1 History Taking

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Introduction

History taking is the critical first step in detecting the aetiology of a patient's problem using a systematic approach. Historically, history taking has been the domain of the medical practitioner whilst other professions focused on assessment skills related to particular body systems, or on assessing activities of daily living (ADL) such as communication, eating and drinking, washing and dressing. In recent years, professional boundaries between different healthcare professionals have begun to blur in response to healthcare reform. Subsequently, history taking skills are becoming increasingly important to non-medical healthcare professionals (Kaufman, 2008) and arguably the most important aspect of patient assessment (Crumbie, 2006). History taking should be clear and all elements should be conducted in the same way with the same purpose; to inform patient care, provide clear communication to other professions and prevent repetition and omission of relevant data. This chapter will therefore focus on the history, taking process using the medical model to structure this process. A brief introduction of why history taking is important will be offered followed by tools and mnemonics that you can use to support and guide your questioning techniques when obtaining information. There will be reference to the importance of communication skills needed when taking a patient's history; however, due to the complexity of this subject area, this has been explored fully in Chapter 2.

Obtaining the information

History taking is a process whereby the patient or others familiar with the patient report relevant complaints (subjective data) referred to as symptoms. Symptoms and clinical signs are ascertained by direct examination (objective data) by the healthcare professional. History taking is like

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playing detective; searching for clues, collecting information without bias, yet staying on track to solve the puzzle (Clarke, 1999). Essential and active listening skills are required and this is described by Duffy (1999) as the most fundamental communication skill and is central to obtaining a history. An accurate history can provide 80% or more of the information required for diagnosis (Epstein et al., 2008; Bickley and Szilagyi, 2009). The clinical examination and/or diagnostic testing should only confirm or disprove this diagnosis.

Medical histories vary in their depth and focus from case to case and according to their purpose. The medical history has a traditional format (see Box 1.1) which is considered the 'gold standard' (Bickley and Szilagyi, 2009). This provides a systematic approach, yet will generally require a flexible attitude and questioning techniques as opposed to a rigid interrogation or a checklist of questions.

Box 1.1 Traditional medical history

Date and time
Identifying data
Presenting complaint
History of presenting complaint
Past medical history
  Previous illness and surgery
  Drug history
  Allergies
Family history
Social history
Mental health history
Review of systems

There will be circumstances where a comprehensive history is required such as:

- Where reaching the diagnosis is difficult or complex
- Where the patient has a range of different health problems
- When the patient is a new patient in the hospital/GP setting
- Baseline for future assessments

Otherwise, there will be circumstances where the history should be more selective which is described as a focused history (Rushforth, 2009). Selected questions are directed towards the presenting problem or need may be more appropriate such as:

- Emergency situations where it is necessary to undertake a primary survey

- Minor illness or information where the information can focus directly to the patients' problem
- General mental health assessment

Irrespective of which approach is used, the history-taking process allows patients to present their account of the problem and provides essential information for the healthcare professional. It provides the opportunity for the patient to tell their story with an unfolding of symptoms, problems and feelings. It is important to recognise that patients tell their stories in different and usually unstructured ways which may lead to necessary information being omitted. It is, therefore, imperative for the practitioner to use effective communication skills within a systematic framework (see Chapter 2). This will prevent information being overlooked that is essential for diagnostic accuracy. There are several systematic frameworks to support the history-taking process. AMPLE (see Box 1.2) is advantageous for situations where depth and focus of the history are based on the case at hand. It is quick and easy to use especially in an emergency situation. A disadvantage of this framework is the lack of enough detail and structure to enable generation of a patient's condition, especially when asking events leading up to the emergency. Subsequently, the potential to miss out relevant questions is possible.

Box 1.2 AMPLE survey

Allergies
Medication/drug history
Past medical history
Last meal or oral intake
Events leading up to the emergency

Identifying the data

Start the history-taking process by identifying the age, sex, occupation and marital status of the patient. This will become important through other sections of this process. This source of information is generally obtained from the patient, but can also be obtained from a family member, friend or from a written source. Where appropriate, it is important to identify and record the source of information, as the accuracy of information obtained may be questionable. The patient's mood, memory, trust and clinical condition may affect the reliability of information given and these factors must also be identified and recorded.

