CONSULTATION, MEDICAL HISTORY AND RECORD-TAKING

The ability to take an accurate medical history from a patient is one of the core clinical skills and an essential component of clinical competence. The success of the medical consultation depends not only on the doctor’s clinical knowledge and interview skills but also on the nature of the relationship that exists between doctor and patient. Patients need to feel sufficiently at ease to disclose their problems and express their concerns, and to know they have been understood by the doctor. Patients also need to reach a shared understanding with the doctor about the nature of their illness and what is proposed to deal with it.

In any consultation the doctor has a number of tasks to perform. Ideally these should be undertaken in a structured way so as to maximise the efficiency and effectiveness of the process. A number of consultation models exist but an increasingly influential model is the Calgary-Cambridge approach. This identifies five main stages in a consultation within a framework which provides structure and emphasises the importance of building a good doctor–patient relationship. The stages are:

• initiating the session
• gathering information
• physical examination
• explanation and planning
• closing the session

This chapter primarily addresses the first two stages – initiating the session and gathering information. In addition it describes an approach to recording information from the consultation in the clinical record.
INTERVIEWING TECHNIQUES AND HISTORY-TAKING

The medical consultation is the main opportunity for the doctor to explore the patient’s problems and concerns and to start to identify the reasons for the patient’s ill health. Models of history-taking are becoming more patient-centred and seeking to assess both main components of ill health – the biomedical component and the psychosocial component.

STARTING THE CONSULTATION

There are three main aspects to initiating the session: preparation, establishing initial rapport, and identifying the patient’s problems/concerns.

Preparation

In preparing for a consultation, you should plan for an optimal setting – ideally a location that is quiet and free from interruption. Most patients have clear expectations of what constitutes appropriate dress and appearance. Given this, you should adopt a dress code which projects a professional image and allows patients to feel comfortable in your presence. This may vary according to setting and patient group.

Initial rapport

On first meeting a patient it is important to establish rapport and put the patient at ease. You should greet the patient, introduce yourself and clarify your role, giving the patient an outline of what you intend to do. The first contact should also be used to obtain/confirm the patient’s name, and to check how the patient prefers to be called.

Identifying the patient’s problems and concerns

Begin by asking patients to outline their problems and concerns by using an open-ended question (e.g. ‘Tell me what has brought you to the doctor today’). Remember patients may have more than one concern they wish to raise and discuss. The order of their problems may not relate to their importance from either the patient’s
or doctor’s perspective. It is therefore particularly important in this opening phase not to interrupt the patient in case this inhibits the disclosure of important information.

Once the problems have been identified it is worth taking some time to check that you have understood correctly by summarising and repeating back to the patient. It is also good practice to check for additional concerns: ‘Is there anything else you would like to discuss?’.

GATHERING INFORMATION – THE HISTORY

Exploration of the patient’s problems

You now need to explore each of the patient’s problems in greater detail from both biomedical and psychosocial perspectives. In doing so you should seek to avoid medical jargon, combine both open and closed questions, and summarise your understanding of the patient’s problems (this allows the patient an opportunity to check you have understood correctly).

Biomedical perspective

Questions on the biomedical perspective should seek to clarify the sequence of events and help inform an analysis of the cause of the symptoms. Symptoms from an organ system have a typical location and character: chest pain may arise from the heart, lungs, oesophagus or chest wall but the localisation and character differ. Establish the location of the symptom, its mode of onset, its progression or regression, what it feels like, and aggravating or relieving factors. Enquiry should also be made about associated symptoms.

Symptoms and signs

Five fundamental questions you are trying to extract for the history

- From which organ(s) do the symptoms arise?
- What is the likely cause?
- Are there any predisposing or risk factors?
- Are there any complications?
- What are the patient’s ideas, concerns and expectations?
For the assessment of pain, use the framework shown in the box above. Ask whether medication has been necessary to alleviate the pain and whether the pain interferes with work or other activities. It is difficult to assess pain severity. Offering a patient a numerical score for pain, from ‘0’ for no pain to ‘10’ for excruciating pain, may provide a quantitative assessment of the symptom.

