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Pocket Manual on The Art of History Taking

3rd Edition

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Foreword
BM Hegde

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1

The Art of History Taking

WHY IS IT AN ART AND NOT MERELY A SCIENCE?

Well, history taking is an art simply because you can never be perfect in it. In any art, perfection can only be an ideal. One can only work towards it without ever achieving it. An artist, in the strictest sense will always be a student. Also an art cannot exactly be taught. Different people perceive it differently. It is for the interested individual to persue and learn the art himself. The same holds good when pursuing the art of history taking.

Medical students working in the wards should keep their eyes and ears open all the time and be constantly on the lookout for useful bits of information coming from any source. A pearl of wisdom might come forth from an experienced teacher at any time and not be repeated again. Such bits of common sense might come forth even from the ward nurse or the patient himself. If the student latches on to all such information that comes his way, in time a rich and highly useful bank of clinical information will be at his/her disposal. This will assist the student in gaining new insight into the patient's predicament.

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History taking can never be mastered by anybody without being able to speak the patient's language. In fact, history taking involves the art of communication as well. Communication is well nigh impossible if there is a language barrier. Hence, a medical student working in the ward should make every effort to learn the local language. For example, there is no excuse for a student from a Hindi speaking state not knowing Kannada if he is studying in Bangalore and *vice versa*. Using a translator can only be a temporary arrangement. Unfortunately, I have seen students going through the whole medical course without learning even bits of the local language. Perhaps this is a sign of the times we live in where standards expected are being lowered all the time. I am afraid their time in the wards was simply wasted. On the other hand, there is no point expecting the patient to learn doctor's language. It will never happen. The mountain does not come to Muhmad!

Last but not least, one should provide adequate privacy in the examination room for the patient to feel comfortable and be able to come out with details of his trouble and innermost anxieties. The quality of history taken in a crowded and noisy outpatient clinic is not likely to be of the highest order.

Once you have the right attitude and the necessary linguistic as well as communicative skills you are on your way to be the maestro. It is not easy to be able to collect a good history. But I can assure you that the satisfaction that comes out of being able to take a good history and thus help in making an accurate diagnosis will more than compensate for the effort put in.

I have a small piece of advice before proceeding to history proper. It is said " Common sense in an uncommon degree is what the world

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calls wisdom". Apply your common sense at every step and you will slowly find out that clinical surgery is nothing but collection of small bits of common sense applied judiciously. In surgery most of the disease processes occur at a macro level and affect an anatomical organ that can easily be visualised. An adequate knowledge of the functional anatomy of particular organ will enable the clinician to visualise the symptoms the disease affecting it is likely to produce. Such knowledge is definitely the forerunner of a well taken history. I will not be surprised if after reading this book you feel that you already knew every bit of what is written in this book. It is then only a case of practising what we already know. That should not be too difficult. Come on, lets get started.

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2

Preliminary Information About the Patient

Preliminary information refers to the details regarding patient's age, sex, religion, residential address, occupation, etc. Most of us routinely note down these facts. Many a time these details are already entered into the case file either by the billing clerk or by the nurse before the patient meets his doctor. We rarely pause to ponder over these data as we are usually impatient to hear the patient's complaints. Hence, let us first find out why these details about the patient need be collected personally and how they can direct the line of questioning occasionally.

One should always note down a patient's full name. It helps to establish an immediate rapport with the patient. The significance of doctor-patient relationship is too great to require emphasis here. Imagine a patient waiting in the ward for morning rounds by the consultant. He will obviously be physically infirm and emotionally insecure. And then the consultant comes and asks him sympathetically " how are you today, Mr Shetty?" It will have a two-fold effect on Mr Shetty, the patient. One is that he feels emotionally reassured that his doctor remembers him and hence likely to take care of his health. And the other is that he can narrate his worries or symptoms without hesitation, now that he has been invited to talk.

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A seemingly minor gesture on the part of the clinician, but the effect on the patient is immense.