The presenting complaint

Normally, the presenting complaint (PC) may only consist of two signs and symptoms; for example, 'chest pain', 'ankle injury' and 'feeling unwell' are initially reported and recorded. A range of differential diagnosis will be considered at this point of the history taking process. It is important to gather further information to eliminate some of the differential diagnosis and consider causes as to why the patient has sought medical assistance (Gregory and Murcell, 2010).

History of presenting complaint

This section of the process is the main component of history taking. A detailed and thorough investigation into the current illness is performed to provide a complete, clear and chronological account for the PC(s) prompting the patient to seek care. This usually comprises two sequential (but overlapping) stages:

- The patient's account of the symptoms
- Specific, detailed questions by the health professional undertaking the history

To obtain the patient's account of symptoms, the use of open-ended questions is required. This is to avoid a yes or no answer so that the patient can expand on their story. For example, 'tell me more about your chest pain' encourages the patient to tell the practitioner more. In contrast, closed questions such as 'is the chest pain severe?' can be answered in a 'yes' or 'no,' which is useful for seeking specific answers that are required to gain a deeper understanding of the patient's problem (Kaufman, 2008).

It is important to listen to patients as they tell you their story as generally they are telling you their diagnosis. Listening should be an active process and patients should be given every opportunity to talk freely at the start of the consultation with minimal interruption (Marsh, 1999). A common mistake is for the health professional to intervene too early, and research has shown the importance of listening to patients' opening statements without interruption (Gask and Usherwood, 2002). Once a patient has been interrupted, they rarely introduce new issues (Gask and Usherwood, 2002) and vital information may never come to light (Kaufman, 2008). If uninterrupted, most patients will tell you their problem in 1–2 minutes (Snadden et al., 2005). It is a matter of judgement when to start interrupting and asking open questions, but as a general rule, think twice before interrupting a patient in full flow as this may not be what is concerning the patient the most. A combination of art, experience and patience determines when and how to interrupt a patient in full flow and every attempt to use the patient's own words is essential. Remember the most important facts given by the patient as these may need further clarification.

Once the patient has given their account of the signs and symptoms of the presenting problem, closed questions may be used to focus on gathering information that is relevant to the history of the presenting complaint (HPC). A chronological account of the symptoms and associated symptoms should be explored in a systematic manner, and include onset of the problem, the setting in which it has developed, its manifestations and any therapeutic interventions used to relieve symptoms (Bickley and Szilagyi, 2009). The use of a mnemonic can provide a systematic approach so that a single event or system can be explored more fully and consequently encourage patients to expand and describe their symptoms. One mnemonic is the OPQRST (Morton, 1993). This mnemonic is mostly used in describing pain but can also be used as a symptom analysis (see Box 1.3). Other mnemonics which can be used are illustrated in Boxes 1.4 and 1.5.

Box 1.3 OPQRST mnemonic

O onset
P provocative/palliative
Q quality
R region/radiation
S severity
T temporal/timing

Box 1.4 TROCARSS mnemonic

T timing
R rapidity
O occurrence
C characteristics
A associations
R relief
S site
S spread
S severity

Box 1.5 SOCRATES mnemonic

S site
O onset
C character . . . sharp, dull
R radiation
A alleviating factors
T timing
E exacerbating factors
S severity 1–10

Onset

It is important to determine when the symptom/pain started as this is a key factor to determine whether it is acute, chronic, urgent or non-urgent. Establishing the speed of onset to determine the rate of development (seconds, minutes, hours etc.) is useful too. Start with open-ended questions such as 'what were you doing when this started?' or 'do you have a history of this problem?' or 'when did you last feel well?' It is important not to ask leading questions that may elicit the wrong response. For example, 'did it start yesterday?' or 'were you active at the time?'

Provocative/palliative

Questions relating to what provoked the symptom/pain; and any medication either prescribed over the counter or herbal/homeopathic or other alternatives that made the symptom/pain better or worse should be considered. Factors such as movement, lying down, sitting up, on rest, on exertion and breathing should also be considered as this is important towards confirming or disproving differential diagnosis. For example, a patient complaining of left-sided chest pain lasting for several minutes that developed following an exertion or emotional stress (provocative factors) and/or relieved by rest or Glyceryl Trinitrate (palliative) may be indicative of unstable angina, whereas persistent chest pain that may not have provocative factors and is unresponsive to palliative measures may be indicative of unstable angina or myocardial infarction.

