SECTION I

History and examination

CHAPTER 1
History taking

General procedures

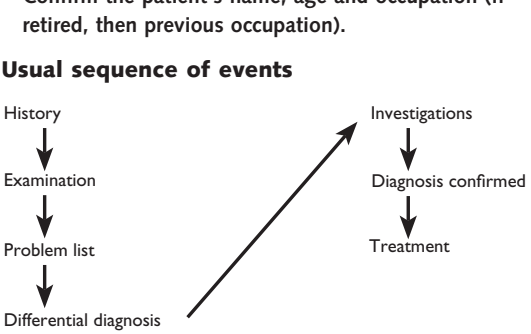
Approaching the patient

- **Look the part of a doctor and put the patient at ease. Be confident and quietly friendly.**
- **Greet the patient politely: 'Good morning, Mr Smith'.**
- **Shake the patient's hand or place your hand on their hand if they are ill.**
- **State your name and that you are a medical student.**
- **Make sure the patient is comfortable.**
- **Explain that you wish to ask the patient some questions to find out what happened to them.**

  Inform the patient how long you are likely to take and what to expect. For example, after discussing what has happened to the patient, you would like to examine them. Most patients are very happy to have someone to chat to but if they do not then don't take it personally.

- **Confirm the patient's name, age and occupation (if retired, then previous occupation).**

Usual sequence of events



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Importance of the history

- It identifies:
  - what has happened
  - the personality of the patient
  - how the illness has affected them and their family
  - any specific anxieties
  - the physical and social environment.
- It establishes the physician–patient relationship.
- It often suggests the diagnosis.

- **Find the principal symptoms or symptom with an open question. Ask:**
  - **'What has the problem been?'**
  - **'What made you go to the doctor?'**

  Avoid:
  - 'What's wrong?' or 'What brought you here?'
- **Let the patient tell their story in their own words as much as possible.**

At first listen and then take discreet notes as they talk. When learning to take a history there can be a tendency to ask too many questions in the first 2 minutes. After asking the first question you should normally allow the patient to talk uninterrupted for up to 2 minutes.

Do not worry if the story is not entirely clear, or if you do not think the information being given is of diagnostic significance. If you interrupt too early, you run the risk of overlooking an important symptom or anxiety.

- **You will be learning about what the patient thinks is important.**
- **You have the opportunity to judge how you are going to proceed.**

Different patients give histories in very different ways. Some patients will need to be encouraged to enlarge on their answers to your questions; with other patients you may need to ask specific questions and interrupt in order to prevent too rambling a history. Think consciously about the approach you will adopt. If you need to interrupt the patient, do so clearly and decisively.

- **Try, if feasible, to conduct a conversation rather than an interrogation, following the patient's train of thoughts.**

You will usually need to ask follow-up questions on the main symptoms to obtain a full understanding of what they were and of the chain of events. Try to note down the main points and then explore those.

- **Obtain a full description of the patient's principal complaints.**
- **Enquire about the sequence of symptoms and events.**

  Beware pseudomedical terms and jargon, e.g. 'gastric flu'—enquire what happened.

- **Do not ask leading questions at first.**

  A central aim in taking the history is to understand the patient's symptoms from their point of view. It is important not to colour the patient's history with your own expectations. For example, do not ask a patient whom you suspect might be thyrotoxic: 'Do you find hot weather uncomfortable?' This invites the answer 'Yes' and then a positive answer becomes of little diagnostic value. Ask the open question: 'Do you particularly dislike either hot or cold weather?'

- **Be sensitive to a patient's mood and non-verbal responses.**

  For example, hesitancy in revealing emotional content. Remember the importance of non-verbal communication.

- **Be understanding, receptive and matter-of-fact without excessive sympathy.**
- **Rarely show surprise or reproach.**
- **Clarify symptoms and obtain a problem list.** When the patient has finished describing the symptom or symptoms:
  - **briefly summarise the symptoms**
  - **ask whether there are any other main problems.**

  For example, say, 'You have mentioned two problems: pain on the left side of your tummy, and loose motions over the past 6 weeks. Before we talk about those in more detail, are there any other problems I should know about?'