### Psychosocial perspective

Information on psychosocial perspectives of a problem requires questions to be asked about a person’s ideas, concerns, expectations and the effect of the problem on his or her life. For example, if you wanted to explore a patient’s psychosocial perspectives of headaches, potential questions include: ‘What concerns you most about the headaches?’, ‘What do you think is causing the headache?’, ‘Is there some specific treatment you had in mind?’, and ‘How do the headaches affect your daily life?’.

Combining information on psychosocial perspectives with biomedical information aids diagnosis and helps to provide a foundation for decisions about the future management of a problem.

### Background information

The information that is gathered about a patient’s problems needs to be set in the context of the individual. Contextual information

<table>
<thead>
<tr>
<th>Symptoms and signs</th>
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<tbody>
<tr>
<td><strong>Pain assessment</strong></td>
</tr>
<tr>
<td>• Type</td>
</tr>
<tr>
<td>• Site</td>
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<tr>
<td>• Spread</td>
</tr>
<tr>
<td>• Periodicity or constancy</td>
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<td>• Relieving factors</td>
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<td>• Exacerbating factors</td>
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<tr>
<td>• Associated symptoms</td>
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</tbody>
</table>
requires enquiry into a person’s family history, personal and social history, past medical history and drug and allergy history.

### Family history

Ask about any disorders that might be inherited, social partnerships (e.g. does the patient have a regular partner, is the patient married) and children. It may be helpful to construct a family tree (Fig. 1.1).

![Fig. 1.1 A standard family tree.](image-url)
Personal and social history

Enquire about education, employment (past and present – is there suspicion of exposure to an occupational hazard?), social support networks, home circumstances (does the patient live alone? Can the patient attend to his or her personal needs – bathing, cooking? Are there financial worries?).

Also at this point ask about tobacco and alcohol.

TOBACCO CONSUMPTION

Ask patients what form of tobacco they consume and for how long they have been smoking. If they previously smoked, when did they stop and for how long did they abstain?

ALCOHOL CONSUMPTION

Alcohol history is often inaccurate and the tendency is to underestimate intake. Calculate the amount in units. Certain questions may reveal dependency without asking the patient to specify consumption. Ask whether they ever drink alone or during the course of the day as well as the evenings. Do they have days without alcohol? Has anyone ever expressed concern about their drinking? Have they ever failed to do what was expected of them because of their drinking?

Symptoms and signs

Units of alcohol equivalents (approximate)

1 unit is equal to:
- 1/2 a pint of beer
- 1 glass of sherry
- 1 glass of wine
- 1 standard measure of spirits

FOREIGN TRAVEL

Ask the patient if he or she has been abroad recently. If so, determine the countries visited and exposure to risk factors.
Past medical history

Patients recall their medical history with varying degrees of detail and accuracy. You can jog a patient’s memory by asking if he or she has ever been admitted to hospital or undergone a surgical procedure. If the patient mentions specific illnesses or diagnoses, explore them in detail rather than accepting them verbatim.

Drug history

As well as prescribed medication ask about non-prescription medicines: e.g. non-steroidal anti-inflammatory drugs (NSAIDs) commonly cause dyspepsia, codeine-containing analgesics cause constipation. Ask about and list any drug allergies. Ask the patient about the use of illicit drugs.

SYSTEMS REVIEW

A systems review can provide an opportunity to identify symptoms or concerns that the patient may have failed to mention in the history so far. Develop a routine that helps to avoid missing out a particular system.

