



HISTORY TAKING

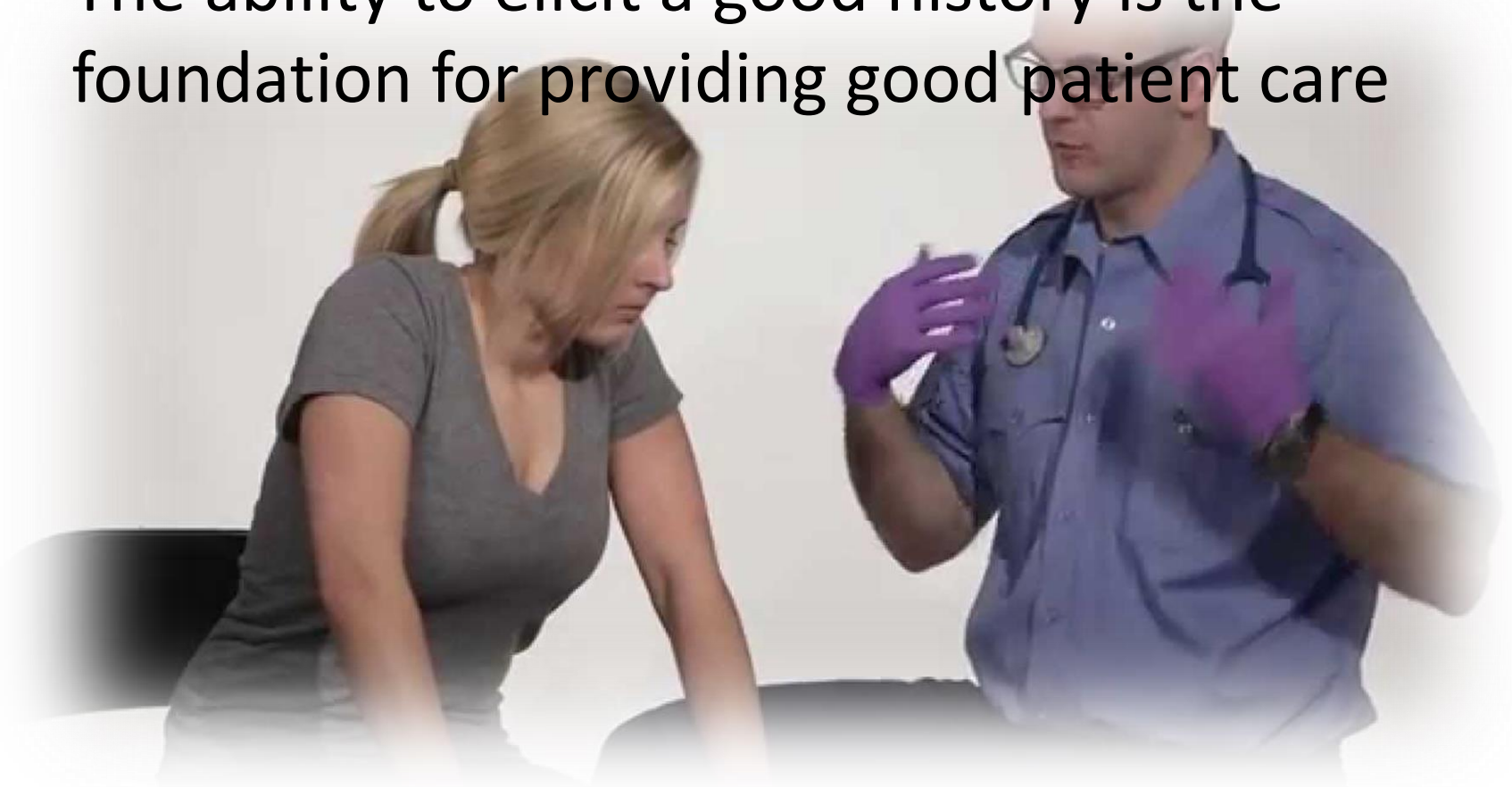
DND Primary Care Paramedicine

Module: 01

Section: 12

- Introduction
- Establishing patient rapport
- Comprehensive patient history
- Special challenges

- The ability to elicit a good history is the foundation for providing good patient care



- The challenge:
 - To get as much relevant patient information and history to provide rationale for treatment and transport decisions
- The obstacles:
 - Establish rapport in a patient that you have just met
 - Conduct primary and secondary assessments and implement treatments simultaneously
 - Do so within the time constraints of effective prehospital care and the patient's primary problem
 - Multitasking (interviewing the patient while completing skills or procedures)