Usual sequence of history

- **nature of principal complaints, e.g. chest pain, poor home circumstances**
- **history of present complaint—details of current illness**
- **enquiry of other symptoms (see Functional enquiry below)**
- **past history**
- **drug history including allergies and over the counter medication**
- **family history**
- **personal and social history, including travel and animal contact**

- **If one's initial enquiries make it apparent that one section is of more importance than usual (e.g. previous relevant illnesses or operation), then relevant enquiries can be brought forward to an earlier stage in the history (e.g. past history after finding principal complaints).**

History of present illness

- **Start your written history with a single sentence** summing up what your patient is complaining of. It should be like the banner headline of a newspaper. For example:

  c/o chest pain for 6 months.

- **Determine the chronology of the illness by asking:**
  - 'How and when did your illness begin?' or
  - 'When did you first notice anything wrong?' or
  - 'When did you last feel completely well?'
- **Begin by stating when the patient was last perfectly well.** Describe symptoms in **chronological order of onset**.

  Both the **date of onset** and the **length of time** prior to admission should be recorded. Symptoms should never be dated by the day of the week as this later becomes meaningless.

- **Obtain a detailed description of each symptom by asking:**
  - 'Tell me what the pain was like', for example. Make sure you ask about all symptoms, whether they seem relevant or not.
- **With all symptoms obtain the following details:**
  - **duration**
  - **onset—sudden or gradual**
  - **what has happened since:**
    - **constant or periodic**
    - **frequency**
    - **getting worse or better**
  - **precipitating or relieving factors**
  - **associated symptoms.**
- **If pain is a symptom, also determine the following:**
  - **site**
  - **radiation**
    - **character**, e.g. ache, pressure, shooting, stabbing, dull
    - **severity**, e.g. 'Did it interfere with what you were doing? Does it keep you awake?'
  - have you ever had this pain before?
  - is the pain associated with nausea, sweating, e.g. angina?

Avoid technical language when describing a patient's history. Do not say 'the patient complained of melaena', rather: 'the patient complained of passing loose, black, tarry motions'.

Students often find the mnemonic SOCRATES useful: **S**ite, **O**nset, **C**haracter, **R**adiation, **A**lleviating factors/ **A**ssociated symptoms, **T**iming (duration, frequency), **E**xacerbating factors, **S**everity.

Supplementary history

When patients are unable to give an adequate or reliable history, the necessary information must be obtained from friends, relations or carers. A history from a person who has witnessed a sudden event is often helpful.

Accordingly, the student should arrange with the F1 doctor to be present when the relatives or witnesses are interviewed. This is particularly important with patients suffering from disease of the central nervous system. The date and source of such information should be written in the notes.

When necessary, arrange for an interpreter. This can be done via local authorities. Be careful about using family members to translate.

Make use of the GP's letter and contact the GP if necessary.

Functional enquiry

This is a checklist of symptoms not already discovered. Do not ask questions already covered in establishing the principal symptoms. This list may detect other symptoms.

- **Modify your questioning according to the nature of the suspected disease, available time and circumstances.**

If during the functional enquiry a positive answer is obtained, full details must be elicited. Asterisks (*) denote questions which must nearly always be asked.

General questions

- Ask about the following points.
  - ***Appetite**: 'What is your appetite like? Do you feel like eating?'
  - ***Weight**: 'Have you lost or gained weight recently?' This is a crucially important question!
  - ***General wellbeing**: 'Do you feel well in yourself?'
  - **Fatigue**: 'Are you more or less tired than you used to be?'
  - **Fever or chills**: 'Have you felt hot or cold? Have you shivered?'
  - **Night sweats**: 'Have you noticed any sweating at night or any other time? Enough to soak the bedclothes?'
  - **Aches or pains**.

- **Rash**: 'Have you had any rash recently? Does it itch?'
- **Lumps and bumps**.

Cardiovascular and respiratory system

- Ask about the following points.
  - ***Chest pain**: 'Have you recently had any pain or discomfort in the chest?'

The most common causes of chest pain are:

Ischaemic heart disease: severe constricting, central chest pain radiating to the neck, jaw and left arm.

Angina is this pain precipitated by exercise or emotion; relieved by rest.

In a *myocardial infarction* the pain may come on at rest, be more severe and last hours.

Pleuritic pain: sharp, localised pain, usually lateral; worse on deep inspiration or cough.

Anxiety or panic attacks are a very common cause of chest pain. Enquire about circumstances that bring on an attack.