Quality

Patients will use a variety of words to describe their symptoms; and prompting the patients to define this symptom is particularly useful in arriving at a diagnosis (Crumbie, 2006). For example, crushing chest pain is almost diagnostic of myocardial infarction. Throbbing, burning, hot, heavy, stabbing, sharp, shooting, tender are various other descriptions patients may use to describe their discomfort.

Region/radiation

Discovering where the symptom/pain is being experienced is fundamental as it often gives clues to the aetiology. This may be a vague description by the patient as the patient may describe the region more broadly, for example, 'pain in my stomach'. As there are several structures within the abdominal cavity, it would be difficult to identify the exact nature of the problem. It is, therefore, useful to ask the patient to point to the exact

location where possible to eliminate a range of causes associated with abdominal pain/discomfort. For example, appendix pain may start in the central abdomen and then localise to the right lower quadrant (Welsby, 2002). Any radiation of the symptom/pain should also be noted. A patient may present with abdominal pain, when on further exploration may also radiate into the back which is suggestive of aortic aneurysm. Without asking the relevant questions to explore radiation, the true extent of the problem may never be discovered (Crumbie, 2006).

Severity

This refers to the severity of the symptom/pain has on the patient. Asking patients to compare it with previous common type presentations such as toothache, earache, menstrual cramp is of some benefit, but the use of a pain scale would offer a robust method of diagnosing or measuring the patients' pain intensity. The most commonly used scales are visual, verbal and numerical or some combination of all three forms. The practitioner must decide whether a score given is realistic within their experience – for instance, a pain score of 10 for a stubbed toe is likely to be exaggerated. The scales may also be used for assessing pain/symptom now, compared to the time of onset, or pain on movement. It may also be used to reassess pain after the administration of analgesia to assess the efficacy of their treatment. There are alternative assessment tools which can be used if a patient is unable to vocalise a score. One such method is the use of Wong–Baker FACES Pain Rating Scale (Wong and Baker, 1988). This uses cartoon faces with different expressions to assess and it is commonly used with children. Patients are often descriptive with their symptom/pain and reflect how it is affecting them rather than describing it as the health professional would interpret the problem. It is useful to record direct quotations from the patient such as 'Feels like a stabbing knife' and 'It's like being crushed'.

Timing

Patients can often overestimate the duration of the pain/symptom, so determining the timing is an important factor in several illness/injury processes (Crumbie, 2006). It is important to ask the patient how long the condition/pain has been going on and how it has changed since onset (better, worse, different symptoms); if no longer a problem/discomfort, when did it end, how long has it lasted or lasts for, the timing in the day, the pattern of the symptom, its consistency or if it is intermittent. This is also important as symptoms can change suddenly from chronic to acute; acute to life-threatening; urgent to non-urgent.

Mechanism of injury

For patients presenting with injuries, a different approach for obtaining an HPC is required. An injury is a mechanical process that can cause damage to the skin, muscles, organs and bones. Therefore, it is important to establish the mechanism of injury (MOI) to determine the extent and severity of the injury and also to anticipate any immediate or potential problems the injury may provoke. The general rule of thumb is to ask when, how, where, what, who and why. These are referred to as Kipling's six honest men, trusty questions, and we will get to the facts in every situation (Purcell, 2010). Box 1.6 illustrates some key questions using this framework.

Box 1.6 Mechanism of injury

When did this happen?	Signs and symptoms occur at different times following injuries which will indicate the severity of the injury
How did it happen?	Relate to mechanical factors – speed, direction, height, duration and any other element
What caused the injury?	Knife (type and length), broken glass, crushed by machinery?
Where did it happen?	Have they fallen on grass or concrete? Fallen down 2 steps or 16 steps?
Why did this happen?	Has the patient fallen? Do they remember falling? Ask why they fell, if unknown, consider medical reasons
Who caused the injury?	Human, animal, insect bite wound? Consider non-accidental injury, domestic violence

Data from Purcell (2010).

