

# 3

## History taking

General history taking .....	<b>57</b>
Cardiovascular history .....	<b>61</b>
Respiratory history .....	<b>62</b>
Gastrointestinal history .....	<b>66</b>
Genito-urinary history .....	<b>70</b>
Obstetric, gynaecological and sexual history .....	<b>71</b>
Neurological history .....	<b>75</b>
Psychiatric history and mental health .....	<b>78</b>
Paediatric history .....	<b>87</b>
Preoperation clinic .....	<b>90</b>



## GENERAL HISTORY TAKING

Taking the history of a patient is the most important tool you will use in diagnosing a medical problem. To be able to obtain a history that is targeted to the presenting complaint takes practice, as well as knowledge of possible differential diagnoses. In this chapter, we will provide you with a basic structure for asking questions. In the following chapters, we will provide **target questions** to help make a rough diagnosis. These target questions should only be used as a guide, and you should tailor them to your own style. It is also important that the 'physician-driven history-taking approach' must not overwhelm or ignore the patient's agenda and their needs.

### General structure

#### Presenting complaint (PC)

Ask — *What is the main problem that has caused you to come to hospital today?*

Find out the main problem/problems that have made this patient present to you. It can sometimes be difficult to pin down the exact symptom(s) making the patient present. If the patient has not come to you directly, find out why they presented to someone else first.

#### History of the presenting complaint (HPC)

- *Where is it? And in the case of pain – Does it move anywhere?*
- *How would they describe the pain? – sharp, stabbing, dull, aching, squeezing? (let them use their own words).*
- *Time course. When did it start? How did it come on? Was it sudden or gradual? How did it continue? Did it come and go/worsen/improve?*
- *Does anything make it better or worse?*

- *How bad is it?* Can they use a severity scale 1–10 or describe it in terms of how it affects their life?
- *Did you feel anything else?* First ask them an open question, then ask about specific symptoms that may also arise from the systems most associated with the presenting complaint.

At this stage you may have an idea of the cause. You may want to ask specific targeted questions to identify further evidence for your initial differential.

### **Past medical and surgical history (PMHx)**

- *What medical problems do you suffer from currently and what problems have you suffered from in the past?* Find out, in particular, when were they first diagnosed.
- *How have you been recently?*
- *Have you had any surgery? When did this happen?*

Ask about important diseases that the patient may have forgotten to mention:

- Ischaemic heart disease (IHD), e.g. myocardial infarction (MI)
- Rheumatic fever
- Hypertension
- Diabetes
- Cerebrovascular accident (CVA)
- Pulmonary embolus (PE)
- Deep vein thrombosis (DVT)
- Asthma/COPD
- Epilepsy
- Jaundice
- Infectious conditions.

### **Drug history (DHx)**

- *What medications are you currently on?*
- *What dose do you take?*

- *How many times a day do you take it/them and at what times of day?*
- *How do you take it/them? (oral or injection etc.)*
- *Have you any allergies?*

Ask if anything happens to them when they take the drug. Sometimes the patient may be intolerant to the medication. However, be aware of rashes, swelling and other signs of anaphylaxis.

### **Family history (FHx)**

Ask – *Are there any diseases that run in your family?*

Drawing a family tree will help to illustrate this. Diseases to watch out for are heart disease, strokes, hypertension, diabetes, cancer and genetic conditions.

### **Social history (SHx)**

- *Do you smoke? Have you ever smoked for a significant period of time? When did you stop?*
- *How much do you/did you smoke on average every day?*

Express smoking as pack years. Number of years the patient has smoked, multiplied by the number of packs smoked per day. There are usually 20 cigarettes in a pack.

- *How much alcohol do you drink in an average week? (express in units)*
- *What do you do for a living?*
- *Do you have any pets?*
- *Have you travelled anywhere recently?*
- *What sort of housing do you live in?*
- *Do you live with anyone else at home?*

Determine if they live alone in a house, flat, sheltered housing, residential or nursing home:

- *How are you coping at home?*
- *Are you able to cook/clean/wash/go shopping on your own or do you need help?*
- *Do you need help to move around?*
- *Do you need a walking stick/wheelchair?*
- *Do you have stairs to climb?*
- *Do you have any carers? How often do they come?*

### **Systemic enquiry (S/E)**

At this stage, in order to conclude the history, it is important to ask about symptoms from systems not yet enquired about in the history of the presenting complaint (HPC):

- **General:** fever, weight loss, loss of appetite, lethargy
- **Cardiovascular system:** chest pain, palpitations, shortness of breath, paroxysmal nocturnal dyspnoea (sudden breathlessness during the night), orthopnoea (breathlessness on lying flat), leg swelling, nausea, sweating, dizziness, loss of consciousness
- **Respiratory system:** shortness of breath, cough, haemoptysis, wheeze, chest pain
- **Gastrointestinal system:** nausea and vomiting, haematemesis, dysphagia, heartburn, jaundice, abdominal pain, change in bowel habit, rectal bleeding, tenesmus (sensation of incomplete bowel emptying)
- **Genito-urinary system:** dysuria (pain on passing urine), frequency, terminal dribbling, urethral discharge
- **Gynaecological system:** pelvic pain, vaginal bleeding, vaginal discharge, LMP
- **Neurological system:** headaches, dizziness, loss of consciousness, fits, faints, funny turns, numbness, tingling, weakness, problems speaking, change in vision.

