Section 1
HISTORY TAKING AND GENERAL EXAMINATION

History taking
General examination
History taking

DAVID SNADDEN • ROBERT LAING • GEORGE MASTERTON • NICKI COLLEDGE

Talking with patients
Patient participation
Beginning
Starting the consultation
Listening
Exploring your patient’s context
Sharing information
Situations which influence communication

The presenting complaint
Diagnosis
Pain
Past history
Drug history
Compliance/concordance
Drug allergies/reactions
Family history
Social history
Occupational history
Travel history
Sexual history
Tobacco
Alcohol
Illicit drug use
Systematic inquiry
Completing the history taking
Key points

The psychiatric history
History
Content
Risk assessment
Sensitive issues
Premorbid personality
Other sources of information
Physical examination
Mental state examination
Appearance
Behaviour
Speech
Mood
Thought content
Perception
Cognitive functions
Insight
Psychiatric rating scales
Therapeutic role of the psychiatric interview
Key points

Documenting the findings – the case notes
Computer records
Clinical coding
Confidentiality
Key points
People visit doctors for many reasons. Sometimes it is because something unexpected and catastrophic has happened to them, but usually it is because of an ongoing problem, a relatively minor complaint or because something ‘isn’t right’. Before coming to the doctor they may have spoken to family or friends, tried remedies suggested by them, spoken to other health professionals, e.g. pharmacists, or complementary practitioners, or may have found information on the internet and brought this with them. Their decision to go to a doctor may only have been made after these attempts to explain or heal their illness or problem have been unsuccessful. By the time they have reached a doctor most patients have formed some idea of what might be wrong with them and will have worries or concerns that they need to talk about.

The general practitioner (GP) or family doctor is usually the first point of contact. Even a straightforward visit can be a big event for patients. They have to decide to go, usually make an appointment, work out what they are going to say and may have to arrange time off work or for child care. They then have to sit in a waiting room. This is an almost universal human experience; think about how it affected you the last time you had to do this. Things can become even more perplexing if the visit is to a hospital outpatient department or part of a hospital admission when their anxiety and apprehension can get worse as this is where ‘serious’ things happen. Whatever the cause, patients are seeking explanation and meaning for their symptoms. Whatever the setting, the doctor needs to try to work out why patients are there, what they are most concerned about and to agree with them the best course of action. The first and major part of that is talking with the patient (Table 1.1). If you listen carefully they will probably tell you what is wrong with them, will certainly tell you what is concerning them, and the physical examination will help you to confirm this or not. Communication is integral to the clinical examination and is most important at the beginning to gather information, and at the end to share information and engage your patients in their management.

### Patient participation

Good communication is essential in good patient care; it supports the building of trust between doctor and patient and helps you provide clear and simple information that improves health. This allows you and the patient to understand each other and agree goals together which suit each individual patient. Communication is much more than ‘taking a history’, it is an integral and important part of looking after patients and is the only way they can be involved effectively in their health care. Poor communication leads to misunderstanding, conflicting messages and patient dissatisfaction and is the root cause of many subsequent complaints and litigation.

### Beginning

That all sounds very well but how do you do it? (Table 1.2)

Our personal experience of illness is unique and often difficult or embarrassing to explain. To make this easier for your patient consider the following.

**Where will you see your patient?**

Ideally in a quiet, private space. This is usually easy in a GP surgery, but often difficult in hospital. In hospital outpatient departments nurses or students are often present, and in hospital wards privacy is often only afforded by curtains – which means no privacy at all. You must be sensitive to your patients’ privacy and dignity in all circumstances. If you are seeing the patient in a room and have others with you, for example junior colleagues, introduce them and ask permission for them to be there. If your patient is in a

<table>
<thead>
<tr>
<th><strong>1.2 BLISS: the stages of the consultation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beginning</strong></td>
</tr>
<tr>
<td>Preparation</td>
</tr>
<tr>
<td>Setting</td>
</tr>
<tr>
<td>Introductions</td>
</tr>
<tr>
<td><strong>Listening</strong></td>
</tr>
<tr>
<td>Problems</td>
</tr>
<tr>
<td>Ideas</td>
</tr>
<tr>
<td>Concerns</td>
</tr>
<tr>
<td>Expectations</td>
</tr>
<tr>
<td>Clarify, summarize, context</td>
</tr>
<tr>
<td><strong>Information gathering</strong></td>
</tr>
<tr>
<td>Systematic enquiry</td>
</tr>
<tr>
<td>Clinical examination</td>
</tr>
<tr>
<td><strong>Sharing information</strong></td>
</tr>
<tr>
<td>Chunk it</td>
</tr>
<tr>
<td>Check it</td>
</tr>
<tr>
<td>Share decisions</td>
</tr>
<tr>
<td><strong>Setting goals</strong></td>
</tr>
<tr>
<td>Ending</td>
</tr>
<tr>
<td>Follow-up</td>
</tr>
</tbody>
</table>
hospital bed but can get up, a side room or interview room may be used. Often there is no alternative to speaking to patients at their bedside, so let them know that you understand that your conversation may be overheard and give them permission not to answer sensitive things if they feel too uncomfortable about it.

**How long will you have?**

Consultation length varies. In general practice in the UK the average length is 10 minutes. This is usually adequate as the doctor may have seen the patient on several occasions and know the family and social background. In hospital 5–10 minutes may be adequate for return outpatients, but for new and complex problems much longer – 20–30 minutes – may be needed. If you are a student learning to talk with and examine patients allow 30 minutes at least. Plan your time around how long you expect your patients to take so that others are not kept waiting, and be prepared to be flexible.

**How will you sit?**

Arrange the seating in a non-confrontational way. If you use a desk, arrange the seats at the corner of the desk. This is less formal and helps communication (Fig. 1.1A, B). If you use a computer make sure the screen and keyboard do not get in the way or provide a distraction. Turn away from the screen to talk to your patient. If you are in a ward, pull up a chair and sit level with your patient (Fig. 1.1C). It is important that you can see your patient easily and gain eye contact.

**Non-verbal communication**

First impressions are important. Your demeanour, attitude and dress influence your patient from the outset. At all times you need to be professional in dress and behaviour. This does not mean you need to be formal, but you must be neat, clean and polite. Showing concern for your patient’s situation is important.

Pick up non-verbal cues from your patients. Are they distressed? What is their mood like and how do their demeanour and body language change during the consultation? This gives clues to difficulties they are having that they cannot express verbally. If people are getting uncomfortable during a line of questioning their body language may become ‘closed’, i.e. they may cross their arms and legs and fail to keep eye contact.

**Starting the consultation**

Before starting, make sure you are talking to the correct patient. Introduce yourself, as your patients should know who you are and what you do. If you are in training, tell
HISTORY TAKING

them, as patients are usually eager to help. It helps to create a
good impression if you appear to have prepared to see
them. Look at the patient records and at any transfer or
admission letters before the consultation. It is easier to give
your patient your attention if you do not write notes during
the consultation, but you may have to write some things,
e.g. blood pressure readings or family trees, which are easily
forgotten. If you are going to take notes let your patient
know.

Throughout this part of the chapter there are examples
of a doctor and a patient talking with each other. These are
only illustrations, not hard and fast rules. Remember that it
is the principles of communication that are important. If you
get the principles right, then the words you use will change
depending on the situation. To begin with, here are a few ideas
on how to get an interview going.

Good morning Mrs Jones, I have got the right person
haven’t I? I am Mr Brown. I am a fourth year medical
student. I’ve been asked if I could come and talk to you and
examine you as you have just come into the ward today. Is
that OK?
It might take me 20–30 minutes if that is alright with you.
I would like you to tell me what has been happening and
then I’ll want to ask a few questions and examine you.
I see that you can’t really get out of bed so I am afraid we’ll
need to talk here. I’ll pull the screens round, but I’m sorry it
is not that private, so if I ask you anything that you don’t
want to tell me in case others hear then just say so.
Because I’ll have to get quite a bit of information from you,
i’ll need to make a few notes. I hope that is alright because
I’ll forget otherwise. Now if I am writing things down it
doesn’t mean I’m not listening to you, I still will be.
Are you happy with all that?

Listening
The patient’s own story is vital. Ask patients to tell you
what has happened to bring them into the hospital, or, if
in the community, try ‘How can I help you today?’ or ‘What
has brought you along to see me today?’ Patients know
doctors are busy and most will tell you their problem within
1–2 minutes so do not interrupt.
This first stage is ‘active listening’. This means
encouraging patients to talk by looking interested, making
encouraging comments or noises, e.g. ‘tell me a bit more’
or ‘uhuh’, and giving them the impression that you have
time for them. Active listening is used to gather information.
Also, it allows them to tell their story in their own words.
This might not make complete sense to you, so you may
have to ask for ‘clarification’. To do this ask them to explain
a bit more about their symptoms. You can also tell them
what you think they have said and ask if your interpretation
is correct.

Can we start with you telling me what has happened to
bring you into hospital? (Opening)
Well doctor, I have been getting this funny feeling in my chest
over the last few months. It’s been getting worse and worse till it
got to the point today I had to call my GP and he sent me in. It
was really awful this morning, I got really breathless and felt
someone was standing on me.
Tell me a bit more about the feeling in your chest. (Open questioning)
Well it was here, across my chest, it was sort of tight and I was
sweaty.
And did it go anywhere else? (Clarifying)
No, well maybe up here in my neck a bit.
So what you are saying is that you had this pain in your chest this morning that went on a long time – how long do you think? (Summarizing and clarifying)
Oh, a couple of hours.

And the pain was tight and up into your neck. How is it
now? (Open questioning)
Oh it is not bad, the injections I had seem to have put it away.
OK, now you said that you had had the pain for the last
few months. Can you tell me more about that? (Open questioning)
Well it was the same but not that bad, though it has been
getting worse recently.
OK, can you remember when it first started? (Clarifying)
Oh 3 or 4 months ago.
And how often has it been coming? (Open questioning)
To start with just now and again, but in the last 2 to 3 weeks,
probably every day anyway.
Does anything makes it worse? (Open questioning)
Well if I go up steps or up hills that can bring it on.
What do you do?
Stop and sometimes take my puffer.
Your what? (Clarifying)
This spray the doctor gave me to put in my mouth.
Can you show me it please?
This spray the doctor gave me to put in my mouth.

Once you have established what has happened, find out the
patient’s ‘ideas’, ‘concerns’ and ‘expectations’.
I Ideas
C Concerns
E Expectations.
Patients will have thoughts and feelings about what has happened to them which may or may not be accurate, but which can help you. For instance, a patient with chest pain might think he has indigestion while you are considering angina. This can cause confusion so ask ‘Do you have any thoughts about what might be happening to you?’ A young mother bringing her child to the doctor with a sore throat may only want reassurance, not medicine. A simple question like ‘What were you thinking I might do today?’ can get surprising answers and avoid unnecessary prescriptions or investigations.