Red flags

It is vital to check for the presence or absence of red flags. Red flags are clinical features that indicate a serious condition is present and may require urgent attention. For example, when assessing patients with acute or chronic low back pain, check for the presence or absence of the red flags such as saddle anaesthesia and/or bladder dysfunction that is suggestive of cauda equina syndrome. Central crushing chest pain is a major clinical feature of a myocardial infarction but for some patients such as the elderly, people with diabetes and women, there may be a little or no chest pain.

Past medical history

Previous illnesses and surgery

Once the patient has given an account of the presenting illness/injury, a general medical history should be established (Purcell, 2010). The past medical history (PMH) can often be a significant factor to understand the presenting illness of the patient as they are often related. It is important to establish whether the patient has any known medical problems such as diabetes, asthma, chronic obstructive pulmonary disease (COPD) or coronary heart disease (CHD). Open-ended questions, for example 'do you have any medical problems?', can be too generalised as patients can often consider this as insignificant and omit this information. It may be more appropriate to ask closed questions, for example 'do you have asthma, diabetes?'. Another helpful mnemonic is *JAM THREADS* (see Box 1.7), which will identify common medical conditions, but further questions may be required.

Box 1.7 Mnemonic for obtaining past medical illnesses

J jaundice
A anaemia and other haematological conditions
M myocardial infarction
T tuberculosis
H hypertension and heart disease
R rheumatic fever
E epilepsy
A asthma and COPD
D diabetes
S stroke

Other key areas to explore are previous hospital admissions including when and why; previous surgery; recent history of foreign travel, including immunisations taken before travelling; childhood immunisations and other immunisations such as tetanus and influenza. In relation to the presenting illness, exploring risk factors are essential. For example, if a patient presents with chest pain, ask specifically about previous episodes of angina, myocardial infarction or hypertension. According to Marsh (1999), exploring the components of the PMH takes the most skill, as an awareness of the likely differential diagnosis is needed and more importantly, this is paramount for safety in treatment regimens as contraindicated treatments must be avoided.

Drug history

A list of current prescribed medications with doses is a minimum requirement. A detailed drug history (DH) is vital as it may give an indication of disease processes that the patient was either unaware of and/or fail to disclose this information. Patients can often perceive to have no medical conditions if it is controlled effectively with medication; for example, thyroxine suggestive of hypothyroidism, salbutamol suggestive of asthma, metformin suggestive of type 2 diabetes.

The patient's current medication may also be the cause of their symptoms as a result of the withdrawal of therapy, e.g. sudden withdrawal of benzodiazepines will induce seizures and adverse drug reaction (ADR) causing unwanted effects from drugs. There is a vast amount of drugs now in use, and the effect of this has led to an increase of ADRs which account for 5% of hospital admissions (Greenstein, 2004). The majority of ADRs are common, harmless and of no clinical importance. In contrast, less common adverse reactions are potentially harmful, which can be fatal. Rawlins and Thompson (1991) proposed two types of ADRs and classify these as type A and type B.

Type A ADRs are common and are due to the normal pharmacological reactions of the drug. They are dose dependant and predictable and together they cause unwanted effects after a normal or higher than normal dose (Bennett and Brown, 2003) They are readily reversible on reducing dose or withdrawing treatment. Table 1.1 provides some well-known examples of type A reactions. Conversely, type B ADRs are pharmacologically unexpected, unpredictable and not dose dependant (Greenstein, 2004). They are less common and only occur in susceptible individuals. Examples of type B ADRs include anaphylaxis with penicillin and agranulocytosis with chlorpromazine. Type B ADRs have a low incidence, but when they do occur, they tend to be more serious. Patients at increased risk from drug interactions include the elderly and those with impaired renal or liver function (Joint Formulary Committee, 2012). Furthermore, the severity of the reaction will vary from one patient to another.