Although one can use the generalised template to obtain an adequate history, we have provided a range of questions, which will be useful when addressing different symptoms.

We have grouped the symptoms according to which physiological system they best represent, although some symptoms may belong to more than one.

## CARDIOVASCULAR HISTORY

### Chest pain

When taking a history of chest pain ask the patient:

- *Where is the pain?*
- *Does it move anywhere?*
- *When did it start and was it a sudden or gradual onset? What were you doing at the time?*
- *Since the onset, how has the pain continued – i.e. constant or coming and going?*
- *Can you describe its character?*
- *Does anything make it better or worse?*
- *Can you grade its severity from 1 to 10? (1 is the least and 10 is the most).*

### ● Target questions

Do you: suffer from hypertension, diabetes, high cholesterol? Have you ever smoked? Do you have any family history of heart problems such as angina or heart attack? **Risk factors for ischaemic heart disease (IHD)**

Does it hurt more on deep breathing or coughing, i.e. pleuritic chest pain? **PE, pneumonia**

Do you have a fever or a productive cough? **Pneumonia**

Recent surgery, recent immobility – long haul flights, bed rest, on the pill/HRT, current diagnosis of cancer, previously diagnosed PE/DVT, pro-clotting disorder, swollen tender legs? **PE risk factors**

Have you done any recent straining/lifting? **Musculoskeletal/IHD**

Do you have any history of heartburn, hiatus hernia or reflux disease? **Gastro-oesophageal reflux disease (GORD).**

## Palpitations

When taking a history of palpitations ask the patient:

- *When did you first notice palpitations?*
- *Do they occur continuously or do they come and go (paroxysmal)?*
- *Were they fast or slow? Were they regular or irregular? Did you notice extra beats? Can you tap the beat with your hand?*
- *What were you doing at the time?*
- *Did you experience any other symptoms such as chest pain, shortness of breath, loss of consciousness/feeling faint, leg swelling?*

## Target questions

Were you very anxious? **Anxiety provoked**

Do you have a fever? What medications are you taking? **Sinus tachycardia**

Do you have any heart murmurs or valve problems? Do you have any thyroid problems? Do you suffer from angina? Have you had a heart attack? How much alcohol do you drink? **Atrial fibrillation**

Shortness of breath – see *Respiratory history*, below

Loss of consciousness – see *Neurological history*, p. 75.

## RESPIRATORY HISTORY

### Shortness of breath

When taking a history of shortness of breath, ask the patient:

- *How long have you been short of breath?*
- *Do you normally get short of breath?*



- *Has it got worse recently?*
- *Did it come on suddenly or gradually?*
- *What were you doing at the time?*
- *Is there anything that makes it better or worse?*
- *How far can you walk before having to stop due to breathlessness?*
- *Do you get short of breath on lying flat? How many pillows do you sleep on?*
- *Do you ever wake up in the middle of the night feeling breathless?*

### ● Target questions

Do you cough up anything? What colour is it? Do you have chest pain which is worse on breathing in deeply? **Lower respiratory tract infection (LRTI)**

Do you get short of breath when lying flat or in the middle of the night? Have you noticed your legs getting more swollen? Do you have any known heart problems? Are you taking any water tablets (diuretics)? Are you good at taking them? **Left ventricular failure**

How much do you smoke? Have you been gradually getting more breathless for a while? Do you cough up phlegm most of the time? **Chronic obstructive pulmonary disease (COPD) or infective exacerbation**

Do you have sharp chest pain that is worse when you breathe in? Do you have tender swollen legs? Have you coughed up any blood? Check if there are any other PE risk factors – recent surgery, recent immobility, long haul flights, bed rest, on the pill/HRT, current diagnosis of cancer, previously diagnosed PE/DVT, pro-clotting disorder. **Pulmonary embolus (PE)**

Do you suffer from or have a family history of asthma, eczema, hay fever or allergies? Is it worse at night or in the morning? Does exercise, cold air or pollen make it worse? Do you get heartburn? **Asthma**

Have you had any recent chest injury or trauma? **Pneumothorax**

Have you noticed any tingling? Swollen lips? Rash? Have you any allergies? **Anaphylaxis**

How is your appetite? Have you noticed any weight loss? Do you feel tired? How much do you or have you smoked? **Bronchial cancer**

## Cough

When taking a history of a cough, ask the patient:

- *How long have you been coughing for?*
- *Do you bring anything up? What colour is it?*
- *When do you cough? Does anything make it better or worse?*
- *Have you noticed any blood in your sputum?*

## Target questions

Do you cough up yellow/green sputum? Are you short of breath? Have you any chest pain? Fever? Any recent travel? Do you have any pets? **LRTI**

Do you have any history of heart problems? Do you have swollen ankles, get breathless lying flat or wake up in the middle of the night feeling breathless? **Left ventricular failure**

Do you suffer from or have a family history of asthma, eczema, hay fever or allergies? Is it worse at night or in the morning? Does exercise, cold air or pollen make it worse? Do you get heartburn?

