History taking and physical examination

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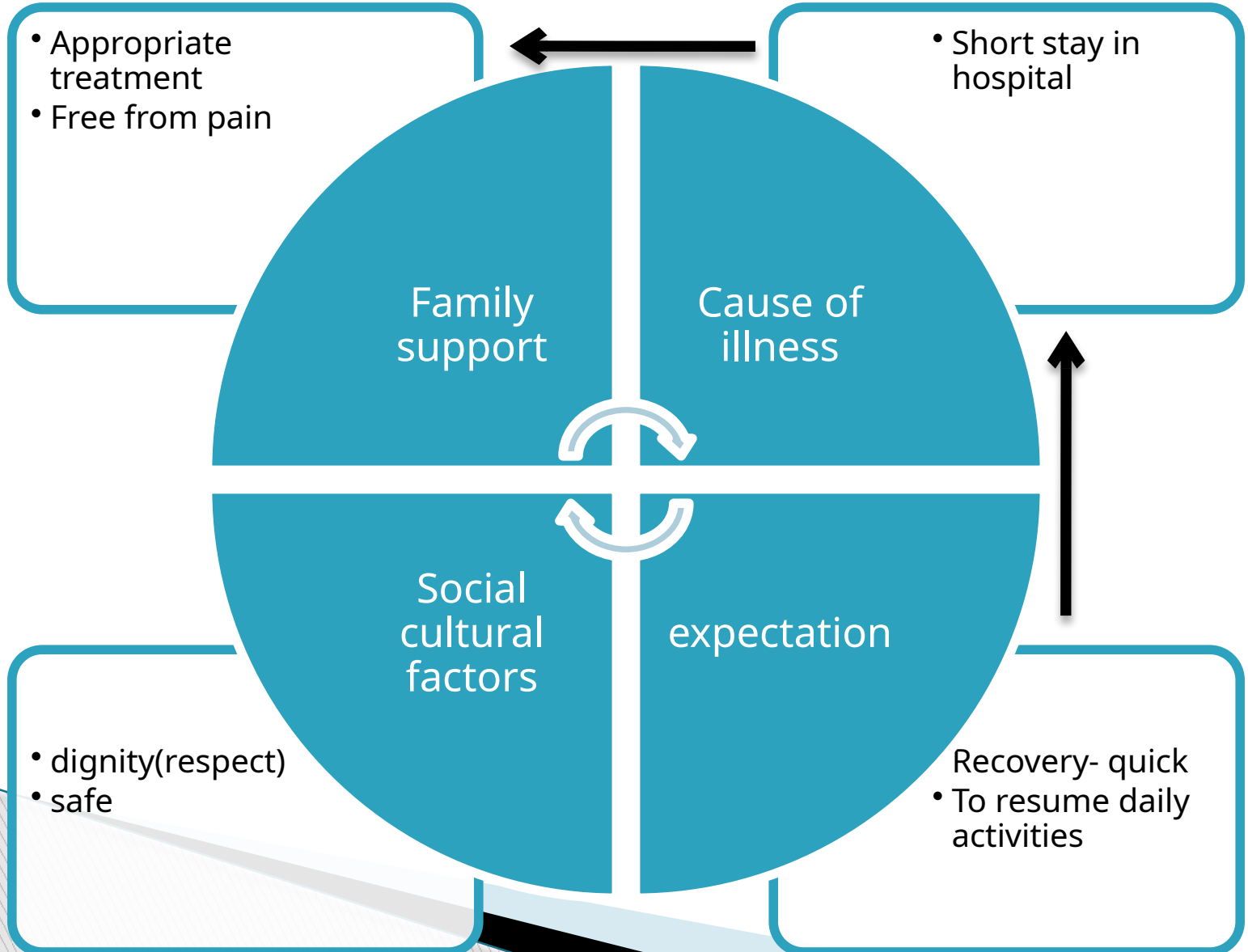
Patient's Perception of illness



History taking

- Systematic procedure of gathering subjective and objective data about a client/ patient' health status
- Information can be obtained from
  - patient/client
  - guardian/companion
  - Previous records through interview

Nursing history

- Narrative of the clients’ past health and health practices that focus on the information needed to:
- Diagnose illness
- Plan nursing care
- Plan investigations and treatment