The way you ask a question is important. Open questions encourage the patient to talk. Closed questions seek specific information as part of a systematic inquiry. Both have their place. Open questions usually start with a word like ‘where’ or ‘what’, or a phrase like ‘tell me more about …’, and are more useful at the beginning when you are trying to find out what is going on and to encourage the patient to talk. Closed questions, e.g. ‘Have you been sick today?’ invite yes or no answers.

Exploring your patient’s context

Illness never happens in isolation. The context of our lives has a major influence on how we deal with illness. This can be complex, and finding out the context is a crucial part of gathering information about your patient. Many people call it the ‘social history’, but it is more than this. It allows you to understand the personal constraints and supports available to your patient. Your patient’s context is a mixture of where they live, who they live with, where they work, what they do, their cultural and religious beliefs and their relationships and past experience.

These are sensitive areas to explore. It may not be appropriate to explore all of them with everyone, but they are important in any long-term doctor–patient relationship. Understanding context modifies the information you give and the way you give it, the treatment you advise and the drugs you use.

Establish your patient’s job, and explore in some depth what this job entails as it may have a bearing on the illness. This means you need to find out in detail not only what the job is, but what the patient actually does, whether there are any stresses in the job and whether there are any relationships at work that might affect the patient, e.g. a bullying boss or a harassing colleague.

Clearly, one job description can cover many tasks and you need to understand what your patient actually does. Patient A is under stress and patient B may be suffering the consequences of exposure to fungal spores which can cause farmer’s lung. However, their initial answer to the first question was the same. Just as your patients’ illness can have an influence on their ability to do their job, their job (past or present) may be an influence on their illness. A full occupational history means your patients should tell you what jobs they have done in their working life. Try to find out if any of those could have had an influence on their symptoms (see Occupational history, p. 16).

Find out about their home circumstances. Relationships in modern society are complex, so choose your words carefully; for example ‘Is there anyone at home with you?’ or ‘Is there anyone that can help?’ are useful ways of finding out diplomatically.

You need to be equally tactful in enquiring about relationships and the home environment. For example, if a 15-year-old newly diagnosed diabetic is about to go home you need to know the home circumstances, who is there and whether the relationships are supportive. Different arrangements are made for a patient whose mother is a health worker in a stable home, compared to one from a deprived background, with one parent and poor relationships. The decision to return to work depends on the content of the job, the sympathy and support of the employer and the patient’s financial situation.

Patients’ beliefs influence health care. Religious beliefs affect how a family copes with a disability, a dying relative, or whether some people accept certain treatments, and you need to be sensitive to and tolerant of these issues. Other moral beliefs need to be explored in some situations, e.g. requests for termination of pregnancy.

Now gather information in a more systematic way to clarify any issues and focus on the actual problems. Do this
Sharing information

Clarifying and summarizing

Use the same techniques as at the beginning of your consultation, except now your patient needs to understand your use of words. Clarify and summarize what you say. Set realistic goals to achieve together. Your use of language is vital and you should use words that your patient understands. Tailor your explanation to your patient; you would use very different terms when dealing with a lawyer compared to dealing with a farm labourer.

First explain what you have found and what you think this means. Give important information first and check what has been understood. Put the information into small chunks and warn the patient how many important things are coming. For example ‘There are two important things I want to discuss with you, the first is …’.

Use simple language, if you have to use a term like ‘cancer’, spend time ensuring your patient understands the treatment options and likely prognosis. If the news is bad, ensure you have time for patients to let the news sink in. Suggest they have a friend or relative with them if they wish. Go at your patients’ pace and do not give more information than they want or can handle at any one time. Hearing bad news often blocks patients’ ability to retain any further information so you should arrange follow-up to discuss all their further questions.

Some doctors try to avoid using emotive terms, e.g. cancer, but if you need to give bad news it should be accurate, unambiguous, and given sensitively. There is no place for being abrupt or for brutal honesty. Most people understand the word ‘cancer’, but ‘tumour’ can be interpreted in many ways.

Enabling

Make sure that your patients are involved in any decisions; this is called enabling. Share your own ideas with them, make suggestions and encourage them to contribute their thoughts. Help their decision making by giving written information to take home or suggest other sources of information, e.g. self-help groups or the internet. Check they have understood you and discuss any investigations or treatment you think might be needed, including any risks or side-effects.

In this way negotiate a mutually agreeable plan. For example a patient with cancer may have the choice of surgery or radiotherapy, each of which has different risks and side-effects. It may not be easy to decide, but by involving your patients and discussing with them the pros and cons of treatments you will reach a decision that they understand and agree with. They have to live with the consequences of the treatment, and it is much easier for them to accept if they have had a hand in choosing.

Setting goals

Setting goals allows you and your patient to agree on what you are trying to achieve. These might be areas that your patient needs to work on. For example if patients are trying to stop smoking then you may set goals with them about when they are going to stop, what help they will use, e.g. support groups or nicotine replacement therapy or both, how they will identify risky situations, e.g. socializing, and how to handle these in an effort to avoid being tempted to have a cigarette.

Goals should follow the SMART principle:

S Specific
M Measurable
A Achievable
R Relevant
T Time related.

Outcomes that might be agreed are that you provide discussion of the problem, advice, or reassurance, or that you may advise referral, investigation, or drug treatment.

Finally, you need to arrange for follow-up if necessary, or give patients some idea as to when they might want to return. This depends on how they are feeling and the effects of any treatment you have suggested. End a complex discussion by very briefly summarizing what you have agreed, or ask your patient to summarize for you.

Situations which influence communication

Transference/countertransference

Transference is the process where your patient unconsciously projects on to you thoughts, behaviours and emotional reactions that originate with other significant relationships from childhood onwards. For example, people who are very ill or have just been given some news about a specific diagnosis, the implications of which are overwhelming, may behave in uncharacteristic ways. They might return to a
position of dependency and may seek care and comfort that was absent in their past. If you do not provide this, patients may get very angry. These are difficult concepts, but have a major part to play in any doctor–patient relationship. You cannot avoid transference because it is an unconscious process, but be aware that it is happening.

Recognizing transference helps you to understand unexpected behaviour and to continue to provide care for your patient. Transference can be used positively, to enhance your communication with your patient. Many medical students have had a patient say ‘Oh you are just like my son/daughter’.

Countertransference is where the doctor responds to patients in a way similar to significant past relationships. For example the repeated failure to listen to a patient’s stories of failed relationships may echo experiences in a doctor’s own life. The signs of countertransference are not listening, misjudging your patient’s feelings, repeatedly going over the same story and always running late with the same patient. Self-awareness is the most important way to deal with these issues, which arise at some stage for all doctors.

Empathy

If your patients see you as an empathic doctor it will help your relationship with them, and improve their health outcomes. What is empathy and how do you express it? Empathy is not sympathy, the expression of sorrow; it is much more. It is helping your patients feel that you understand what they are going through. Try to see the problem from their point of view and relate that to them. For example, consider a young teacher who has recently had disfiguring facial surgery to remove a benign tumour from her upper jaw. She has recovered in terms of wound healing, but now has a drooping lower eyelid, and significant facial swelling. She returns to work. Think how you would feel and imagine yourself in this situation. You can express empathy by sensitive questions which show you can relate to your patient’s experience.

... So you have all healed up from your operation now?
Yes – but I still have to put drops in my eye.

And what about the swelling under your eye?
That gets worse during the day, and sometimes by afternoon I can’t see that well.

And how does that feel at work?
Well it is really difficult, you know the kids and everything, it is all a bit awkward.

I can understand that that must make you feel pretty uncomfortable and awkward – that must be very difficult. How do you cope? Thinking about that makes me wonder if there are any other areas that are awkward for you, maybe in the other bits of your life, like the social side ...

Sensitive situations

Doctors have to explore questions of a personal or sensitive nature, or have to examine intimate parts. These need time and care.

If you are talking to a patient who you think may have a sexually transmitted disease, you need to be very sensitive in broaching this subject. First give some indication that you are going to ask questions in this area, and make sure the conversation is entirely private. Here are some examples of questions that might work.

Because of what you are telling me I need to ask you some rather personal questions, is that OK?
Can you tell me if you have had any casual relationships recently?
Are you worried that you might have picked anything up, I mean in a sexual way?
Having told me that you think you are at risk of something, can I ask if you have a regular sexual partner?
Follow this up with ‘Is your partner male or female?’ If there is no regular partner ask how many sexual partners there have been in the past year and how many have been male and how many female.

Use the same sensitivity to seek permission to examine intimate areas. First warn your patients, then seek their permission to examine them and explain what you need to do. Offer a chaperone, and record in the notes if they do not wish this (see Ch. 7).

... So I need to examine you down below since that seems to be where the problem is. I will need to examine you with my hands, I’ll have gloves on. I will also need to look at you down below through a small instrument. Is that OK? It would be helpful if we had a chaperone who can help us. Would that be OK? So while I fetch her could you get undressed behind the screens and I’ll examine you once you are ready?

You also need to give your patients clear instructions about what clothes they need to remove.

There may be times when it is appropriate to delay an intimate examination until sufficient time, appropriate facilities or a chaperone is available.

Difficult situations

Breaking bad news is one of the most difficult communication tasks you will face. Always speak to the patient in a quiet and private environment, ideally, if the patient agrees,
in the presence of a relative or partner and if possible with a nurse or counsellor. Be honest. Do not tell your patients anything that is not true; the truth always emerges over time. Your patients may only wish to know some things, and they may appear not to hear or retain what you tell them. This is called denial and is a normal defence mechanism. Go at your patients’ pace; find out how much more they want to know and continually check their understanding. They will need time to reflect on what you have said and may need to return to see you at another time. They might ask for a prognosis: ‘How long have I got?’ is a common question. Take care with this and never give a specific time – you will usually be wrong. Even in the most difficult circumstances do not take away hope. There is always something that can be done for a patient.

Dealing with emotions

At some point you will encounter angry or distressed patients and relatives who may be crying insconsolably. You may also encounter talkative or over-familiar patients. Illness can bring anger and frustration. Getting angry yourself or ignoring their anger does not help. If you feel angry with your patients, it is likely that they feel angry themselves. Exploring the reasons for this often defuses the situation. Do this by recognizing that your patients are angry and asking them to explain why.

If an apology is needed, give it; it may defuse the situation. Use such phrases as, ‘you seem angry about something’ or ‘is there something that is upsetting you?’ Similarly with other emotions follow the same basic guidance. Recognize the emotion, show empathy and understanding, encourage your patient to talk and offer what explanations you can.

If your patients are too talkative, or where they want to deal with too many things, you have to sometimes lead with statements: ‘Now I only have a short time left with you, so what is the most important thing we need to deal with now.’

If they have a long list of complaints suggest: ‘Well of the six things you have brought today I can only deal with two, so which are the most important to you and we will deal with the rest next time.’ It is important to set professional boundaries if your patient becomes over-familiar: ‘Well it would be inappropriate for me to discuss personal issues with you. I am here to help you so let’s focus on your problem.’

