PRE-COURSE WORKBOOK

BELMATT
HEALTHCARE TRAINING

History Taking

JESHNI AMBLUM-ALMER

Jeshni Amblum-Almer is your course director for this programme. She has been a nurse for 30yrs, and has been a nurse practitioner and university lecturer for the past 16years.

Trained in South Africa as a midwife, psychiatric nurse and community nurse, I've worked mainly in A&E and community clinics. In England, I initially worked in the emergency department, before taking a site clinical manager post. Since 2006, I have worked part time in urgent care and my main role included the Minor Illness and Minor Injuries modules and teaching on various other courses including Prescribing, Interprofessional Problem Based Learning at St. Georges Medical School and pre reg nurses at Kingston University. More recently, I have been the Course Director for the RCN accredited MSc Advanced Practice at City University.

My main role now is reviewing the lectures, applying for accreditation and teaching on some of the courses.

I have recently been elected as the next President of the General Practice and Primary Care Section at the Royal Society of Medicine, the first nurse in its 200year history. I have been an external examiner for the MSc Advanced Practice programme at Glyndwr university in Wales and hold positions on various governing bodies. I also hold a Masters in Medical Law.

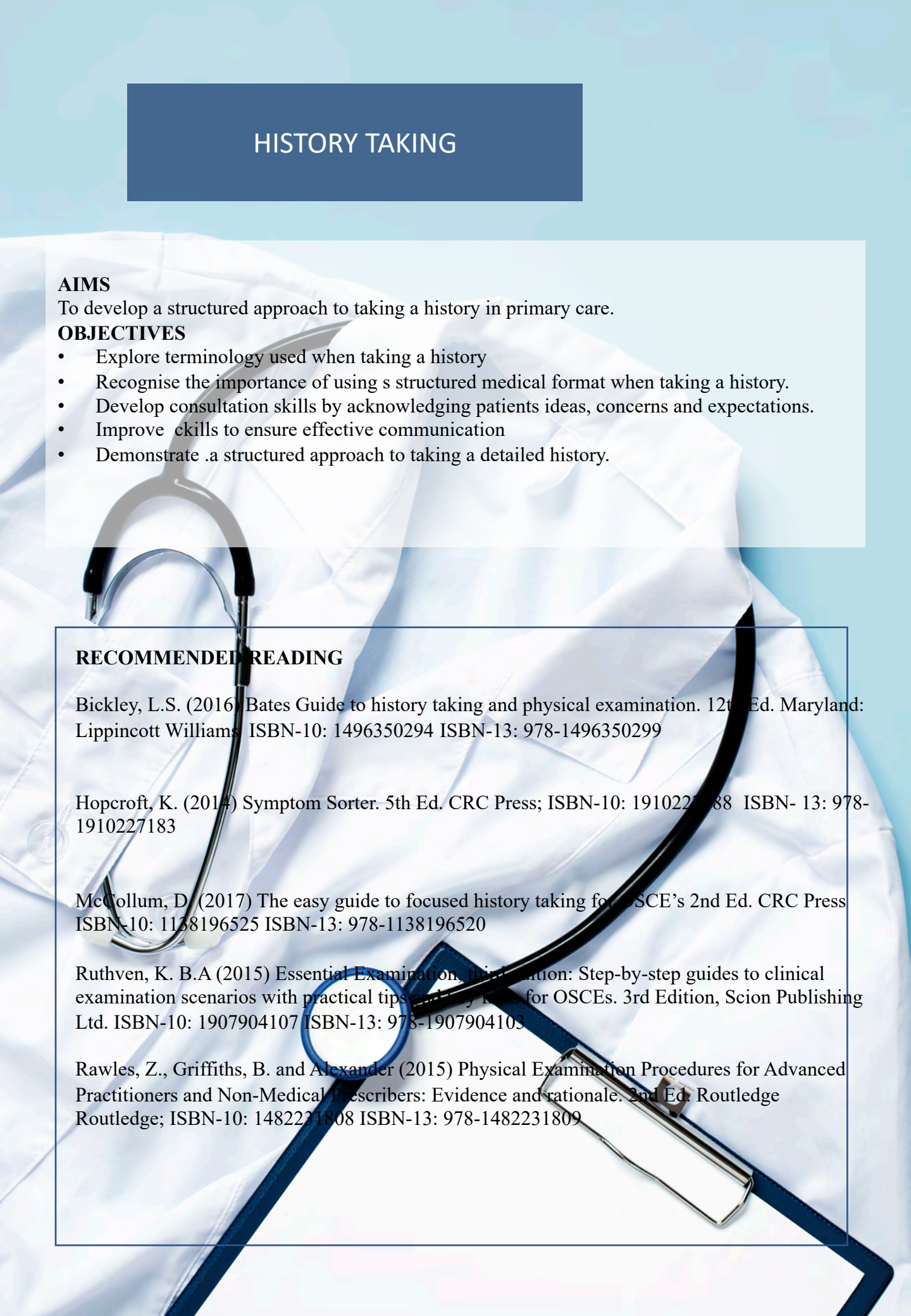
HISTORY TAKING

AIMS

To develop a structured approach to taking a history in primary care.