Once established, a DH is important to ascertain whether or not they are, in fact, taking them and how long they have taken medication. Studies have revealed that only about a third of general practice patients take medication as prescribed (Welsby, 2002). Patients do not like to admit they have not taken their medication, and the exploration of this must be sensitively undertaken in an attempt to not appear judgemental. Reviewing the medication with the patient, taking into account the dates they were prescribed, the dosages, frequency and route will give a good indication of compliancy. Using statements such as 'do you ever forget to take your tablets?' or 'do you have difficulty taking your tablets?' or 'when was the last time you took your medication?' may give clues to whether the patient has taken their medication. Nevertheless, Marsh (1999) states that even when approached sensitively, few patients admit to poor concordance. Some

Table 1.1 Examples of common type A ADRs and their pharmacological basis

Drug(s)	ADR	Pharmacological cause
Antibiotics	Diarrhoea, *Clostridium difficile* colitis, thrush	Disruption of normal intestinal/mucosal flora
Calcium channel blockers	Headache, peripheral oedema, flushing, palpations, heart block (diltiazem and verapamil only)	Peripheral vasodilation Blocking of cardiac conduction system
Digoxin	Arrhythmias, heart block	Slowing of atrioventricular (AV) conduction
Immunosuppressant	Susceptibility to infection, increased risk of cancers	Depression of immune system
Levodopa	Hypomania, psychosis, nausea, vomiting	Action on many cerebral dopaminergic neurones
Loop diuretics	Hypokalaemia, hypernatraemia, hypomagnesaemia, increased calcium excretion, hypotension	Diuretic activity (on renal tubules), with 'unbalancing' of iron excretion
NSAIDs	Peptic ulcer, acute renal failure, exacerbation of asthma, etc.	Blockade of physiological prostaglandin synthesis
Tricyclic antidepressants	Drowsiness, dry mouth, blurred vision, constipation, urinary retention, cardiac arrhythmias	Disruption of autonomic control (antimuscarinic anticholinergic effect)

factors may lead to non-concordance with medication such as side effects, perceived lack of efficacy and ignorance. It is therefore to establish any reasons for this. In addition, clinical conditions may affect the patient's mental status such as hypoxia resulting from exacerbation of COPD or asthma or hyperpyrexia. This can lead to patients forgetting to take any medication or conversely taking a double dose. In these circumstances, it is important to see the packages to check whether the correct number has been taken since the date prescribed.

You would also need to ask specifically about the use of over-the-counter medication such as paracetamol and herbal/homeopathic health food type preparations such as vitamins. Always ask women in the appropriate age group whether they take the oral contraceptive. These are often not considered to be 'medication' and patients will not disclose this information if not prompted.

Allergies

Establishing any known allergies caused by drugs, environmental factors, foods, and wound dressings and other agents are essential as this may be the cause of their symptoms. Allergic reactions cause a number of clinical disorders such as the following:

- Acute anaphylaxis
- Serum sickness

- Rashes
- Renal disorders
- Other allergies

Penicillin and related antibiotics are the most common cause of drug allergies. Many people confuse an uncomfortable, but not serious, ADR to a drug (such as nausea). This would be categorised a type A ADR, and not type B. For example, people who experience stomach discomfort after taking aspirin (type A ADR) often say they are allergic to aspirin; however, this would not be categorised as a type B ADR (Porter et al., 2009). For that reason, it is significant to recognise the differences.

Establishing any food allergies is a necessity, as well as medication allergies. Foods such as poultry, meat and dairy products which are protein based; eggs which contain albumin; or sea food which is often rich in iodine may be highly significant as protein, iodine or albumin-based medications or vaccine may cause a serious allergic reaction. Recording the specific nature and severity of any allergies and the allergic reaction is important in any history, irrespective of a focused or comprehensive history as this is vital for the safe administration of medicines.

Family history

The patient's family medical history is significant as there is often discernible genetic component of some medical problems such as:

- Hypertension
- Coronary heart disease
- Cancer
- Type 2 diabetes mellitus
- Inflammatory bowel disease
- Mental illnesses or mental health problems

or possible inherited diseases such as inherited haemolytic anaemia more commonly in the appropriate ethnic group (Marsh, 1999), for example:

- Sickle cell anaemia – especially in Sub Saharan Africans and malarial areas
- Thalassaemia – especially in those from the Mediterranean, Middle East, India, Southeast Asia

Try to establish the current and previous health of parents. Consider asking 'Are your mother and father living?' If not, establish age and cause of death. In a similar manner, ask about any other health problems they had, as you could miss a disease with an important familial risk; for example, the father may have died of stroke but may have had lung cancer. If

parents are alive, consider asking 'has anyone in your family had similar problems?' and 'do any diseases run in the family?'.