NB/ both medical and nursing histories are collected through interview to collect data that forms the reason why the client visits the doctor

Qualities of GP: must be

- Professional in dress and behavior
- Neat, polite, clean
- Show concern to patient situation
- Pick up non-verbal cues from the patient:
- Are they distressed, how are their mood, demeanor, changes in body language during consultation ⇒ gives clues to difficulties they have that cannot be expressed verbally

Objectives / purpose of history

- To gather information related to the patient's background as a base for treatment (baseline data to make clinical judgment on client's health status)
- Be able to understand the patient and identify the problems faced by the patient then plan for therapeutic interventions

Objectives / purpose of history

- Establish previous consultations/ hospitalization with details of treatments given
- To confirm observations made while the patient is in the ward
- The rationale for history taking therefore is to provide information and relevant details for making a diagnosis and subsequent decision on patient management

indications

- 1st contact with patient or informant/companion
- Any patient seeking health care services

NOTE: consultation time ranges between:

- 5-10 minutes
- 20-30 minutes for complex problems

Uses of history

- Make diagnosis
- Plan care
- For insurance claims: Compensation
- As evidence in a court of law: homicide, malpractice, negligence
- For teaching medical students
- For research purposes

Communication Skill used

- Active listening and observation skills
- Exploration skills
- Questioning skills (open and closed ended)
- Summarizing skills

Steps in history taking

- B-Beginning
- L-Listening
- I-Information gathering
- S-Sharing information
- S-Setting goals

beginning

- Involves:
- Preparation
- Setting
- introductions

listening

- Problems
- Ideas
- Concerns
- Expectations

clarify, summarize context

- Active listening helps in :

1. recognition of what is wrong
2. Patients satisfaction is improved if patient understands what is wrong and what they can do to help

Information gathering

- Systemic enquiry
- Clinical examination (physical examination)

Sharing information

- Chuck it
- Check it
- Share decisions

Setting goals

- Ending
- Follow up

Phases of history taking

- **INTRODUCTORY PHASE:**
- Initiating the session
- Greet, welcome, introduce self and role, establish rapport, ensure client/informant is comfortable
- Assume relaxed and open sitting position, non confrontational sitting, gain eye contact
- Set time Hx is taking and expectation (20-30min)
- Decide language
- Enquire relationship between client and companion
- Respect and empathy
- Confirm reason for encounter

Working phase

- Exploration of the problem (gathering information)
- Use communication (interview) skills
- Attend to non-verbal communication- validate them
- Open to closed ended questions, simple language (no medical jargon or emotive words, be audible and clear)
- Encourage to tell his story openly
- Clarify patient statements- give important information 1st in small amounts and check understanding
- Establish dates

Working phase

- Understand patient's perspective:
- Determine and acknowledge patient ideas and causes as they are narrated
- Explore concerns/problems- social Hx eg job, religion, hobbies, beliefs, moral beliefs eg for termination of pregnancy, home environment and coping capabilities, family size
- Encourage expression of emotion
- Attend to non-verbal cues- is pt distressed, mood, body language change during Hx

Cont: working phase

- Obtain, interpret and record information on the following:
- ✓ Identifying data/biodata
- 3 names
- Age
- Sex
- Residence
- Religion
- Marital status
- occupation

Cont:

- Chief complain
- Ask what brought patient to the hospital
- Main complain
- Duration
  - Usually stated in patients words

Cont:

- History of presenting illness
- Ask the Onset-acute or gradual
- The Location-e.g. location of pain
- The Duration- hours, days, weeks
- The Character-example sharp, radiation
- Aggravating factors-what makes it worse
- Relieving factors-what makes it better
- Timing-on exertion or at rest or time of the day
- Severity- degree of pain example on a scale of 1-10
- OLD CARTS-MNEMONIC TO HELP US REMEMBER

Cont:

- REVIEW OF SYSTEMS
- General health: the weight, sleep, energy. Report what the patient says about their general health
- Cardiovascular systems: chest pains, palpitations, dyspnoea, pre-syncope, syncope(fainting), orthopnoea, peripheral oedema

Cont:

- Respiratory symptoms: dyspnoea, cough, sputum, wheeze, haemoptysis(coughing up blood), pleuritic chest pain.
- Gastro-intestinal symptoms: appetite change, nausea, vomiting, dyspepsia, dysphagia, weight loss, abd. Pain, abd.distension, jaundice, constipation, diarrhoea, melaena, hematochezia