OBJECTIVES

- Explore terminology used when taking a history
- Recognise the importance of using s structured medical format when taking a history.
- Develop consultation skills by acknowledging patients ideas, concerns and expectations.
- Improve ckills to ensure effective communication
- Demonstrate .a structured approach to taking a detailed history.



RECOMMENDED READING

Bickley, L.S. (2016) Bates Guide to history taking and physical examination. 12th Ed. Maryland: Lippincott Williams ISBN-10: 1496350294 ISBN-13: 978-1496350299

Hopcroft, K. (2014) Symptom Sorter. 5th Ed. CRC Press; ISBN-10: 191022[illegible]88 ISBN- 13: 978-1910227183

McCollum, D. (2017) The easy guide to focused history taking for OSCE's 2nd Ed. CRC Press ISBN-10: 1138196525 ISBN-13: 978-1138196520

Ruthven, K. B.A (2015) Essential Examination, third edition: Step-by-step guides to clinical examination scenarios with practical tips and key points for OSCEs. 3rd Edition, Scion Publishing Ltd. ISBN-10: 1907904107 ISBN-13: 978-1907904103

Rawles, Z., Griffiths, B. and Alexander (2015) Physical Examination Procedures for Advanced Practitioners and Non-Medical Prescribers: Evidence and rationale. 2nd Ed. Routledge Routledge; ISBN-10: 1482231808 ISBN-13: 978-1482231809

TEMPLATE:

PC
HPC

PMH
GYNAE
MEDS
ALLERGIES

FH
SH
SYSTEMS OVERVIEW

O/E
JACCOL
VITAL SIGNS

EXAMINATION

DIFFERENTIAL DIAGNOSES

RED FLAG

INVESTIGATIONS

DIAGNOSIS
TREATMENT

WORSENING CARE ADVICE

SAFETY NETTING

SIGNED

HISTORY TAKING

Communication is integral. Ensure, you introduce yourself, take consent before taking the history and before the examination. Consider use of language line or any other language
aids available. Keep language simple and clear for patient to understand.
Gain patient consent at the outset. Enquires about source of referral.

PC - Clarifies presenting complain (PC) and uses patients own words when possible. Be succinct e.g. Cough

HPC - Uses a recognised pseudonym to obtain a structured history of presenting complaint. PQRST/SOCRATES. Any first aid. Relief / aggravation /radiation. Associated symptoms, timing, exacerbation, severity

MEDICAL: Checks past medical history using JAMTHREADSCA

SURGICAL HISTORY AND/OR HOSPITALISATIONS

GYNAECOLOGY: Checks gynecological history in females included LMP, parity, gravida and gynae conditions
Gravida – No of pregnancies over 24weeks
Parity – How many live births.

MEDICATION: Checks medication history including prescribed, over the counter, street, herbal and 'other drugs'. Checks immunization history.

ALLERGIES: Obtains a history of allergies including medication, food intolerances, animal or other e.g. latex or plasters.

SOCIAL HISTORY: Take a thorough social history including home environment, marital status, hobbies, occupation, travel, smoking and alcohol including diet and exercise

FAMILY HISTORY: Takes a family history and able to complete a genogram

SYSTEMS OVERVIEW – Take a structured history relevant to each system including cardiac, respiratory, skin, endocrine, abdomen, HEENT

Communication Skills In The Patient Interview

Listening: capturing and understanding verbal and non-verbal cues

Deep listening is a skill that demands energy and commitment and means setting aside our own thoughts, being fully present and attentive to the other person. In a busy clinical environment, it is a challenge to set aside thoughts on all the other tasks that awaits us, or we may be pre-occupied with what we wish to say next that we may miss important information relayed by the patient. Other barriers to listening are; anxiety, stress, exhaustion, poor attention, interruptions or rehearsed responses.

