

General aspects of history taking

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The importance of a clear history

- The process of history taking requires **patience, empathy and understanding** to yield the key information leading to correct diagnosis and treatment.

*Taking a detailed and accurate history is
the best starting point for a correct diagnosis.*

- In a perfect situation a calm, articulate patient would describe clearly their experience of their symptoms in the order of their occurrence, understanding and answering supplementary questions where required to add detail and certainty. In reality, a multitude of factors commonly complicate this encounter and confound the clear communication of information.
- “It has been suggested that between 70% and 90% of patient diagnoses are made on history taking alone (Keifenheim 2015). ”

Beginning the history

Preparation :

- Read your patient's past records, if they are available.
- Allowing sufficient time (Consultation length varies).
- In all settings, clinicians must learn the skill of managing the pace of the consultation to avoid running late, while not giving any impression that they are short of time.

The scheme in history taking

1. The profile
2. Chief complaint
3. History of present complaint
4. Systemic review
5. Past medical/ surgical history
6. Drug history
7. Family history
8. Social history
9. Occupational history
10. Personal history

Starting your consultation

- Introduce yourself and anyone who is with you.
- The appropriate physical greeting depends on both the cultural and infection control context.
- Confirm the patient's name and how they wish to be addressed.

The profile

- Name
- Age
- Marital status
- Occupation
- Residency
- Date of writing history
- Patient referred from
- The history taken from

- Using different styles of question

Begin with **open questions** that encourage them to think back and report their symptoms in order, such as 'When did you first notice something wrong, and how did it start?' Listen actively, and encourage the patient to talk by looking interested and making encouraging comments such as 'Tell me more'.

Always give the impression that you have **plenty of time**. Allow patients to tell their story in their own words, ideally without interruption. You may occasionally need to interject to guide the patient gently back to describing their symptoms, as anxious patients commonly focus on describing the events or the reactions and opinions of others surrounding an episode of illness rather than what they were feeling.

While avoiding unnecessary repetition, it may be helpful occasionally to tell patients what you think they have said and ask if your interpretation is correct (reflection).

Open questions vs. Closed questions

The way you ask a question is important:

- **Open questions** are general invitations to talk that avoid anticipating particular answers: for example, 'What was the first thing you noticed when you became ill?' or 'Can you tell me more about that?'
- **Closed questions** seek specific information and are used for clarification: for example, 'Have you had a cough today?' or 'Did you notice any blood in your bowel motions?' Both types of question have their place, and normally clinicians move gradually from open to closed questions as the interview progresses

The history of the presenting symptoms

- Having established the patient's reason for seeking a consultation.
- Pick out the two or three main symptoms they are describing (e.g. pain, cough and shivers); these are the essence of the history of the presenting symptoms.

The history of the presenting symptoms

2.1 Examples of terms used by patients that should be clarified		
Patient's term	Common underlying problems	Useful distinguishing features
Allergy	True allergy (immunoglobulin E-mediated reaction) Intolerance of food or drug, often with nausea or other gastrointestinal upset	Visible rash or swelling, rapid onset Predominantly gastrointestinal symptoms
Indigestion	Acid reflux with oesophagitis Abdominal pain due to: Peptic ulcer Gastritis Cholecystitis Pancreatitis	Retrosternal burning, acid taste Site and nature of discomfort: Epigastric, relieved by eating Epigastric, with vomiting Right upper quadrant, tender Epigastric, severe, tender
Arthritis	Joint pain Muscle pain Immobility due to prior skeletal injury	Redness or swelling of joints Muscle tenderness Deformity at site
Catarrh	Purulent sputum from bronchitis Infected sinonasal discharge Nasal blockage	Cough, yellow or green sputum Yellow or green nasal discharge Anosmia, prior nasal injury/polyps
Fits	Epilepsy Transient syncope from cardiac disease Abnormal involuntary movement	Witnessed tonic/clonic movements; postictal amnesia Witnessed pallor during syncope; known heart disease No loss of consciousness
Dizziness	Labyrinthitis Syncope from hypotension Cerebrovascular event	Nystagmus, feeling of room spinning, with no other neurological deficit History of palpitation or cardiac disease, postural element Sudden onset, with other neurological deficit

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- The patient is a 65-year-old male smoker. A cough for 2 months increases the likelihood of lung cancer and COPD. Haemoptysis lasting 2 months greatly increases the chance of lung cancer. If the patient also has weight loss, the positive predictive value of all these answers is very high for lung cancer. This will focus your examination and investigation plan.

