of symptoms from the main bodily systems that might be appropriate to use. It should be noted that this is not an exhaustive list, nor is it necessarily appropriate to go through them all. It depends on the presenting complaint and the patient. Summary Once you have completed the history, it is helpful to repeat back to the patient the timeline of events and information obtained. This enables you to check whether the information is accurate and has been interpreted correctly, as well as highlighting any further or missing details. You may also find it helpful to review the ICE framework, if used. The summary can lead to the patient's questions. If you are not sure of the answers, tell them you don't know and will get back to them with more information. Do not give patients false hope, do not answer questions unless you can answer those questions with absolute certainty. Conclusion History taking is a logical and systematic approach to the collection of personal and healthcare information, but the approach still needs to be patient-centered and where possible include patient ideas, concerns and expectations. Use of ICE and the SOCRATES framework provides health professionals with a simple structure to follow, both for asking questions and documenting medical history consultations. The next article in this series will explore how to assess older people for frailty Also in this series This series is aimed at nurses and midwives working at or towards advanced practice. Advanced practitioners are educated at masters level and are assessed as competent to make autonomous decisions in assessing, diagnosing and treating patients. Advanced assessment and interpretation is based on a medical model and the role of advanced practitioners is to integrate this into a holistic package of care. Professional responsibilities - Only undertake this procedure after appropriate training, supervised practice and competency assessment, and by following local policies and protocols References Abdelrahman W, Abdelmageed A (2014) Medical record keeping: clarity, accuracy, and timeliness are essential. BMJ; 348: f7716. Abe T et al (2022) Tailored opening questions to the context of using medical questionnaires: qualitative analysis in first-visit consultations. 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Tatum M (2021) Supplements versus medicines: untold interactions and the dangers they can pose. pharmaceutical-journal.com, 5 August (accessed 13 February 2024). Help Nursing Times improve Help us better understand how you use our clinical articles, what you think about them and how you would improve them. Please complete our short survey. Taking a history from a patient is a skill necessary for examinations and afterwards as a practicing doctor, no matter which area you specialise in. It tests both your communication skills as well as your knowledge about what to ask. Specific questions vary depending on what type of history you are taking but if you follow the general framework below you should gain good marks in these stations. This is also a good way to present your history.In practice you may sometimes need to gather a collateral history from a relative, friend or carer. This may be with a child or an adult with impaired mental state.Procedure StepsStep 01Introduce yourself, identify your patient and gain consent to speak with them. Should you wish to take notes as you proceed, ask the patients permission to do so.Step 02 - Presenting Complaint (PC)This is what the patient tells you is wrong, for example: chest pain.Step 03 - History of Presenting Complaint (HPC)Gain as much information you can about the specific complaint.Sticking with chest pain as an example you should ask:Site: Where exactly is the pain?Onset: When did it start, was it constant/intermittent, gradual/ sudden?Character: What is the pain like e.g. sharp, burning, tight?Radiation: Does it radiate/move anywhere? Associations: Is there anything else associated with the pain, e.g. sweating, vomiting.Time course: Does it follow any time pattern, how long did it last?Exacerbating / relieving factors: Does anything make it better or worse?Severity: How severe is the pain, consider using the 1-10 scale?The SOCRATES acronym can be used for any type of pain history.Step 04 - Past Medical History (PMH)Gather information about a patients other medical problems (if any).Step 05 - Drug History (DH)Find out what medications the patient is taking, including dosage and how often they are taking them, for example: once-a-day, twice-a-day, etc.At this point it is a good idea to find out if the patient has any allergies.Step 06 - Family History (FH)Gather some information about the patients family history, e.g diabetes or cardiac history. Find out if there are any genetic conditions within the family, for example: polycystic kidney disease.Step 07 - Social History (SH)This is the opportunity to find out a bit more about the patient's background. Remember to ask about smoking and alcohol. Depending on the PC it may also be pertinent to find out whether the patient drives, e.g. following an MI patient cannot drive for one month. You should also ask the patient if they use any illegal substances, for example: cannabis, cocaine, etc.Also find out who lives with the patient. You may find that they are the carer for an elderly parent or a child and your duty would be to ensure that they are not neglected should your patient be admitted/remain in hospital.Step 08 - Review of Systems (ROS)Gather a short amount of information regarding the other systems in the body that are not covered in your HPC.The above example involves the CVS so you would focus on the others.These are the main systems you should cover:CVSRespiratoryGINeurologyGenitourinary/renalMusculoskeletalPsychiatryPlease note these are the main areas, however some courses will also teach the addition of other systems such as ENT/ophthalmology.Step 09 - Summary of HistoryComplete your history by reviewing what the patient has told you. Repeat back the important points so that the patient can correct you if there are any misunderstandings or errors.You should also address what the patient thinks is wrong with them and what they are expecting/hoping for from the consultation. A useful acronym for this is ICE [I]deas, [C]oncerns and [E]xpectations.Step 10 - Patient Questions / FeedbackDuring or after taking their history, the patient may have questions that they want to ask you. It is very important that you don't give them any false information. As such, unless you are absolutely sure of the answer it is best to say that you will ask your seniors about this or that you will go away and get them more information (e.g. leaflets) about what they are asking. These questions aren't necessarily there to test your knowledge, just that you won't try and 'blag it'.Step 11When you are happy that you have all of the information you require, and the patient has asked any questions that they may have, you must thank them for their time and say that one of the doctors looking after them will be coming to see them soon.This guide is designed for students and doctors. If you are applying for medical school and would like more information on the UCAT please check out our complete guide and our guide on how to practice for your exam. We've also prepared a UCAT Practice Test to help you prepare for the exam.