Positive steps to promote active listening: using prompts to encourage the patient to go on and give more information, reflecting on what is being said and demonstrating an understanding of the patient's perspective. Non-verbal cues such as nodding, open posture, eye contact and facial expression shows that you are fully engaged in what is being said. The tone of voice, timing and rate of speech may further indicate underlying anxiety experienced by the patient. Detecting speech impairments such as slurred speech, or stuttering could also be detected from active listening that forms an integral part of taking a clinical history.

Empathy: communicating to clients your understanding of what is being said.

Probing: Silence used appropriately will encourage the patient to expand on what they are saying. Facilitating clients to explore feelings, behaviors and experiences allows the practitioner to gain a deeper understanding of the problem, leaning forward, or occasionally saying 'Go, on' or 'I'm listening' encourages the patient to explore the problem.

Ethical consideration must be woven throughout the entire patient-practitioner encounter:

Nonmaleficence: Do no harm.

Beneficence: To act in the best interest of the patient and do good.

Autonomy: patient should have the right to determine what is best for themselves.

Questioning:

Showing concern: Start by asking about the patient's comfort and needs.

Open-ended question initially; seek reason for patient visit e.g. 'How can I help you?' This gives the patient the opportunity to express their concerns and expand on underlying problems that may be bothering them.

Showing interest: for example basing a question on what you have observed. E.g. 'I notice that you are limping when you came in today'.

Direct questions: Enables you to guide the patient to focus on the problem; For example, 'Are you bringing up any phlegm when you cough?'

Probing Questions:

'Tell me more', 'Uh Huh', or echoing the last part of what the patient said are all ways that probing techniques may be used to get more information. However it is essential to recognize signs of discomfort and return to less invasive questions until the patient show signs of readiness for deeper questioning. An example of a probing question could be: 'what color is the phlegm?'

Silence:

This is a useful strategy in allowing the patient to explore their problem. Avoid premature interruptions and don't be afraid to stay silent at times as this is a facilitative tool in encouraging the patient to expand on telling their story. It is a form of probing the patient to tell more or to 'muse aloud'.

Summarize: This allows you to check that they match the patient's understanding of the problem. Furthermore it demonstrates that you have been listening to what has been said and gives the patient an opportunity to clarify any issues that may have been misinterpreted.

Presenting Complaint:

Ask an open-ended question to encourage the patient to describe his problem or symptom in their own words; For example - 'Tell me, what brings you here today?' or, 'How can I help you today'?

Do: Give eye contact and show interest to facilitate the patient telling their story.

Avoid: 'What is the problem?'. Do not interrupt.

If the patient states the complaint but wanders off the point such as:
'I've had this terrible cough and its not getting any better so that's why I thought I better come and see someone about it'… 'Its terrible trying to get an appointment in this place'. You can show empathy but at the same time bring the patient back to focus on the chief complaint:

Note that, by doing this you have demonstrated that you listened to the patient and is now ready to get them to explore their reason for attending.
Throughout the patient interview note the patient's non-verbal cues.

Explore associated signs and Symptoms:
•Rashes
•Diarrhoea & vomiting?
•Pain?
•Weight loss?
The mnemonic 'OPQRSTU' could be used to make finer assessment of the associated symptom or pain experienced: Or SOCRATES

Ideas

•“Tell me about what you think is causing the problem.”
•“Do you have any theories about what might be going on?”
•“It’s clear that you’ve given this a lot of thought and it would be helpful to hear what you think might be going on.”
•“What do you think might be happening?”
•“What’s your best guess as to what is causing this?”
•“Do you have any ideas as to what is going on at the moment?”

Concerns

•“What’s your biggest worry at the moment regarding what this might be?”
•“Are you worried about this being anything in particular?”
•“In your darkest moments, what do you worry about?”
•“What’s the worst thing you were thinking it might be?”
•“What’s your number one concern regarding this problem at the moment?”

Expectations

•“What were you hoping I’d be able to do for you today?”
•“What would ideally need to happen for you to feel today’s consultation was a success?”
•“What do you think might be the best plan of action?”
•“What were you hoping would happen today?”
•“You’ve obviously thought about this quite a bit, did you have any thoughts on the best way we could tackle the issue?”