- Genital urinary system: urine output, colour, haematuria, frequency, dysuria, flank pain, offensive discharge, pelvic pain, urinary urgency, urinary incontinence, terminal dribbling, nocturia, pruritis, uremic symptoms – fatigue, nausea anorexia

- Neurologic symptoms: visual eg blurred vision, headache, motor or sensory disturbance, confusion, loss of consciousness
- Musculoskeletal symptoms-bone and joint pains, muscular, trauma, joint swelling
- Integumentary (dermatology)- rashes, skin lesions, skin colour changes, ulcers, breast lump, breast discharge

- Metabolic/endocrine
- Cold intorence
- Heat intorence
- Excessive thirst
- Excessive hunger
- Hematologic
- Easily bleeds, easily bruises, lymphedema(swelling in an arm or leg caused by lymphatic system blockage), issues with blood clots

- Immunologic: food allergies, seasonal allergies

Past medical history

- Issues affecting current health
- Childhood illnesses eg mumps
- Vaccinations in childhood period
- Hospitalization if yes why and when and the outcome
- Chronic illnesses: cancer, cardiac/respiratory diseases, DM, arthritis, psychiatric illness
- Blood transfusion
- Drug allergies

Surgical history

- When and why the surgery was done
- Outcome of the surgery
- History of major injuries or accidents

Personal history

- Prenatal history
- Infancy history
- Childhood infancy
- Adolescence
- Adulthood
- Education
- religion

Conti:

- Occupation
- Work record
- Social cultural
- Sexual and marital relationships

Family history

- Age
- Health
- Position in family
- Cause of death of each immediate family member
- Any occurrence of any chronic or family disoder

Social history

Includes lifestyles that create risk or promote health and maintenance measures

- ✓ Alcohol use
- ✓ Drugs use
- ✓ Exercise
- ✓ Diet
- ✓ Occupation
- ✓ Educational status

Female gynecological and obstetric history

- Last normal monthly period
- Age of onset- menarche
- Regularity of periods
- Amount of bleeding
- Duration of flow
- Associated problems-eg abdominal pains
- Last delivery
- Mode of delivery

Termination phase

- Explain to the patient that required information has been obtained.
- If more will be required then the patient will be informed
- Thank the client and the companion and release them
- Keep the clients notes and files in respective cabinets
- Store unused stationary in the right place.

PHYSICAL EXAMINATION

- HEAD TO TOE

Physical examination

- Def: A systematic review of body systems, structures by use of inspection, palpation, percussion and auscultation techniques
- ***Purpose:***
- Establish database for patient abilities- determine risk factors for dysfunction and current pathology
- For diagnosis on current health state in order to plan for appropriate care

Physical examination

- Uses:
- To verify findings of history or determine meaning of findings
- Information is used to explain client's problems
- Indications:
- New client/ patient- on routine assessment to plan patient care
- FP clients
- Unexplained physical discomfort and when necessary
- On admission

Types of P/EXAMINATION

- Comprehensive (general):
  - Evaluate every body system and every area of function
  - Often limited to first visit
- Focused (local):
  - Based on reason for visit and client's current needs e.g abdominal examination in labour

Used to judge whether the client's condition is improving or worsening and identify factors that place client at risk for additional health problems

Cont

- Ongoing

Done daily or in every shift to assess progress

requirements

- Quiet room with sufficient privacy and ventilation
- Examination couch or a bed
- A gown
- Stethoscope
- Sphygmomanometer
- Torch with dry cells
- Spatula in a receiver
- Tendon hammer
- Pins
- Tape measure
- Watch
- Thermometer
- Weighing scale
- Cotton wool swabs in a receiver
- Blanket or draw sheet
- Ophthalmoscope
- Otoscope
- Examination gloves

Senses used

- Sight
- Smell
- Touch
- Hearing

Four Techniques used

- Inspection
- Palpation
- Percussion
- Auscultation
- NOTE: the above order is followed during examination except during examination of the abdomen when palpation is done last so that it does not alter bowel sounds or change findings on percussion and auscultation

inspection

-
  - Observing signs indicating a healthy or a pathological state of certain systems within the patient by use of sight
- Involves observation of: color, shape, size, symmetry, position, movement using sense of: smell, hearing, sight- facial appearance
- It is a continuous process and begins as the patient enters or 1st contact and throughout History

Cont....