### Asthma

Have you coughed up any blood? Do you have sharp chest pain that is worse when you breathe in? Do you have tender swollen legs? Check on any other PE risk factors – recent surgery or recent immobility, long haul flights, bed rest, on the pill/HRT, current diagnosis of cancer, previously diagnosed PE/DVT, clotting disorder. **PE**

How is your appetite? Have you noticed any weight loss? Do you feel tired? How much do you, or have you smoked? **Bronchial cancer**

Have you started any new medications, e.g. **ACE (angiotensin-converting enzyme) inhibitors**

Do you have a runny nose? **Post-nasal drip**

## Wheeze

When taking a history of a wheeze, ask the patient:

- *How long have you been wheezy for?*
- *Do you get it all the time or only intermittently?*
- *Do you get short of breath?*
- *Is there any chest pain?*
- *Do you have a cough?*

## Target questions

Do you suffer from or have a family history of asthma, eczema, hay fever or allergies? Is it worse at night or in the morning? Does exercise, cold air or pollen make it worse? Do you get heartburn?

### Asthma

How much do you smoke? Have you been gradually getting more breathless for a while? Have you coughed up phlegm most days, for more than 3 months? For more than 2 years?

### COPD

Do you have any history of heart problems? Do you have swollen ankles, get breathless lying flat or wake up in the middle of the night feeling breathless? **Left ventricular failure**

Have you noticed any tingling? Swollen lips? Rash? Have you any allergies? **Anaphylaxis**

Chest pain – see *Cardiovascular history*, p. 61.

## GASTROINTESTINAL HISTORY

### Dysphagia

When taking a history of dysphagia (difficulty swallowing) ask the patient:

- *What have you found most difficult to swallow? Solids or liquids, or both?*
- *Where does the food stick?*
- *When did you first notice this?*
- *Did it come on suddenly one day or has it been a gradual process?*
- *When does it happen?*
- *Do you find it is painful to swallow? (odynophagia)*
- *Has food ever gone down the wrong way?*
- *Do you have a cough or feel short of breath?*

### Target questions

Has there been a gradual problem with solids or liquids? How is your appetite? Have you lost any weight? Do you smoke? Drink alcohol? **Oesophageal malignancy**

Do you find your swallowing problems come only every so often? Do you suffer from heartburn? Do you have problems drinking hot drinks? **Gastro-oesophageal reflux disease (GORD)**

Do you find your swallowing gets worse over the course of the day and towards the end of the meal? Do you become more physically tired and weak over the course of the day? **Myasthenia gravis**

Do you find the skin over your fingers and lips is tight? Do your fingers get cold, painful and change colour? **Systemic sclerosis**

Does it happen only intermittently? **Oesophageal spasm**

Do you gurgle when drinking? **Pharyngeal pouch**

Are you on iron tablets? **Plummer – Vinson syndrome**

## Haematemesis

When taking a history of haematemesis (blood in vomit), ask the patient:

- *When did it start?*
- *Was this of sudden onset or have there been previous smaller episodes?*
- *How much blood did you vomit?*
- *Is it fresh blood or clotted blood? Does it look like coffee grounds?*

### ● Target questions

Were you retching or vomiting before the blood? **Mallory – Weiss tear**

Do you have pain in your upper abdomen? Do you have any past history of indigestion or ulcer disease? **Ulcer bleed**

Are you on painkillers or blood-thinning drugs? **Gastritis from NSAIDs, aspirin, warfarin**

Do you drink alcohol and how much? Have you any liver problems? **Variceal bleed**

Have you noticed any weight loss or decreased appetite? Any problems swallowing? **Upper GI cancer**

Is the stool black in colour? **Melaena**

## Diarrhoea

When taking a history of diarrhoea, ask the patient:

- *How long have you had it for? Longer than 2 weeks?*
- *When was the last formed stool that you passed?*
- *What is the consistency of the stool?*
- *How often do you pass stool? How much stool do you pass?*
- *Have you noticed any blood in your stool?*
- *Do you get this regularly?*
- *Have you been previously investigated for this?*

## ● Target questions

Do you suffer from fevers, abdominal pain or vomiting?  
Have you eaten any uncooked foods? Have you travelled anywhere recently? Is anyone else you know affected? Is it improving? Have you had it for less than 2 weeks? **Infective gastroenteritis**

Do you have blood in your diarrhoea? Do you have abdominal pain? Do you have mouth ulcers? Do you have a family history of inflammatory bowel disease? **Inflammatory bowel disease**

Have you lost weight? Have you had any loss of appetite?  
Do you have alternating constipation and diarrhoea?  
Do you have the feeling of not completely emptying your bowels? Have you had it for more than 2 weeks? **Colonic carcinoma**

Do you find your stool floats and has a greasy appearance?  
**Malabsorption, e.g. pancreatic insufficiency/coeliac disease**

Do certain foods seem to cause the diarrhoea more than others?  
**Coeliac disease**

Have you recently taken antibiotics? **Antibiotic induced**

Are you on laxatives? **Laxative abuse**

Are you diabetic? **Autonomic neuropathy**

Have you any thyroid problems? Do you feel hot and shaky? Do you find your appetite increased? **Thyrotoxicosis**

## Jaundice

When taking a history of jaundice, ask the patient:

- *When did you first notice the yellow tinge to your skin and eyes?*
- *Have you ever had this before?*