SOCRATES

- **S**= Site (where is the pain worse? Ask the patient to point to the site with *one finger*)
- **O**= Onset (how did it come on? Over how long?)
- **C**= Character (i.e. 'dull', 'aching', 'stabbing', 'burning', etc.)
- **R**= Radiation (does the pain move or spread to elsewhere?)
- **A**= Associated symptoms (e.g. nausea, dyspepsia, shortness of breath)
- **T**= Timing (duration, course, pattern)
- **E**= Exacerbating and relieving factors
- **S**= Severity (scored out of 10, with '10' as the worst pain imaginable).

- To complete the history of presenting symptoms, make an initial assessment of how the illness is impacting on the life of your patient.
- While taking the history of the presenting complaint you should also explore the patient's perspective on their symptoms, often referred to as their ideas, concerns and expectations (ICE).

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2.3 Questions to ask about common symptoms	
System	Question
Cardiovascular	Do you ever have chest pain or tightness? Do you ever wake up during the night feeling short of breath? Have you ever noticed your heart racing or thumping?
Respiratory	Are you ever short of breath? Have you had a cough? If so, do you cough anything up? What colour is your phlegm? Have you ever coughed up blood?
Gastrointestinal	Are you troubled by indigestion or heartburn? Have you noticed any change in your bowel habits recently? Have you ever seen any blood or slime in your stools?
Genitourinary	Do you ever have pain or difficulty passing urine? Do you have to get up at night to pass urine? If so, how often? Have you noticed any dribbling at the end of passing urine? Have your periods been regular?
Musculoskeletal	Do you have any pain, stiffness or swelling in your joints? Do you have any difficulty walking or dressing?
Endocrine	Do you tend to feel the heat or cold more than you used to? Have you been feeling thirstier or drinking more than usual?
Neurological	Have you ever had any fits, faints or blackouts? Have you noticed any numbness, weakness or clumsiness in your arms or legs?

Gastrointestinal tract

- Appetite, weight loss or gain
- Nausea or /and vomiting
- Haematemesis
- Dysphagia, regurgitation, heartburn,
- Abdominal pain, abdominal distension
- Jaundice “yellow discoloration of sclera, skin, urine
- Bowel habit, rectal bleeding, mucus, tenesmus.

Respiratory system

- Cough, sputum, haemoptasis.
- Chest pain
- Exercise tolerance
- Dyspnea, wheezing.

Cardiovascular system

- Chest pain
- Palpitation
- Dizziness
- Dyspnea, paroxysmal nocturnal dyspnea, orthopnea
- Ankle swelling
- Limb pain
- Color change in hands or feet

Urogenital system

- Loin pain
- Frequency of micturition
- Poor stream
- Dribbling
- Hesitancy
- Dysuria, urgency
- Polyurea
- Hematuria
- Incontinence

Gynecological history

- Date of menarche or menopause
- Frequency, duration and quantity of menses
- Dysmenorrhea
- Vaginal discharge
- Previous pregnancies

Nervous system

- Headache
- Dizziness
- Muscle weakness
- Paresthesia
- History of loss of consciousness or fits
- Memory loss
- Tremor

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2.4 Typical patterns of symptoms related to disease causation			
Disease causation	Onset of symptoms	Progression of symptoms	Associated symptoms/pattern of symptoms
Infection	Usually hours, unheralded	Usually fairly rapid over hours or days	Fevers, rigors, localising symptoms (e.g. pleuritic pain and cough)
Inflammation	May appear acutely	Coming and going over weeks to months	Symptoms may be multifocal, often with local tenderness
Metabolic	Variable, hours to months	Steady progression in severity with no remission	Variable, weakness, altered weight
Malignant	Gradual, insidious	Steady progression over weeks to months	Weight loss, fatigue
Toxic	Abrupt	Rapid	Dramatic onset of symptoms; vomiting often a feature
Trauma	Abrupt	Little change from onset	Diagnosis usually clear from history
Vascular	Sudden	Stepwise progression with acute episodes	Rapid development of associated physical signs
Degenerative	Gradual	Months to years	Gradual worsening with periods of more acute deterioration

Past medical history

- Relevant to the presenting symptoms (e.g. previous migraine in a patient with headache, or haematemesis and multiple minor injuries in a patient with possible excess alcohol intake).
- It may reveal predisposing past or underlying illness, such as diabetes in a patient with peripheral vascular disease, or childhood whooping cough in someone presenting with bronchiectasis.

The referral letter and case records often contain useful headlines, but the patient is usually the best source.

Past surgical history

- Previous admission to surgical ward
- Surgical operations or accidents
- Previous blood transfusion.

