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MEDICAL HISTORY MODULE

STUDENT TEXT

1980
Rural Health Development Project
Ministry of Health and Social Welfare
Maseru, Lesotho

ACKNOWLEDGEMENTS

Nurse Clinician training materials are Lesotho adaptations based upon the MEDEX prototype curriculum for training mid-level health workers.

The prototype MEDEX materials were developed by the Health Manpower Development Staff of the John A. Burns School of Medicine, University of Hawaii. The original prototypes were based on training experience in over a dozen third-world countries. These were revised on the basis of HMDS experience in Micronesia, Thailand, Pakistan, and Guyana before being made available to Lesotho under a U.S.A.I.D. funded contract.

Major adaptation in Lesotho began at the National Nurse Clinician Training Programme Curriculum Adaptation Workshop held at Mazenod in January, 1980. The nearly fifty participants represented all major health and health related activities in Lesotho, both Government and private. These participants and others working as individuals and then as review committees have adapted the Nurse Clinician training materials to meet the conditions and needs of Lesotho.

The Government of Lesotho and particularly the staff of the Nurse Clinician training Programme are grateful to HMDS for supplying the prototype materials and to all those individuals who have helped in the Lesotho adaptation process.

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REFERENCES USED FOR THE
MEDICAL HISTORY MODULE

DeGowin, E.L.; DeGowin, R.L. Bedside Diagnostic Examination,
The Macmillan Company, New York, 1969.

Finch, Clement A. A Patient-Oriented Approach to General
Medicine, 1972.

Walker, Hall, Hurst. Clinical Methods, The History,
Physical and Laboratory Examination, Butterworth
(Publishers) Inc., 1976.

Weed, Lawrence. "Medical Records, Medical Education,
and Patient Care," Press of Case Western Reserve
University, 1971.

SCHEDULE

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5

MEDICAL HISTORY MODULE

GLOSSARY

- Anaemia - A condition in which the blood is deficient either in quantity or quality.
- Arrhythmia - Any variation from the normal rhythm of the heart beat.
- Colic - Acute cramping abdominal pain.
- Constipation - Infrequent and difficult passing of faeces, retention of the faeces.
- Diarrhoea - Increased frequency and liquidity of stools.
- Discharge - Watery substances passed out of the body.
- Discolouration - Change of colour.
- Dyspnoea - Difficult or laboured breathing.
- Fracture - The breaking of a bone.
- Incontinence - Inability to hold urine in the bladder.
- Jaundice - A condition in which because of increased bile pigment in the skin and mucous membranes, a yellow discolouration of the skin and eyes occurs.
- Lesion - Any abnormal change in tissue or loss of function of a part.
- Menopause - The period when menstruation normally ceases; a woman's change of life.
- Menses - The monthly flow of blood from the genital tract of women.
- Obstruction - The act of blocking or clogging.
- Palpitations - Unduly rapid action of the heart which is felt by the patient.
- Swelling - An elevation or elevated area.
- Trauma - A wound or injury.
- Wheezing - Difficult breathing attended with a whistling sound.

STUDENT GUIDE

DATA BASE

I. Entry Level Knowledge and Skills

Before starting this unit, you should be able to:

1. Explain normal adult Anatomy and Physiology.
2. Define words listed in the glossary pages.

II. Objectives

Using the information and experiences provided by the instructor and the module text, you will be able to:

1. Conduct an interview with a patient to obtain historical information.
2. Interpret and record historical information obtained regarding identification data, past medical history, family life, way of life, habits and nutrition.

III. Evaluation

Upon completion of the module you will be assessed on:

1. Knowledge: Written test based upon content of unit in module text. (Acceptable performance, 80%)
2. Skills (see Rating Sheet):
 - a. History taking - Adult and Paediatric Patients.

IV. Activities you will be participating in to accomplish the unit objective.

1. Read text on Data Base and answer review questions.
2. Write at least one of your own questions about interviewing patients to collect historical data. Bring this to discussion session.
3. Participate in discussion of History Taking and Interview Techniques conducted by instructor.
4. Each student will collect a data base on three students using appropriate interviewing techniques and recording the information on hospital or health centre forms.

MEDICAL HISTORY

A medical history is the process of finding out and recording all events in a person's life which may have an effect on his or her health status.

A good medical history can be the most significant guide to making a diagnosis (determination of the cause and name of the illness). It also helps predict what the health status of a person will be in the future.

A medical history is usually combined with a physical exam to make a definite diagnosis. In this way you can combine evidence found in a history with signs found in a physical exam to determine the illness and to eliminate other suspected possible illnesses. Therefore, the medical history module and the physical examination module is best studied and practiced together. You will want to refer back to both modules often during training and also in the field.

The medical history is traditionally divided into three sections -

- a. Data base information
- b. Chief complaint and its expansion
- c. Review of systems

Data base information is that information that should be recorded initially on all patients. This information does not change often although it should be updated occasionally. It includes identification data, past medical history, family history, social history, habits, and nutritional history.

Chief complaint and present illness refers to the problem that brings the patient to the clinic. The specific problem in the patient's words is recorded in brief and then a detailed history related to that problem is obtained and recorded.