  - ***Shortness of breath**: 'Are you breathless at any time?'

Breathlessness (*dyspnoea*) and chest pain must be accurately described. The degree of exercise that brings on the symptoms must be noted (e.g. climbing one flight of stairs, after 0.5 km (1/4 mile) walk).

  - **Shortness of breath on lying flat** (*orthopnoea*): 'Do you get breathless in bed? Can you lie flat? What do you do then? Does it get worse or better on sitting up? How many pillows do you use? Can you sleep without them?'
  - **Waking up breathless**: 'Do you wake at night with any symptoms? Do you gasp for breath? What do you do then?'

Orthopnoea (breathless when lying flat) and *paroxysmal nocturnal dyspnoea* (suddenly waking up breathless, relieved on sitting up) are features of *left heart failure*.

  - ***Ankle swelling**.

Common in *congestive cardiac failure* (*right heart failure*).

- **Palpitations**: 'Are you aware of your heart beating?'

Palpitations may be:
- single thumps (*ectopics*)
- slow or fast
- regular or irregular.

Ask the patient to tap them out.

Paroxysmal tachycardia (sudden attacks of palpitations) usually starts and finishes abruptly.

- ***Cough**: 'Do you have a cough? Is it a dry cough or do you cough up sputum? When do you cough?'
- **Sputum**: 'What colour is your sputum? How much do you cough up?'

Green sputum usually indicates an *acute chest infection*. Clear sputum daily during winter months suggests *chronic bronchitis*. Frothy sputum suggests *left heart failure*.

- ***Blood in sputum** (*haemoptysis*): 'Have you coughed up blood?'

Haemoptysis must be taken very seriously. Causes include:
carcinoma of bronchus
pulmonary embolism
mitral stenosis
tuberculosis
bronchiectasis.

- **Black-outs** (*syncope*): 'Have you had any black-outs or faints? Did you feel light-headed or did the room go round? Did you lose consciousness? Did you have any warning? Can you remember what happened?'
- ***Smoking**: 'Do you smoke? How many cigarettes do you smoke?'

Gastrointestinal system

- Ask about the following points.
  - **Mouth ulcers.**
  - **Nausea**: 'Are there times when you feel sick?'

- **Vomiting**: 'Have you vomited? What is it like?'

'Coffee grounds' vomit suggests altered blood.
Old food suggests *pyloric stenosis*.
If blood, what colour is it—dark or bright red?

- **Difficulty in swallowing** (*dysphagia*): 'Do you have difficulty swallowing? Where does it stick?'

For solids: often organic obstruction.
For fluids: often neurological or psychological.

- **Indigestion**: 'Do you have any discomfort in your stomach after eating?'
- **Abdominal pain**: 'Where is the pain? How is it connected to meals or opening your bowels? What relieves the pain?'
- **Bowel habit**: 'Is your bowel habit regular? How many times do you open your bowels per day? Do you have to open your bowels at night?' (*often a sign of true pathology*).

If *diarrhoea* is suggested, the number of motions per day and their nature (blood? pus? mucus? slime?) must be established.

'What are your motions like?' The stools may be pale, bulky and float (fat in stool—*steatorrhoea*) or tarry from digested blood (*melaena*—usually from upper gastrointestinal tract).

Bright blood on the surface of a motion may be from *haemorrhoids*, whereas blood in a stool may signify *cancer* or *inflammatory bowel disease*.

Tenesmus is a feeling of incomplete evacuation and is highly suspicious of a colonic polyp or malignancy.

- **Jaundice**: 'Have you noticed any yellowing of the eyes? Is your urine dark? Are your stools pale? What tablets have you been taking recently? Have you had any recent injections or transfusions? Have you been abroad recently? How much alcohol do you drink?'

Jaundice may be:

- **obstructive** (dark urine, pale stools) from: *carcinoma of the head of the pancreas* or *gallstones*

- **hepatocellular** (dark urine, pale stools may develop)
  from:
  ethanol (*cirrhosis*)
  intravenous drug abuse, tattoos, unprotected sex or transfusions (*viral hepatitis*)
  drug reactions or infections (travel abroad, *viral hepatitis, malaria* or *amoebae*)
- **haemolytic** (unconjugated bilirubin is bound to albumin and is not secreted in the urine).