Drug History

2.5 Example of a drug history

Drug	Dose	Duration	Indication	Side effects/patient concerns
Aspirin	75 mg daily	5 years	Started after myocardial infarction	Indigestion
Atenolol	50 mg daily	5 years	Started after myocardial infarction	Cold hands (?adherence)
Co-codamol (paracetamol + codeine)	500 mg paracetamol/8 mg codeine up to 8 tablets daily	4 weeks	Back pain	Constipation
Salbutamol MDI	2 puffs as necessary	6 months	Asthma	Palpitation

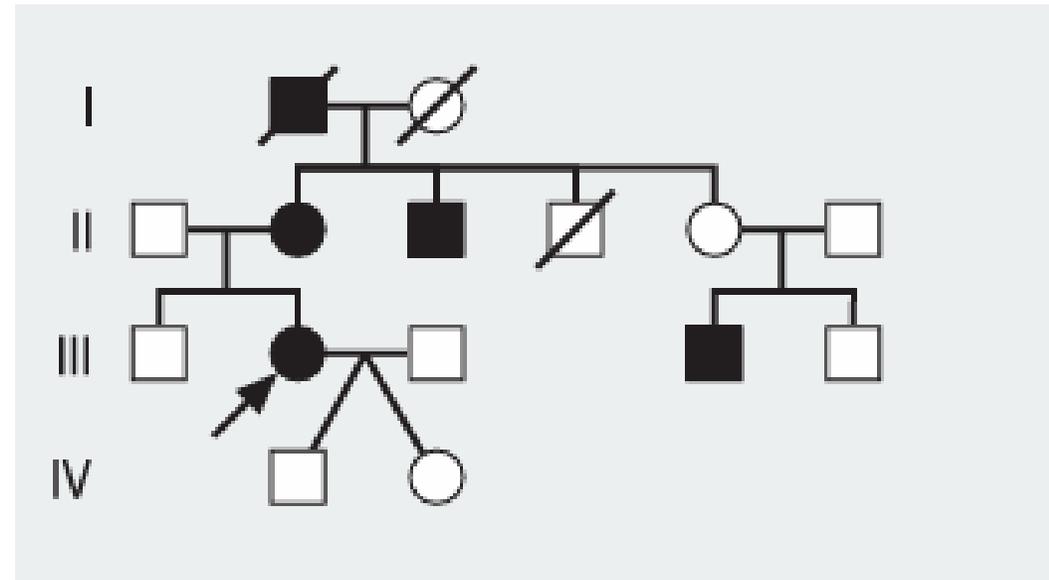
MDI, Metered-dose inhaler.

Drug History

- Enquire also about inhalers and topical medications, as patients may assume that you are asking only about tablets.
- In addition to prescribed drugs, ask patients if they take any over-the-counter remedies, including herbal and homeopathic remedies and vitamin or mineral supplements. Ask also about recreational drug use (mainly cannabis).
- Concordance and adherence
- Drug allergies/reaction.

Family history

- Document illness in first-degree relatives (i.e. parents, siblings and children). If you suspect an inherited disorder such as haemophilia, construct a pedigree chart, noting whether any individuals were adopted.
- The cause of death of close relatives.



Social history and lifestyle

- Establish who is there to support the patient/ Marital status.
- Establish the type and condition of the patient's housing and how well it suits them, given their symptoms.
- Travel abroad.

Smoking

- Tobacco use increases the risk of obstructive lung disease, cardiac and vascular disease, peptic ulceration, intrauterine growth restriction, erectile dysfunction and a range of cancers.
- What form of tobacco they have used (cigarettes, cigars, pipe, chewed).
- Ask if they have smoked only tobacco or also cannabis.
- Do not forget to ask non-smokers about their exposure to environmental tobacco smoke (passive smoking).

2.7 Calculating pack-years of smoking

A 'pack-year' is smoking 20 cigarettes a day (1 pack) for 1 year

$$\frac{\text{Number of cigarettes smoked per day} \times \text{Number of years smoking}}{20}$$

For example, a smoker of 15 cigarettes a day who has smoked for 40 years would have smoked:

$$\frac{15 \times 40}{20} = 30 \text{ pack-years}$$

- Cannabis “Cannabinoids” adversely affect the cardiovascular system, causing myocardial infarction, cerebrovascular accidents, arrhythmia and heart failure.

Chandy, Mark, Nerea Jimenez-Tellez, and Joseph C. Wu. "The relationship between cannabis and cardiovascular disease: clearing the haze." *Nature Reviews Cardiology* (2025): 1-15.

Alcohol

- If they do drink, ask them to describe **how much, the quantity and what type** (beer, wine, spirits) they drink in an average week.