Social history

The social determinants of health are the conditions in which people are born, grow, live, work and age (World Health Organisation (WHO), 2010). Fundamentally, the social history (SH) is crucial as it provides information on how the illness/injury and the patient interact at a functional level. Assessment of the patient's appearance, manner and general conversation will provide some social background, but more specific questions may have to be asked. It may explain behaviour of the patient in relation to illness or loss. It may also give clues as to the cause of an illness/injury. For example, changes in recent lifestyle (stress at home or work, financial difficulties) may be the precipitant for angina or developing non-cardiac chest pain.

It is necessary to find out who the patient lives with, housing, employment status/education, dependants, carer responsibilities and hobbies and interests. Ascertaining the patient's functional status will direct your questioning to the abilities to perform basic ADLs such as eating, bathing and dressing. The ability to perform ADLs will reflect and affect the patient's health, and the sudden changes in ADLs are valuable diagnostic clues. If the older patient stops eating, becomes confused or incontinent, or stops getting out of bed, then you will need to find out the underlying medical problems. Keep in mind the possibility that the problem may be acute. The SH may be basic or very complex and how much information you need to obtain will depend on the individual circumstances. Smoking, alcohol consumption and the use of recreational drugs is also relevant when obtaining the SH.

Smoking

The health risks of smoking are extensive and continue for years even after the patient has given up. Recording the patient's smoking history can be a sensitive issue as some people who smoke may feel they are being judged by healthcare professionals (Crumbie, 2006). Conversely, some patients will often say they smoke less than they actually smoke. You will need to ask 'what they smoke (cigarettes, cigars, pipe etc.)', 'how many they smoke daily' and 'for how long'. This is reported as pack years and this is calculated by multiplying the number of packs of cigarettes smoked daily by the number of years of smoking. It is generally accepted that a pack contains 20 cigarettes, and Box 1.8 demonstrates how this is calculated. A pack year history of greater than 15 increases the patient's risk of long term lung disease and could be a valuable clue in the history taking. It is also important to note if a patient does not smoke. If so, have they ever smoked, how much

and how long or when he or she gave up. If a patient hesitates before saying 'no', it may be because they smoke illegal substance such as cannabis and this should be explored carefully (Rushforth, 2009).

Box 1.8 Pack years

If a patient has smoked 20 a day for 12 years
1 pack (20 cigarettes) × 12 years = 12 pack year history

If a patient has smoked 40 a day for 12 years
2 pack (40 cigarettes) × 12 years = 24 pack year history

If a patient has smoked 10 a day for 30 years
½ pack (10 cigarettes) × 30 years = 15 pack year history

Alcohol and recreational drugs

The harmful use of alcohol is one of the main risk factors to health and often directly contributes to symptoms and the need for care and treatment for illnesses and injuries.

It is responsible for about 2.3 million premature deaths worldwide per year (WHO, 2009). Injuries – both unintentional and intentional – account for more than a third of the burden of disease attributed to alcohol consumption. These include injuries from road traffic crashes, burns, poisoning, falls and drowning as well as violence against oneself or others (WHO, 2009).

Health professionals hesitate to ask patients about the use of alcohol. In some incidents, the smell of alcohol is usually easily detected but heavy drinkers who have stopped drinking before seeking help often have a sweet acetaldehyde breath (Welsby, 2002). Assessment should not go on detection of smell and an attempt should be made to estimate consumption for the patient including what the patient sees as alcohol. Often, people will underestimate the amount of alcohol consumption due to embarrassment (Rushforth, 2009) or may feel they are being judged as social deviants (Crumbie, 2006). Several patients do not perceive wine and beer as alcohol (Bickley and Szilagyi, 2009), but more importantly would not consider alcohol as a drug. Alcohol can cause serious ADRs (see Drug History) and therefore should be avoided when certain drugs are taken. For example,

- *Metronidazole* interferes with the metabolism of alcohol, causing nausea, flushing, headaches and sweating
- *Hypnotics and sedatives* are potentiated by alcohol
- *Warfarin's* anticoagulant action is enhanced with an acute overdose of alcohol
- *Metformin* carries a risk of lactic acidosis with alcohol

- *Aspirin* and other *non-steroidal anti-inflammatory drugs (NSAIDs)* carry a small risk of increased risk of gastric bleeding

When ascertaining alcohol intake, try to use open-ended questions by asking the patient

'What do you like to drink?'
'How much do you drink?'
'When was your last drink?'
'Tell me about your use of alcohol?'