The review of systems breaks down the body into the systems studied in the Anatomy and Physiology module and identifies many of the important symptoms a person can have related to each system. This detailed approach allows you to discover possible links between the chief complaint and other symptoms in order to make the correct diagnosis. The review of systems is included in this module as a reference for you to use when you want to thoroughly investigate a perplexing problem.

DATA BASE INFORMATION

Data Base Information is recorded in the patient's permanent record on the initial visit. It should be recorded prior to attending to the patient's chief complaint unless the chief complaint is an urgent problem. See Sample Medical History Form, Data Base p. 22.

If the patient comes in as an emergency without data base information, you will want to obtain as much of the necessary information usually found in the data base as possible while addressing the problem causing the emergency. For example, a new patient arrives in coma - you must find out immediately whether the patient is a known diabetic or whether there is a family history of diabetes from accompanying family members or friends.

Identification Data

This information identifies the patient so that the clinic staff will not confuse the records of one patient with another; are able to retrieve the record when the patient returns and are able to do home follow ups, when necessary.

Past Medical History

This includes major illnesses or conditions that have occurred in the past that may have some influence on the present or future.

Family History

Certain conditions occur in some families more than others so it is important to find out any such conditions and record them.

Social History

All of a patient's social environment has an effect on health status. This includes habits, education, home life, work, and travel.

Nutrition and Food Habits

Nutrition and food habits are basic to the maintenance of a healthy status. This is especially true during periods of growth as in children and lactating and pregnant women.

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<u>IDENTIFICATION DATA:</u> (All to be recorded)			
1. Name	1. Patient's full name and name he/she goes by (if different).	1. To establish who the patient is.	1. Thabo Malapo
2. Address (house number and village, island, etc.)	2. Exact location where patient lives.	2. You may want to visit the patient for follow-up.	2. Mafeteng, Lesotho
3. Date of visit	3. When the patient came to see you (record first visit).	3. It is useful to know when the data base information was obtained to determine its relevance.	3. 1 January, 1975
4. Sex	4. Male or female	4. Male and female problems are often handled differently.	4. Male
5. Age - Date of birth	5. Both date of birth and age are recorded.	5. Many problems are related to age groups, dosage of medicine differs by age.	5. 36 - 1 September, 1975
6. Marital Status	6. Married, single, widowed, divorced.	6. Some problems and management are related to the family situation.	6. Married
7. Job	7. What work the patient usually does (if any).	7. Some diseases are more common with certain types of work.	7. Gardener

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>IDENTIFICATION DATA:</u> (con't)</p> <p>8. Case or patient number</p>	<p>8. A number is given to the patient, his problem or case.</p>	<p>8. This will help you in organizing your records and/or patient problems.</p>	<p>8. B - 123</p>

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Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>PAST MEDICAL HISTORY:</u></p> <ol style="list-style-type: none"> History of important illnesses, including childhood diseases. Any surgery - what kind? 	<ol style="list-style-type: none"> Any illnesses which may have had a lasting effect on the body; such as rheumatic fever, tuberculosis, cancer, malaria, filariasis, marasmus, kwashiorkor, childhood diseases of measles, mumps. Any surgical procedure - cutting into the body, removal of any tissue or organ, any surgical repair? 	<ol style="list-style-type: none"> Many illnesses occur only once and can therefore be ruled out. Others tend to reoccur with regularity and must be considered more strongly as the basis of a problem. Certain diseases weaken body systems so infections take place more readily. History of surgery to correct disease or repair problems can help to rule out those problems. Example: one could rule out appendicitis in abdominal pain if the patient had previously had his appendix removed. Past surgical procedures for a certain problem may establish a pattern of disease. Surgical procedures may occasionally introduce infection. 	<ol style="list-style-type: none"> Patient has previously had pneumonia, had measles at age four. Patient previously had a lump removed from upper right leg.

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>PAST MEDICAL HISTORY:</u> (con't)</p>			
<p>3. Any drug allergy?</p>	<p>3. Is patient allergic or sensitive to any drug, or ever have any problem with any type of drug?</p>	<p>3. Do not prescribe drug if known or suspected allergy exists.</p>	<p>3. No known drug allergy.</p>
<p>4. Immunizations and status.</p>	<p>4. Any "shots", injections or other medicines to prevent disease. Are immunizations up to date?</p>	<p>4. If patient has had previous shots to prevent a disease, we need not consider that disease as strongly as we would others, although it is still possible.</p>	<p>4. Shots for tetanus and typhoid five years ago at district hospital.</p>
<p>5. Obstetrical (adult females)</p>	<p>5. Number of pregnancies, deliveries, abortions, still births, living children, complications of pregnancy. Menstrual status - active or menopausal, if menopause record date.</p>	<p>5. Many problems affecting females are related to their obstetrical history. Menstrual status helps determine pregnancy and can be related to anaemia.</p>	<p>5. 3 pregnancies, 2 deliveries, 1 abortion, O.S.B., 2 living children. Bled + + with second delivery (1961).</p>