2.8 Features of alcohol dependence in the history

- A strong, often overpowering, desire to take alcohol
- Inability to control starting or stopping drinking and the amount that is drunk
- Drinking alcohol in the morning
- Tolerance, where increased doses are needed to achieve the effects originally produced by lower doses
- A withdrawal state when drinking is stopped or reduced, including tremor, sweating, rapid heart rate, anxiety, insomnia and occasionally seizures, disorientation or hallucinations (delirium tremens); this is relieved by more alcohol
- Neglect of other pleasures and interests
- Continuing to drink in spite of being aware of the harmful consequences

Sexual history

- Take a full sexual history only if the context or pattern of symptoms suggests this is relevant.
- Signal your intentions: 'As part of your medical history, I need to ask you some questions about your relationships. Is this all right?'

Occupational history

- **Ask all patients about their occupation.**
- Clarify what the person does at work, especially about any chemical or dust exposure. If the patient has worked with harmful materials (e.g. asbestos or stone dust), a detailed employment record is needed, including employer name, timing and extent of exposure, and any work place protection offered.
- Unemployment is also associated with increased morbidity and mortality.

Occupational history

2.9 Examples of occupational disorders			
Occupation	Factor	Disorder	Presents
Shipyard workers, marine engineers, plumbers and heating engineers, demolition workers, joiners	Asbestos dust	Pleural plaques Asbestosis Mesothelioma Lung cancer	>15 years later
Stonemasons	Silica dust	Silicosis	After years
Farmers	Fungus spores on mouldy hay	Farmer's lung (hypersensitivity pneumonitis)	After 4–18 hours
Divers	Surfacing from depth too quickly	Decompression sickness Central nervous system, skin, bone and joint symptoms	Immediately, up to 1 week
Industrial workers	Chemicals (e.g. chromium) Excessive noise Vibrating tools	Dermatitis on hands Sensorineural hearing loss Vibration white finger	Variable Over months Over months
Bakery workers	Flour dust	Occupational asthma	Variable
Healthcare workers	Cuts, needlestick injuries	Human immunodeficiency virus, hepatitis B and C	Incubation period >3 months

2.10 Systematic enquiry: cardinal symptoms

General health

- Wellbeing
- Appetite
- Weight change
- Energy
- Sleep
- Mood

Cardiovascular system

- Chest pain on exertion (angina)
- Breathlessness:
 - Lying flat (orthopnoea)
 - At night (paroxysmal nocturnal dyspnoea)
 - On minimal exertion – record how much
- Palpitation
- Pain in legs on walking (claudication)
- Ankle swelling

Respiratory system

- Shortness of breath (exercise tolerance)
- Cough
- Wheeze
- Sputum production (colour, amount)
- Blood in sputum (haemoptysis)
- Chest pain (pleuritic or constant)

Gastrointestinal system

- Mouth (oral ulcers, dental problems)
- Difficulty swallowing (dysphagia – distinguish from pain on swallowing (i.e. odynophagia)
- Nausea and vomiting
- Vomiting blood (haematemesis)
- Indigestion
- Heartburn
- Abdominal pain
- Change in bowel habit
- Change in colour of stools (pale, dark, tarry black, fresh blood)

Genitourinary system

- Pain passing urine (dysuria)
- Frequency passing urine (at night: nocturia)
- Blood in urine (haematuria)
- Libido
- Incontinence (stress and urge)
- If appropriate: Sexual partners – unprotected intercourse

Men

If appropriate:

- Prostatic symptoms, including difficulty starting (hesitancy):
- Poor stream or flow
- Terminal dribbling

- Urethral discharge
- Erectile difficulties

Women

- Last menstrual period (consider pregnancy)
- Timing and regularity of periods
- Length of periods
- Abnormal bleeding

- Vaginal discharge
- Contraception
- If appropriate:
- Pain during intercourse (dyspareunia)

Nervous system

- Headaches
- Dizziness (vertigo or lightheadedness)
- Faints
- Fits
- Altered sensation

- Weakness
- Visual disturbance
- Hearing problems (deafness, tinnitus)
- Memory and concentration changes

Musculoskeletal system

- Joint pain, stiffness or swelling
- Mobility

- Falls

Endocrine system

- Heat or cold intolerance
- Change in sweating

- Excessive thirst (polydipsia)

Other

- Bleeding or bruising

- Skin rash

Closing the interview

- Using simple language, explain briefly your interpretation of the patient's presenting problem and outline the likely possibilities.
- Always give the patient a final opportunity to raise additional concerns.
- Make sure that patients are involved in any decisions by suggesting possible actions and encouraging them to contribute their thoughts.

Sensitive situations

- Because of what you're telling me, I need to ask you some rather personal questions. Is that OK?

Emotional or angry patients

- Although their behavior may be challenging, **never respond with anger or irritation.**
- Recognise that your patient is upset, show empathy and understanding and ask them to explain why.

Set professional boundaries if your patient becomes overly familiar: 'Well, it would be inappropriate for me to discuss my personal issues with you. I'm here to help you, so let's focus on your problem.'