Genitourinary system

- Ask about the following points.
  - **Dysuria**: pain on passing urine, usually burning (*often a sign of infection*).
  - **Loin pain**: 'Any pain in your back?'

Pain in the loins suggests *pyelonephritis* or *renal colic*.

  - ***Urine**: 'Are your waterworks all right? Do you pass a lot of water at night? Do you have any difficulty passing water? Is there blood in your water?'—*haematuria*.

Polyuria and *nocturia* occur in *diabetes*.
Prostatism results in slow onset of urination (*hesitancy*), a poor stream and terminal dribbling.

  - **Sex**: 'Any problems with intercourse or making love?' **If appropriate** ask about last sexual partner, whether regular or casual, oral, vaginal or anal sex. Homosexual contact? Risk factors for HIV should be explored where appropriate.
  - ***Menstruation**: 'Any problems with your periods? Do you bleed heavily? Do you bleed between periods?'

Vaginal bleeding between periods or after the menopause raises the possibility of *cervical* or *uterine cancer*.

  - **Vaginal or penile discharge**.
  - **Menstrual cycle**: last menstrual period (LMP) and abnormal vaginal bleeding:

- *inter-menstrual bleeding*
- *post-menopausal bleeding*
- *post-coital bleeding.*

- **Pain on intercourse** (*dyspareunia*) and whether this is superficial or deep.

Nervous system

- Ask about the following points.
  - ***Headache**: 'Do you have any headaches? Where are they, when do you get headaches?'

For example, early morning headaches may suggest *raised intracranial pressure—tumour*.

Are the headaches associated with flashing lights (*migraine*) or scalp tenderness (*polymyalgia rheumatica*)?

- **Vision**: 'Do you have any blurred or double vision?'
- **Hearing**: ask about tinnitus, deafness and exposure to noise.
- **Dizziness**: 'Do you have any dizziness or episodes when the world goes round (*vertigo*)?'

Dizziness with light-headed symptoms, when sudden in onset, may be *cardiac* (enquire about palpitations). When slow, onset may be *vasovagal* '*fainting*' or an *internal haemorrhage*.

Vertigo may be from *ear disease* (enquire about deafness, earache or discharge) or *brainstem dysfunction*.

- **Unsteady gait**: 'Any difficulty walking or running?'
- **Weakness**: 'Do your arms or legs feel weak?'
- **Numbness** or increased sensation: 'Any patches of numbness?'
- **Pins and needles**.
- **Sphincter disturbance**: 'Any difficulties holding your water/bowels?' (*a very important sign of spinal cord compression*).
- **Fits or faints**: 'Have you had any funny turns?'

The following details should be sought from the patient and any observer:

- **duration**
- **frequency** and length of attacks
- **time of attacks**, e.g. if standing, at night
- **mode of onset and termination**, e.g. post-ictal phase
- **premonition or aura**, light-headed or vertigo
- **biting of tongue, loss of sphincter control, injury, etc.**

Grand mal epilepsy classically produces sudden unconsciousness without any warning and on waking the patient feels drowsy with a headache and sore tongue, and has been incontinent.

Mental state

- Ask about the following points.
  - **Depression**: 'How is your mood? Happy or sad? If depressed, how bad? Have you lost interest in things? Can you still enjoy things? How do you feel about the future?'
    'Has anything happened in your life to make you depressed? Do you feel guilty about anything?'
    If the patient appears depressed: 'Have you ever thought of suicide? How long have you felt like this? Is there a specific problem? Have you felt like this before?'
  - **Active periods**: 'Do you have periods in which you are particularly active?'

Susceptibility to depression may be a personality trait. In *bipolar depression*, swings to *mania* (excess activity, rapid speech and excitable mood) can recur. Enquire about interest, concentration, irritability, sleep difficulties.

  - **Anxiety**:
    - 'Have you worried a lot recently? Do you get anxious? In what situations? Are there any situations you avoid because you feel anxious?'
    - 'Do you worry about your health? Any worries in your job or with your family? Any financial worries?'
    - 'Do you have panic attacks? What happens?'
  - **Sleep**: 'Any difficulties sleeping? Do you have difficulty getting to sleep? Do you wake early?'

Difficulties of sleep are commonly associated with depression or anxiety.

A more complete assessment of mental state is given in Chapter 6.