## ● Target questions

Have you any family history of jaundice? What medications have you been taking? **Prehepatic, e.g. Gilbert's syndrome**

How much alcohol do you drink? What medications are you on? Have you had any recent blood transfusions? Where have you travelled recently? Have you had unprotected sex recently? Do you inject intravenous drugs? Have you eaten any shellfish? Do you have any tattoos? Have you been in contact with someone with jaundice? **Hepatic, e.g. viruses**

Have you noticed any change in the colour of your urine or stool? Are you itchy? Do you feel bloated? Do you have any abdominal pain? Have you any history of gallstones? Have you had any weight loss or loss of appetite? **Posthepatic, e.g. cholangiocarcinoma, pancreatic carcinoma**

## Rectal bleed

When taking a history of a rectal bleed, ask the patient:

- *When did you first notice the bleeding?*
- *What colour is it? (bright red, dark; see p. 67)*
- *Where did you notice it? (on the paper, in the pan, mixed with the stool or covering the stool)*
- *How much blood would you estimate it to be? (thimble, cup or bowl full)*
- *Is it with every bowel motion?*
- *Have you noticed any mucus?*
- *Do you have pain on passing stool?*

## ● Target questions

Have you noticed a recent change in bowel habit? Do you have a feeling of incompletely emptying your bowels? How is your appetite? Have you noticed any weight loss? **Bowel cancer**

Is the blood bright red? Is your bottom itchy? Do you have haemorrhoids? **Haemorrhoids**

Is it so painful to pass stool that you do not want to? **Anal fissure**

Do you have diarrhoea, crampy abdominal pain, fever, an eye problem, joint pains, ulcers or weight loss? **Inflammatory bowel disease**

Are you known to have diverticular disease? Do you have a change in bowel habit, left-sided abdominal pain relieved by passing stool, or flatulence? **Diverticular disease**

## GENITO-URINARY HISTORY

### Haematuria

When taking a history of haematuria (blood in the urine), ask the patient:

- *What colour is your urine?*
- *Is it pure blood or mixed with urine?*
- *Are there any clots?*
- *Does it happen all the time when you pass water?*
- *How long has this happened for?*
- *Is it near the beginning, end or during the entire urine stream?*

### ● Target questions

Are you taking rifampicin? Have you eaten beetroot? (These cause discoloured urine.)

Have you had a fever? Stinging while passing water? Smelly urine? Lower abdominal pain or loin pain? Do you find you go to toilet more often during the day? Or at night? **Urinary tract infection**

Have you ever suffered from kidney stones? Do you suffer from pain in the loin or groin? Is there pain specifically in the lower



tummy or genital area? Does the pain come in waves? **Kidney stones**

Do you feel tired? Do you have night sweats? Have you noticed any weight loss? Pain in your side? **Kidney or ureteric cancer**

Do you smoke? Have you been exposed to industrial chemicals, e.g. aniline dyes? Are you taking any medication, e.g. cyclophosphamide? **Bladder tumours**

Do you get up to go to pass urine often? Is it painless? **Prostatic cancer in men**

## OBSTETRIC, GYNAECOLOGICAL AND SEXUAL HISTORY

The history should follow the same format as the general structure outlined in the *General history taking* section, p. 57, but the following added questions should be asked.

### Past gynaecological history

- *Have you had any problems with your uterus, ovaries or vagina?*
- *Have you ever had any gynaecological surgery?*
- *When was your last cervical smear? What was the result?*

### Past obstetric history

- *Do you have children? Have you had any terminations or miscarriages?*
- *Were the pregnancies to term?*
- *What was the delivery method?*
- *Were there any complications during the pregnancy, e.g. bleeding or infection?*
- *What were the birth weights?*
- *Were there any complications after delivery, e.g. depression?*

## Menstrual history

- *When was the first day of your last period?*
- *Is your period usually regular? What is the cycle length? When did you start/stop your periods?*
- *Are they particularly heavy? Ask about number of tampons or pads used, if clots or flooding occurs.*
- *Do you suffer pain during periods?*

## Systemic enquiry

- *Do you have bleeding in between your periods? After sexual intercourse? Since your menopause?*
  - *How heavy is the bleeding? How many tampons or towels do you use? Do you have clots or find the bleeding is more than the pad or tampon can absorb (flooding)?*
  - *Do you have vaginal discharge? What colour is it? How much is it?*
  - *Do you suffer from pelvic pain? Do you have pain during intercourse? Is it superficial or deep pain?*
  - *Do you wet yourself? Do you find you go to pass urine often?*
- Urinary symptoms can indicate gynaecological pathology.

## Sexual history

This can be one of the trickiest histories because clinicians may get embarrassed talking about the sex lives of patients and do not wish to embarrass the patient. This history is not commonly used except in sexual health clinics, but it is important to know the questions that should be asked to be able to give a good differential diagnosis.

Apart from a GU clinic setting, the history will almost always be asked as part of another history such as an obstetric and gynaecological history. This means that the rapport with

the patient has already been built up, so it is now very important to signpost your new line of questioning. This would be particularly relevant when considering a sexual condition in a non-sexual context, e.g. septic arthritis.

