MEDAVIE HealthEd
College of Paramedicine

ÉduSanté
Collège de formation paramédicale

Patient Assessment – History Taking

Advanced Care Paramedicine

Module: 02
Section: 01a

History Taking

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

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

Introduction

- The challenge:
  - to get as much relevant patient information and history to provide rational 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

- "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

Terminology

- 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

Patient Assessment – History Taking

RAPPORT

Developing a Relationship with the Patient

- 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

Developing a Relationship with the Patient (Cont.)

- 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

Patient-Centered Care

- 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

Rapport

- 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

Rapport

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

Setting the Stage

- 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

Effective Communication

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

Language and Communication

- 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

Enhancing 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

Enhancing Patient Responses (Cont.)

- 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.

Sensitive Topics

- 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

Patient Assessment – History Taking

COMPREHENSIVE PATIENT HISTORY

The History

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

Introduction

- 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

The Patient History

- 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.

Setting for the Interview

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

Structure of the History

- 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)

Building the History

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

Building the History (Cont.)

- 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

Chief Complaint

- 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

Chief Complaint

- 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?”

History of Present Illness

- 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

Present Illness (SAMPLE)

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

History of Present Illness

- 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-ASPN

Present Illness
OPQRST-ASPN

- **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

Past History

- 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

Family History

- 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 Health Status

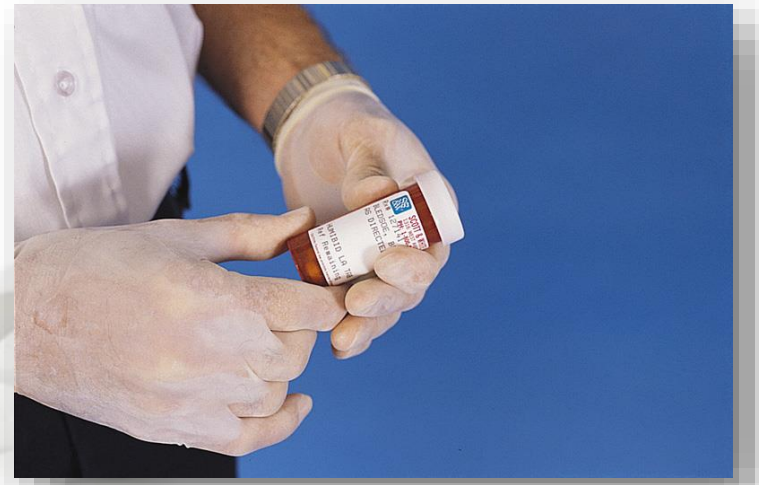
- Current medications including dosages and regimen
  - May take medications with you to the hospital
- Allergies
- Tobacco
- Alcohol, drugs, and related substances
- Diet

Personal and Social History

- 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

Medications

- Medical History
- Compliance
- Dose and Frequency
- Complications



Current Health Status

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

Current Health Status

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

Review of Systems

- 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

Review of Systems

- General
- Skin
- HEENT
- Respiratory
- Cardiac
- Gastrointestinal
- Urinary
- Genitalia
- Peripheral Vascular
- Musculoskeletal
- Neurologic
- Hematologic
- Endocrine
- Psychiatric

General Constitutional Symptoms

- Fever
- Chills
- Malaise
- Fatigability
- Night sweats
- Sleep patterns

- Weight
  - Average
  - Preferred
  - Present
  - Change

Special Challenges

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

Special Challenges

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

Sources of Patient History

- 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

Types of Histories

- 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.

Types of Histories (Cont.)

- 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

Summary

- Establishing patient rapport
- Comprehensive patient history
- Special challenges