Patients who are too ill to talk or who are confused

If your patient is very ill, confused or mentally ill, or impaired for whatever reason, obtain what information you can from third parties. Rapidly assess the situation, treat your patient, and review everything when your patient is fit enough (see Ch. 12).

1.4 Transcultural awareness

- Appropriateness of eye contact
- Appropriateness of hand gestures
- Personal space
- Physical contact between sexes (e.g. shaking hands)
- Cultures and beliefs surrounding illness
- What should happen as death approaches?
- What should happen after death?

Communication difficulties

When you see patients who cannot speak your language, are deaf or who have expressive problems, e.g. dysphasia, dysarthria or stammering, try to establish some method of communication. This may need an interpreter. Writing things down, lip reading, sign language or someone who is used to communicating with your patient often helps.

Transcultural issues

Be sensitive when dealing with someone from a culture different from your own (Table 1.4). The use of eye contact, touching and personal space is different in different cultures. In western, and North American cultures, holding eye contact for long periods is normal; in most of the rest of the world this is seen as confrontational or rude. In some cultures it is normal to shake hands between opposite sexes, but this is strictly forbidden in others. Understand and accept differences in your patients’ cultures and beliefs and be aware of them. When in doubt ask the patients, this lets them know that you are aware of and sensitive to these issues.

Third party information

You may need to obtain information about your patient from someone else, usually a relative and sometimes a friend or carer. Ideally obtain your patient’s permission and have the patient present. In this way confidentiality is not breached. You may be approached by third parties without your patient’s knowledge. Find out who they are, their relationship to your patient, and whether your patient knows they are talking to you. Ensure that third parties understand that you can only listen to what they have to say and cannot divulge any of your clinical information about your patient. They may tell you about sensitive matters, e.g. mental illness, sexual abuse, drug or alcohol addiction. This information needs to be explored with your patients sensitively, as only they will be able to confirm the truth and agree to treatment. In all circumstances confidentiality of your patients’ information is your first priority.

Read Good Medical Practice published by the General Medical Council, which describes the standards of competence, care and conduct expected of you in all aspects of your professional work.
After introducing yourself and confirming your patient’s name continue by asking for details of their background including age, date of birth, marital status and current occupation. Then establish your patient’s presenting complaint. This is often described in a phrase, and helps to identify the principal problem. Start with open questions but then gradually focus down on symptoms by using closed questions. Choose your words carefully since patients may misinterpret questions such as “What are you complaining of?” as implying that you regard them as complainers. Try:

- ‘What would you say your main problem is?’
- ‘When do you think you were last well?’
- ‘When were you last your usual self?’

Follow up with ‘What has happened to you since then?’ If another doctor has referred your patient use the referral letter, e.g. ‘Your own doctor has told me that you have been having some chest pain. Can you tell me about the pain please?’

Examples of presenting complaints are listed in Table 1.6. The list is not comprehensive but includes the most common...
HISTORY TAKING

To do this you need to know what symptoms are caused by each disease or problem. Each disease process or problem has specific characteristics that help you in this task. You will need to become expert in pattern recognition. Work out which organ is affected and what process is going on by identifying these characteristics and patterns in the patient’s story. Diagnosis is based on recognizing the pattern of symptoms which each disease or problem commonly produces. You need to know these characteristics and then you will be able to ask useful questions. Initially you will not know enough to focus your questions and will have to use blanket questioning, but as you gain experience you can refine your questions according to the complaint. Build up your knowledge all the time by reading, seeing patients and listening to and observing colleagues. You should have a good idea of the diagnosis before you examine the patient and you should use your examination to support or refute it.

Make sure that patients tell you what they feel the principal problem is in their own words without pressure or interruption. Prompt to keep the history flowing, and use your knowledge of disease to direct your questioning. When finished their initial description of the presenting complaint, start with the symptom that seems to concern them most. Make sure that you understand exactly what they mean by any term that they use. For example, does ‘weakness’ mean true muscle weakness or are they simply tired? Explore each symptom offered by the patient. For each symptom work out its cardinal features.

The patient in the dialogue is a 65-year-old male smoker.

Each answer weights the probability of a particular diagnosis being more likely, while helping to exclude others. This is conditional probability as described in Bayes’ theorem. In this example the age of the man and the fact he is a long-term smoker increase the probability of certain diagnoses related to smoking. A persistent cough for 2 months increases the likelihood of lung cancer and chronic obstructive pulmonary disease (COPD). The chest pain does not exclude COPD since the man could have pulled a muscle by coughing but it is less likely than pleuritic pain from infection due to obstruction of an airway caused by lung cancer. This is confirmed by his increasing shortness of breath. Haemoptysis lasting 2 months dramatically increases the chance of lung cancer. When the patient confirms his weight loss the positive predictive value of all these answers is very high for lung cancer and you will carry out your examination and plan investigations accordingly.

What would you say is the main problem? (Open question)
I’ve had a cough which I just can’t seem to get rid of. I think it started after I had been ill with the flu about 2 months ago. I thought it would get better but it hasn’t and it’s driving me mad.

Can you tell me a bit more about the cough? (Open question)
Well, it is bad all the time. I cough and cough, and bring up some phlegm. I can’t sleep at night sometimes and wake up feeling rough because I have slept so poorly and sometimes I get pains in my chest because I have been coughing so much. (Follow up by asking key questions to clarify the cough – see Table 4.1, p. 126.)

Tell me about the pains. (Open question)
Well they are here on my side when I cough.

Does anything else bring on the pains? (Open and prompting question)
No. (Follow this up by asking the key questions about pain – see Table 1.7.)

What colour is the phlegm? (Closed question, focusing on the symptom offered)
Clear.

Have you ever coughed up any blood? (Closed question)
Yes, sometimes.

How often? (Closed question, clarifying the symptom)
Oh most days.

How much? (Closed question, clarifying the symptom)
Oh just streaks, but sometimes a bit more.

Do you ever get wheezy or feel short of breath with your cough?
A bit (see Table 4.1, p. 126.)

How has your weight been? (Closed question, seeking additional confirmation of serious pathology)
I have lost about 6 kilos.

Pain

Pain is a very common symptom. Later chapters describe characteristic features of specific presentations, and by knowing these and asking appropriate questions to clarify the patient’s symptoms you will be able to make a differential diagnosis.

Characteristics of pain are summarized in Table 1.7.

Associated symptoms

Ask about associated symptoms to help you work out the significance of any presenting complaint. Any severe pain can be associated with nausea, sweating and faintness as part of the vagal and sympathetic response. Particular associated symptoms may suggest an underlying cause, e.g. visual disturbance preceding a migraine headache or palpitation (suggesting an arrhythmia) in association with angina pain. If the pain is sufficiently severe to disturb sleep, this suggests a physical cause but also, because
patients are exhausted, this changes their perception of and ability to cope with the pain.

Effects on lifestyle

Ask ‘How do you cope with the pain?’ This helps you to gain insight into the patient’s coping strategies and shows your empathy. Areas to be considered in relation to chronic pain are illustrated in Figure 1.2.

Attitudes to illness

This is a difficult area to evaluate objectively. Many symptoms, e.g. pain and fatigue, are subjective and two patients with identical conditions can present dramatically different histories. The following attitudes to illness should always be considered.

**Pain threshold and tolerance.** This varies considerably not only between patients but in the same person in different circumstances (Table 1.8). Patients also vary in their willingness to speak about their discomfort.

**Past experience.** Both personal and family experience of pain influence the response to symptoms. A family history of sudden death from heart disease may well affect how a person interprets and reacts to chest pain.

**Somatization.** When physical symptoms exist without signs of organic disease this is called somatization or functional disorder. It is an expression of emotional illness or distress. To the patient the symptoms are real. Do not sound dismissive of these symptoms. Phrases such as ‘I realize these headaches are very disabling’ or ‘Your chest pain is clearly very distressing’ help to reassure your patients that you take them seriously, while you explore the

<table>
<thead>
<tr>
<th>1.7 Characteristics of pain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Onset</strong></td>
</tr>
<tr>
<td><strong>Character</strong></td>
</tr>
<tr>
<td><strong>Severity</strong></td>
</tr>
<tr>
<td><strong>Radiation</strong></td>
</tr>
<tr>
<td><strong>Associated symptoms</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Timing (duration, course, pattern)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Exacerbating and relieving factors</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Fig. 1.2 The effects of chronic pain – questions you may ask.

Note that pain affects several areas of a patient’s life but that these are interlinked.

<table>
<thead>
<tr>
<th>1.8 Pain threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain threshold can be increased by:</td>
</tr>
<tr>
<td>• exercise</td>
</tr>
<tr>
<td>• analgesia</td>
</tr>
<tr>
<td>• positive mental attitude</td>
</tr>
<tr>
<td>• up-beat personality</td>
</tr>
<tr>
<td>Pain threshold can be decreased by:</td>
</tr>
<tr>
<td>• sleep deprivation</td>
</tr>
<tr>
<td>• depression</td>
</tr>
<tr>
<td>• financial and personal worries</td>
</tr>
<tr>
<td>• anxiety and fear about the cause</td>
</tr>
<tr>
<td>• past experience</td>
</tr>
</tbody>
</table>
possibility of a non-physical cause. For example, a person may concentrate on the tension headache rather than the source of stress that is exacerbating it. Recognizing somatization helps to avoid inappropriate investigations which may ultimately reinforce illness behaviour.

**Gains.** Most illness brings some gains to the patient. These may simply be more attention from family and friends through to considerable financial benefits and being able to avoid unpleasant work or stress. Patients may not be conscious of these as demotivating factors in their illness but sometimes they deliberately exaggerate symptoms.

### PAST HISTORY

Ask about relevant past medical history as part of the history of the presenting complaint, e.g. previous angina in the patient with chest pain. There is often a relationship between the past medical history and the presenting problem. For example, a patient presenting with dyspepsia may have had a past history of multiple attendances for minor injuries. This should raise the possibility of an alcohol problem which could also account for the current symptoms.

Strike a balance between asking open questions about the past history and obtaining relevant, meaningful information (Table 1.9). Asking if your patients have ever had an illness may invite a description of every cold, cough and headache that has troubled them, while asking only about serious illness is to unfairly ask them to decide about the nature of any previous ill health.

### DRUG HISTORY

Ask about prescribed drugs and any other medications your patient is taking (Table 1.10). Include over-the-counter remedies and alternative medicine treatments, particularly herbal or homeopathic remedies, laxatives, analgesics and vitamin/mineral supplements. Note the name of each drug, the dose, dosage regimen and duration of treatment along with significant side-effects. In hospital contact the patient’s general practitioner for a record of the current prescription, although many patients will have a computer counterfoil from their GP with details of medicines. If patients claim to be taking unlikely combinations or amounts of drugs, confirm this with the last doctor to look after them. A drug addict may claim to be receiving a prescription for benzodiazepines and opioids in the hope of receiving the same from the admitting doctor. Always verify the patient’s claims with their GP and inform the addict’s dispensing pharmacy of the admission. This allows the prescription to be halted for the duration of admission and prevents it being collected by someone else on the patient’s behalf.

