CHAPTER 1

History Taking

General procedures

Introduction

The patient's history is the major subjective source of data about his health status. Physiological, psychological and psychosocial information (including family relationships and cultural influences) can be obtained which will inform you about the patient's perception of his current health status and lifestyle. It will give you insight into actual and potential problems as well as providing a guide for the physical examination.

Approaching the patient

- **Put the patient at ease by being confident and quietly friendly.**
- **Greet the patient: 'Good morning, Mr Smith'. (Address the patient formally and use his full name until he has given you permission to address him less formally.)**
- **Shake the patient's hand or place your hand on his if he is ill. (This action begins your physical assessment. It will give you a baseline indication of the patient's physical condition. For example, cold, clammy, diaphoretic or pyrexial.)**
- **State your name and title/role.**
- **Make sure the patient is comfortable.**
- **Explain that you wish to ask the patient questions to find out what happened to him.**

Start the history taking by stating something like 'I will start the history by asking you some questions about your health'. (Always begin with general questions and then move to more specific questions.) Inform the patient how long you are likely to take and what to expect. For example, after discussing what has happened to the patient, explain that you would like to examine him (Fig. 1.1).

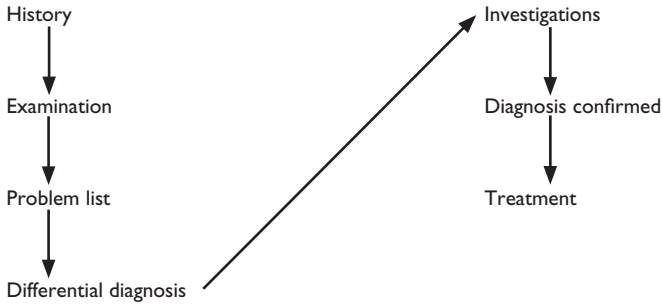

Fig. 1.1 Usual sequence of events.

Importance of the history

- It identifies:
  - what has happened
  - the personality of the patient
  - how the illness has affected him and his family
  - any specific anxieties
  - the physical and social environment.
- It establishes the nurse/patient relationship.
- It often gives the diagnosis.

Find the principal symptoms or symptom. Ask one of the following questions:

- **'How may I help you?'**
- **'What has the problem been?'**
- **'Tell me why have you come to the surgery today?'** or **'Tell me why you came to see me today?'**

Effective history taking involves allowing the patient to talk in an unstructured way whilst you maintain control of the interview. Use language that the patient can understand and avoid the use of medical jargon. Avoid asking questions that can be answered by a simple 'yes' or 'no'. Ask questions that require a graded response – for example, 'Describe how your headache feels'. Avoid using multiple-choice questions that may confuse the patient. Ask one question at a time. Avoid asking questions like: 'What's wrong?' or 'What brought you here?'. Use clarification to confirm your understanding of the patient's problem. Avoid forming premature conclusions about the patient's problem and above all remain non-judgemental in your demeanour. Avoid making judgemental statements.

- **Let the patient tell his story in his own words as much as possible. At first listen and then take discreet notes as he talks.**

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 others, you may need to ask specific questions and to 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.

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

Beware pseudo-medical terms, e.g. 'gastric flu'; instead, enquire what happened. Clarify by asking what the patient means.

- **Do not ask leading questions.**

A central aim in taking the history is to understand patients' symptoms from their own point of view. It is important not to tarnish the patient's history by 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. Instead, 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. Use reflection so that the patient will expand on his discussion.

- **Be understanding, receptive and matter of fact without being sympathetic. Display and express empathy rather than sympathy.**
- **Avoid showing surprise or reproach.**
- **Clarify symptoms and obtain a problem list.**
- **When the patient has finished describing the symptom or symptoms:**
  - **briefly summarize 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 last six weeks. Before we talk about those in more detail, are there any other problems I should know about?'.

Usual sequence of history

- **principal complaints, e.g. chest pain, poor home circumstances**
  - history of present complaint

  - details of current illness
  - enquiry of other symptoms (see Functional enquiry)
- **present medications/allergies**
- **past history**
- **family history**
- **personal and social history**

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. (You may choose to state the patient's chief complaint in the patient's own words when documenting.)
- **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 being seen by you 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 type of pain before? Does the pain make you sweat or feel sick?