If you are having problems getting truthful answers or have concerns about the misuse of alcohol, ask the patient 'if they have ever had a drinking problem'. There are also validated screening tools you can use to support your assessment. The WHO (1980) developed the Alcohol Use Disorders Identification Test (AUDIT) which is a brief screening tool developed for use in primary care settings. The most widely used screening questions are about *C*utting down, *A*nnoyance if criticised, *G*uilty feelings and *E*ye-openers, (CAGE) (Ewing, 1984). When questioning, you should ask the following:

Have you ever felt the need to *cut down* on drinking?
Have you ever felt *annoyed* by criticism of your drinking?
Have you ever felt *guilty* about drinking?
Have you ever taken a drink first thing in the morning (*eye opener*) to steady your nerves or get rid of a hangover?

The CAGE questions should not be preceded by any questions about alcohol intake as its sensitivity is dramatically enhanced by an open-ended introduction (Steinweg and Worth, 1993). Two or more affirmative answers to the CAGE questions suggest alcohol misuse (Bickley and Szilagyi, 2009), nevertheless this cannot lead you to conclude beyond doubt that there is a problem as the diagnostic accuracy for the CAGE framework has not been fully established (Taner and Antony, 2004).

Following on from alcohol screening it would be appropriate at this point to enquire specifically about the use of recreational drugs particularly if needle marks are spotted or the patient presents with a decreased level of consciousness or possible misuse of prescription drugs. As with alcohol, the questions need to be focused if you are to get meaningful answers. Rushforth (2009) suggests that you need to ask this question sensitively as some patients will be offended whereas Welsby (2002) recommends that you ask outright, 'What drugs do you take?'. If nonusers are offended, this will be easily recognised and you can immediately respond by saying 'I mean medical drugs such as painkiller or tablets for your blood pressure'. Drug users will give a truthful answer. From this, you can establish about

either patterns of use (last use, how often, substances used, amount) and/or route of administration (oral, smoking or injecting). The CAGE questions can be adapted to screen for substance abuse by adding 'or drugs' to each question.

Mental health history

One in four people will experience some kind of mental health problem in the course of a year (Office for National Statistics, 2001), and ambulance staff and ambulance crews will frequently be the first contact for many patients with mental ill health in a crisis (Department of Health (DH), 2004). Furthermore, it is estimated that up to 5% of those attending an emergency department have a primary diagnosis of mental ill health, of which substance misuse and deliberate self-harm (DSH) are the largest groups (DH, 2004); 400 per 100,000 patients in the United Kingdom will self-harm (Mental Health Organisation, 2010). A further 20–30% of attendees have co-existing physical and psychological problems, with much of the latter remaining undetected (DH, 2004). Recognition of mental health problems is essential, yet can pose challenges in any environment due to the interplay between mental disorders and physical health. Mental health disturbances can present with physical symptoms (somatisation) and/or with signs suggestive of physical illness (Welsby, 2002), and physical illness can present with behavioural and emotional responses (Bickley and Szilagyi, 2009).

Typically, the 'general medical' mental health assessment is very detailed (Welsby, 2002) and this level of detail would not be commonly undertaken in the pre-hospital setting (Gregory and Murcell, 2010), emergency and urgent care setting. The medical history would include social and physical aspects but the patient's appearance, dress and demeanour may all be important clues to the presence of a mental disorder (Welsby, 2002). It may be necessary to obtain further background information to establish low mood, anxiety and depression. This includes the following:

- Experience of childhood
- Adolescence
- Occupation(s)
- Marital history
- Previous mental health
- Problems with current life situation
- Problems with various addictions (including alcohol and drugs)

The *SAD PERSONS* risk assessment tool (see Table 1.2) will be useful when assessing the risk of DSH. Nonetheless, assessing suicide risk is very complex and as a result, there is limited evidence to support the use of this tool.

Table 1.2 SAD PERSONS assessment

Sex	Female	Male
Age	19–45	<19 >45
Depression or hopelessness	No	Yes
Previous attempts	No	Yes
Excessive alcohol or drugs	No	Yes
Rational thinking	Yes	No
Separated/divorced/widowed	No	Yes
Organised or serious attempts	No	Yes
Social support	Yes	No
Stated future suicide intent	No	Yes
		Number of ticks in this column indicates score
		<3 low risk
		3–6 medium risk
		>6 high risk

Data from Patterson et al. (1983).

