History taking sequence: The basics

Below is a concise way to take a relevant history of a patient, in a succinct way. For more information, refer to Talley and O Connor (full version) pp: 2 – 13.

Personal Information

- Name, sex, *DOB, address*? Date time of examination?

Presenting Principal Symptom (PS)

- Record each presenting symptom (with idea of main symptom) mostly in patient's own words (avoid tech information).

History of presenting illness (HPI)

- Story of each symptom in chronological order
- Current symptoms:
    - When did you notice the symptom? Have you had a similar episode in the past? Is this symptom that brought you here to see the doctor?
    - When did symptom come rapidly/gradually/instantaneously? Continuous/on and off? Symptom getting worse/better, if so – when did it change? What were you doing at time symptom began?
    - Where is the symptom exactly (point)? Localised or spreading? Radiating symptom (mainly pain)?
    - Can you describe the symptom for me?
    - How would you rate the symptom (i.e.: pain) – mild, moderate, severe? Does it interfere with your daily duties / sleep?
    - Aggravating or reliefing factors? Is there anything that makes the symptom worse or better?
    - Associated symptoms? Are there any other symptoms that you have experienced in relation to the presenting complaint?
    - Have you had similar episodes at any time in the past? How similar/dissimilar was the episode to this current one?
- Current treatment/drug history:
    - Are you on any medication at the moment? Dose? What was it given for? How long have you been on it for? (Clue as to other problems missed above) Have you experienced any side effects, allergies?
    - Can you remember any other medications that you might have forgotten? Any natural remedies? Anything that you bought over the counter, without a doctor's prescription (eg: aspirin, vitamins etc)
    - Have you been on any other treatment apart from medicines (eg: physiotherapy, rehab etc).
- Sexual History (for abdominal pain, urethral discharge, dysuria, vaginal discharge, genital ulcer, rash, pain on intercourse, ano rectal symptoms, AIDS, hepatitis is suspected):
    - Last date of intercourse? Number of contacts? Homosexual/bisexual? Prostitute contact? Type of sexual practice?
- Menstrual history (in all case this should be taken, esp: ab pain, endocrine disease, genital problems)
    - Date of last menstrual period? When did menstruation begin (approx)? Are your periods regular, menopause occurred? Are your symptoms related to the period at all? If woman is of child bearing age, rule out possibility of pregnancy?

- Impact of illness:
    - What effect has/have the symptoms had on your life? What effect has the illness had on your life?

Past History

- Past illnesses
    - Have you had any serious illnesses, operations, or admissions to the hospital in the past (include childhood illnesses, if female: obstetric or gyn problems)? What symptoms did you experience, how were you treated, what tests were performed?

Social History

- Where were you born? Ethnic background (don't ask, but take note and confirm)?
- Present occupation (if any) / Education? (Note specifically work exposure to dust, chemicals, disease). Any hobbies (pets etc)
- Have you ever smoked before, if so – how many cigarettes a day, for how long? Have you ever had recreational drugs before, what when, how long,?
- Do you drink alcohol? What type of alcohol, how much, how often?
    - Diagnosis of alcoholism:
        - CAGE questions (thought of cut down? Have people annoyed you over your drinking? Have you felt guilty? Have you had eye opener, drink in mornings to feel better?
- If infectious disease is possibility, have you been overseas lately? Living conditions while away, describe? Immunisation status of patient, any prophylactic treatment prior to travel?
- Marital status? Who is living at home, any with you, living alone? Health of people living at home? Exercise?
- Elderly patients:
    - ADL? Bathe, walk, eat, dress, need help? What do they do about it?

Family History

- Any history of similar illness in family? Any history of major illnesses in family, cause of death, how old?

Systems Review

If other symptoms apart from presenting complaint is made, ask about these symptoms. If they are to do with other systems, then ask about each symptom in accordance with the above guidelines. A combination of symptoms may often lead to a correct confirmed diagnosis, even though the presenting complaint gives it away.

Don't forget to thank the patient for their time and that you appreciate it.