Start with – *You've just mentioned that you were suffering from problems with your genital area, and I would like to ask you further questions regarding this. The questions will be very personal, but please don't feel embarrassed and you don't have to answer them if you do not wish to. The questions are from a standard list that we ask all patients.*

Now use the history structure. People commonly present with:

- discharge
- itchiness
- sores and lumps.

The key questions to ask to ascertain risk to the patient and their partner are:

- *Are you sexually active?*
- *When the symptoms came on, was the person you had sex with a regular or casual partner?*
- *How many partners have you had in the past year?*
- *Were they exclusively male or exclusively female or both?*
- *Do you use sex toys?*

And for each partner, you should ask:

- *Were they a regular/casual partner?*
- *Did you have vaginal/anal/oral sex with them? (With anal intercourse, it is important to know if they received it or were giving it.)*
- *Did you use protection? What protection did you use?*
- *Did you pay the partner for sex and have you ever paid for sex?*
- *Did your partner at the time have a sexually transmitted disease?*

In this history, it is also important to ascertain HIV risk as well. You must warn the patient that these questions relate

to this by saying – *Thank you for answering the questions truthfully, but I must also ask you some standard questions regarding the level of risk for HIV infection. Once again you don't have to answer these, but it would greatly assist my understanding of your problem if you did.*

Other questions relating to the risk of HIV infection:

- Sexual practices as above.
- *Have you ever injected drugs into your veins or have you had a partner or friends who have?*
- *Have you ever had a blood transfusion either in the UK before 1985 or abroad at any time? Have you been diagnosed with a blood disorder?*

## **Legal Guidance – Termination of pregnancy**

The law governing termination of pregnancy has its roots in the 1939 case of *R-v-Bourne* [(1939) 1 KB 687, (1938) 3 All ER 615].

Mr Bourne openly performed an abortion on a 15-year-old girl who was pregnant following a rape. He was charged with a criminal offence but acquitted after the court decided that abortion was not illegal if it was performed because a woman's health – physical and/or mental – was in jeopardy.

This principle was eventually codified in the Abortion Act 1967. This Act was amended by the Human Fertilisation and Embryology Act 1990s.37. Prior to the 1967 Act, abortion was a crime under common law in Scotland and under the Offences Against the Person Act 1861 in England and Wales.

The position now is that terminations of pregnancy are lawful, or to put it another way, that no-one will be guilty of a criminal offence if:

- the termination is carried out by a registered medical practitioner; **and**

- two registered medical practitioners have decided that the continued pregnancy would present a greater risk than a termination, in terms of the woman's physical or mental health, or that of any children she already has; **and**
- the termination takes place before the end of the 24th week of pregnancy.

Alternatively, a termination may be carried out by a registered medical practitioner without fear of prosecution, *without* time limit and *without* a second opinion where:

- there is a risk of grave permanent injury to the woman **or**
- the risk to life of continuing the pregnancy outweighs the risk of termination.

Or it may be carried out by a registered medical practitioner *without* time limit but *with* a second opinion where:

- there is a substantial risk that the child, if born, would suffer from severe physical or mental handicap.

Note: In emergency situations a second doctor is not required.

## Conscientious objections

If termination of pregnancy conflicts with a doctor's religious or moral beliefs, they may be excused from performing the procedure. This exemption does not apply in emergency situations.

A conscientious objector must, however, explain their position to the patient and make arrangements for them to see another practitioner without delay.

## NEUROLOGICAL HISTORY

### Loss of consciousness

- *Was it witnessed?* Try to get answers from a witness.
- *When did this happen?*

- *What happened beforehand?*
- *Did you know you were going to lose consciousness?*
- *How long were you unconscious for?*
- *Did you hurt yourself? Did you hit your head?*

## ● Target questions

What were you doing at the time?

- Were you watching TV or flashing lights? **Epileptic fit**
- Were you coughing? **Cough syncope**
- Were you passing urine? **Micturition syncope**
- Were you turning your head? **Carotid hypersensitivity**
- Were you standing up? **Postural hypotension**
- Were you exerting yourself, e.g. climbing stairs? **Cardiac valve abnormality**

Did you have a warning? Any palpitations? **Arrhythmia**

Were there any visual or sensory changes? **Epileptic fit**

Did you wet yourself? Did you bite your tongue? **Epileptic fit**

How did you feel afterwards? Confused for a while? **Epileptic**

Did you feel fine afterwards? **Non-fit**

Did you feel weak or have muscle pain after coming round?

**Epileptic fit**

Ask any witnesses what the patient looked like when they were coming round.