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>FAMILY HISTORY</u></p> <p>1. Any disease common to family or which occur more in this family than other people.</p>	<p>1. If there are health problems in the family, or which occur more commonly in the patient's family than the rest of the community, these problems must be considered when making a diagnosis and treatment plan.</p>	<p>1. Health problems such as tuberculosis and venereal disease, common in the patient's family are often passed from one family member to another, or occur often enough that the patient may have the same problem. If the patient has had his illness treated, other family members with the same problem should be seen.</p>	<p>1. Mother has coughing spells and weakness. She coughs up blood sometimes, and is usually weak. Has had this problem for two years. Never saw health workers (suspected tuberculosis).</p>

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>FAMILY HISTORY:</u> (con't)</p> <p>2. State of health of family members, causes of death, if known.</p>	<p>2. State of health, of father, mother, grandparents, brothers/sisters and any others living with or in close contact with patient. Brothers and sisters with malnutrition. Causes of deaths if any.</p>	<p>2. If the mothers and fathers had certain illnesses, it is very likely that the children will also have them. Some illnesses are "passed" from grandparents - parents - children. That is the children are born with the possibility of having the problem such as sickle cell disease. The state of health of those living with patient needs to be known because of the possibility of passing the disease or having same conditions exist cause the disease in another person; for example, malnutrition. Cause of death may have been due to infectious disease. If so, this must be considered.</p>	<p>2. Everyone else in house is in good health.</p>

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p>5. Habits (con't)</p> <p>c. Any Medicines</p>	<p>c. Does the patient take any medicine regularly (include aspirin, antacids, vitamins, any medicine). Why does the patient take the medicine? Who advised patient to take the medicine? Self, family, traditional healer, health assistant, public health nurse, staff nurse, nurse clinician, doctor.</p>	<p>c. All drug influence on the body much be considered. Some drugs can cause more harm than good over long periods of time. If current illnesses were not established in the past medical history, they may be elicited here. An important consideration in prescribing drugs is if they will react with other drugs the patient is taking.</p>	<p>c. Aspirin for headaches.</p>

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>NUTRITION:</u></p> <p>1. Usual diet</p> <p>2. Diet of children and lactating and pregnant women.</p>	<p>1. What types of food does the patient routinely eat? Is there any food which may be occasionally added and how often.</p> <p>2. If under 2 years, is the infant breast feeding? Is the infant bottle feeding? Has supplementary food been started at six months of age? How often is the child fed? Is she fed regularly even when sick?</p> <p>Is the pregnant or lactating woman getting more vegetables and protein rich foods than usual?</p>	<p>1. If the patient is not eating foods to meet his body needs, he may be suffering from poor nutrition. Some of the damage caused by poor nutrition is permanent. Nutrition affects pregnancies, child growth and development, and the length and quality of life.</p> <p>2. Infants and children need breast milk until 2 years of age and additional foods at least 3-4 times a day starting at 5-6 months for proper growth. Bottle feeding is always dangerous to an infant's health and may cause diarrhoea, dehydration and death.</p>	<p>1. Regular diet includes fish, rice vegetables. May have chicken, or port one or two times a week.</p> <p>2. Knows the importance of proper child feeding for family.</p>

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>NUTRITION:</u> (con't)</p> <p>3. Physical growth and development relative to those of same age/area/sex</p>	<p>3. Is patient's physical development (height, weight, etc) about the same ; ; for those of the same age.</p>	<p>Children need food when ill. Mothers who are pregnant or lactating need more food because they are nourishing two people - themselves and their infant.</p> <p>3. Physical growth and development is a good simple way of checking nutrition. In a child, if there is a noticeable physical difference, poor nutrition must be suspected.</p>	<p>3. Physical growth and development average, except for weight loss in recent months.</p>

REVIEW QUESTIONS

1. Add the missing data for identification of this patient.
 - a. Thabo Malapo
 - b. Mafeteng, Lesotho
 - c. Married
 - d. Gardener
 - e.
 - f.
 - g.
 - h.
2. Circle the correct answer:

Recording the family history is important because:

 - a. Health problems common in the patient's family unit are often passed from one family member to another.
 - b. The department of health keeps statistics on frequency of illness within a family unit.
3. Next to each statement write a "P" for data which is recorded in the category of past medical history. Write an "F" next to a statement about family history.
 - a. The patient had mumps as a child.
 - b. The patient's mother had bronchitis last year.
 - c. Two years ago the patient had a cold which lasted two months.
 - d. The patient and his sister are allergic to penicillin.
 - e. All members of the patient's immediate family are living.
 - f. The patient's sister is pregnant.
 - g. The patient has had a DPT immunization.
4. Make up a short Social History section in a historical data base and write it below. Be sure to include information about each of the headings listed on page 14-17.

DATA BLANK
PERMANENT RECORD
(6 years and older)

NAME: _____ Year of Birth: _____

Address: _____

Sex: F/M _____ Marital Status: _____ Job: _____

Past Medical History:
Illnesses: _____

Operations: _____ Drug allergies: _____

Family History: _____ Immunizations: Date when vaccine given

Family conditions: _____ 1st. 2nd. 3rd.