- Main systems of observation upon the patients entrance:
- Posture
- Gait
- Colour
- Unusual odours
- Inspection continues throughout history and physical examination.
- Validate inspection findings with your patient

Inspection- teach eyes to see

- An example of what is meant by "teaching the eye to see" can be demonstrated in the following illustration. Read the sentence in the box. Then count the number of "f's" in the sentence.
- How many did you count?
- This example clearly shows that eyes have to be trained to see

Finished files are the result of years of scientific study combined with the experience of years.

inspection

- Expose only the area you want to inspect
- Use natural light to avoid distortion of color
- Tangential lighting- one shining from the side and cast shadows to increase ability to detect variations in body surfaces eg changes in abdominal contours

palpation

- Examination of the body through the use of touch
- Used to obtain information- temperature, moisture, size, shape, consistency, texture, position and movement
- To check pulses, tenderness, guarding, abdominal distension, masses and edema

palpation

- Involves the use of hands and fingers to gather information through sense of touch
- Parts of hands and fingers used in palpation: palmer surface and finger pads- most suitable for position, texture, size, form, consistency and presence of fluid or crepitus of a mass or structure
- Ulna surface- suitable for vibrations
- Dorsal surface- suitable to assess temperature

Types of palpation

- Light palpation:
- Precedes deep palpation
- Used to examine masses or lesions on the surface of the skin or lying immediately under the skin. Press 1-2cm (½-¾ inches)
- In abdomen, begin palpation with light systematic palpation of four quadrants while avoiding areas of tenderness or problem spots
- It identifies areas of muscle resistance and tenderness

Types of palpation

- **Deep palpation:**
- Done only in abdomen
- Used to identify abdominal organs and abdominal masses
- Fingers are held at 60^{o}, fingers together and use pads of fingers and finger tips- press fingers 4cm (2inches)
- Can be done using one hand or two hands on top of each other with the upper one exerting pressure (reinforced palpation)
- Bimanual palpation- palpation of organs using both hands

Preparation for palpation

- Finger nails MUST be short
- Wash hands and dry them, warm hands to avoid producing muscle contractions
- Patient is relaxed and comfortable
- Client supine, hands to the sides (assist in relaxing abdominal muscles)
- Stand on the right side of the patient

Preparation for palpation

- If patient is ticklish, add pt fingers to yours till hypersensitivity is lessened then remove clients hand
- Client to take slow deep breath through mouth to decrease muscle tension
- Tender area MUST be palpated last and stop if client has pain

method

- Lay palm of hand on the area to be palpated with fingers extended and approximated
- Mould the palpating palm of the hand on surface to be palpated.
- Depress the surface being palpated using the palmer surface of the fingers with an even pressing motion.
- Begin with non-tender area.
- Avoid using finger tips

Cont....

- Watch the patients face for any signs of discomfort during palpation
- Palpate lightly in each region
- Repeat this palpation deeply
- Avoid short, quick jabs

Percussion

- Tapping of body lightly but sharply to determine the position, size and density of underlying structures and to detect fluid or air in a cavity
- Is striking one object against another to produce vibrations and subsequent sound waves
- Middle finger used as hammer and vibration produced by impact of the finger against underlying tissue

percussion

- Sound waves produced are heard as percussion notes (tones) and determined by the density of medium through which sound waves travel eg air, fluid or solid

Percussion notes

Sound	Pitch	Intensity	Quality	Location
Flatness	High	Soft	Extreme dullness	Normal: sternum, thigh Abnormal: atelectatic lung
Dullness	Medium	Medium	Thud like	Normal: liver, diaphragm Abnormal: pleural effusion
Resonance	Low	Loud	Hollow	Normal: lung Abnormal: emphysematous lung
Hyper-resonance	Lower than resonance	Very loud	Broom like	Normal: gastric air bubble Abnormal: air distended abdomen

Types of percussion

- Mediate or indirect:
- Middle finger act as hammer (plexor), other finger of other hand act as striking surface (pleximeter)
- Downward snap of pleximeter originate from the wrist and NOT from movement in the forearm or shoulder
- It is quick, sharp but relaxed wrist motion