The eye

- Ask about the following points.
  - **Eye pain, photophobia or redness**: 'Have your eyes been red, uncomfortable or painful?'
  - Painful red eye, particularly with photophobia, may be serious and due to:

iritis (*ankylosing spondylitis, Reiter's disease, sarcoid, Behçet's disease*)
scleritis (systemic vasculitis)
corneal ulcer
acute glaucoma
photophobia may be a sign of meningitis.

  - Painless red eye may be:

episcleritis
temporary and of no consequence
systemic vasculitis.

  - Sticky red eye may be *conjunctivitis* (usually infective).
  - Itchy eye may be *allergic*, e.g. *hayfever.*
  - Gritty eye may be dry (sicca or *Sjögren's syndrome*).
  - **Clarity of vision**: 'Has your vision been blurred?'
    - Blurring of vision for either near or distance alone may be an error of focus, helped by spectacles.
    - Loss of central vision (or of top or bottom half) in one eye may be due to a *retinal* or *optic nerve disorder*.
    - Transient complete blindness in one eye lasting for minutes—*amaurosis fugax* (fleeting blindness)—suggests retinal arterial blockage from embolus, may be from *carotid atheroma* (listen for bruit) or may have a cardiac source.

- Subtle difficulties with vision, difficulty reading—problems at the chiasm, or visual path behind it:

complete *bitemporal hemianopia—tumour* pressure on chiasm

homonymous hemianopia: *posterior cerebral* or *optic radiation lesion*—usually *infarct* or *tumour;* rarely complains of 'half vision', but may have difficulty reading.

- **Diplopia**: 'Have you ever had double vision?'

Diplopia may be due to:

- *lesion* of the motor cranial nerves III, IV or VI
- *third-nerve palsy*
  causes double vision in all directions
  often with dilatation of the pupil and ptosis
  the eye hangs 'down and out'
- *fourth-nerve palsy*
  causes doubling looking down and in (as when reading)
  with images separated horizontally and vertically and tilted (not parallel)
- *sixth-nerve palsy*
  causes horizontal, level and parallel doubling
  worse on looking to the affected side
- *muscular disorder*
  e.g. thyroid-related (see below)
  myasthenia gravis (weakness after prolonged muscle use, antibodies to nerve end-plates).

Locomotor system

- Ask about the following points.
  - **Pain, stiffness, or swelling of joints**: 'When and how did it start? Have you injured the joint?'

There are innumerable causes of *arthritis* (painful, swollen, tender joints) and *arthralgia* (painful joints). Patients may incorrectly attribute a problem to some injury.

Osteoarthritis is a joint 'wearing out', and is often asymmetric, involving weight-bearing joints such as the hip or knee. Exercise makes the joint pain worse.

Rheumatoid arthritis is a generalised autoimmune disease with symmetrical involvement. In the hands, fusiform swelling of the interphalangeal joints is accompanied by swollen metacarpophalangeal joints. Large

joints are often affected. Stiffness is worse after rest, e.g. on waking, and improves with use.

Gout usually involves a single joint, such as the first metatarsophalangeal joint, but can lead to gross hand involvement with asymmetric uric acid lumps (*tophi*) by some joints, and in the tips of the ears.

Septic arthritis: this is important not to miss—a single, hot painful joint.

- **Functional disability**: 'How far can you walk? Can you walk upstairs? Is any particular movement difficult? Can you dress yourself? How long does it take? Can you work? Can you write?'

Thyroid disease

- Ask about the following points.
  - **Weight change**.
  - **Reaction to the weather**: 'Do you dislike the hot or cold weather?'
  - **Irritability**: 'Are you more or less irritable compared with a few years ago?'
  - **Diarrhoea/constipation**.
  - **Palpitations**.
  - **Dry skin or greasy hair**: 'Is your skin dry or greasy? Is your hair dry or greasy?'
  - **Depression**: 'How has your mood been?'
  - **Croaky voice**.

Hypothyroid patients put on weight without increase in appetite, dislike cold weather, have dry skin and thin, dry hair, a puffy face, a croaky voice, are usually calm and may be depressed.

Hyperthyroid patients may lose weight despite eating more, dislike hot weather, perspire excessively, have palpitations, a tremor, and may be agitated and tearful. Young people have predominantly nervous and heat intolerance symptoms, whereas old people tend to present with cardiac symptoms.