### Compliance/concordance

Compliance is the traditional model of medical care where patients take their medication as prescribed by the doctor. The modern term, concordance, means a shared decision between doctor and patient where they arrive at an agreement that respects the wishes and beliefs of the patient.

Half of all patients do not take medicines as directed. Ask them to describe how and when they take their medication. Give permission for them to admit that they do not take all their medicines by saying ‘That must be difficult to remember’. Many GPs can use their computerized databases to confirm whether patients have picked up their prescriptions on time. However, this does not provide evidence that the patient has obtained the drugs from the pharmacist or taken them at the correct time.

### Drug allergies/reactions

Always ask if your patient has ever had an allergic reaction to medication. In particular enquire about previous reactions before prescribing an antibiotic, particularly penicillin. Clarify exactly what patients mean by allergy, as this term is used loosely.

Ask about other allergies, e.g. foodstuffs, animal hair, pollen or metal. Record true allergies prominently in the

---

**1.9 Past history**

- Have you had any illness that you saw your doctor about?
- Have you had to take time off work because of ill health?
- Have you had any operations?
- Have you attended any hospital clinics?
- Have you been a patient in hospital? If so, why was that?

**1.10 Example of a drug history**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Duration</th>
<th>Indication</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>75 mg daily</td>
<td>5 years</td>
<td>Started after myocardial infarction</td>
<td></td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>25 mg at night</td>
<td>6 months</td>
<td>Takes for poor sleep</td>
<td>Feels drowsy in morning</td>
</tr>
<tr>
<td>Atenolol</td>
<td>50 mg daily</td>
<td>5 years</td>
<td>Started after myocardial infarction</td>
<td>Causes cold hands (? compliance)</td>
</tr>
<tr>
<td>Codydramol (paracetamol+dihydrocodeine)</td>
<td>Up to 8 tabs daily</td>
<td>4 weeks</td>
<td>Back pain</td>
<td>Causes constipation</td>
</tr>
</tbody>
</table>
patient’s case records and drug chart. Otherwise the patient may receive a substance which precipitates a life-threatening adverse reaction.

FAMILY HISTORY

Obtain the family history by asking open-ended questions, e.g. ‘Are there any illnesses that run in your family?’ It is possible that the presenting complaint directs you to a particular line of inquiry, e.g. ‘Is there any history of heart disease in your family?’ Many illnesses, e.g. thyroid disease, coronary artery disease, may be associated with a positive family history but are not due to a single gene disorder (Table 1.11), and so family history is just one risk factor.

Some patients require prompting with suggestions about common familial diseases, e.g. diabetes mellitus, thyroid disease or coeliac disease. Document illness in parents, any siblings and children. If there is a suspicion of an inherited disorder, e.g. Huntington’s disease or haemophilia, family history should go back at least three generations with details of racial origins and consanguinity (Fig. 1.3). In these circumstances ask if your patient or any close relative has been adopted.

In addition to blood relatives, ask about the health of other household members since this gives clues about environmental risks to the patient’s health. For example, if a woman’s husband died of lung cancer she may have been exposed to passive smoking.

SOCIAL HISTORY

The social history places a disease in the context of the patient’s life and reveals factors relevant to the presenting illness (Table 1.12). A social history can be expansive, incorporating everything from childhood experiences to coffee intake. With experience you will focus on the relevant issues. It is rarely appropriate to ask an elderly woman with

---

**Table 1.11 Examples of single gene inherited disorders**

<table>
<thead>
<tr>
<th>Autosomal dominant</th>
<th>Autosomal recessive</th>
<th>X-linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult polycystic renal disease</td>
<td>Cystic fibrosis</td>
<td>Duchenne muscular dystrophy</td>
</tr>
<tr>
<td>Huntington’s disease</td>
<td>Sickle cell anaemia</td>
<td>Haemophilia A</td>
</tr>
<tr>
<td>Mystonic dystrophy</td>
<td>Alpha thalassaemia</td>
<td>Fragile X syndrome</td>
</tr>
<tr>
<td>Neurofibromatosis</td>
<td>Alpha-1-antitrypsin deficiency</td>
<td></td>
</tr>
</tbody>
</table>

---

**Fig. 1.3** Symbols used in, and example of a pedigree chart.
a hip fracture whether she is injecting drugs but it is always necessary to know if she lives alone, has any friends or relatives nearby, what support services she receives and how well suited her house is for someone with poor mobility.

Remember that your patient’s illness affects others. There may be an infirm relative at home for whom the patient cares or there may be no one at home to look after the patient because, although she is married, her husband works abroad for 3 weeks out of 4. GPs usually know the social circumstances, so ask them if there is any doubt about the accuracy of the social history. If the GP referred the patient to hospital because of a crisis at home, your patient’s discharge from hospital is likely to prove short-lived unless these problems, e.g. lack of downstairs toilet, no carer, a patient’s inability to cook for himself, have been addressed along with the medical problems.

Ask about any dietary restrictions. These may be self-imposed or have been recommended by a health practitioner.

### Occupational history

The work people do may have a profound influence on their health. Some occupations are known to be associated with certain illnesses (Table 1.13). You should take a full occupational history from all patients. An appropriate question to ask might be ‘Please tell me about all the jobs you have done in your working life.’ Follow this up by asking what the patient actually does when at work; in particular, any chemical or dust exposure, the use of protective devices and whether other workers have become ill. Symptoms which improve over the weekend or during holidays should always suggest an occupational disorder. Remember that hobbies may also be associated with certain illnesses, e.g. psittacosis pneumonia and extrinsic allergic alveolitis in those who keep birds.

### Travel history

Travel is common for holidays, business and study purposes. One person in eight of those who travel outwith Europe or North America attend their GP on returning with possible travel-related illness. Travellers to hot climates are at risk of contracting tropical infections, and air travel itself may increase the risk of certain conditions e.g. middle ear problems and deep venous thrombosis. The incubation period is useful in deciding on the likelihood of an illness (Table 1.14). As well as the country your patient visited you should ask about the type of accommodation, e.g. a five-star hotel or a tent, and the activities undertaken, e.g. water sports, sexual contacts while abroad.

### Sexual history

It is not always appropriate to take a full sexual history (see Ch. 7). If it is relevant, ask questions in an objective fashion. Precede the questions with a statement, e.g. ‘As part of your medical history, I need to ask you some questions about your relationships. I hope that you don’t mind this.’

Examples of some objective questions are

- Do you have a regular sexual partner at the moment?
- Is your partner male or female?
- Can I ask if you have had any (other) sexual partners in the last 12 months?
- How many were male? How many female?
• Do you use barrier contraception – sometimes, always or never?
• Have you ever had a sexually transmitted infection?

**Tobacco**

Ask if your patients have ever smoked; if so, for how long and how much. Record when they started and stopped. If they smoke ask what (cigarettes, cigars or pipe); the quantity (number of cigarettes/cigars or amount of pipe tobacco per day) and the duration. Use ‘pack years’ (Table 1.15) to estimate the risk of tobacco-related health problems in your patients (Fig. 1.4) (see Ch. 4).

**Alcohol**

Patients may be upset if you ask bluntly ‘How much alcohol do you drink?’ Try ‘Do you ever drink any alcohol?’ Sensitively work out with them how much and when. Do this by asking open questions giving permission for them to tell you, and do not appear to judge them. Then follow up with closed questions covering:
• What?
• When?
• How much?
1

HISTORY TAKING

If they still have difficulty answering, ask them:
• When did you last have a drink?
• What’s the most you ever drink?

From this calculate the number of units of alcohol consumed each week. This can be calculated in one of two ways (Table 1.16).

1.16 Calculating units of alcohol

<table>
<thead>
<tr>
<th>Method one</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard measure (1 unit) = One small glass of wine</td>
</tr>
<tr>
<td>One half pint of beer</td>
</tr>
<tr>
<td>One short of spirits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard measure (1 unit) = 25 ml of 40% alcohol</td>
</tr>
</tbody>
</table>

Examples
1 litre of 40% proof spirits contains 400 ml ethanol or 40 units |
750 ml (standard bottle) contains 30 units alcohol |
1 litre of 4% beer contains 40 ml ethanol or 4 units |
500 ml can contains 2 units of alcohol |

Alternatively, use an online calculator, e.g. The Portman Group calculator: http://www.portmangroup.org.uk

1.17 The content of a detailed alcohol history

- Quantity and type of drink
- Amount of money spent on alcohol
- Daily/weekly pattern (especially binge drinking and morning drinking)
- Usual place of drinking
- Alone or accompanied
- Purpose
- Attitudes to alcohol

The first uses standard measures but is inaccurate and often underestimates intake. The second method is based on direct calculation of the alcohol content of drinks. This is more accurate given the range of alcohol strengths in beers, cider and wine, but it is less convenient.

If a person drinks one glass of wine per night, the first method would estimate the intake to be 7 units per week. However, if the pure alcohol content of each glass was 17.5 ml (1.75 units in 175 ml) then the patient’s intake by method two is 12.25 units per week. Many bottles of alcohol are now labelled with the number of units per bottle or per standard glass. Record alcohol consumption in the notes as units of alcohol consumed per week.

Table 1.17 lists the content of a detailed alcohol history.

Alcohol problems

Terms, e.g. problem drinking and alcohol dependence, are sometimes used interchangeably. It is more accurate to use the following terms.

Hazardous drinking. This is ‘at-risk’ drinking and is the regular consumption of:
• 24 g of pure ethanol (3 units) per day for men |
• 14 g of pure ethanol (2 units) per day for women |

Drinking at this level doubles a man’s risk of liver disease, raised blood pressure and violent death and increases a women’s risk of developing breast cancer and liver disease. In anyone it increases the chance of depression and obesity, and impairs cognitive function.

The pattern of drinking is important because binge drinking of a large amount of alcohol causes acute intoxication. This is more likely to result in trauma, e.g. a head injury, than consuming the same amount over 4 or 5 days. Everyone should have at least 2 days per week when they drink no alcohol.

Harmful drinking. This is when the pattern of drinking has caused physical or mental health damage.

Alcohol dependence. This is where a person’s use of alcohol takes a higher priority than other behaviours that previously had greater value. The features are:
• A strong, often overpowering, desire to take alcohol |
• Difficulty in controlling starting or stopping drinking and in the amount that is drunk.
• Tolerance, so that increased doses are needed to achieve the effects originally produced by lower doses.
• A withdrawal state when drinking is stopped or reduced. This produces tremor, sweating, rapid heart rate, anxiety, insomnia, and occasionally seizures, disorientation or hallucinations (delirium tremens). It is relieved by more alcohol.
• Progressive neglect of other pleasures and interests.
• Continuing to drink in spite of being aware of the harmful consequences.