Many a time while working in the wards we heartlessly refer to patient's as 'cases'. We often ask things like "how is yesterday's hernia case doing ?" "When is the hydrocele case being discharged ?" and so on. At times we do not even acknowledge the patient's presence while discussing the details of the case in front of him. All this is nothing but dehumanising the patient. A patient would like to be treated with respect, if not with love and affection. Put yourself in the patient's place and you will never call him a case again.

Also, knowing a patient's name might give a clue to the patient's religious faith and thus his social customs and dietary habits. Often the surname part of a patient's name will provide a good indication as to which part of India he/she hails from, e.g. A Mr Nair is likely to be from Kerala, whereas Mr Shinde is from Maharashtra, India. This piece of information will help in suspecting endemic diseases prevalent in those regions especially when one is working in a tertiary care hospital catering to a large part of the country.

Age and sex are to be recorded routinely as they might indicate the possible pathology affecting the patient. Though one can guess a patient's age just by looking at him, such guesstimates are not always accurate and should be avoided. Many diseases are age related, e.g. children are more likely to suffer from congenital conditions, malnutrition, gastroenteritis, viral diseases, skin and soft tissue infection, etc. In young adults active tuberculosis, accident and trauma, psychosomatic illness, sexually transmitted conditions, etc. are more common than in other age groups. Middle aged persons might suffer from diabetes, chronic lung conditions, coronary

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artery disease, etc. And elderly people are prone for malignancy, degenerative diseases, malnutrition, etc. A more comprehensive list of diseases affecting different age groups is given at the end of this chapter. This list is by no means exhaustive and should never be relied on for anything more than initial suspicion regarding the possible pathology. After all, diseases do not read textbooks and have a nasty habit of affecting all age groups to a lesser or greater degree. Hence, age alone should not be used to include or exclude any pathology as a possibility.

Recording the patient's sex may seem superfluous on most occasions as the fact is obvious at sight. But it may not always be so, especially in very young children and grossly emaciated and bedridden patients. It is always a good policy to get the fact clarified if there is any doubt. Thus you will save yourself from acute embarrassment flowing out of ignorant assumptions. As is well known, many diseases are more common in females like thyroid disorders, varicose veins, functional disorders, etc. One need not stress that gynaecological conditions often present in surgical OPD as acute abdominal pain thus complicating the picture. Similarly certain other conditions like oropharyngeal malignancies, cirrhosis of the liver, peripheral vascular disease, etc. are more common in men. Again a list of diseases more common in either gender is given at the end of the chapter.

Everybody knows why a patient's address has to be recorded. It helps to inform the relatives in case of an emergency and also gives a clue to the probable endemic diseases prevalent in the area of patient's residence. But unfortunately knowledge does not always

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get translated into practice. It is only when one tries to contact the patient after his discharge from the hospital that one finds out how inadequately the address had been recorded. Hence, patient's full residential address along with the telephone number should ideally be recorded in the case sheet.

Somehow we have all been taught to ask about patient's occupation in the same breath as his address. There is nothing inherently wrong with such a policy, but it is likely that the due importance is not given to it by the students at this stage, as they will be anxious to start with the history of presenting complaints. One cannot afford to overlook this important aspect of patient's history which might indeed be the source of his problems. Hence, it is necessary to ask the details of occupation as a separate entity later in the history.

Pointed questions regarding patient's religion may not be considered polite by many. It is indeed so. But occasionally religion tends to dictate lifestyle. For example, some religions like Jainism strictly prohibit non-vegetarian food. Hence, the quality of diet will change. Sometimes faith controls the behaviour of the patient too, e.g. Jehovah's witnesses do not accept blood transfusions and organ transplants as a matter of faith. Unless it is absolutely unavoidable, one should try not to offend the patient's religious sensibilities. Replacing faith with logic is not always easy and should not be tried without a good reason.

