The History

Personal Details

Name:
Age:
Sex:
Nationality:
Marital Status:
Occupation:

Presenting Complaint(s) (P.C.)

Take each complaint in turn and state its nature as concisely as possible.

E.g. 1. Generalized headache
2. Pain in the right knee etc.

History of the Presenting Complaint(s) (H.P.C.)

Take each of the presenting complaints in turn and obtain a full history with respect to duration, nature, relieving factors, exacerbating factors etc. If the presenting complaint relates to a particular system or systems, ask the relevent systematic questions at this stage and omit them from the Systematic Review (See below).

Past Medical History (P.M.H.)

Obtain details of significant past illnesses and dates of their occurrence. Diabetes mellitus, diphtheria, rheumatic fever and tuberculosis are examples of significant past illnesses.

Past Surgical History (P.S.H.)

Ask specifically about any operations. Record their date, nature and where they were performed e.g.

1967 Hysterectomy for menorrhagia; Shemaisi Hospital, Riyad.

Family Medical History (F.M.H.)

Record family illnesses (e.g. Diabetes, Hypertension, Renal disease etc.) either in full or as a Genealogical Table. (See Prof. Moloney's book, pages 9 & 10).

Social History (S.H.)

Record details of the patient's habits e.g. smoking, drinking alcohol etc. Enquire into details of any financial or domestic worries and past and present employment.

Treatment or Drug History (T.H. or D.H.)

Record details of all treatment in a meaningful way. Recording "takes little white pills" is usually meaningless.

Allergies

Record details of abnormal reactions to drugs and evidence of atopy viz: Hay-fever, eczema, asthma.

Bleeding Diathesis

Record any evidence of abnormal bleeding tendency e.g. easy extensive bruising, prolonged bleeding after relatively

minor cuts, repeated nose-bleeds.

Systematic Review (S.R.)

Respiratory System (R.S.)

Cough
Sputum
Haemoptysis
Wheeze
Shortness of breath

Cardiovascular System (C.V.S.)

Palpitations
Chest pain
Orthopnoea
Paroxysmal nocturnal dyspnoea
Ankle swelling
Intermittent claudication

Gastro-intestinal Tract (G.I.T.)

Weight: increasing, steady, decreasing ?
Anorexia, Nausea, Vomiting
Abdominal pain
Jaundice
Haematemesis

Bowel Habits: $\frac{x}{y}$, where x = number of times,
y = number of days

E.g. $\frac{1}{2}$ = bowels open *once* every *two* days

$\frac{3}{1}$ = bowels open *three* times *each* day

Stools: colour, consistency
Fresh blood
Mucus
Melaena

Urogenital Tract (U.G.T.)

Frequency of micturition $\frac{D}{N} = \frac{x}{y}$

where x = number of times urine is passed during the day
y = number of times patient has to get out of bed at night, when previously asleep, specifically to pass urine.

Frequency
Dysuria
Haematuria
Loin pain

In older men Enquire about hesitancy, poor stream, terminal dribbling.

In women

a) If pre-menopausal

Age of onset of periods (Menarche)
Record as e.g. K = 12 yrs. if periods started aet. 12 yrs.

Nature of menstrual cycle Record as $\pi = \frac{3-5}{28\pm2}$

which in this example means that a period (menstruation) lasts between 3 and 5 days

with 28 days (varying by 2 days shorter or longer) between the first days of successive menstrual periods.

Leukorrhoea
Intermenstrual bleeding
Menorrhagia

Number of pregnancies

Record as Para x + y, where x = number of ***live*** births and y = number of **stillbirths**, miscarriages, abortions.
In a full Obstetric History, further details of each pregnancy are required.

b) If post-menopausal

Record the age at which periods ceased (Menopause) E.g.: Menopause = aet. 45 yrs.
And enquire about post-menopausal bleeding (which, if present, suggests the presence of cancer until proven otherwise.)

Nervous System (N.S. or C.N.S.)

Headache (R.I.C.P. headache is worse on waking)
Visual acuity, photopsiae, diplopia
Auditory acuity, tinnitus, vertigo
Fits, faints or other loss of consciousness
(e.g. Skull injury)
Strength
Numbness and/or paraesthesiae
Ataxia (Clumsiness)
Gait
Speech

Joints

Pain
Stiffness
Swelling
Limitation of movement

(N.B. Rheumatological disorders can affect extra-articular structures – e.g. eyes, tear glands, liver, kidney, skin etc.)

Skin

Rashes
Itching

The Examination

General Statement

E.g. A thin, pale, ill-looking Saudi male
A fat, breathless, wheezing Egyptian male

General Abnormalities

Fever (Record temperature)
Anaemia
Cyanosis (Central and peripheral)
Clubbing
Lymph nodes
Thyroid enlargement (Goitre)
Teeth, hair and nails
Skin: look for pigmentation, lesions, jaundice, stigmata of chronic liver disease etc.

Cardiovascular System (C.V.S.)

Pulse: Rate, rhythm, character, volume, state of vessel wall.

Peripheral pulses (Are they all present and equal?)
Blood pressure (Lying and standing)
Jugular venous pressure (J.V.P.) Dependent oedema
Apex beat (A.B.) Location: usually 5th L.I.C.S., M.C.L.
Character: normal, tapping, heaving?
Heart Sounds (H.S.) usually: I + II + 0

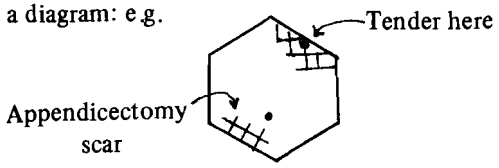
Respiratory System (R.S.)

Comment on nature of respiration and patient's posture if abnormal.
Respiratory rate
Centrality of trachea
Excursion (Usually equal on both sides of chest. If diminished on one side, this is usually the side of the pathology).
Percussion note: usually equal and tympanic (resonant)
(Tactile vocal fremitus)
Breath sounds: usually equal, vesicular with no added sounds.
Vocal resonance

Abdomen

General statement: e.g. soft, not obese, moves with respiration, no masses felt.
If distended, think of 5 F's (4 for men!)

Draw a diagram: e.g.



LKKS: Feel for enlargement of liver, both kidneys and spleen. If enlarged, indicate on diagram.

BS: listen for bowel sounds

Herniae: Check hernial orifices

Genitalia: Inspect and ***feel*** testes

Rectal examination: For ***every*** patient.

Nervous System (N.S. or C.N.S.)

Higher Mental Functions (H.M.F.)
Cranial nerves: Examine each in turn.
Muscular wasting, Muscular tone
Muscular power
Tendon reflexes (Do not record as absent before attempting reinforcement)
Are they all present and ***equal*** ?
Plantar responses
Abdominal reflexes
Assess sensation (All modalities in all areas)
Co-ordination e.g. Finger-nose and Heel-shin tests.
Romberg's test
Gait

Joints

Inspect for swelling, tenderness, effusion, hotness, limitation of movement etc. if history suggests involvement.

Urine

Should be tested using COMBUR-8 test strips and the centrifuged deposit examined under the microscope if any abnormality found.

The urine is often the sole clue to clinical diagnosis and should be tested in every patient.

Outline

History **Personal Details**

P.C.
H.P.C.
P.M.H.
P.S.H.
F.M.H.
S.H.
T.H.
Allergies
Bleeding Diathesis

S.R.

R.S.
C.V.S.
U.G.T.
G.I.T.
C.N.S.
Joints
Skin

Examination

General statement
General abnormalities
C.V.S.
R.S.
Abdomen
C.N.S.
Joints

URINE

Short summary of positive findings