Sexual health

Obtaining a sexual history is often not appropriate in the pre-hospital, emergency and urgent care environment unless it is relevant to their presenting problem such as vaginal or penile discharge or where pregnancy may be a complication such as lower abdominal pain which has the potential to be an ectopic pregnancy. A sexual history should also be considered together with a urinary history, if the patient presents with a urinary problem. Due to the close location of the urinary and reproductive systems, it can be difficult for you and the patient to differentiate signs and symptoms.

Many patients (and sometimes healthcare practitioners) are not willing to discuss their sexual history with a healthcare practitioner due to feeling embarrassed and uncomfortable (Tomlinson, 1998); consequently, it is essential to be tactful and sensitive to this. Men, particularly younger men, older people, people from different cultures and teenagers may all have particular sensitivities about the sexual health issues they need to discuss. It is important to think about the young people in particular, in respect of their age, the age of sexual partners, competency to consent, confidentiality and safeguarding.

When taking a sexual history, it is vital that you feel comfortable discussing their problem, as this will encourage the patient to talk openly. Begin with explaining to the patient for having to ask sensitive questions and why it is appropriate.

Review of systems

A history is not complete without a review of systems. The questions commonly pertain to symptoms, but can sometimes include diseases such as pneumonia or tuberculosis (Bickley and Szilagyi, 2009). The purpose of this is to search for hidden clues to uncover problems that the patient has overlooked, particularly in areas that are not related to the presenting problem; and to double check that significant information has not been left out. It is usual to start the review in a logical order from 'head to

Box 1.9 Review of systems

Nervous	Visual problems	**Urinary**	Frequency
	Hearing problems		Pain on passing urine
	Headaches		Urinary stream
	Fits/faints/blackouts		Back pain
	Muscle weakness		Urine characteristics
	Abnormal sensations		Incontinence
Respiratory	Cough	**Genital**	Pain/discomfort/ itching
	Sputum production		Discharge
	Haemoptysis		Unusual bleeding
	Chest pain		Sexual history, if relevant
	Shortness of breath		
	Wheezing		
Cardiovascular	Chest pain	**Musculoskeletal**	Muscle weakness
	Shortness of breath		Joint swelling
	Ankle swelling		Joint pain
	Palpitations		Muscle pain
Gastrointestinal	Appetite		Cramp
	Weight change		Loss of strength
	Difficulty in swallowing		
	Pain on swallowing		
	Nausea or vomiting		
	Abdominal pain		
	Jaundice		
	Change in bowel habit		
	Heartburn, indigestion, flatulence		
	Haematemesis, melaena		

toe', and start with the general questions as you address each system. For example:

'How are your ears and hearing?'
'How are you at remembering things?'
'How about your lungs or breathing?'
'Do you have any trouble with your heart?'
'How are your eating habits?'
'How about your bowels?'

If you identify any areas of concern, a more focused exploration will be required. Box 1.9 demonstrates some key examples.

Summary

History taking is a fundamental skill in clinical practice and the importance of history taking and why we need to obtain thorough accurate data cannot be over emphasised. To achieve that requires a vast range of knowledge and skills such as communication, history-taking methods, pathophysiology, prevalence of disease, differential diagnosis to name a few, to ensure the patient receives the appropriate care and management. There are several models that can be used to guide the history taking process and depending on the situation of the clinical incident, the correct approach will be used. However, for the majority of patients the traditional medical model is the preferred method to ensure that relevant data is collated. This chapter has briefly introduced some basic methods, but has focused predominantly on the traditional medical model together with some useful mnemonics that can be used to structure your questioning.

History taking is a complex process as you need to consider other factors of relevance such as the PMH, DH and the psychosocial aspects and this chapter has explored the importance of capturing this data and its relationship to the patient's clinical condition. It is evident that communication is vital in the history-taking process and this has been briefly introduced. As a vast subject area, this has been explored fully in Chapter 2 and it is highly recommended that you read this chapter in conjunction with this to fully understand the impact, both positive and negative, this will have when obtaining information to assess and manage care effectively.

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