_____ Polio _____

Status of health: _____ Tetanus _____

Mother _____ Father _____ (TT, DPT or DT) _____

Siblings: _____ Measles _____

Causes of deaths: _____ BCG _____

_____ Other _____

Social History:

Education _____ Habits _____

Latrine _____ Medicines _____

Water supply _____ Travel _____

Nutrition _____

Obstetrical History:

Menstrual status _____

Number of pregnancies: _____ Complications: _____

Abortions: _____

Still births: _____ Causes: _____

Living children (F) (M)

and their ages: _____

CHIEF COMPLAINT AND PRESENT ILLNESS

The chief complaint is the reason the patient tells you that he has come to the clinic. It is usually recorded briefly in the patient's own words. Some examples are "Diarrhoea for three days", "Cough and cold for one week," "Tired and run down for a month", "Fever and sweating especially at night."

After recording the chief complaint in brief then an intensive history of the present illness is taken related to that complaint and a story of the illness is obtained. This part of the history, if done well, will be a great aid in determining the cause of the problem correctly.

Practice in history taking should be concentrated on this section because this is the heart of a diagnostic history. You are identifying clues in order to make correct diagnoses. Reference to the diagnostic protocols will always be helpful and occasional reference to the review of systems will also be helpful.

If a diagnosis cannot be made, the patient should be referred with your recorded history and physical.

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>CHIEF COMPLAINT:</u></p>	<p>The patient tells you why he came to see you (what is wrong?)</p>	<p>To establish a starting point for finding out about the problem that brought the patient to the clinic.</p>	<p>"Coughing and weak all the time."</p>
<p><u>HISTORY OF PROBLEM:</u> (Story of Illness)</p>			
<p>1. Date of onset</p>	<p>1. When did it start?</p>	<p>Diseases follow a pattern and some symptoms/complaints relate to certain diseases. In taking the history of the problem, we are taking the first step in finding out what the problem is. As we find out about onset, duration, locations, etc., we find a story of illness developing. We follow this story throughout our history, physical examination and treatment/management of the problem.</p>	<p>1. One year ago</p>
<p>2. Type of onset</p>	<p>2. Suddenly or gradually</p>		<p>2. Came on slowly</p>
<p>3. Description of symptoms</p>	<p>3. Is the problem constant or does it let up? For how long?</p>		<p>3. Problem is constant. Moderate coughing with frequent pain in mid-chest, worse at night. Blood streaked sputum noted over past 4-5 days.</p>
<p>4. Things that make illness better or worse</p>	<p>4. Does anything aggravate the problem - make it worse? Make it better?</p>	<p>Certain symptoms are relieved by certain behaviors and give clues to diagnosis. For example, abdominal pain relieved by milk or eating may be an ulcer.</p>	<p>4. Worse with smoking or hard work. Rest makes it better.</p>

Data Base
Medical History Taking

INFORMATION REQUIRED	EXPLANATION	WHY NEEDED	EXAMPLE (CASE STUDY)
<p><u>CHIEF COMPLAINT</u> (con't)</p> <p>5. Associated symptoms/ diseases</p> <p>6. Contacts</p>	<p>5. Ask about other symptoms.</p> <p>6. Has patient been in contact with anyone or anything that is related to his illness?</p>	<p>The patient may be concen- trating on the major symptoms and not mention other important factors.</p> <p>This is especially important when dealing with a probable infectious illness.</p>	<p>5. Headache, nausea, especially just before eating.</p> <p>6. Brother's family being treated for active pulmonary T.B.</p>

REVIEW OF SYSTEMS

As in the study of Anatomy and Physiology and the Physical Examination Modules, the history can be divided into systems. Certain symptoms are related to the respiratory system, others to the nervous system, etc. and asking questions related to these systems gives you clues to health status and causation of illnesses.

This section of the Medical History Module lists some problems a patient may have had or presently has which could be identified as originating in a specific system.