- “Building” a history rather than “taking” one because you and your patient are involved in a joint effort
- Context of that relationship in emotional, physical and ethical terms
- Verbal and nonverbal behavior that you may adapt to your individual comfort and style
- Approaches to the structure of a history with adaptations suggested for age, gender, and disability

- Chief complaint
 - The main reason that you were called to attend to the patient
 - Use quotations to emphasize the patient's own words (patient is complaining of "difficulty breathing")
 - Differentiate from the primary cause
- Differential diagnosis
 - The working diagnosis that you come up with based on the patient's signs and symptoms and the variety of potential causes

History Taking

RAPPORT

- The first meeting with the patient sets the tone for a successful communication
- You will be open, flexible and eager to deal with questions and explanations
- You will explain the boundaries of your practice and the degree of your availability in any situation
- Trust evolves from honesty and candor

- Primary objectives:
 - To discover the details about a patient's concern
 - To display genuine interest, curiosity and partnership
- To prevent misinterpretations and misperceptions, you must make every effort to sense the world of the patient as that patient sees it

- Defined by the Institute of Medicine as:
 - “Respecting and responding to patients’ wants, needs and preferences, so that they can make choices in their care that best fit their individual circumstances”
- Your own beliefs, attitudes and values cannot be discarded, but you do have to discipline them.

- By asking the patient the right questions you will discover their chief complaint and symptoms
- By responding with empathy, you will win their trust and encourage them to discuss their problems with you

- Describe the techniques that the attendant is using to establish rapport



- If the patient's chart is available, it may provide valuable insight into the patient's condition (e.g. nursing home, inter-hospital transfer)
- Ensure that insight doesn't turn into bias
- As much as possible choose an environment that allows for effective interaction

- Establishing a positive patient relationship depends on communication built on:
 - Courtesy
 - Comfort
 - Connection
 - Confirmation
 - Confidentiality

- Use appropriate language
- Use an appropriate level of questioning, but do not appear condescending.
- Generally start with open-ended questions and progress to more closed
- Avoid a pre-arranged script of questions, modify questioning in response to patient responses

- Open-ended question
 - Allows patient discretion about the extent of an answer
- Direct (closed-ended) question
 - Seeks specific information
- Leading question
 - May limit the information provided to what the patient thinks you want to know

- If the patient does not understand what you are asking, remember to:
 - Facilitate: encourage your patient to say more.
 - Reflect: repeat what you have heard.
 - Clarify: ask “what do you mean?”
 - Empathize: show understanding and acceptance.
 - Confront: address disturbing patient behavior.
 - Interpret: repeat what you have heard to confirm the patient’s meaning.

- Patients will experience problems that you may find sensitive, embarrassing or very personal
 - Sexual activities, violence, physical deformity
- Dealing with problems comfortably and professionally will enhance patient trust
- Approaching sensitive topics
 - Ensure privacy
 - Be direct and firm
 - Do not apologize for broaching the issue
 - Do not preach
 - Use language that is understandable
 - Do not push too hard

History Taking

COMPREHENSIVE PATIENT HISTORY

- Taking the history usually begins your relationship with the patient.



- Theory
 - A comprehensive patient history will provide the components in a systematic order
- Practice
 - You will ultimately select only those components that apply to your patient's condition and status

- Identify those matters the patient defines as problems.
- Establish a sense of the patient's reliability.
- Consider the potential for intentional or unintentional suppression or underreporting of information.
- Remain in a constant state of subjective evaluation of the patient's words and behaviors.
- Adapt to the modifications that age, pregnancy, and physical and emotional disabilities mandate.

- Comfort for all involved
- If possible:
 - Removal of physical barriers
 - Good lighting
 - Privacy
 - Relative quiet

- The identifiers: name, age, gender
 - Chief complaint
 - History of present illness (HPI)
 - Past medical history (PMH)
 - Family history (FH)
 - Current health status
 - Review of systems (ROS)

- Introduce yourself
- Address patient properly
- Be courteous
- Make eye contact
- Do not overtire patient
- Do not be judgmental
- Be flexible

- Avoid medical jargon
- Take notes sparingly
- Avoid leading questions
- Start with general concerns, then move to specific descriptions
- Clarify responses with where, when, what, how, and why questions
- Verify and summarize what you have heard

- The main reason that you were called to attend to the patient
 - Generally a sign or symptom
- Primary Cause
 - The medical condition that resulted in the chief complaint
 - Also referred to as the primary problem

- Note all significant concerns.
- Seek answer to the question “What underlying problems or symptoms brought you here?”
- Determine the duration of the current illness by asking “How long has this problem been present?” or “When did these symptoms begin?”