•Taken form Geeky Medics
https://geekymedics.com/ice/

	Assessment	Findings
O	Other	Has there been any other person in contact who have had similar symptoms e.g. rash in chickenpox.
P	Palliative / Provocative	Explore what makes the symptom (e.g. pain) better or worse
Q	Quality	Ask the patient to describe the character of their pain; e.g. dull, sharp, burning, colicky or cramping?
R	Region / Radiation	Ask where is the pain experienced and does it radiate to any other region. E.g. lower back pain that radiates to the lower leg in sciatic pain. The patient's interpretation of the quality of the pain may be influenced by culture, language and past experiences of pain experienced. Some conditions have specific quality of pain or discomfort experienced. For example: burning sensation- peptic ulcer, dull or aching in constipation.
S	Severity	On a scale of 0 - 10 ask the patient to rate the severity of pain experienced. Use 0 to be the least painful and 10 being most severe. This is useful when measuring the effects of analgesia and if the condition is worsening or improving. Does the pain limit certain activities?
T	Timing	When did symptoms first start and does it get worse at a particular time? For expel cough related to asthma may be worse at night. Has it been a sudden onset or gradual?
U	Understanding	Explore the patients' understanding or health beliefs about their problem. This may help to uncover underling fears and anxiety. Questions such as 'What do you think it could be'/ 'What has it been like for you' enables the practitioner to consider the patient's emotions regarding the problem.

PAST MEDICAL HISTORY

JAMTHREADSCA JAUNDICE, ANAEMIA, MI, TB/THYROID, RH FEVER, EPILPESY,ASTHMA,DIABETES, STROKE, CANCER

Have you ever had this problem in the past? For example patients with past history of myocardial infarction are at greater risk of having a further event.

SURGERY/HOSPITALISATIONS

OBSTETRIC HISTORY : GRAVIDA AND PARITY

MEDICATION**:**

This should include prescribed medicines, over the counter remedies or alternative therapies. Explore also the risks of drug and substance misuse. See more detailed guidelines

https://geekymedics.com/how-to-take-a-medication-history/

Allergies:

Is there a past history of drug sensitivity including with over the counter medication. If yes, get the patient to describe the reaction experienced; E.g. facial swelling, perioral itching, wheezing, rashes, nausea vomiting. Consider, food allergies such as peanut, diary products or eggs.

IMMUNISATIONS

Are their immunisations up to date. Have they had all their childhood immunisations including BCG. Remember that Polio is still prevalent in Nigeria,

SOCIAL HISTORY

Occupation:
What does the job involve? (*e.g. heavy lifting, repetitive movements,*
sitting for prolonged periods, driving)
Stress –
Diet
Exercise –
Living situation:
House/bungalow? – *adaptations / stairs*
Who lives with the patient? – *Is the patient supported at home?*
Any carer input? –*What level of care do they receive?*
What is their normal level of mobility? – D*o they use mobility aids such*
as walking sticks?

Activities of daily living:
Is the patient independent and able to fully care for themselves?
Can they manage self-hygiene/housework/food shopping?

Assessing Alcohol intake:

Patients may not be aware of what constitutes a 'unit' of alcohol. Furthermore some alcohol products do not contain the standard drink model. Thus ask questions such as:

•The type of drink

•The size of glass

•'Do you drink most evenings or only on the weekends?'

•If they drink spirits at home; ask what size bottle and how long does it normally last?

The CAGE questionnaire could be used to assess the possibility of alcoholism:

Have you ever felt the need to cut down on drinking?

Have you ever felt annoyed by criticism of drinking?

Have you ever had guilty feelings 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?

Adapted from Mayfield D, McLeod G, Hall, P. (1974)The CAGE Questionnaire: Validation of a new alcoholism screening instrument, American Journal of Psychiatry 131, 1121-1123

Smoker? If yes, find out how long have they smoked and number of cigarettes per day: Offer smoking cessation advice. Never smoked cigarettes?

Dietary History: does daily intake of food consists of fruits and vegetables. Excessive caffeine intake? Adequate fluid intake. Is there a sensitivity to certain foods?

SYSTEMIC ENQUIRY	**Systemic enquiry** involves performing a brief screen for symptoms in other body systems. This may pick up on symptoms the patient failed to mention in the presenting complaint. Some of these symptoms may be relevant to the diagnosis (e.g. calf pain in pulmonary embolism). Choosing which symptoms to ask about depends on the presenting complaint and your level of experience. **Cardiovascular** – *Chest pain / Palpitations / Dyspnoea / Syncope / Orthopnoea / Peripheral oedema* **Respiratory** – *Dyspnoea / Cough / Sputum / Wheeze / Haemoptysis / Chest pain* **GI** – *Appetite / Nausea / Vomiting / Indigestion / Dysphagia / Weight loss / Abdominal pain / Bowel habit* **Urinary** – *Volume of urine passed / Frequency / Dysuria / Urgency / Incontinence* **CNS** – *Vision / Headache / Motor or sensory disturbance/ Loss of consciousness / Confusion* **Musculoskeletal** – *Bone and joint pain / Muscular pain* **Dermatology** – *Rashes / Skin breaks / Ulcers / Lesions*

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