This review of systems is included as a study guide and reference information. You may occasionally want to go through a complete systems review in a patient with a perplexing problem, but a complete review of systems takes a considerable amount of time. More often you may want to concentrate on a selective number of systems from the clues you have obtained in the chief complaint and its expansion and the diagnostic protocols.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>NOSE</u>	<ol style="list-style-type: none"> 1. Smell - Can patient smell and pick out different smells. 2. Trauma - Any injury to the nose. 3. Bleeding - any bleeding from the nose. 4. Obstruction - any blockage of the nose on either side. 	<ol style="list-style-type: none"> 1. Can smell well. 2. No present injury or past injury. 3. No bleeding. 4. Can breathe easily through either nostril. 	<ol style="list-style-type: none"> 1. Cannot smell or has trouble smelling. 2. Injury with resultant problems (i.e. obstruction). 3. Any bleeding with or without injury. 4. A blockage of one or both nostrils.
<u>MOUTH</u>	<ol style="list-style-type: none"> 1. Teeth problems - <ul style="list-style-type: none"> -Any pain in the teeth or pain while chewing? -Any pain when eating hot or cold food? -A large number of missing teeth? Do teeth fall out easily? -Do child's teeth grow in straight and with a little pain or bleeding? 	<ul style="list-style-type: none"> -History of toothache, no pain while chewing. -Mild tenderness to hot or cold food. -A few missing teeth - patient can still chew. -Child's teeth grow in with little pain/bleeding. 	<ul style="list-style-type: none"> -Constant toothache and/or pain while chewing. -Hot or cold food causes mouth/tooth pain. -Many teeth missing and patient unable to chew. -Child's teeth grow in with much pain, bleeding or don't grow at all.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>MOUTH</u> (con't)	2. Lips, gum, tongue - any problems with lips, tongue. 3. Taste - Can patient taste food?	-Lips, tongue are same colour as other people of the same ethnic group. -No lesions or growths. 3. Taste is normal.	-Lips and tongue are different colour than others in same ethnic groups, i.e. paler or bluer. -Growths or sores. 3. Patient cannot determine familiar foods by taste.
<u>THROAT</u>	1. Infections - Many infections occurring within a short time. 2. Swelling - Any enlargement in the area of the throat or neck. 3. Pain with swallowing food and/or liquid. Pain in the throat. 4. Blockage of throat.	1. No throat infections, soreness, or hoarse voice. 2. No swelling in area of throat, or neck. 3. No pain or difficulty with swallowing. 4. No blockage of throat.	1. Throat infections, sore throat problems or hoarse voice. 2. Swelling or lumps in the throat or neck. 3. Difficulty or pain with swallowing. Painful throat. 4. Throat blocked.
<u>RESPIRATORY</u>	1. Coughing - Amount and type of coughing; does cough produce sputum, what kind? Duration.	1. Occasional coughing. No sputum with cough.	1. Constant coughing, painful coughing, coughing productive of green, brown, yellow or white sputum. Cough longer than a month.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>RESPIRATORY</u> (con't)	<ul style="list-style-type: none"> 2. Chest pain - location, duration and what brings it on? 3. Wheezing - Does patient take a long time to inhale or exhale with effort? 4. Coughing blood - Does patient cough up any blood? 5. Shortness of breath - Does patient feel he has a problem getting enough air? 6. Aspiration - has patient breathed something (water, alcohol, etc) into lungs? 7. Dyspnoea - Painful breathing. 	<ul style="list-style-type: none"> 2. No chest pain. 3. Inhales and exhales without prolonged time or increased sound. 4. Does not cough up blood. 5. Feels he gets enough air. Can breathe easily in any position. 6. Has not breathed foreign substance. 7. No pain with breathing. 	<ul style="list-style-type: none"> 2. Chest pain (mild or severe) at rest or exercise, when deep breathing or coughing. 3. Problem with exhaling or inhaling. Effort or prolonged time required, and a wheezing sound. 4. Coughs up blood, light or dark. 5. Feels he cannot get enough air. Has difficulty breathing when lying down. 6. Has breathed in foreign substance, water, alcohol or beans or peanuts in children, etc. 7. Painful or difficult breathing.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>RESPIRATORY</u> (con't)	8. Painful breathing with position change - any pain with breathing or when patient changes position. 9. Sweating. 10. "Coughed up" worms. 11. Infections - What kind of past chest infections.	8. No pain with positional change. 9. Normal sweating pattern as related to temperature and exercise. 10. No worms. 11. No past chest infection.	8. Painful breathing when laying down or on side etc. 9. Night sweats. 10. Has coughed up worms. 11. Past infection of tuberculosis or cancer, asthma, emphysema, or others.
<u>CARDIOVASCULAR</u>	1. Chest pain - Any pain in chest especially middle chest, pain going from chest into arms or neck. 2. Palpitation or arrhythmias, troublesome or irregular heart beats.	1. No chest pain, no pain going from chest to other parts of the body. 2. No irregular or troublesome heartbeat.	1. Chest pain - either dull or ache or crushing, squeezing in character, onset at rest or when exercising - Pain goes from mid-chest to arms, neck, or back. 2. Heart misses beats, is pounding or irregular.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<p><u>CARDIOVASCULAR</u></p>	<p>(con't)</p> <p>3. Swelling or oedema of ankles or legs.</p> <p>4. High blood pressure - Blood pressure previously measured and found to be high.</p> <p>5. Heart problem - Any problems patient relates to the heart or has been under treatment for.</p> <p>6. Enlarged lymph nodes - Lymph nodes which are enlarged, or tender and painful.</p> <p>7. Tiredness - Tired all the time for no reason (work or stress).</p> <p>8. Anaemia - or low blood with paleness of skin or repeated pregnancies or heavy bleeding.</p>	<p>3. No swelling of ankles or legs.</p> <p>4. Blood pressure was measured and OK.</p> <p>5. Patient has no known trouble with the heart.</p> <p>6. No problems with enlarged lymph nodes.</p> <p>7. No tiredness that is not related to periods of stress, work or exercise.</p> <p>8. No paleness, spaced pregnancies, normal menses.</p>	<p>3. Legs and ankles were swollen.</p> <p>4. Blood pressure was measured and found to be high.</p> <p>5. Patient relates problems with heart or trouble he blames on his heart.</p> <p>6. Lymph nodes are enlarged, or tender and painful. Peripheral infection with tender regional nodes. Primary TB in childhood.</p> <p>7. Constantly tired.</p> <p>8. Skin and mouth paler in colour than other people of same ethnic group. Repeated pregnancies, heavy menses.</p>