- Once you have determined the chief complaint, explore each of your patient's complaints in greater detail.
- Be naturally inquisitive when exploring the events surrounding these complaints.
- A practical template for exploring a general history follows the mnemonic SAMPLE
- A practical template to explore each complaint follows the mnemonic OPQRST-ASPN

- **S**igns and **S**ymptoms
- **A**llergies
- **M**edications
- **P**ast medical history
- **L**ast oral intake
- **E**vents preceding the incident

- Once you have determined the chief complaint, explore each of your patient's complaints in greater detail.
- Be naturally inquisitive when exploring the events surrounding these complaints.
- A practical template for exploring each complaint follows the mnemonic OPQRST-ASPEN

- **O**nset of the problem
- **P**rovocative/ Palliative factors
- **Q**uality
- **R**egion/Radiation
- **S**everity
- **T**ime
- **A**ssociated **S**ymptoms
- **P**ertinent **N**egatives

History of Present Illness

Explore the following

- Chronology of events
- Health state before present problem
- First symptoms
- Symptom analysis
- Typical attack
- Exposure to infection or toxic agents
- Illness impact on lifestyle
- Immediate reason for visit
- Review of involved systems
- Medications list
- Complementary or alternative therapies
- Chronology review

- May provide significant insights into your patient's chief complaint and your field diagnosis.
- May reveal general or specific clues that will help you correctly assess the current problem.
- Assess in further depth:
 - General state of health
 - Childhood diseases
 - Adult diseases
 - Psychiatric illnesses
 - Accidents or injuries
 - Surgeries or hospitalizations

- Blood relatives with illness similar to the patient's illness
- Blood relatives with history of major disease
- Determine if any cancers have been multiple, bilateral, occurring more than once in the family, and occurring at a young age (less than 50 years)
- Note the age and outcome of any illness

- Current medications including dosages and regimen
 - May take medications with you to the hospital
- Allergies
- Habits (Tobacco, alcohol, drugs, and related substances)
- Diet

- Other factors that may be elicited and important to the care and treatment of the patient include:
 - Self care
 - Sexual history
 - Home conditions
 - Access to care
 - Occupation
 - Environment

- Screening tests
- Immunizations
- Sleep patterns
- Exercise and leisure activities
- Environmental hazards
- Use of safety measures
- Family history

- Home situation and significant others
- Daily life
- Important exercises
- Religious beliefs
- The patient's outlook

- Functional inquiry
- A system-by-system series of questions designed to identify problems your patient has not already identified
- Mainly determined by patient chief complaint, condition and clinical status

- General constitutional symptoms
- Skin
- HEENT
- Immune
- Respiratory
- Cardiac
- Gastrointestinal
- Urinary
- Peripheral vascular
- Musculoskeletal
- Neurologic
- Hematologic
- Genitourinary
- Endocrine
- Psychiatric

- Fever
 - Chills
 - Malaise
 - Fatigability
 - Night sweats
 - Sleep patterns
- Weight
 - Average
 - Preferred
 - Present
 - Change

- Silence
- Overly talkative patients
- Multiple symptoms
- Anxiety
- Depression
- Sexually attractive or seductive patients
- Confusing behaviours or symptoms

- Patients needing reassurance
- Anger and hostility
- Intoxication
- Crying
- Limited intelligence
- Language barriers
- Hearing problems
- Blindness
- Talking with families or friends

- Patient may or may not be the best source of a history
- Family, bystanders may provide or validate the history you obtain
- Partner can obtain history from family/bystanders while you are performing other assessments and/or treatments if required

- A “complete” history is not always necessary.
- You may know the patient well and be considering the same problem over time.
- Adjust your approach to the need at the moment.

- Complete history
 - Most often recorded the first time you see the patient
- Inventory history
 - Related to but does not replace the complete history
 - Touches on major points without complete detail
 - Entire history will be completed in more than one session
- Problem (or focused) history
 - Taken when a problem is acute so that only the need of the moment is given full attention

- Establishing patient rapport
- Comprehensive patient history
- Special challenges