Past history

- **All previous illnesses or operations**, whether apparently important or not, must be included.

For instance, a casually mentioned attack of influenza or chill may have been a manifestation of an occult infection. Try to establish a date.

For operations try to get an approximate date (which year or how many years ago), name of surgeon and institution where it was carried out.

- The importance of a past illness may be gained by finding out **how long the patient was in bed or off work.**
- **Complications of any previous illnesses** should be carefully enquired into and, here, leading questions are sometimes necessary.

General questions

- Ask about the following.
  - **'Have you had any serious illnesses?'**
  - **'Have you had any emotional or nervous problems?'**
  - **'Have you had any operations or admissions to hospital?'**
  - **'Have you ever:**
    - **had myocardial infarction (heart attack), jaundice (yellowing of the eyes), TB, hypertension (high blood pressure), rheumatic fever, epilepsy, anaemia, diabetes, syncope (faints)? (remember MJTHREADS)**
    - **had allergies?'**
  - **'Have any medicines ever upset you?'**

Allergic responses to drugs may include an itchy rash, vomiting, diarrhoea or severe illness, including jaundice. Many patients claim to be allergic but are not, e.g. GI upset with antibioics. An accurate description of the supposed allergic episodes is important.

- Additional questions can be asked:
  - if the patient has high blood pressure, ask about kidney problems, or if relatives have kidney disease
  - if a possible heart attack, ask about hypertension, diabetes, diet, smoking, family history of heart disease

- if the patient's history suggests cardiac failure, you must ask if they have had *rheumatic fever*.

Patients have often had examinations for life insurance or the armed forces.

Family history

The family history gives clues to possible predisposition to illness (e.g. heart attacks) **and whether a patient may be particularly anxious about a certain disease** (e.g. mother died of cancer). Death certificates and patient knowledge are often inaccurate. Patients may be reluctant to talk about relatives' illnesses if they were mental diseases, epilepsy or cancer.

General questions

- Ask about the following.
  - '**Are your parents alive?** Are they fit and well? What did your parents die from?'
  - '**Have you any brothers or sisters?** Are they fit and well?'
  - '**Do you have any children?** Are they fit and well?'
  - '**Is there any history of:**
    - **heart trouble?**
    - **diabetes?**
    - **high blood pressure in the family?'**

These questions can be varied to take account of the patient's major complaint.

Personal and social history

One needs to find out what kind of person the patient is, what their home circumstances are and how their illness has affected them and their family. Your aim is to understand the patient's illness in the context of their personality and their home environment.

Can they convalesce satisfactorily at home and at what stage? What are the consequences of their illness? Will advice, information and help be needed? An interview with a relative or friend may be very helpful.

General questions

- Ask about the following.
  - **Marital status**: 'Are you in a relationship?' Find out whether the patient is married or in a partnership and whether they have any children.
  - **Family**: 'Is everything alright at home? Do you have any family problems?'

It **may be appropriate** to ask: 'Is your relationship all right? Is sex all right?' Problems may arise from physical or emotional reasons, and the patient may appreciate an opportunity to discuss worries.

  - **Accommodation**: 'Where do you live? Can you normally manage at home? Is the toilet downstairs or upstairs? Do you cook for yourself at home? Who gets in the shopping?'
  - **Job**: 'What is your job? Could you tell me exactly what you do? Will your illness affect your work?'
  - **Hobbies**: 'What do you do in your spare time?'
  - **Alcohol**: 'How much alcohol do you drink in a week?' The Department of Health advises that men should not drink more than 3–4 units of alcohol per day (28 per week), and women should drink no more than 2–3 units of alcohol per day (21 per week). If there is a suspicion of a drinking problem the CAGE questions are useful to identify problems. 'Have you ever felt you should CUT DOWN on your drinking? Have people ANNOYED you by criticising your drinking? Have you ever felt bad or GUILTY about your drinking? Have you ever had a drink first thing in the morning (as an 'EYE OPENER') to steady your nerves or get rid of a hangover?'
  - **Smoking**: 'Do you smoke? Have you ever smoked? (Remember patients often 'give up' on admission to hospital!) Why did you give up? How many cigarettes, cigars or pipefuls of tobacco do you smoke a day?'

This is particularly relevant for heart or chest disease, but must always be asked.