Types of percussion

- Immediate (direct)
- Striking finger or hand directly against the body eg clavicle and skull (in hydrocephalus)

auscultation

- Listening for sounds produced by the body
- Done last after other techniques have provided information about what you hear except in abdomen where it is done before palpation and percussion which may interfere with bowel sounds
- Most sounds require stethoscope to augment the sound to aid in hearing
- Others can be heard with the ear without stethoscope eg speech

preparation

- Quiet, environment
- Calm patient
- Bell or diaphragm of stethoscope placed on naked skin- clothing obscure sound
- Avoid touching tubing with your fingers or tubing rubbing against other surface to prevent extraneous noise

Summary of patient diagnosis- steps

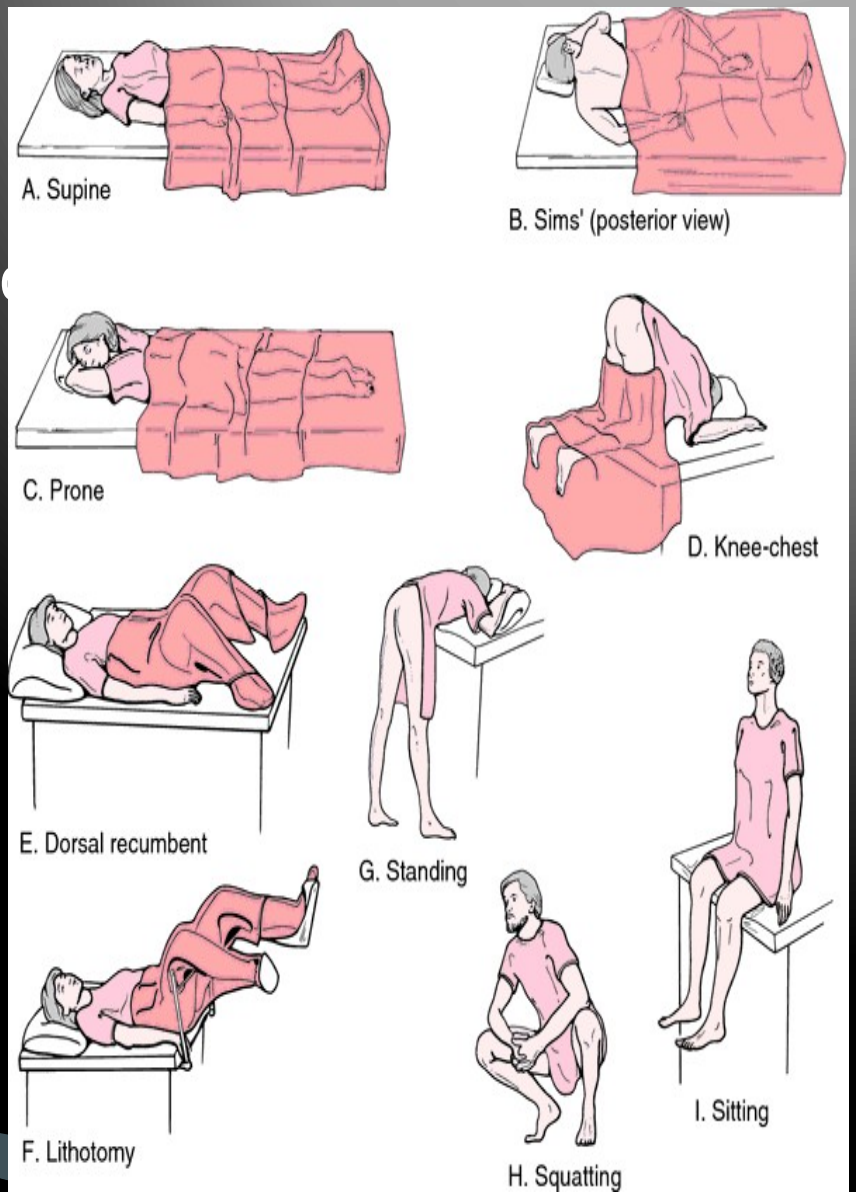
- Greet, welcome, offer seat
- Biodata- name, age, sex, marital status, residence, address, telephone, NOK…….
- History of illness and details of progress
- Systemic review
- Physical examination performed
- Lab investigations and other investigations (special) ordered
- Make Differential diagnosis, followed by specific Diafnosis once results are (ready) confirmed
- Prescribe appropriate treatment