Early detection of alcohol problems is important because of the health risks to patients and their families (Fig. 1.5). Screening tests help increase the detection of problem drinking. The CAGE questionnaire (Table 1.18) is still used by many clinicians but is not sensitive unless combined with two additional questions about the maximum daily intake and total weekly consumption. A more sensitive questionnaire is FAST but this has a more complex scoring system (Table 1.19).

Illicit drug use

You do not need to ask all patients about use of illicit drugs. But remember that about 30% of the adult population in Britain have used illicit drugs (mainly cannabis) at some time. Symptoms associated with drug use should prompt you to ask further questions (Table 1.20). These questions are to confirm the patient is taking or has taken drugs and the amounts involved; to assess the degree of dependence and other coexistent problems and the patient’s motivation to tackle the problem. Complications of drug misuse are listed in Table 1.21.

The purpose of the systematic inquiry is to uncover symptoms that the patient may have felt uncomfortable about disclosing earlier or has forgotten to mention. The patient’s response to an open question is likely to be more important than that to the closed questions of systematic inquiry. A suitable open-ended question, often asked after the history of the presenting complaint, might be: ‘Is there anything else you would like to tell me about?’

Start by running through the symptoms in Table 1.6 (p. 11) as part of your routine history with every patient. You will eventually be able to focus on those symptoms that are most relevant. Experienced clinicians often carry out the systematic inquiry as they talk about the presenting complaint, but this takes practice and knowledge of the conditions you are trying to exclude or diagnose.

Some examples of targeted systematic inquiry are:
• The smoker with weight loss: are there any respiratory symptoms, e.g. unresolved chest infection or haemoptysis, to suggest lung cancer? Are there any symptoms that suggest another organ being affected, e.g. bowel changes?
• The patient with recurrent mouth ulcers: do any alimentary symptoms suggest Crohn’s disease or coeliac disease or do any locomotor symptoms suggest Behçet’s disease?
• The patient with palpitation: are there any endocrine symptoms to suggest thyrotoxicosis, or a family history of thyroid disease?
• When you observe something that raises your suspicion, e.g. smell of alcohol, or an obvious goitre, ask questions about symptoms related to those conditions.
1.21 Complications of illicit drug misuse

Infections
- Hepatitis B and C
- HIV
- Abscesses, cellulitis and necrotizing fasciitis
- Septic pulmonary thromboembolism or lung abscesses
- Aspiration pneumonia
- Endocarditis
- Tetanus
- Wound botulism
- Sexually transmitted disease: many work in the sex industry to finance their habit

Injury
- Thrombophlebitis and deep vein thrombosis
- Arterial injury and occlusion
- Skin ulceration

Overdose
- Respiratory failure
- Rhabdomyolysis and renal failure

Chaotic life style leading to
- Poor nutrition
- Poor dental hygiene
- Failure to care for dependents
- Debt
- Prison
THE PSYCHIATRIC HISTORY

Psychiatry is the medical specialty that deals with those disorders in which mental or behavioural abnormalities are the presenting complaint, or are most prominent. These conditions are classified by their clinical presentation rather than aetiology or pathology, and diagnoses are made by satisfying the inclusion and exclusion criteria according to either the World Health Organization’s International Classification of Diseases (ICD 10) or the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM IV).

Mental and behavioural disorders are very common, with a prevalence of about 20% in the adult general population: they account for about 40% of consultations in primary care. Most conditions are mild, and are managed without specialist input. However, severe mental disorders pose serious threats to the health and safety of the patient, and sometimes to the well-being of others.

Physical and mental disorders often coexist – sometimes coincidentally but more often as cause and effect. For example, a severe infection may precipitate delirium (an acute confusional state), while intravenous drug abuse may result in the patient acquiring infections, e.g. hepatitis C and HIV. Consequently the prevalence of mental disorders (particularly organic brain disorders, mood illnesses and substance misuse disorders) is even greater among the physically ill, and affects mortality and morbidity. Because of these considerations all clinicians should be competent at basic psychiatric assessment of a patient.

HISTORY

Psychiatric interviewing has three core purposes:

- to obtain a history
- to assess the mental state of the patient
- to establish rapport that will facilitate further management.

Sometimes it is assumed that a psychiatric interview is invariably a lengthy procedure in which a detailed history of the patient’s entire life is necessary: this is not so! Assessment interviews usually do have to cover background personal and social factors to establish an understanding of how the illness evolved and to guide management, but the focus, as in all history taking, is the presenting problem and its solution for the patient.

Before meeting the patient it is important to obtain as much background psychiatric, medical and social information as possible – from the source of referral and from ward staff if the patient is in hospital. It is particularly important to establish the nature of the problem and whether it is the patient’s complaint or somebody else’s concern. Additionally, it is helpful to establish whether:

- the patient knows about and accepts the referral
- the patient is able to understand and communicate
- the patient wishes to be seen alone or with somebody else
- there is an element of danger
- behavioural disturbance or other impediments to interview are likely.

Plainly, there are circumstances when a standard ‘one-to-one interview’ is not feasible, notably when the patient:

- is a child (when family or parental interviewing is the norm)
- has a severe learning disability
- has a mental disorder that prevents normal communication
- is too disturbed
- refuses to be assessed.

Otherwise, the interview follows conventional procedures:

- Put the patient at ease.
- Listen attentively and react to the patient’s verbal and non-verbal cues – be empathic verbally and non-verbally.
- Allow patients to tell their story in their own words.
- Allow breaks and digressions (within reason) if the patient requires these – notably with sensitive topics or when distress emerges.
HISTORY TAKING

- Concentrate on the presenting complaint, using a technique of nested, open questions to explore the key elements.
- Switch to choice questions if the patient struggles with open questions.
- Clarify, echo, reflect, emphasize, summarize.
- Once the presenting situation is clear, the patient is settled and rapport permits, take greater control of the interview content through focused questioning and greater use of closed questions. Closed questions then enable the crucial background facts to be established.

Content

The content of a psychiatric history is as follows:

- Reason for referral
- Presenting complaint(s)
- History of presenting complaint(s)
- Family history (including psychiatric disorders specifically)
- Personal history – childhood; education; occupational history; sexual and marital history; children; current social circumstances
- Past medical/psychiatric history
- Prescribed medication; other remedies
- Psychoactive substance use, including alcohol, tobacco and caffeine
- Forensic history
- Premorbid personality.

Some aspects of psychiatric history taking differ from standard medical interviewing, and merit further consideration.

Risk assessment

Mental disorders can be associated with danger: classically depression with harm to self, and paranoid states with harm to others. Whenever the presentation suggests such hazards may be a possibility, then inquiries about thoughts, impulses and actions concerning suicide or violence must be made. How and when this is broached during the interview depends on cues: generally it is best left until rapport is firmly established, as patients often find these matters difficult to reveal. Many patients are relieved to be able to confide what is frightening to them and unacceptable to share with their family.

Sensitive issues

There are other themes that can be tricky for the patient and doctor during an interview, notably sexual matters and criminal activities. The sexual history is a component in a standard psychiatric history, the forensic history is another, while illicit drug-taking is part of the history of psychoactive substance use. It is far more important to build an effective relationship than to obtain a complete account at the expense of alienating the patient. Enquiring about sensitive matters can and sometimes should be omitted from initial psychiatric history taking unless the presenting problem is such that there is an obvious relevance which the patient can understand, or it is essential for establishing management. Such topics can be returned to if necessary at later interviews when rapport will enable the patient to divulge such material more comfortably (and probably more accurately too).

Premorbid personality

Assessment of premorbid personality is, by convention, the last section in the psychiatric history. It is also the most difficult for students and non-psychiatrists. Personality influences vulnerability to mental illnesses, colours the clinical presentation, determines the patient’s attitudes and coping strategies, and has to be taken into account in the management plan. Assessing premorbid personality involves evaluating what kind of person the patient was before the illness emerged – and because of this, it is the one section of history for which an informant who knew the patient well is essential. It is helpful to summarize premorbid personality under these subheadings:

- interests and hobbies
- social activities, friendships and other relationships
- moral/religious beliefs
- predominant mood
- coping strategies and reactions to stress and setback
- strengths, weaknesses, basic character.

One useful approach is to start by asking patients how they might have spent an average week in their life before they became ill.

Other sources of information

In psychiatric assessment, information obtained from other sources is usually necessary, sometimes vital and occasionally the only available history.

- Background medical information will be available in the case records of known patients and from the general practitioner.
- Speaking to a relative or carer will provide useful collateral history that may confirm, refute or supplement the patient’s history.
- Contacting the patient’s social worker, community nurse, counsellor or support worker is often helpful.
- With inpatients, speaking to ward nurses informs about aspects such as sleep pattern, hallucinatory activity and cooperation.
PHYSICAL EXAMINATION

Psychiatric assessment concentrates on mental functioning, but physical examination is often required too. The content and extent of the physical examination depend on the history and likely diagnosis; usually general observation, coupled with basic cardiovascular and neurological examination will suffice.

MENTAL STATE EXAMINATION

The mental state examination is a vital part of psychiatric assessment. Like a physical examination, it is systematic with the aim being to elicit signs of disorder. The main areas are:

• appearance
• behaviour
• speech
• mood
• thought content
• perception
• cognitive functioning
• insight.

Mental state examination involves:

• observation of the patient
• assimilation and analysis of the history
• consideration of the form as well as the content of the patient’s mental life
• specific questions exploring various mental phenomena
• short tests of cognitive function.

This will be channelled by the history and potential diagnoses so, for example, when an organic brain disorder is suspected, more thorough assessment of cognitive functioning is required, while for depression the assessment of mood is central.

Appearance

• General, e.g. attire and cleanliness, especially evidence of self-neglect
• Facial appearance
• Posture and gait.

Behaviour

• Cooperation/reaction to the interview/eye contact/rapport
• Level of consciousness
• Social behaviour
• Motor overactivity – includes hyperkinesis (a disorder of children), restlessness, agitation, compulsions and rituals
• Motor underactivity – includes stupor, slowing (retardation) and poverty of movement (akinesis)
• Motor abnormality – includes involuntary movements and mannerisms.

Speech

• Rate – includes pressure of speech and slowing
• Quantity – includes mutism, poverty of speech and pressure of speech
• Articulation – includes stammering, stuttering and dysarthria
• Form – covers the way in which a patient speaks rather than the content:
  – flights of ideas: where ideas flow rapidly but remain connected although sometimes by unusual associations, e.g. clang words (associated with mania)
  – loosening of association/formal thought disorder (found in schizophrenia): when the logical sequence of ideas is lost; specific abnormalities include thought blocking when thinking suddenly ceases and there is a pause before a different thought emerges, and word salad which is the extreme case when words emerge as a jumble
  – perseveration: an inability to change theme, resulting in inappropriate repetition of a response
  – circumstantiality: slowed thinking, loaded down with unnecessary detail and digression, but maintaining the goal of the thought
  – neologisms: invented words, or established words with a novel meaning.