## Headache

- *When did you first notice it?*
- *What were you doing before it started?*
- *Did you notice anything before the onset?*
- *How did it come on? Suddenly or gradually?*
- *How long has it lasted for?*

- *Where does it hurt?*
- *Have you ever had a similar one before? How often do they come on?*
- *How severe is it? (Grade 1–10)*

## ● Target questions

Was it the worst headache you have ever had? Did it feel as if someone had hit you on the head? Were you straining prior to onset? Was there any vomiting? Any neck stiffness? Any fear of lights? Is there anyone in the family who has had a subarachnoid bleed? **Subarachnoid haemorrhage**

Do you have a stiff neck? Fever? Dislike of lights? Do you have a rash or any joint pains? Have you been feeling unwell recently? **Meningitis**

Did you see any zigzag lines/other visual changes before onset? Was the pain mainly on one side? Did you feel sick or have you vomited? Did you want to go to quiet dark corner of your house? Has it been triggered by certain foods, e.g. cheese, caffeine or alcohol? **Migraine**

Does your headache occur frequently for a few weeks then stop for months in a cycle? Does it start around the eye and remain on that side of the head? Do you notice anything that might trigger it? **Cluster headaches**

Have you noticed any weakness or change in sensation? Is it worse on lying down? Do you feel sick? Have you vomited? **Raised intracranial pressure**

Have you recently stopped/started taking painkillers? **Rebound headache/analgesia induced**

Is your scalp sore? Does your jaw hurt after you have chewed for a while? Have you had any sudden loss of vision? Do you feel tired? **Giant cell arteritis**

Have you had any recent/current stresses? Does it feel like a general tightness around the head? **Tension headache**

Have you had any recent increased lethargy or confusion over the last few days? Have you had a recent head injury? **Subdural haemorrhage**

## PSYCHIATRIC HISTORY AND MENTAL HEALTH

A psychiatric history is different from the mental-state examination which determines the actual mental state of the patient at the time.

Start off with:

- name
- age
- how they were admitted (elective vs police)
- presenting complaint.

### Changes in mood

- *Have you felt low recently?*
- *What did you enjoy doing before? Do you still enjoy doing those things?*
- *How is your sleep pattern? (early morning waking or sleeping in?)*
- *How is your appetite?*
- *Do you still feel like sex?*
- *How do you see the future?*

### Deliberate self harm

- *Have you ever had thoughts about hurting yourself? Have you done so?*
- *Have you ever had thoughts about ending your own life?*
- *Did you leave a suicide note or try to tie up your affairs?*
- *What exactly did you do?*
- *Do you have any regrets that you did not succeed? Do you have any intention to go and do it again?*



If you suspect paranoid schizophrenia it is advisable at this stage to ask about Schneider's First Rank Symptoms.

### **Past psychiatric history**

- *Have you had any mental health issues?*
- *Have you ever seen a psychiatrist or been admitted to a psychiatric hospital?*

### **Past medical history**

- *What is your health like?*
- *What medical problems do you suffer from?*

### **Drug history**

- *Are you taking any doctor prescribed medication at the moment? What is it?*
- *Are you allergic to anything?*

### **Recreational drug history**

- *Have you ever taken any recreational drugs? Are you doing so now? What are you taking? How do you take it? How much do you take?*
- *Do you drink alcohol? How much do you drink in a typical week? Have you had any today?*
- *Do you smoke?*

### **Criminal history**

- *Have you ever been in trouble with the police? Do you have a criminal record?*

### **Life history**

Find out about the patient, starting from their early childhood all the way to the present day.

Early childhood:

- *What memories do you have of growing up?*
- *Do you have any brothers or sisters? How was your relationship with them?*
- *Were you adopted or fostered?*

Later childhood:

- *Did you make any friends?*
- *How did you find school?*

Adulthood:

- *Did you go to university? How did you find university?*
- *Have you ever had a job?*

## **Sexual and relationship history**

- *Are you sexually active? When did you start?*
- *Do you have sexual relations with men or women or both?*
- *Are you in a relationship? Tell me about your relationships up till now.*

Note any mention of sexual abuse that surfaces in the interview.

## **Personality**

- *What was your personality like before this current illness?*
- *How would you describe it now?*

## **Thoughts and beliefs**

These usually reveal themselves during the interview and direct questioning may not reveal them. One way is to ask very general questions:

- *How do you view yourself?*
- *How do you view others around you?*

## Current social history

- *Do you have a job?*
- *Where do you live? Is it a hostel or your own place?*
- *Do you live with any one?*
- *How are your relationships with your partner, your family and your friends?*
- *Have you ever been in trouble with the law?*

## Family history

Particular emphasis should be on any psychiatric problems, deliberate self harm or substance abuse, e.g. *Has anyone in your family had mental health issues/tried to hurt themselves/taken recreational drugs?*

## Legal Guidance – Mental health

### Categories of mental health patient

There are three categories of mental health patient: formal, voluntary and informal.

**Formal patients** are those who have been ‘sectioned’ or detained under the Mental Health Act 1983. Whilst such patients may be deprived of their liberty and be subject to other restrictions on their rights, they also have rights of appeal and other statutory protection.

**Voluntary patients** are people who have mental capacity to make their own choices regarding their treatment and have chosen to receive treatment as an inpatient. They have exactly the same rights as someone receiving treatment for a physical illness (see *Dealing with potential self-discharging patients*, p. 46).

An **informal patient** is an inpatient who lacks capacity to make choices regarding treatment but is not actively trying to leave. In the case of *Bournewood HL v. United Kingdom* (2004) the European Court of Human Rights held that it was

unlawful to hold such patients without ensuring they have similar rights to formal and voluntary patients. The Government addressed this gap in the law by amending the Mental Capacity Act 2005. These new provisions close the Bournewood gap.

### Overview of the Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The 1983 Mental Health Act had two aims: to give specific rights to patients who are, or appear to be, suffering from a **mental disorder**, whilst at the same time allowing for their compulsory detention and treatment.