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

Supplementary history

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

When the patient does not speak English, arrange for an interpreter to translate for the patient. Bear in mind that Barkauskas *et al.* (2002) indicate that if possible, family members and patients' young children should not be used as interpreters. Family members will frequently tell you what they think the patient's problem is rather than what the patient thinks his problem is. Because some questions that you may ask the patient are sensitive in nature, children should not be asked to interpret for their parents.

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 that 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?'
- ***general well-being**: 'Do you feel well in yourself?'
- ***feelings of sadness or depression** (to rule out feelings of suicide.) 'Do you feel sad or depressed?'
- **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?'
- **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*: pain frequently precipitated by exercise or emotion and relieved by rest; *myocardial infarction*; the pain may come on at rest, be more severe and last hours
  - *pleuritic pain*: sharp, localized pain, usually lateral; worse on inspiration or cough
  - *anxiety or panic attacks*: 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? 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* (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
- **blackouts** (*syncope*): 'Have you had any blackouts 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 each day?'

Gastrointestinal system

Ask about the following points:

- **nausea**: 'Are there times when you feel sick?'
- **vomiting**: 'Do you vomit? 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**: 'How often do you open your bowels?' or '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?) 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 within a stool may signify *cancer* or *inflammatory bowel disease*.
- **jaundice**: '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
  - gallstones
- **hepatocellular** (dark urine, pale stools may develop) from:
  - *ethanol* (cirrhosis)
  - drugs or transfusions (viral hepatitis)
  - drug reactions or infections (travel abroad, viral hepatitis 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 urination – usually burning (often a sign of infection/cystitis)
- **loin pain**: 'Any pain in your back?'
  Pain in the loins suggests pyelonephritis.
- ***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?' (suggests haematuria)
  Polyuria and *nocturia* occur in *diabetes*.
  Prostatism results in slow onset of urination, a poor stream and terminal dribbling.
- **sex**: 'Any problems with intercourse or making love?'
- ***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*.
  Menstrual cycle: last menstrual period (LMP) and length of bleeding. (Normal cycle is 21–35 days. Normal period is between 5 and 8 days with between 70 and 200 ml of blood loss.) If indicated, ask about intermenstrual, postmenopausal or postcoital bleeding.
- **vaginal discharge** (if present, ask about colour, consistency and odour; does it cause itching?)
- **pain on intercourse** (*dyspareunia*)

Nervous system

Ask about the following points:
- ***headache**: 'Do you ever have any headaches? Where are they? (location) When do you get headaches? What are they like?' (quality/intensity)

Headaches often originate from tension and can be either frontal or occipital. Occipital headache on waking in the early morning may be due to *raised intracranial pressure* (e.g. from a *tumour* or *malignant hypertension*). Ask if the headache is associated with flashing lights (*amaurosis fugax*).

- **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* (*labyrinthitis/infection, Ménière's disease*; enquire about deafness, earache or discharge) or *brain-stem dysfunction*.
- **unsteady gait**: 'Any difficulty walking or running?'
- **weakness** (consider ME or *myasthenia gravis*)
- **numbness** or increased sensation: 'Any patches of numbness?'
- **pins and needles**
- **sphincter disturbance**: 'Any difficulties holding your water/bowels?' (sign of spinal cord compression; ask about back injury)
- **fits or faints**: 'Have you had any funny episodes?'

  The following details should be sought from the patient:
  - **duration**
  - **frequency and length of attacks**
  - **time of attacks, e.g. if standing, at night**
  - **mode of onset and termination**
  - **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 health

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 sad or depressed? Do you feel guilty about anything?'. If the patient seems 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 affective disease*, 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.

Refer to Chapter 8 for more comprehensive information on mental health assessment.