Mood

Mood is defined in DSM IV as ‘a pervasive and sustained emotion that in the extreme colours the patient’s perception of the world’. Examining mood involves consideration of the patient’s subjective emotional state and your objective evaluation.

Subjective mood

Subjective mood is established by inquiry, introduced by an open question, e.g. ‘How have you been feeling recently?’ or ‘How do you feel in your spirits?’ This leads on to further exploration in the usual way.

Objective mood

Objective mood is picked up during the interview. It requires a degree of experience as well as empathy to assess accurately. It takes into account the patient’s demeanour, facial expression and behaviour as well as observed emotional expression. Not infrequently you can sense the patient’s
emotional state, be it sadness, anger, irritability, anxiety, bewilderment or elation, by considering your own response during the interview.

Dysphoric (abnormal) mood states take two forms:

- abnormal pervasive mood
- abnormal expression of mood.

Abnormal pervasive mood states occur in many types of mental disorder, but are the central feature of:

- depression, when there is sustained low mood which may include sadness, tearfulness, hopelessness, despair and, in severe illness, loss of emotion such that the patient feels nothing
- mania, when the patient feels elated or euphoric
- anxiety, when worry, apprehension and tension feature.

Abnormal expression of mood includes:

- labile mood, when emotions are superficial, rapidly changing and poorly controlled; extreme lability is sometimes termed flattening of affect.
- incongruous mood, when the emotional expression is inappropriate for the thought
- blunting, when normal expression of mood is diminished or lost (sometimes termed flattening of affect).

Incidentally, the terms mood and affect are often used interchangeably, but they are subtly different. Mood refers to the pervasive emotional state, whereas affect is the observable expression of emotions, which is variable over time. A useful analogy is to think of a patient’s mood as a climate, in which case the patient’s affect is the current weather.

**Thought content**

This is a central part of the mental state examination, and is primarily based on the history the patient has provided. Thought content is subdivided into preoccupations and abnormal beliefs.

**Preoccupations**

Preoccupations include:

- Ruminations: repetitive ideas or themes on which the patient broods. Ruminations often reflect the mood state, e.g. incessant worrying in anxiety states and morbid thinking in depression (Table 1.22). Morbid ideation includes ideas of guilt, unworthiness, burden and blame as well as dwelling on past losses, failures and disappointments. Suicidal or homicidal ruminations are particularly important to establish and evaluate (Table 1.23).
- Hypochondriasis: a specific, unjustified preoccupation with having a serious disease.

**Abnormal beliefs**

Abnormal beliefs are subdivided into overvalued ideas and delusions.

**Overvalued ideas.** These are not pathognomonic of mental illness. They are beliefs that are held, expressed and acted on by the patient about matters which are of particular importance to them – but to a degree that others from the same culture would regard as unreasonable. Eccentrics and unconventional people, e.g. members of unusual sects or cults, exemplify this phenomenon: while some may be mentally ill, many are not.

**Delusions.** Delusions are invariably of clinical significance. A delusion is a false belief which is held with total conviction, which is not shared by others from the same culture and which is maintained in spite of proof or logical argument to the contrary. Together with hallucinations, delusions are regarded as ‘psychotic symptoms’: psychosis is a collective term that encompasses mental illnesses in which the patient’s experience and reasoning do not reflect reality.

Delusions are subdivided into primary and secondary. Primary delusions, which are characteristic of schizophrenia, are fully formed de novo. Secondary delusions, which can
occur in various mental illnesses, can be understood to have arisen in a context of another mental process – usually an abnormal mood state or abnormal perceptions. In this setting, they provide an explanation for patients as to why they are having these feelings or experiences.

The content of delusions can give a clue to the nature of the mental illness – for instance, grandiose delusions are associated with mania, nihilistic delusions with depression, and paranoid delusions with delirium and schizophrenia. When delusions are bizarre their recognition is easy, but delusions may seem quite ordinary ideas, e.g. being followed, victimized or impoverished, when establishing their psychotic nature can be much harder.

When conducting a psychiatric interview it is inappropriate to ask routinely about delusions: such inquiries will upset many patients and damage rapport, while deluded patients are unlikely to give a straight answer anyway. Exploring delusions requires tact and timing. Questions usually have to be focused on information the patient has provided, or sometimes other information brought to your attention. Technique generally involves greater use of closed questions to pin down the beliefs, e.g. ‘Do you really believe that you are the Messiah?’ If the patient answers ‘yes’ then explore this as a nest for further inquiry; for example, lead on with ‘What proof can you give me?’

**Perception**

Alterations in normal perception consist of changes to our normal, familiar awareness of ordinary experiences. Abnormal experiences may be referred to:

- the environment, which includes illusions, hallucinations and derealization
- the patient, which includes somatic hallucinations and depersonalization.

An illusion is a false perception of a real, external stimulus. Such misinterpretations may affect any sensory modality but auditory and visual illusions are commonest. Frequently, illusions arise from a sensory impairment, e.g. partial sightedness or deafness, or because of clouding of consciousness (common in delirium), and the illusion is an understandable attempt to fill in the gap. For example, a coat hanging behind a door may give the illusion of a person standing there.

An hallucination is a false perception which is not based on a real stimulus, so a person is seen at the door where there is no stimulus to prompt this sighting. Hallucinations are located in external space and are authentic to the patient. Hallucinations can affect any of the sensory modalities although visual and auditory are commonest. Visual hallucinations are particularly associated with delirium and auditory hallucinations with schizophrenia, but almost any form of hallucination is possible in any of the mental illness in which psychotic features can occur.

Some hallucinatory experiences are normal, for example on going to sleep (hypnagogic) and on waking (hypnopompic), while people in mourning may experience visual, auditory or tactile hallucinations that involve contact with the deceased. Similarly, depersonalization (a feeling of having become unreal or that the body has altered in some way) and derealization (when the same changes have occurred in the patient’s surroundings) often occur as a normal experience, especially when tired or stressed.

Hallucinations need to be distinguished from pseudohallucinations which are common, and often lead to a misdiagnosis of psychotic illness. Pseudohallucinations are identified by patients as arising from within their own mind, and are experienced as an internal phenomenon, sometimes described as an inner voice or eye. They tend to lack the reality for the patient of true hallucinations, i.e. they have an ‘as if’ quality, and so do not have knock-on effects on other mental functions.

As with assessment of delusions, it is necessary to explore this aspect of the mental state tactfully and timeously in order to avoid damage to rapport (‘You must think I’m mad’).

**Cognitive functions**

Assessing attention and concentration is routine in mental state examination. Other aspects can be tested more selectively, but this becomes essential and wide-ranging when an organic brain disorder is suspected. This phase of the examination must be carefully explained before starting so that the patient does not get upset or annoyed by questions that could justifiably be regarded as insulting or silly.

Cognitive assessment comprises:

- attention and concentration
- orientation
- memory
- general knowledge and intelligence.

**Attention and concentration**

Attention and concentration can be impaired in many mental disorders. It is important to establish the presence of impairment because this will affect the patient’s ability to retain and comply with information given and treatment requirements, and hence has a major bearing on how the management plan is formulated. When testing indicates significant impairment, it is unnecessary to proceed to test registration, immediate recall and short-term memory as these will inevitably be affected as a consequence.

Impaired attention is usually evident at interview as increased distractibility, with the patient responding to extraneous cues – both real that would normally be ignored (e.g. a muffled conversation outside the room), and unreal (e.g. auditory hallucinations).

Testing involves examining patients’ ability to follow sequences that should be familiar to them (i.e. do not involve
HISTORY TAKING

new learning). The traditional method is the serial sevens test. The patient is asked to count back aloud in sevens from 100 as quickly as possible and as far as possible. Mistakes are noted and the patient is asked to try again. Time taken, number of errors and the finishing point should be noted. This test requires some mathematical ability and hence is influenced by intelligence and educational attainment. When these attributes are dubious, serial threes, counting back from 20 in the same manner, is an alternative. However, sequencing months in reverse from December is a better method.

Orientation

Disorientation is the best sign of an organic mental disorder. Orientation should be checked for time, date (including day of the week), place and person. Minor anomalies can occur normally in hospital when the patient’s routine is broken and the passage of time is lost through severe illness or an operation. Other evidence should be incorporated, for instance a relative’s information that the patient wanders from home at night, thinking it is daytime, and then cannot find the way home.

Memory

Memory function is subdivided into registration and immediate recall, short-term memory, recent memory and long-term memory. It is unnecessary to test all of these in all patients, the extent of examination being determined by the history and likely diagnosis. The following summarizes simple tests that can be used:

- Registration and immediate recall: immediate repetition of a series of digits. Normal forward digit span is seven or more; five or fewer indicates impairment.
- Short-term memory: name and address test. Give the patient a six-item fictitious name and address to remember (not your own!) after explaining what you are doing. Registration and immediate recall is tested by getting the patient to repeat this information back immediately. This should be scored, e.g. 4/6 items correct, and then repeated until 6/6 is obtained; count the number of attempts required and abandon the test after five attempts if the patient cannot assimilate all the information. Ask for the information again after 5 minutes during which other inquiries have been made. Note the score, the nature of errors and the patient’s attempts at correction/awareness of mistakes. Normal scores are 5 or 6; 4 is borderline; fewer than 4 indicates significant memory impairment.
- Recent memory: ask the patient about current events reported in the news over the past week, bearing in mind the patient’s access to information and interests.

Alternatively ask about visitors or events in the patient’s own life over the past week, making sure that the answers can be verified.

- Long-term memory: problems are evident from the history, for example failing to remember key events, dates and people in the patient’s life. In dementing illnesses, long-term memory is often spared until later stages of the disorder, sometimes to a remarkable degree when compared with other memory functions.

General knowledge/intelligence

General knowledge is an expression of both intelligence and long-term memory, and as such it is not particularly useful to assess. Impaired intelligence, notably learning disability, is usually evident:

- in the history – schooling and educational attainment in particular, but also occupational history
- in the presentation – use of language, understanding of language and concepts, abilities to plan, organize, anticipate.

Formal standard tests include closed questions on subjects like history (e.g. the dates of major wars), geography (e.g. capitals of countries) and important people (e.g. names of prime ministers, monarchs or American presidents). Another technique is to check breadth of knowledge by asking the patient to name different kinds of items in a collection, e.g. 10 kinds of fruit, vegetable, flower or colour. Finally basic numeracy and literacy should be checked by asking the patient to do simple calculations and to read newspaper headlines.