A mental disorder is defined as follows: **any disorder or disability of the mind.**

This includes, but is not limited to:

- affective disorders, such as depression or bipolar disorder
- schizophrenia
- neurotic, stress-related and somatoform disorders
- organic mental disorders, such as dementia and delirium
- personality and behavioural changes brought on by brain injury
- personality disorders and mental and behavioural changes caused by substance and/or alcohol misuse
- eating disorders
- learning disorders (as long as there is attendant abnormally aggressive or seriously irresponsible conduct for s.3)
- autism.

Alcohol or substance misuse does not of itself constitute a disorder or disability of the mind.

Part II of the Mental Health Act deals with the compulsory admission to hospital for patients not involved in criminal proceedings.

Short-term compulsory powers can only be used if the individual is suffering from a mental disorder of a degree

that warrants their detention in hospital for assessment, or assessment followed by treatment, and if the detention is thought to be necessary for the health and safety of the individual or for the protection of others.

Longer-term compulsory powers can only be used if the individual is suffering from a mental disorder of a degree that makes it appropriate to receive treatment in hospital. Appropriate treatment must be available and the circumstances must be such that the treatment can only be delivered in a hospital setting. Additionally, the detention must be necessary for the health and safety of the individual or for the protection of others.

## **Psychiatric personnel involved**

### ***Section 12 doctor***

A section 12 doctor has particular experience in the treatment or diagnosis of mental disorder and has received special training in the Mental Health Act. One of the medical practitioners making an application for detention must be s.12 approved.

### ***Approved Mental Health Practitioner (AMHP)***

An AMHP is a social worker or other professional approved by a local Social Services authority to carry out certain functions under the Act, including making the application for detention (which will then be supported by two medical recommendations).

### ***Responsible Clinician***

This is the person with overall responsibility for a patient's care. They will not necessarily be a doctor, but must be an Approved Clinician.

### *Approved Clinician*

This is a mental health professional who has received special training and is authorised to make certain decisions under the Act. Again, they need not be a doctor.

### *Nearest Relative*

Section 26 of the Act determines the identity of an individual's **nearest relative**. In order of priority it is the individual's:

- husband or wife or partner in a civil partnership (unless the couple are permanently separated)
- son or daughter
- father or mother
- brother or sister
- grandparent
- grandchild
- uncle or aunt
- nephew or niece.

Out of the above, full blood relatives take precedence over half blood, and out of each pair, the elder of the two takes precedence.

If the individual's parents weren't married when he or she was born, the mother takes priority over the father, unless the father also has parental responsibility, in which case it is the elder of the two parents.

If the individual normally lives with a relative who acts as carer, or otherwise has a relative who acts as carer for them, that person goes top of the list.

If the individual and someone else have lived together as a couple for at least 6 months, that counts as husband or wife.

If the person at the top of the list is under 18 and is not the individual's husband, wife, civil partner or parent, they do not qualify.

## Mental Health Act sections

### *Section 2*

Section 2 allows for **admission for assessment** for a period of up to 28 days. The application is made by an Approved Mental Health Practitioner or the patient's nearest relative (defined in section 26 of the Act) and must be authorised by two doctors.

### *Section 3*

Section 3 allows for **admission for treatment** for a period of up to 6 months, with an option to renew for another 6 months and thereafter for a year at a time. The application is made by the patient's nearest relative or an approved mental health practitioner and again must be authorised by two doctors.

### *Section 4*

Section 4 allows for compulsory assessment in emergency circumstances for a period of up to 72 hours, with the application being made by the nearest relative or an approved mental health practitioner. However, only one doctor is needed to authorise the admission. The doctor must confirm that:

- the case is one of urgent necessity
- that waiting for a second doctor to confirm the need for a section 2 detention would cause an undesirable delay.

If a second medical certificate is provided within the 72-hour period the admission becomes a section 2 admission.

## *Section 5*

Section 5(2) allows for **compulsory detention of patients already in hospital** for a period of up to 72 hours.

Under section 5(4) a mental health nurse has a **holding power** for up to 6 hours whereby he or she can prevent an inpatient from leaving pending the arrival of a doctor or Approved Clinician.

## *Section 136*

Section 136 allows for the **removal and detention of a patient from a public place** to a place of safety for a period of up to 72 hours. The power is exercisable by a Police Officer.

## *Guardianship*

**Guardianship orders** are a mechanism by which a patient over the age of 16 can be compelled to:

- live in a certain place
- attend certain places for work, training or medical treatment. The patient cannot, however, be made to receive treatment
- receive home visits from doctors or other professionals.

## *Part III*

Part III of the Act covers patients who are involved in criminal proceedings.

Section 35 authorises a Crown or Magistrates' Court to **remand an accused in hospital rather than prison** so that a **medical report** regarding an accused person's mental condition can be prepared. The remand may be for a period of up to 28 days, renewable in blocks of 28 days to a maximum of 12 weeks.



Section 36 authorises a Crown or Magistrates' Court to **remand an accused person in hospital rather than prison for the purposes of treatment**. The remand may be for a period of up to 28 days, renewable in blocks of 28 days to a maximum of 12 weeks.

