

CLINICAL SKILLS: TAKING A HISTORY

Consider your environment before taking a history. Specifically, make sure it is private (draw curtains, move to a private room, ensure nobody else is in ear-shot).

- Wash hands
- Introduce yourself to ask for permission to discuss their illness

Patient Details:

- Name
- Age
- Gender
- Occupation

Presenting Complaint: (PC)

- This is a sentence or two explaining exactly why the patient came in and what they have come to see the doctor about
- E.g.: abdominal pain, shortness of breath, tired all the time

History of Presenting Complaint: (HPC)

- This section allows you to go into more detail about the presenting complaint, e.g.: if there was pain, what was it like? Were there other symptoms that the patient experienced at the same time?
- Use this section to build on your understanding of the initial complaint. Ask questions which are going to help lead you to a differential diagnosis
- Ensure you have a good timeline of the symptoms - what started first, how long has it been going on for, has it been getting better or worse, has it ever happened before now?
- Helpful tip: for any form of pain, use the helpful anagram SOCRATES:
 - S ite (where the pain is)
 - O nset (when it started)
 - C haracter (cramp, stabbing pain, tight band, etc.)
 - R adiation (if the pain moves)
 - A ssociated symptoms (fever, diarrhoea, wind, etc.)
 - T iming (constant or comes and goes)
 - E xacerbating/relieving factors (what makes it feel worse or better?)
 - S everity (to rate /10)

Past Medical History: (PMHx)

- Find out what other illnesses the patient has now or has had previously. This may be related to the presenting complaint.
- List the most recent illnesses first.
- Ideas for questions include;
 - Have you been into hospital for anything before?
 - What other illnesses do you have?
 - Do you visit your GP for anything regularly?
 - Have you ever had surgery before?

- Helpful tip: run through the anagram MJ THREADS for a list of important diseases to pick up in your history:
 - **M** yocardial infarction
 - **J** aundice
 - **T** uberculosis
 - **H** yper/hypo tension
 - **R** heumatic fever (damages heart valves)
 - **E** pilepsy or fits
 - **A** sthma, eczema, hay fever
 - **D** iabetes (and type)
 - **S** urgery/ stroke

Drug History: (DHx)

- This is where you find out the patient's current medication list. Include;
 - Names of drugs (in capital letters, preferably generic names)
 - Dosage/strength
 - Number of times taken per day
 - Check whether patient is regularly taking them.
 - Allergies (N.B.: NKDA = No Known Drug Allergies)
 - Immunisations (especially if a child or other risk factors)

Family History: (FHx)

- Some diseases run through families. This is the time in the history where you can find out if the patient is more at risk of certain diseases.
- Ask if father and mother still alive
- If not, what did they pass away from, and how old were they
- Ask if patient has siblings or children
- Ask if any of these relatives have/had any illnesses themselves
- Specifically ask about:
 - Cancer
 - Heart disease
 - Blood pressure
 - Diabetes

Social History: (SHx)

- This is the time where you can find out details about a patient's non-medical history. It includes;
 - Smoking (packs per day, for how long. If they say they don't smoke, ask if they ever have and for how long and how often)
 - 1 pack-year = 20 cigarettes a day for 1 year
 - Alcohol (in units, and pattern of consumption recorded)
 - Recreational drug use (Intravenous? Shared needles?)
 - Living situation:
 - Who patient lives with
 - If the patient has carers
 - If they live in a flat/house
 - If there are stairs
 - Exercise

- Impact their symptoms have on their life (will help in forming a management plan for patient)
- Sexual history
 - This will not always be appropriate to include, but some presenting complaints will require a sexual history. You will find full details of how to take a sexual history (for example, in a GUM clinic) in our gynaecology section
- Travel
 - Very important to ask about if there is a possible infective cause for the presenting complaint

Systems review:

- This is where you ask general questions about the other bodily systems which may have not been asked about previously.
- Go through each bodily system, asking 2-3 questions about each of; cardiovascular, respiratory, abdominal, neurological, and musculoskeletal systems

To close the discussion:

- Ask the patient if they have any questions
- Ask them about their current 'ideas', 'concerns' and 'expectations' about their current illness or morbidity (ICE). This takes some practice to ask these questions sensitively and to gain valuable responses, but can give you important insight about what the patient wants you to focus on in subsequent discussions.
- Thank the patient
- Wash your hands

A 'Long Station History' OSCE can have a slightly different focus to the standard 'acute illness' history that is described above, as Universities are fond of using real patients instead of actors. For tips on how to get the most out of the 'Long Station History' OSCE, [click here](#).