Insight

Insight refers to how patients understand or explain their condition. Insight is almost invariably present to some extent but rarely completely; it also fluctuates during the course of the illness and may appear to vary depending on the nature of the inquiry – for example, patients not infrequently deny they are mentally ill yet accept psychiatric admission. Hence commenting that insight is present or absent is unhelpful. In assessing insight, three elements are important:

- recognition of illness
- acceptance of illness
- willingness to accept treatment and agree to a management plan.

PSYCHIATRIC RATING SCALES

The use of psychiatric rating scales as clinical tools in psychiatric assessment is increasingly widespread. Most of
these scales were developed for research purposes, either to identify potential cases or to provide a numerical measure of change in a condition. Some scales require special training; all require to be used sensibly and appropriately. Rating scales should never replace standard psychiatric interviewing, but they can be useful adjuncts, either to screen for a disorder or to provide a reliable indication of change in an illness.

Screening tools should be brief, easy to use, valid and reliable: widely used examples are the CAGE and FAST (alcohol problems), Hospital Anxiety and Depression Scale (HADS) (mood disorders) and the Abbreviated Mental Test (AMT) (organic brain disorders) (Table 1.24). Progress measures have to be used repeatedly, so they tend to be longer to reduce practice learning and to enable finer discrimination of change. Although screening measures, e.g. HADS and AMT, can be used, good examples are the Beck Depression Inventory (BDI) (depression) and the Mini Mental State Examination (MMSE) (organic brain disorders).

<table>
<thead>
<tr>
<th>1.24 Abbreviated mental test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Time (nearest hour)?</td>
</tr>
<tr>
<td>2. Day of week?</td>
</tr>
<tr>
<td>3. Month?</td>
</tr>
<tr>
<td>4. Year?</td>
</tr>
<tr>
<td>5. Age?</td>
</tr>
<tr>
<td>6. Place?</td>
</tr>
<tr>
<td>7. Names of three objects at 2 minutes, e.g. apple, table, coin (score 1 if only one item is remembered)</td>
</tr>
<tr>
<td>8. Dates of Second World War?</td>
</tr>
<tr>
<td>9. Name of Prime Minister?</td>
</tr>
<tr>
<td>10. Count backwards from 20 to 1 (0 for any uncorrected error)</td>
</tr>
</tbody>
</table>

Each item scores 1 point
Normal scores 8–10
Mild–moderate dementia 4–7
Moderate–severe dementia 0–3

When conducting a psychiatric assessment interview, you must bear in mind the third purpose mentioned at the start of this chapter. This is establishing rapport that will facilitate further management. Patients need to feel that they have derived something from the encounter and not simply answered a lot of questions, some of which seem irrelevant or are frankly embarrassing, for no apparent reason other than to satisfy your need to complete the records. Active listening, sensitive questioning, tolerating difficult thoughts, experiences and emotions, empathizing, supporting and reassuring when appropriate are all therapeutic activities that facilitate further management and ensure that the patient leaves the interview, it is hoped, feeling better and certainly not feeling worse.

Key points
- Get as much background information and history from other sources as you can (with the patient’s permission if indicated).
- Concentrate initially on establishing rapport by helping your patient feel at ease and enabling him to tell his story as he wishes.
- Be willing to modify the extent, order and content of the assessment to take account of your patient’s background and presentation.
- Observe your patient closely to gain objective evidence of his mental state, especially nonverbal information.
- Your patient’s speech gives you access to his thought form and content, mood and cognitive functioning.
- Consider your own response to your patient: you can often sense his mood. Do you feel sad, angry, irritated or confused, for example?
- Use brief formal tests to assess cognitive function.
- Consider standardized rating scales as a screening tool (and sometimes to monitor progress).
- Do not forget the importance of selective physical examination.
- Remember to assess these key issues – potential risks to self or others, degree of distress and disability, capacity to take decisions, insight into illness.
legible and clearly signed. In primary care, case records may span the whole of a person’s life and record the development of a condition over several consultations.

You may write notes while talking to the patient and taking the history but do not let this interrupt the flow of your discussion, and maintain as much eye contact as possible. Active listening is difficult if you are writing, so practice making brief notes at the time so that you do not forget important points. Write up the full history after you have left the patient. If the consultation is short, you can write up the notes afterwards because it is easier to remember all the details. Write up the physical findings when you have completed the examination and not as you proceed. Only record objective findings and never make judgemental, flippant or pejorative comments. This is unprofessional, and remember that patients or their lawyer may subsequently read their notes.

Although structured pro formas for recording the initial history and examination findings are used as an aide-memoire in many hospitals, it is not possible to record every detail of the history and examination in every patient. Only record negative findings if they are relevant; for instance, in a patient presenting with breathlessness, the negative details of the respiratory inquiry are important but you can condense the negative responses to the gastrointestinal inquiry to one entry of ‘none’ or ‘nil’. You may use abbreviations but they should not be obscure or ambiguous. Widely recognized ones are included in the case example (Fig. 1.6). The prefix ‘o’ is often used to signify ‘no’, for example ‘tenderness, or ‘headache. Use diagrams to show the site and size of superficial injuries or ulcers, and for the abdomen to illustrate the position of tenderness, masses or scars (see Fig. 5.9, p. 168). Describe injuries accurately, because if the patient has been the victim of assault you may be asked to give legal evidence from the notes months or years after the event (Table 1.26).

**1.25 Information in the case record**

- History and examination findings
- Investigations and results
- The management plan
- Assessments of other health professionals, e.g. dieticians, health visitors
- Information and education provided to patients and their relatives
- Correspondence about the patient
- The patient’s progress
- Advance directives or ‘living will’
- Contact details about next of kin.

**1.26 Describing wounds**

**Position**

- Where on the body, including which aspect of a limb

**Size and orientation**

- e.g. 5 cm by 3 mm vertical scratch

**Appearance**

- e.g. colour, shape

**Type of lesion**

- Abrasion: loss of the outer skin due to impact with a rough surface
- Scratch: linear abrasion due to drawing of a sharp point over the skin
- Bruise: bleeding within the tissues beneath the skin
- Laceration: tearing of the skin due to blunt trauma; ragged edges
- Incised wound: cut or gash; sharp edges
- Penetrating wound: depth is greater than length; breaches full skin thickness

**Unitary notes**

Unitary or ‘multidisciplinary’ notes allow the whole team to record their findings in one document, rather than each health professional keeping separate case records. Although a bulky unitary record can be cumbersome, it encourages a shared approach to care, avoids duplication and makes it easy for different professionals to access information.

**Primary care**

Primary care records follow the patient between practices and contain the whole story of a patient’s health, rather than discrete episodes of hospital care. Diagnoses in primary care may emerge over a series of consultations so the entries are often short, but include a description of the problem, any working diagnosis, advice given, investigations or treatment arranged, follow-up and the doctor’s initials or signature.

**Computer records**

Most records are still held on paper but comprehensive computer records are increasingly used in primary care and hospital settings. Computer records allow easy access to medical and prescribing information during the consultation, and paper summary sheets are an easy way of transferring legible, relevant information. Many general practices, however, still use a mixture of paper and electronic records, although in the future smart cards carried by patients will hold their entire medical record. Paperless practices have all patient information held on computer. It is arranged to highlight important medical events unobscured by routine information. This can be downloaded onto portable palmtops for domiciliary use.

**Clinical coding**

When computers are used, conditions and diagnoses are documented systematically so that information can be
retrieved in a way that makes clinical sense. In the UK, Read Codes are used. These are a comprehensive list of clinical terms that describe the diagnoses, care and treatment of patients in a hierarchical way (Fig. 1.6). Each clinical term has a unique Read Code and, once coded, the data can be used for audit and statistical analysis.

The College of American Pathologists has developed a different clinical classification called SNOMED®. This system is now being combined with the Read Code system to produce SNOMED CT which will bring together the two leading international clinical terms systems to provide one unified system for worldwide use. These clinical terms systems are not classifications of diseases but systems of coding clinical terms in everyday use.

Confidentiality

The case record is confidential and must be stored securely. It is also a legal document that may be used in a court of law.

Details cannot be shared with anyone who is not involved in a patient’s care, unless the patient gives full, informed, written consent. This includes insurance companies, lawyers, the police and research workers. You may only break confidence if a patient is a risk to him/herself or other members of the public. For example in the UK, if your patient with active epilepsy continues to drive against medical advice, you must inform the Driving and Vehicle Licensing Centre, advise the patient you are doing so and record this clearly in the notes.

In the UK the Health Records Act of 1990 gives patients the right to see and receive a copy of their paper case record. Some patients already hold their own paper records, usually when care is shared between hospital and community, for example in antenatal care and diabetic care. The Data Protection Act 1998 gives patients the right to see anything held on computer about them. You can stop patients seeing a part of their case record if you think this would cause serious harm to their physical or mental health or to any other individual. Remember this when you record information about third parties, for example in cases of sexual abuse.

Key points

- Always record, date and sign your findings, investigations and management plan for the patient.
- Record only objective findings.
- Record all abnormal findings but only record the negative findings if they are relevant.
- The notes are confidential and details must be shared only with professionals directly involved in the patient’s care.
- Patients have the right to see their case notes, should they wish.
Date: 03.08.04  
Time: 14.00  
Emergency admission to CCU via GP: Dr Wells, High St., Edinburgh

MARY BROWN aged 76  
32 Tartan Cresc.  
Edinburgh  
DOB 17.09.22

History from patient  
PC  Chest pain  2 hours  
Breathlessness  1 hour  
Dizziness  30 mins

HPC  
Severe pain ‘like a band around chest’ while watching TV which has now lasted 2 hours despite using GTN. Radiates to jaw and inner aspect of L arm. Has gradually become breathless over the last hour and dizzy in last 30 minutes.

First began six months ago: episode of lower retrosternal chest pain after walking about ½ mile uphill.  
• relieved by rest after 5 minutes  
• no associated palpitation or SOB  
Two further episodes over the next 3 months  
3 months ago: increasing frequency of pain  
• now brought on by walking 200 yards on the flat or climbing 1 flight of stairs  
• worse after heavy meals  
• other features of pain as before  
2 months ago: visited GP who diagnosed angina. Prescribed GTN which gave effective relief.

1 week ago: 3 episodes of chest pain at rest, all immediately relieved by GTN.

Smokes 20/day since aged 19  
°blackouts  °pain in calves on exertion.

PH  
Tonsillectomy  1952  
Hospital X  
Perforated peptic ulcer  1977  
Hospital Y  
COPD  Since 1990  
General practitioner  
°MI, °DM, °J, °HBP, °Stroke, °RF, °TB

DH  
Salbutamol inhaler  DOSE  FREQUENCY  DURATION  
2 puffs  4 times daily  3 years  
Temazepam  10mg  At night  6 months  
Senokot (self medication)  2 tabs  2–3 times per week  10 years  
GTN spray  1 puff  As required  2 months  
NKA.