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>GASTROINTESTINAL</u>	<p>1. Nausea and/or vomiting - Urge to vomit.</p> <p>-Vomiting blood</p> <p>2. Diarrhoea - Three or four or more watery stools in a day.</p> <p>-Blood, pus or mucous in stool.</p> <p>3. Black, tarry stools, indicates bleeding high in the G.I. tract.</p>	<p>1. Occasional nausea or vomiting.</p> <p>-No vomiting of blood</p> <p>2. Occasional loose stools - One or two per week.</p> <p>-No blood, pus or mucous in stools.</p> <p>3. No black and tarry stools, black stools may be seen normally when patient is taking iron.</p>	<p>1. Nausea and vomiting after a normal meal. Pregnant women may have more nausea and vomiting during the first trimester of the pregnancy.</p> <p>-Any vomiting of blood, history of ulcers or alcoholism.</p> <p>2. Episodes of diarrhoea, other family members with diarrhoea, infants on bottle feeding or weaning.</p> <p>-Blood, mucous or pus in stools, history of amoebic dysentery, cramping relieved by passing of a stool.</p> <p>3. Black and tarry stools, history of ulcers or alcoholism.</p>

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
GASTROINTESTINAL (cont'd)	<p>4. Pain in rectal area when passing a stool, can be associated with bright red bleeding.</p> <p>5. Worms - Any worms seen in stools or treated, when and type of worm.</p> <p>6. Abdominal pain-</p> <ul style="list-style-type: none"> -Constant, full feeling or discomfort. -Off and on cramping pain. -Heartburn. -Food or drink intolerance. 	<p>4. No pain or blood when passing a stool.</p> <p>5. No worms seen or treated.</p> <ul style="list-style-type: none"> -No abdominal pain or only occasional mild abdominal pain. -No colic. -No heartburn. -Minimal food or drink intolerance. 	<p>4. Pain when passing a hard stool, sometimes with fresh blood on outside of stool - fissures, haemorrhoids, constipation.</p> <p>5. Worms seen or treated.</p> <ul style="list-style-type: none"> -Abdominal pain, recurrent constant or moderate to severe, localized or generalized. -Colicky, cramping pain. -Heartburn, especially when lying down, often in pregnant women. -Recurrent food and drink related nausea and vomiting to fatty, oily foods, or spicy foods, etc.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>GASTROINTESTINAL</u> (cont'd)	<p>-Operations or trauma.</p> <p>7. Yellow colouration of skin and whites of the eyes.</p>	<p>-No operations or trauma.</p> <p>7. No yellow discolouration of skin. White sclera.</p>	<p>-Operation or major abdominal trauma.</p> <p>7. Yellow discolouration of skin, yellow eyes - may be associated with nausea and vomiting - termed jaundice.</p>
<u>GENITO-URINARY</u>	<p>1. Painful urination, very frequent urination.</p> <p>2. Night time urination</p> <p>-In childhood - many times during night.</p> <p>-In older men, with hesitancy.</p>	<p>1. No pain with urination, no increased frequency.</p> <p>-sleeps through night - or up once to urinate.</p> <p>-No more than one urination per night.</p>	<p>1. Painful urination, complaints of more urination than usual. History of repeated urinary infections or stones.</p> <p>-Frequency of urination increased during pregnancy.</p> <p>-Urinate many times during the night.</p> <p>-Several urinations per night in older men, often has difficulty starting the urine - prostatic disease.</p>

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>GENITO-URINARY</u> (cont'd)	<p>3. Blood in urine.</p> <p>4. Incontinence - inability to hold urine in the bladder.</p> <p>5. Lesions, swelling, or masses - Any lesions on the genitalia or discharge.</p> <p>-Swelling or masses in the genital region.</p> <p>6. Discharges - Urethral in males or vaginal in females.</p>	<p>3. No blood in the urine.</p> <p>4. Holds urine in bladder without problem.</p> <p>5. No lesions (other than circumcision scars) on genitals.</p> <p>-No swelling or masses.</p> <p>6. No discharges.</p>	<p>3. Any blood in the urine, history of stones, tumour, infection or nephritis.</p> <p>4. Cannot hold urine or loses urine easily when coughing, sneezing or laughing.</p> <p>5. Active lesions or scars of unknown origin on genitals.</p> <p>-Swelling or masses on any part of genitals.</p> <p>6. -Pus like or watery discharge from male urethra.</p> <p>-Thick or watery discharge from vaginal - with or without itching - type will depend on age of woman and description of discharge.</p>

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>GENITO-URINARY</u> (cont'd)	<p>7. VD history - Any past or present problems with venereal disease.</p> <p>8. Sexual function - Is the patient able to have satisfactory sexual relations?</p>	<p>7. No knowledge of venereal disease infection</p> <p>8. Patient able to have satisfactory sex.</p>	<p>7. Past or active venereal disease infection, GC or syphilis.</p> <p>8. Pain when having sex or inability to function sexually or satisfactorily in a sexual manner.</p>
<u>OB/MENSES</u> (Female)	<p>1. Age at onset of menstrual periods.</p> <p>2. Last normal period - Date of last normal period.</p> <p>3. Regularity and duration - How often does menstruation occur and for how long? Any change in menstrual pattern?</p> <p>4. Menstrual pain or other symptoms - Any back or lower abdominal pain with menstruation, or other symptoms such as nausea or headaches?</p>	<p>1. Onset of menses at same age as most females in community.</p> <p>2. Last period within six weeks, frequency approximately one month.</p> <p>3. Every four weeks. Flow 3-7 days.</p> <p>4. Mild discomfort with menstruation.</p>	<p>1. Very early or late onset of menses.</p> <p>2. Last period over two months ago, possible pregnancy.</p> <p>3. Periods are irregular or menstrual flow is longer or shorter than usual. Amount of flow is greatly increased or decreased from the usual.</p> <p>4. Menstrual pain which is severe or disabling. Any nausea, vomiting, or other complaints occurring with menstruation that healthy women do not experience.</p>