The eye

Ask about the following points:

- **eye pain, photophobia or redness**: 'Have the eyes been red, uncomfortable or painful?'
- painful red eye, particularly with photophobia, may be serious and due to:

  iritis – anterior/posterior uveitis must be treated as a medical emergency (it may be related to *ankylosing spondylitis, Reiter's disease, sarcoid, Behçet's disease*)
  scleritis (systemic vasculitis)
  corneal ulcer
  acute glaucoma
- 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. *hay fever*
- 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)
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 seen double?'
  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 dilation of the pupil and ptosis
  - *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 muscle use, antibodies to nerve endplates)

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.

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

  Rheumatoid arthritis is a generalized 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 asymmetrical uric acid lumps (*tophi*) by some joints, and in the tips of the ears.

Septic arthritis is a single, hot, painful joint.

- **functional disability**: 'How far can you walk? Can you walk up stairs? Is any particular movement difficult? Can you dress yourself? (Observe how the patient is dressed.) How long does it take? Are you able to work? Can you write?' (In the physical examination observe how the patient walks and his manual dexterity.)

Thyroid disease

Ask about the following points:

- **weight change**
- **reaction to the weather**: 'Do you dislike 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. (Exophthalmos may be present.)

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.
- The importance of a past illness may be determined 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 yellow skin (jaundice), fits (epilepsy), TB, high blood pressure (hypertension), low blood pressure (hypotension), rheumatic fever, kidney problems or diabetes?**
  - **travelled abroad?**
  - **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. An accurate description of the supposed allergic episodes is important.
- Other questions can be included when relevant such as: **'Have you ever had a heart attack?'**
- **Additional questions can be asked** depending on the patient's previous responses such as:
  - if the patient has high blood pressure, ask about kidney problems, if relatives have hypertension or whether he eats liquorice
  - 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 he has had *rheumatic fever*

Patients may have 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 have reason to 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. It will be useful to construct a genogram of the patient's family history for quick referral.

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 family history of:**
  - **heart trouble?**
  - **diabetes?**
  - **high blood pressure?'**

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

Personal and social history

You need to find out what kind of person the patient is, what his home circumstances are and how his illness has affected him and his family. Your aim is to understand the patient's illness in the context of his personality and his home environment.

If in hospital or following day surgery, can the patient convalesce satisfactorily at home and at what stage? What are the consequences of his 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:

- **family**: 'Is everything all right at home? Do you have any family problems?'

  It may be appropriate to ask: 'Is your relationship with your partner/husband/wife all right? Is sex all right?'. Problems may arise from physical or emotional reasons, and the patient may appreciate an opportunity to discuss worries. Note that a patient's sexual preference and sexual orientation may be different.
- **accommodation**: 'Where do you live? Is it all right?'
- **job**: 'What is your job? Could you tell me exactly what you do? Is it satisfactory? Will your illness affect your work?'
- **hobbies**: 'What do you do in your spare time? Do you have any social life? What is your social life like?'
- **alcohol**: 'How much alcohol do you drink?'

  Alcoholics usually underestimate their daily consumption. (Normally intake should not exceed 21 units per week for a male and 14 units per week for a female.) It may be helpful to go through a 'drinking day'. If there is a suspicion of a drinking problem, you can ask: 'Do you ever drink in the morning? Do you worry about controlling your drinking? Does it affect your job, home or social life?'.

- **smoking**: 'Do you smoke?' Have you ever smoked? 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**: 'Do you take any recreational drugs? If so, what do you take?'
- **prescribed medications**: 'What pills are you taking at the moment? Have you taken any other pills in the last 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, visits abroad, previous or present work exposure 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. Ask, for example:

- **What do you think is wrong with you?**
- **What are you expecting to happen to you whilst you are in the surgery or 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 his visit to the surgery, the hospital admission or outpatient appointment from what you assume. If you fail to address the patient's concerns, he is likely to be dissatisfied, leading to a difficult nurse/patient relationship and possible non-compliance.

Strategy

Having taken the history, you should:

- **have some idea of possible diagnoses (in 90–95% of cases the patient will tell you what his problem is whilst you are taking the history)**
- **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.

Reference

Barkauskas, V., Baumann, L. & Darling-Fisher, C. (2002) *Health and Physical Assessment*, 3rd edn. Mosby, London.