FH  
Fit accident aged 36  
‘Old age’ aged 85  
Breast cancer aged 79  
1 aunt died aged 57 of acute MI

Fig. 1.7 Case notes example.
**Presenting Complaint (PC)**
State the major problem in one or two of the patient’s own words (or give a brief list), followed by the duration of each. Do not use medical terminology.

**History of Presenting Complaint (HPC)**
Describe the onset, nature and course of each symptom. Paraphrase the patient’s account and condense it if necessary. Omit irrelevant details. Put particularly telling comments in inverted commas. Include other parts of the history if relevant, such as the smoking history in patients with cardiac or respiratory presentations, or family history in disorders with a possible genetic trait such as hypercholesterolaemia or diabetes. Correct grammar is not necessary.

GTN – glyceryl trinitrate
SOB – short of breath

**Demographic Details**
Always record
- The patient’s name and address, date of birth and age
- Any national health identification number such as CHI in the UK
- Source of referral e.g. from Accident and Emergency or General Practitioner
- GP’s name and address
- Source of history e.g. patient, relative, carer
- Date and time of examination

**Family History (FH)**
Record the age and current health or the causes of or the ages at death of the patient’s parents, siblings and children. Use the symbols shown in Chapter 1 (p.15) to construct a pedigree chart.

**Drug History (DH)**
Tabulate these and include any allergies particularly to drugs. Record any previous adverse drug reactions prominently on the front of the notes as well as inside.

NKA – No known allergies

**Past History (PH)**
Tabulate in chronological order. Include important negatives, e.g. in a patient with chest pain ask about previous myocardial infarction, angina, hypertension or diabetes mellitus and record whether these are present or absent. Jaundice is important because it may pose a risk to health care workers if due to hepatitis B or C.

COPD – Chronic obstructive pulmonary disease
MI – Myocardial infarction
DM – Diabetes mellitus
J – Jaundice
HBP – Hypertension
RF – Rheumatic fever

**Presenting Complaint (PC)**
State the major problem in one or two of the patient’s own words (or give a brief list), followed by the duration of each. Do not use medical terminology.
HISTORY TAKING

SH
Retired cleaner.
Widow for 3 years. Lives alone in sheltered housing.
Smoked 20/day from age 19.
Teetotal.
HH once a week for cleaning and shopping. Daughter nearby visits regularly.

SE
CVS: See above
RS: Long-standing cough most days with white sputum on rising in morning only. haemoptysis
Wheezy in cold weather.
GI: Weight steady
Nil else of note
GUS: PARA 1 + 0. urinary symptoms
CNS: Nil of note
MSS: Occasional pain and stiffness in right knee on exertion for 5 years
ES: Nil of note

O/E
Anxious, frail, cachectic lady.
Weight 45 kg. Height 1.25 m
2 cm craggy mass in upper, outer quadrant L breast. Fixed to underlying tissues.
Patient unaware of this
1 cm node in apex of left axilla.
pallor, cyanosis, jaundice, clubbing

CVS
P90 reg, small volume, normal character,
BP 140/80 JVP + 3 cms normal character oedema AB SICS MCL thrills
HS I + II + 2/6 ESM at LLSE radiation
bruits
PP:
Radial Brachial Carotid Femoral Popliteal Post. Tibial Dorsalis pedis
R + + + + + + +
L + + + + + + +
(Normal +, Reduced +/-, Absent -)

RS
Trachea central. Reduced cricosternal distance and intercostal indrawing on inspiration.
Expansion reduced but symmetrical.
PN resonant
BS vesicular and quiet
VR normal and symmetrical.
**Social History (SH)**
- Occupation
- Marital status
- Living circumstances; type of housing and with whom
- Smoking
- Alcohol
- Illicit drug use (if appropriate)
- Social support in the frail or disabled
- HH—home help

**Systematic Enquiry (SE)**
Document positive responses that do not feature in the HPC.

**Cardiovascular system (CVS)**
- Pulse (P) rate, rhythm, character and volume
- Blood pressure (BP)
- Jugular venous pressure (JVP) height and character
- Presence or absence of ankle oedema
- Apex beat (AB) position, character, presence of thrills
- Heart sounds (HS) any added sounds, murmurs and grade
- Peripheral pulses (PP) and bruits
  - 5ICS—5th intercostal space
  - MCL—Mid clavicular line
  - ESM—Ejection systolic murmur
  - LLSE—Lower left sternal edge

**Respiratory System (RS)**
- Any chest wall deformity
- Trachea central or deviated
- Signs of hyperinflation
- Expansion and its symmetry
- Percussion note (PN) and site of any abnormality
- Breath sounds (BS), any added sounds and site of abnormality
- Vocal resonance (VR) and site of abnormality

**General/On examination (OE)**
- Physical appearance e.g. frail, drowsy, breathless
- Mental state e.g. anxious, distressed, confused
- Undernourished, cachectic, obese
- Abnormal smells e.g. ketones, alcohol, uraemia, foetor hepaticus
- Record height, weight and waist circumference
- Skin e.g. cyanosis, pallor, jaundice, any specific lesions or rashes
- Breasts, normal or describe any mass
- Hands; finger clubbing, or abnormalities of skin and nails
- Lymph nodes; characteristics and site

**Cardiovascular System (CVS)**
- Pulse (P) rate, rhythm, character and volume
- Blood pressure (BP)
- Jugular venous pressure (JVP) height and character
- Presence or absence of ankle oedema
- Apex beat (AB) position, character, presence of thrills
- Heart sounds (HS) any added sounds, murmurs and grade
- Peripheral pulses (PP) and bruits
  - 5ICS—5th intercostal space
  - MCL—Mid clavicular line
  - ESM—Ejection systolic murmur
  - LLSE—Lower left sternal edge
**Abdo.**
Normal oral mucosa
Upper midline scar
Hernial orifices intact
°tenderness or guarding
°masses
°LKKS or ascites
BS normal
PR faecal loading. No mucosal abnormality
FOB negative
PV not performed

**CNS**
AMT 9
Crani al nerves II–XII: PERLA, NAD
Speech normal

<table>
<thead>
<tr>
<th></th>
<th>RIGHT</th>
<th>LEFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power</td>
<td>UL</td>
<td>5</td>
</tr>
<tr>
<td>Tone</td>
<td>normal (n)</td>
<td>n</td>
</tr>
<tr>
<td>Light touch</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>Position</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>Coordination</td>
<td>n</td>
<td>n</td>
</tr>
</tbody>
</table>

Reflexes
K++ A++ B++ T+ S+ Pl flexor
R++ L++ (increased ++, normal +, diminished +, absent -)

**M5S**
Heberden’s nodes on index and middle fingers bilaterally.
Full ROM in all joints.
Crepitus in right knee. No other bony abnormality

**IMPRESSION**
Active problems
1 Chest pain suggestive of angina or acute myocardial infarction (MI)
2 Left breast lump and axillary node suspicious of cancer
3 Smoker

Inactive problems
1 Stable COPD
2 Perforated duodenal ulcer 1977
3 Possible osteoarthritis of right knee
DOCUMENTING THE FINDINGS – THE CASE NOTES

Central Nervous System (CNS)
In older patients record the abbreviated mental test (AMT) score
In impaired consciousness, head injury or possible raised intracranial pressure record the Glasgow Coma Scale (GCS) (pp. 239–240)
Abnormal speech
Cranial nerves; record abnormalities only
Fundoscopy
Tabulate the remaining examination
If it is relevant record the presence or absence of tremor, gait, abnormality, fasciculation, dyspraxia, two point discrimination, stereognosis or sensory neglect.
PERLA—Pupils equal and react to light and accommodation
NAD—No abnormality detected
UL—Upper limb
LL—Lower limb
K—Knee
A—Ankle
B—Biceps
T—Triceps
S—Supinator
Pl—Plantar

Abdominal System (AS)
Mouth
Any abnormality—own teeth or dentures
Abdo
Scars and site
Shape, distended or scaphoid
Hernial orifices
Tenderness and guarding and site of this
Masses and description of these
Enlargement of liver, kidneys or spleen (shorten to LKKS)
Ascites if present
Bowel sounds (BS); presence and character
Rectal examination (PR) record whether or not it was performed and your findings
In women; vaginal examination (VE) is only carried out if relevant
In men; external genitalia
FOB—Faecal occult blood testing

Musculoskeletal System (MSS)
Gait if abnormal
Muscle or soft tissue changes
Swelling, colour, heat, tenderness
Deformities in the bones of joints
Limitations of ranges of movements (ROM) in any affected joint

Clinical Diagnosis or Impression
Record your conclusions and the most likely diagnoses in order of probability.
In patients with multiple pathology make a problem list so the key issues are seen immediately

△ Diagnosis
**HISTORY TAKING**

**Plan**
- ECG performed on admission shows sinus rhythm and deep ST depression in leads II, III and aVF
- Troponin at 12 hours
- Repeat ECG in 1 hour
- Chest X-ray
- Full blood count
- Urea and electrolytes, glucose
- Oxygen and cardiac monitor
- Aspirin and clopidogrel
- Buccal nitrate
- Low molecular weight heparin
- Diltiazem as beta-blocker contraindicated due to COPD
- Advice to stop smoking
- When stable
  1. Review anti-anginal management
  2. Referral for mammography and fine needle aspiration of breast lump
  3. Spirometry and assessment of inhaler technique

**Information given**
- Diagnosis and treatment explained to patient and family
- N.B. Breast lump not mentioned at this stage until discussed with senior staff

A. Doctor  
A. DOCTOR (House Officer)

**Progress notes**
3.8.04  
1800 Ward Round—Dr Consultant
- No further chest pain
- O/E
- P70 BP 100/70
- JVP not elevated  
-  
- Oedema
- HS I + II and ESM as above
- Chest clear
- Breast lump noted
- ECG at 4 hours—resolution of inferior ST changes

**Impression**
- Probable unstable angina—now settling
- Await troponin

**Plan**
- Continue LMW heparin until pain-free for 48 hours
- Check cholesterol
- For echocardiography in view of murmur
- Spirometry and assessment of inhaler technique
- Consultant to discuss finding of breast lump with patient and daughter

A. Doctor  
A. DOCTOR (House Officer)
Plan
• List the investigations required. When a result is already available, for example of an electrocardiograph, record it.
• Record any immediate management instigated
• If uncertain about an investigation or treatment, precede with a '?' and discuss with a more senior member of staff

Information given
Document what you have told the patient and any other family member. It is also important to document any diagnosis that you have not discussed.
If the patient voices any concerns or fears, document these too.

Progress Notes
Follow the same structure with these additions
• Changes in the patient’s symptoms
• Examination findings
• Results of new investigations
• Clinical impression of the patient’s progress
• Plans for further management, particularly drug changes
Make progress notes regularly depending on the speed of change in the patient’s condition; in an intensive therapy setting, this may be several times a day but, in a stable situation, daily or alternate days.
Date and sign all entries.
Record any unexpected change in the patient’s condition as well as routine progress notes.