Summary of patient diagnosis-steps

- Give patient return date (TCA) for review
- If patient has acute condition, admission for close monitoring (observation) and review
- NB/ Dx of patient will change depending on the presenting S/S each time he/she is reviewed
- As pt improves, discharge home
- NOTE: people are individuals, no two people are alike, some may have started treating themselves before coming for help from you

Head to toe physical examination

- Preparation:
- Assist the patient to change in a gown and position:
- Dorsal recumbent
- Sitting
- Lithotomy
- Genupectoral (knee-chest)
- Prone
- Sim's



- Preparation:
- Ensure patient is relaxed
- Cover pt body not included in examination (only expose PRN)
- Self:
- Wash hands and dry them
- Don examination gloves
- Perform head to toe examination

General appearance

- General health status- any sign of obvious disease eg skin moisture and color, unusual odors
- Nutritional status
- Behavior- verbal statements and body language
- Mental state- alertness, eye contact
- Speech
- Gait
- hygiene
- NB/ validate inspection findings with your patient eg “ I see a black spot here, have you noted it?”

head

- Hair- distribution, color, cleanliness, pediculosis
- Rash, scars

Child:

- Measure head circumference, check for state of sutures and fontanelles
- Shape
- Swelling
- injury

face

- Facial expression
- Involuntary muscle movement
- Shape
- Swellings
- symmetry

Eyes

- Eye lashes and eye lids
- Conjunctiva- color (pallor, inflammation)
- Discharge
- Cataracts
- Pupils reaction to light, size of the pupils
- Squint (strabismus)
- Sense of sight

ears

- Discharge
- Pain
- Sense of hearing
- hygiene

Neonate:

- Pinna-cartilage
- Position
- discharge

nose

- Nasal flaring
- Swelling
- Discharge
- Blockage
- Polyps
- Nasal septum
- Deformities
- Frontal and maxillary sinuses tenderness

mouth

- Color of lips
- Lesions eg cheilitis, bleeding gums
- Color of the tongue, halitosis
- Check for teeth decay/missing teeth, oral ulcers
- Inflammation of the gums
- Check for dentures
- Size of tonsils, any exudate

neck

- Lymph nodes- palpate for:
- Swellings (examine neck round)
- Enlargement- thyroid gland, salivary gland
- Ask client to extend neck and swallow saliva twice and observe for any mass on the throat
- Range of movement

chest

- Inspect shape: dome, pigeon,
- Respirations-count respiratory rate and characteristics
- Nipple size and discharge
- Chest indrawing, sounds
- Auscultation:
- Count heart rate
- Breath sounds
- Percussion:
- Resonance, dullness, flatness
- In female do breast examination

Upper limbs (arms)

- Equity
- Range of movement
- Deformities e.g extra or missing digits,
- Clubbing of fingers
- Webbed fingers
- hygiene
- Capillary refill
- Wipe axilla with dry cotton swabs and palpate for swollen glands (lymph nodes)
- take temperature
- Take MUAC, BP
- Start with proximal to distal arm

abdomen

- Inspection:
- Shape, size, scars, swelling, visible bowel movement
- Auscultation:
- Bowel sounds
- If pregnant: FHR
- Percussion:
- Resonance, dullness, flatness
- Palpation:
- Size of internal organs
- Hernias
- Tenderness
- masses

genitalia

- Inspection:

Scars, color, discharge, abnormal growths and swellings, hygiene, infestation, sores

- Palpation:

Palpate inguinal glands for tenderness, swelling and enlargement

- VE is done if indicated

Male genitalia

- Inspection:
- Urethral meatus for discharge, lesions, growths, position of urethral meatus, hygiene
- Palpation:
- Palpate for inguinal hernias, lymph nodes enlargement and swellings, descent of testes, tenderness/ pain

Lower limbs

- Inspection:
- Check for equity, deformities, edema, vericose veins, DVT, reflexes
- Range of movement

back

- Inspection:
- Check for curves, growths
- Palpate: for continuity of the spine and check for tenderness
- Range of movement

Rectum/anus

- Rectal examination if indicated