- **Drugs**: 'Have you ever taken any recreational drugs? Have you ever injected drugs? Have you ever shared needles?'
- **Overseas travel**: 'Have you travelled abroad? Especially to exotic areas within the past month.'
- **Prescribed medications**: 'What pills, tablets or medicines are you taking at the moment? Have you taken any other pills in the past few months?'

This is an extremely important question. A complete list of all drugs and doses must be obtained.

If relevant, ask about any pets, animal contact, previous or present exposure during working to coal dust, asbestos, etc.

The patient's ideas, concerns and expectations

Make sure that you understand the patient's main ideas, concerns and expectations. Either now, or after examining the patient, ask for example:

- **What do you think is wrong with you?**
- **What are you expecting to happen to you while you are in hospital?**
- **Is there something particular you would like us to do?**
- **Have you any questions?**

The patient's main concerns may not be your main concerns. The patient may have quite different expectations of the hospital admission, or outpatient appointment, from what you assume. If you fail to address the patient's concerns they are likely to be dissatisfied, leading to difficult doctor–patient relationships and non-compliance.

Strategy

Having taken the history, you should:

- **have some idea of possible diagnoses**
- **have made an assessment of the patient as a person**
- **know which systems you wish to concentrate on when examining the patient.**

Further relevant questions may arise from abnormalities found on examination or investigation.

Recently some proformas have been developed to enable rapid and focused questions to be asked so that appropriate treatment is not delayed. For example, a care pathway for thrombolysis in patients with suspected heart attacks, a clerk-in sheet for patients with gastrointestinal bleeding containing a Rockall score or a surgical clerk-in sheet. It is worth reviewing these to show which questions are crucial. See examples below.

Specimen history

Date and time of examination in margin
Mr John Smith.
Aged 52. Machine operator. Oxford.
c/o severe chest pain for 2 hours.

History of present illness

- Perfectly well until 6 months ago.
- Began to notice central, dull chest ache, occasionally felt in the jaw, coming on when walking about 1 km (1/2 mile), worse when going uphill and worse in cold weather. When he stopped, the pain went off after 2 minutes.
- Glyceryl trinitrate spray relieved the pain rapidly.
- Last month the pain came on with less exercise after 100 yards.
- Today at 10 am, while sitting at work, the chest pain came on without provocation. It was the worst pain he had ever experienced in his life and he thought he was going to die.
- The pain was central, crushing in nature, radiating to the left arm and neck and with it a feeling of nausea and sweating. The patient was rushed to hospital where he received an intravenous injection of diamorphine, which rapidly relieved the pain, and intravenous streptokinase. An electrocardiogram confirmed a myocardial infarction and the patient was admitted to the coronary care unit.
- The patient had noticed very mild breathlessness on exertion for 3 months, but had not experienced

palpitations, dizziness, breathlessness on lying flat, ankle swelling or coughing. On one occasion, however, 2 weeks ago, the patient had woken with a suffocating feeling and had had to sit on the edge of the bed and subsequently open the bedroom window in order to get his breath. This had not recurred and he did not report it to his doctor.

Functional enquiry

Respiratory system (RS):

- morning cough over the last 3–4 winters with production of a small amount of clear sputum
- no haemoptysis

Gastrointestinal (GI):

- occasional mild indigestion
- bowels regular
- appetite normal
- no other abnormalities

Genitourinary (GU):

- no difficulties with micturition
- normal sex life

Nervous system (NS):

- infrequent frontal headaches at the end of a hectic day
- otherwise no abnormalities
- no psychiatric symptoms

Past medical history

Fifteen years ago, appendicectomy. No complications.
No other operations or serious illnesses.
No history of rheumatic fever, nephritis or hypertension.
Never been abroad.

Family history

Father died aged 73—'heart attack'.
Mother died aged 71—'cancer'.
Two brothers fit and well (aged 48 and 46).
Two sons (aged 23, 25), both fit and well.
No family history of diabetes or hypertension.

Personal and social history

Happy both at work and home. Both sons married and living in Oxford. Wife works as an office cleaner. No financial difficulties.

Smokes 20 cigarettes per day. Two pints of beer on Saturdays only.

Patient always worked as machine operator since leaving school except for 2 years in Hong Kong, where he had no illness.

Medication

Other than glyceryl trinitrate spray, no drugs currently being taken. No allergies.

Signed with name printed and designation (e.g. Medical Student).