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>OB/MENSES</u> (Cont'd) (Female)	5. Now pregnant? If pregnant, ask about high risk factors. a. Age b. Number of previous pregnancies. c. Plan for delivery. d. Previous operative deliveries. e. Previous retained placenta or haemorrhage. f. Length of labour. g. Medical illnesses.	Pregnancy is a normal state. a. Middle of child-bearing years. b. Five or less. c. Assisted delivery by TBA or midwife. d. No previous operative deliveries. e. No history of retained placenta or haemorrhage. f. Normal length - less than 24 hours. g. No medical illnesses.	a. Women below 16 years, over 30 for first baby and over 35 years for any pregnancies. b. Women with more than 5 previous pregnancies have more problems. c. No assistance with delivery. d. Previous caesarian section, forceps or vacuum extraction. e. Retained placenta or haemorrhage. f. Prolonged labour during last delivery. g. Heart disease, diabetes or tuberculosis.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<p><u>OB/MENSES</u> (Cont'd) (Female)</p>	<p>h. Past history of toxemia.</p> <p>i. Stillbirths, miscarriages or early infant deaths.</p> <p>6. Diet of pregnant women - What special foods is she eating while pregnant? Is she taking iron and folic acid?</p> <p>7. Pregnancies, deliveries, abortions.</p> <p>8. Status of deliveries - Did deliveries result in the birth of a healthy baby and a well mother? Any problems?</p>	<p>h. No history of toxemia.</p> <p>i. No history of fetal or early child deaths.</p> <p>6. She is eating more food than usual to support pregnancies including more protein rich foods and green leafy vegetables. She is taking iron and folic acid supplements.</p> <p>7. Normal number is determined by health of mother and normal outcome of pregnancies.</p> <p>8. Deliveries result in living infants with no problems to mother.</p>	<p>h. History of hypertension, swelling or convulsions during previous pregnancy.</p> <p>i. Any stillbirth, miscarriage, or early infant death.</p> <p>6. Diet has not been increased. She is not taking iron and folic acid. She is abstaining from several important foods because she is pregnant (cultural reasons) or because she is nauseated.</p> <p>7. Abortions. Many deaths among children.</p> <p>8. Problems with deliveries, pain, bleeding, caesarian section, stillbirths, early death of infant.</p>

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>MUSCULO-SKELETAL</u>	<ol style="list-style-type: none"> 1. Joint pains or swelling. 2. Muscle wasting and/or weakness. 3. Fractures - Any broken bones? If so, where and what kind of break? 4. Deformities - is the patient deformed, such as having one short leg or arm, or an unnatural angle to any body part. 	<ol style="list-style-type: none"> 1. No pain or swelling in joints. 2. Muscles relatively equal in size, shape, strength. Normal muscle strength and size for age. 3. No broken bones. 4. No deformity. 	<ol style="list-style-type: none"> 1. Painful or swollen joints, arthritis, sprains or recurrent dislocations. 2. Muscles of one group (i.e. arm) are lacking in usual size and strength. Wasting and weakness of muscles. 3. Any current problems with known or suspected broken bones. Past broken bones. 4. Deformity
<u>NEUROPSYCH</u>	<ol style="list-style-type: none"> 1. CNS problems - Any trouble with or damage to the central nervous system (brain and spinal cord). 2. CVA - Cerebral vascular accident - "stroke". 	<ol style="list-style-type: none"> 1. No CNS problems or damage. 2. No strokes. 	<ol style="list-style-type: none"> 1. CNS problems or damage, head or spinal trauma, meningitis. 2. Has had one or more strokes (CVA).

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>NEUROPSYCH</u> (Cont'd)	<p>3. Headaches - troublesome or recurrent headaches, headaches associated with "black outs," visual disturbances, dizziness, nausea or vomiting.</p> <p>-Location and type of pain.</p> <p>-Association with fever.</p> <p>4. Fainting - short periods of unconsciousness.</p> <p>5. Sensory disturbance - change in vision, hearing, smelling, touch, or taste.</p> <p>6. Twitching or seizures - "Fits" or uncontrollable shaking or spasm. Any uncontrolled movement of the body.</p>	<p>3. No headaches.</p> <p>-No fever.</p> <p>4. No fainting spells or loss of consciousness.</p> <p>5. No sensory problems or changes.</p> <p>6. No uncontrolled movements.</p>	<p>3. Occasional headaches with stress, has constant headaches.</p> <p>-Disabling headaches associated with nausea/vomiting, visual disturbances or dizziness.</p> <p>-Location</p> <p>-Fever.</p> <p>4. Has fainting spells, or loss of consciousness.</p> <p>5. Patient has noticed sensory changes, or sensory changes reported by family.</p> <p>6. Patient or family has noticed fits, seizures, twitching or any uncontrolled movement.</p>