Section 37 authorises a Crown or Magistrates' Court to make **Hospital or Guardianship Orders** regarding a person convicted of an offence or, where the person was not convicted due his mental condition, where the Court is satisfied he committed the offence as charged. The order may be for a period of up to 6 months, renewable for a further 6 months and thereafter for a year at a time.

#### Mental health in Scotland



After much consultation, the Scottish Parliament enacted the Mental Health (Care and Treatment) Act 2003. This Act contains all the provisions relating to compulsory measures for mental health care, as well as provisions concerning people who enter the mental health system through the criminal justice process. A range of measures for both compulsory treatment and support for people who are not the subject of any compulsory measure are covered by the Act.

## PAEDIATRIC HISTORY

Taking a history of a child is similar to taking that of an adult, but there are a few more questions that need to be asked. Some sections already mentioned in the adult history-taking section need to be emphasised.

### Presenting complaint

Gather information about the presenting complaint directly from the child if they are old enough, or direct from the carer, usually the parents or legal guardian.

Obtain the time line of the complaint as children's illnesses can fluctuate over time.

## Past medical history

- *Were there any complications during pregnancy?*
- *Was the baby born at term? What was the mode of delivery? How much did the baby weigh? Were there any complications at birth?*
- *Have there been any operations, hospital admissions, medical problems, e.g. congenital heart disease, asthma, epilepsy, diabetes or genetic disease?*

## Developmental history

- *Do you have any concerns about your child's development?*
- *Has she been reaching her milestones:*
  - *Gross and fine motor, language, social skills?*
  - *Does she look up at you and seem interested in her surroundings? Does she smile?*
  - *Can she walk/crawl/pull herself up? What age could she do that?*
  - *Does she play with other children yet?*
- *Manual dexterity:*
  - *Can she hold a pencil and use it?*
  - *Does she transfer things between hands or show a preference for one particular hand?*
  - *Does she ever pick anything up with her index finger and thumb or does she try to clasp everything?*
  - *When did she start using her index fingers and thumbs?*
- *Can she speak words yet? When could she do that? What can she say?*

## Immunisation history

Check that the child's vaccinations are up to date. If not, ask why not.

## Drug history

Ask if the child is taking any regular medication and if they have any allergies.

## Family history

- *Who makes up your family? or What family members are there?*
- *Are there any medical problems running in the family? (very important to draw a family tree).*

If – and only if – you have a compelling reason to ask, inquire tactfully about consanguinity, e.g. *Have there been any relationships between members of your family that produced children?*

Asking questions here needs particular sensitivity. Ask whether the child is doing well at school, who looks after the child, who makes up the family unit, and what do the parents do.

## Systemic enquiry

Older children who are able to articulate their problems may be asked the same questions as adults.

For younger children ask the carers about:

- general – appetite, fever, rashes, alertness, crying (are they pacifiable?)
- CVS – breathing, wheezing, looking blue, sweating
- respiration – breathing difficulties, coughing
- gastro – appetite, vomiting, diarrhoea, abdominal pain
- genito-urinary – number of wet nappies
- ear, nose and throat (ENT) – ear discharge, grasping of outer ear, runny nose, noisy breathing
- neurological – fits, walking gait.

## PREOPERATION CLINIC

This is a common area for questions in medical student finals, since it tests whether you have ever been to a pre-operation clinic. Conducting a preoperative interview is a fundamental skill for the F1 foundation year. The patients seen are most often there for elective or minor surgery. Most will be treated as day cases and will go home either the following day or even the same day. It is extremely important that any risk factors that may affect a patient's safety are identified in advance.

Preoperative interview:

- Introduce yourself.
- Ask about the operation the patient is coming in for (so that they know and you know that they know).
- Inquire if the patient is happy to proceed with surgery.
- Take a quick history of symptoms (*When did it start?*) and check on symptoms between the last clinic appointment and now.

## Past medical and surgical history

Ask about ischaemic heart disease, diabetes, lung disease, kidney disease, chronic infection, joint problems (especially neck problems, e.g. cervical spondylolysis) and clotting problems leading to DVT or PE. Try to use non-scientific language, e.g. *Have you had a blood clot in your legs or lungs?*

Ask about previous general and local anaesthetic exposure and any reactions to either: ask – *Have you ever been put to sleep before?*

## Drug history

Ask about:

- what medications the patient is taking/has taken recently and their doses, paying particular concern to anticoagulants

- allergies – especially to drugs, rubber, latex, plasters or dyes
- vaccination status, especially tetanus.

## Social history

Ask about employment, smoking, drinking, recreational drugs and social support available after surgery (e.g. is there anyone to take them home?).

## Family history

Ask about any medical problems that run through the family.

## System review

Ask about any other symptoms that may indicate an infection, which may in turn mean that the operation has to be postponed.

Then:

- Examine the patient and the part of the body that is going to be operated on.
- If appropriate, request bloods, chest X-rays, ECGs and any further investigations as required.
- Again, ask if the patient is happy to proceed with surgery, but tell them that the surgeon will run through the operation information on the day of the surgery.
- Give them certain preoperative advice: *Have nothing to eat or drink from midnight before you come in* (if they are a day case).
- For medication: see local preoperative protocols.
- Give them postoperative advice.
- Address any concerns or questions.
- Wish them well and tell them that you'll see them when they come in.