Epstein et al, 978-0-7234-3465-8
CARDIOVASCULAR SYSTEM
- Chest pain
- Dyspnoea
- Ankle swelling
- Palpitations

RESPIRATORY SYSTEM
- Cough
- Haemoptysis
- Wheezing
- Pain

GASTROINTESTINAL SYSTEM
- Change in weight
- Abdominal pain
- Vomiting
- Flatulence and heartburn
- Dysphagia
- Bowel habit

GENITOURINARY SYSTEM
- Frequency
  Summarise the findings as a ratio: \( \frac{\text{Day}}{\text{Night}} = \frac{6 - 8}{0 - 1} \)
- Pain
- Altered bladder control
- Menstruation
- Sexual activity

NERVOUS SYSTEM
- Headache
- Loss of consciousness
- Dizziness and vertigo
- Speech and related functions
- Memory

CRANIAL NERVE SYMPTOMS
- Vision
- Diplopia
- Facial numbness
- Deafness
- Oropharyngeal dysphagia
- Limb motor or sensory symptoms
- Loss of coordination

ENDOCRINE HISTORY
- Diabetes mellitus (polydipsia, polyuria)
- Thyroid

MUSCULOSKELETAL SYSTEM
- Bone or joint pain?
- Swelling, tenderness, redness?
- Single joint or more diffuse?

SKIN
- Rashes?
- Itching?
- Chemicals or cosmetics?
PARTICULAR PROBLEMS

THE PATIENT WITH DEPRESSION OR DEMENTIA

There is some logic in coupling these clinical problems. In both cases the patient can appear withdrawn and uncommunicative. Determine whether or not there has been any suicidal intent. When depression or dementia interferes with history-taking, it is crucial to involve family, friends and carers in the assessment.

THE HOSTILE PATIENT

A patient may be hostile or angry for a number of reasons. The reaction may have a biomedical cause or reflect psychosocial origins such as anxiety or anger at being ill. If a patient is hostile to your attempts to take a history, you may wish to conclude the interview.

Examination of elderly people

History-taking

There are special problems when recording a history from elderly patients. Consider the following.

Hearing loss
- Common in the elderly
- May be helped by hearing aid
- Important to speak clearly and slowly
- Face the patient and avoid extraneous sound
- If necessary, write questions in bold letters

Visual handicap
- Cataracts, glaucoma and macular degeneration are common in the elderly
- Ensure the room is well lit
- Engage an assistant or carer to help patients move in and out of the consulting room and examination area

Dementia
- Often occurs in patients who appear physically fit
- Forgetfulness, repetition and inappropriate answers characterise responses
- Family members, friends and carers often note the development of dementia
Alternatively you may feel it reasonable to question the patient gently about the anger and use the encounter to recreate trust and confidence.

**RECORDING THE MEDICAL INTERVIEW**

Almost every encounter between doctor (or student) and patient involves recording information. The medical record chronicles the patient’s medical history from the first illness through to death. It is a multi-authored document which may follow the patient whenever he or she moves home. There is an onus on the author of each medical entry to recognise the historical importance of each record and to ensure that the entry conveys a clear and accurate account which can be easily understood by others.

The medical record has other uses: it is the prime resource used in medical audit, a practice widely adopted for quality control in medical practice, and it provides much of the evidence used in medicolegal situations; under judicial examination, your professional credibility relies solely on the medical record if your memory fails. Medical records are also a valuable source of data for research. There are a number of different approaches to clinical record-keeping. The problem-orientated medical record (POMR) is one widely accepted framework for both standardising and improving the quality of medical records. Whilst it is probably more widely used in hospital practice rather than general practice and there is also an increasing use of computers to record medical interviews with software packages that provide a rigid template for recording
consultation notes, many of the principles underlying the POMR can give useful insights and guidance to those learning about how to maintain good medical records.

**PROBLEM-ORIENTATED MEDICAL RECORD**

The POMR provides a framework for standardising the structure of follow-up notes (Fig. 1.2); this stresses changes in the patient’s symptoms and signs and the evolution of clinical assessment and management plans. The POMR also provides a flow sheet that records sequential changes in clinical and biochemical measurements.

**The history**

The history guides the patient through a series of questions designed to build a profile of the individual and his or her problems. By the end of the first interview you should have a good understanding of the patient’s personality, social habits and clinical problems. You will have considered a differential diagnosis that may explain the patient’s symptoms.