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>NEUROPSYCH</u> (Cont'd)	7. Memory - Any sudden or very noticeable change in memory inappropriate to the situation. 8. Anxiety - Depression and emotional stress - Very anxious, nervous, fearful or very sad and feels hopeless. 9. Temperament - sudden bizarre changes in outlook/personality. 10. Orientation - Does patient know where he is, the time of day/month/year, or who he is.	7. No sudden loss of memory. 8. No particular anxiety or depression. 9. No bizarre or sudden changes in outlook or personality. 10. Patient is orientated.	7. Has had noticeable loss of memory. Loss of memory with aging. 8. Patient is very anxious or fearful and/or sad and depressed without good cause. 9. Patient or family/friends have noticed sudden or bizarre personality changes. 10. The patient is not orientated to person/place/time.
<u>ENDOCRINE</u>	1. Excessive hunger, thirst, and/or urination.	1. Normal hunger, thirst or urination.	1. Always hungry even after eating, drinks excessive amounts of water and other fluids, passes large amounts of urine frequently.

Medical History
Review of Systems

SYSTEM	PROBLEM AREAS AND DEFINITIONS	NORMAL LIMITS	ABNORMAL
<u>ENDOCRINE</u> (Cont'd)	2. Desire to eat.	2. Eats regularly.	2. No desire to eat and refuses food, even if malnourished.
<u>SKIN</u>	1. Lesions - Any sores or breakdown of the skin surface, especially those which do not heal. 2. Discolouration - Areas of skin which are different colour than most of the skin. 3. Trauma - Any wounds resulting from injury. 4. Itching - Any itching and its location. Does anything relieve the itching? 5. Texture - Is the surface of the skin even and smooth?	1. No lesions or lesions which have healed. 2. The skin is the same colour throughout the body. 3. No wounds. 4. No itching. 5. Surface of skin is even without lumps and scars.	1. Patient has sores, non-healing sores, or breakdown of the skin surface. 2. Different coloured areas. -No sensation. -No sweating. 3. Has wounds - current or not healed. 4. Constant itching. -Itching relieved by time of day (like scabies or pin worms). 5. Skin surface is not smooth and even, but is broken by lesions, lumps, many scars, etc.

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HISTORY TAKING
EVALUATION SHEET

Student's Name: _____ Date: _____

Patient Case No.: _____

Evaluator's Note:

Observe student during patient interview. Note in the columns on the right your judgement of the completion of each item. In order to be certified competent in history taking, the student must obtain a score of 11 points on one adult and one paediatric history.

Student Note:

Bring this form with you when you are to be evaluated on your history taking skills.

Data Base:

	yes	no
1. Collects all necessary information for patient identification.		
2. Asks about past medical problems		
3. Asks others in family if the patient is unable or unwilling to provide the information.		
4. Gathers information about family history.		
5. Obtains information about way of life including habits.		
6. Checks other available records if indicated.		
7. Attempts to double check accuracy of information by repeating questions when appropriate.		
8. Adjusts language to patient's level so patient understands.		
9. Elicits all appropriate symptoms relating to the chief complaint.		

HISTORY TAKING EVALUATION SHEET (cont'd)

	yes	no
10. Obtains a complete history of chief complaint.		
11. Inquires about other symptoms unrelated to chief complaint. Does a complete review of systems.		
12. Shows consideration for obvious patient discomfort.		
13. Completes appropriate record.		
*TOTAL POINTS		

*One (1) point for each yes answer.
Must score 11 points or more to pass.

REVIEW QUESTIONS

Medical History

1. A person visits the dispensary and tells you about the problem that has caused him to seek your help. In addition to recording his "chief complaint" you need additional information about his problem. List this information:
 - a.
 - b.
 - c.
 - d.
 - e.
 - f.

2. When asking a patient for a description of symptoms, three factors should be noted. List these:
 - a.
 - b.
 - c.

3. Write two statements which would indicate abnormal functioning in the following organs:
Eyes: (1)
(2)
Ears: (1)
(2)
Nose: (1)
(2)
Throat: (1)
(2)
Mouth: (1)
(2)

REVIEW QUESTIONS - Medical History

4. Write four statements which would indicate abnormal functioning of the respiratory system.
 - a.
 - b.
 - c.
 - d.
5. Dyspnoea is defined as _____ .
6. Write three statements which would indicate abnormal functioning of the cardiovascular system.
 - a.
 - b.
 - c.
7. Write three statements which when reported by a patient would indicate abnormal functioning of the gastrointestinal system.
 - a.
 - b.
 - c.
8. The definition of jaundice is _____ .
9. Write four statements which when reported by the patient would indicate abnormal functioning of the genitourinary system.
 - a.
 - b.
 - c.
 - d.

REVIEW QUESTIONS - Medical History

10. Write two statements which when reported by a female patient would indicate abnormal functioning of the reproductive system.
 - a.
 - b.

11. Write two statements which when reported by a patient would indicate abnormal functioning of the endocrine system.
 - a.
 - b.

12. Write three statements which when reported by a patient would indicate abnormal functioning of the neurological system.
 - a.
 - b.
 - c.