**The examination**

The examination may confirm or refute a diagnosis suspected from the history and by adding this information to the database you will be able to construct a more accurate problem list.

![Fig. 1.2 Structure of the problem-orientated medical record (POMR).](image-url)
## Setting up the problem list (Fig. 1.3)

Divide the problems into those that are active (or require active management) and those that are inactive (problems that have resolved or require no action but may be important at some stage in the patient’s management).

Your entries into the problem list may include established diagnoses (e.g., ulcerative colitis), symptoms (e.g., dyspnoea), psychosocial concerns (e.g., concern that he will die of colon cancer like his brother), physical signs (e.g., ejection systolic murmur),

### Initial problem list

<table>
<thead>
<tr>
<th>No.</th>
<th>Active problems</th>
<th>Date</th>
<th>Inactive problems</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>jaundice (Jan ‘07)</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>anorexia (Dec ‘06)</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>weight loss</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>recurrent rectal bleeding</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>smoking (since 1980)</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>unemployed (Nov ‘06)</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>stutter</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>brother died of colon cancer – patient concerned he may have similar condition (Dec ‘06)</td>
<td>9/1/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>duodenal ulcer (1996)</td>
<td></td>
<td></td>
<td>9/1/09</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
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</tbody>
</table>

**Fig. 1.3** Problem list entered on 9 January 2009.
laboratory tests (e.g. anaemia), psychological and social history (e.g. depression, unemployment, parental or marital problems) or special risk factors (e.g. smoking, alcohol or narcotic abuse). The problem list is designed to accommodate change; consequently, it is not necessary to delete an entry once a higher level of diagnosis (or understanding) is reached. The list should be under constant review to ensure that the entries are accurate and up to date.

### Initial problem-related plans

By constructing the problem list so it should be reasonably easy to develop a management plan by considering four headings:

- **Diagnostic tests (Dx)** Write differential next to each problem. Construct a logical flow of investigations by considering bedside tests, side ward tests, plain radiographs, ultrasound, blood tests and specialised imaging examinations.

- **Monitoring tests (Mx)** Consider whether a particular problem can be monitored. Document the appropriate tests and the frequency with which they should be performed.

- **Treatment (Rx)** If drug treatment is indicated, note the drug and dosage.

- **Education (Ed)** Patients are able to cope better with their illness if they understand its nature, its likely course and the effect of treatment. It is important to share information and involve people in decisions.

### Progress notes

The POMR provides a disciplined and standardised structure to follow-up notes:

- **Subjective (S)** Record any change in the patient’s symptoms.

- **Objective (O)** Record any change in physical signs and investigations that may influence diagnosis, monitoring or treatment.

- **Assessment (A)** Comment on whether the information has confirmed or altered your assessment plans.

- **Plans (P)** Consider whether any modification of the original plan is needed.

### Flow charts

A flow sheet is convenient for recording these data in a format that, at a glance, provides a summary of trends and progress (Fig. 1.4). Graphs may be equally revealing (Fig. 1.5).
Clinical notes contain confidential information and it is important that you protect this confidentiality. Ensure that there is control over access to the medical record and that only individuals directly involved in the patient’s care read or write in the notes. Computerised notes should be password-protected.
Fig. 1.5 Example of the use of a graph to illustrate changes in bilirubin levels following acute type A hepatitis.

Review
The history

- Welcome
- Note the patient’s body language
- Begin with an open-ended question
- Take a history of the presenting complaint(s); use closed questions to answer the following:
  – which organ system?
  – likely cause?
  – predisposing factors?
  – complications
- Social history
- Medical history
- Education
- Employment
- Medicines, drugs and tobacco
- Alcohol consumption
- Foreign travel
- Home circumstances
- Family history
- Systems review
  – cardiovascular
  – respiratory
  – gastrointestinal
  – genitourinary
  – nervous
  – endocrine
  – musculoskeletal
  – skin and hair