Many a time the preliminary data collected is read out in a disjointed manner by the student presenting the case for discussion, e.g. "Ramappa, male 62 years, occupation farmer,

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resides in Mangalore." Does not it sound jarring? Now listen to this "Mr Ramappa, 62-year-old farmer, residing in Mangalore has the following complaints". The second statement contains the same information but is streamlined and has a nice ring to it. Well begun is half done as they say.

Occasionally patient himself may not be able to give the history for a variety of reasons-poor general condition, deaf-mutism, etc. Also when the patient is a very young child or is mentally retarded history will have to be taken from a relative or the person accompanying the patient. In all such cases it is necessary to record the name of such person and his relationship with the patient.

Remember that history has to be recorded in the same way that it is told by the patient. In other words, using layman's language. For example, if a person gives history of passing stools admixed with blood it should be recorded the same way in the history sheet and not as haematochezia.

DISEASE MORE COMMON IN MEN (EXCLUDING DISEASES OF THE GENITALIA)

- Malignancies of the upper aerodigestive tract
- Peripheral vascular disease like Buerger's disease and atherosclerosis
- Inguinal hernia
- Acid peptic disease
- Pilonidal sinus
- Haemophilia
- Cirrhosis of the liver

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- Trauma
- Hodgkin's lymphoma
- Adenolymphoma
- Congenital hypertrophic pyloric stenosis
- Pharyngeal pouch (Students are encouraged to add to this list).

DISEASES MORE COMMON IN WOMEN (EXCLUDING DISEASES INVOLVING GENITALIA)

- All thyroid disorders
- Gallstone disease
- Femoral hernia
- Cushing's syndrome
- Urinary tract infection
- Raynaud's disease
- Hiatus hernia
- Rectal prolapse
- Idiopathic thrombocytopenic purpura
- Functional disorders
- Melanoma
- Carpal tunnel syndrome
- Keloid
- Desmoid tumour
- Erythrocyanotic (Bazin's) ulcer.

DISEASES COMMON IN CHILDREN

- All congenital abnormalities including malformations, embryological aberrations and genetic disorders

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- Tumours like neuroblastoma, Wilms' tumours, Burkitt's lymphoma, leukaemias, etc.
- Skin and soft tissue infections
- Middle ear infections
- Ingestion of foreign bodies.

DISEASES COMMON IN ELDERLY

- Most malignancies, especially carcinoma of breast in women
- Benign prostatic hypertrophy in men
- Atherosclerosis and related cardiovascular problems
- Diabetes and it's long-term complications
- Malnourishment and asthenia
- Constipation
- Loneliness and other emotional problems
- Osteoarthritis
- Senile cataract
- Alzheimer's disease and other cerebral disorders of senescence.

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3

Chief Complaints and History of Presenting Illness

Well, we have now come to the most important part of the history taking. A patient's history is indeed "his story". This story begins when the patient first experiences any of the symptoms which ultimately bring him to the hospital and leads right up to that day on which history is being taken. It is necessary to remember that history taking does not end with the patient getting admitted to the hospital. Many times a patient will have been in the hospital for weeks before the student gets to examine him. Indeed, he will have undergone tests and investigations about which he may tell you, if asked. These details may throw light on the probable diagnosis.

It is expected by now, one will have established a working relationship with the patient. Not too many patients enjoy being interviewed and examined repeatedly, least of all by beginners. It is indeed a delicate situation. The patient should be reassured that his predicament is understood by you and that you will do your utmost to make him comfortable. Of course, your actions should reflect your concern. Patient's sensibilities will have to be respected and anything that might cause pain either physical or emotional should be avoided, if at all possible. Questions related to patient's personal or marital life should be phrased carefully to avoid embarrassment.

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The most important thing to remember while taking history is that the patient may not tell you the full story. He or she will have their reasons for suppressing parts of history. For example, the patient may not be very intelligent and hence may not understand your question fully. He might just tell you the symptom that bothers him most and keep quiet. This requires rephrasing the question in simpler terms. Remember, it is the less intelligent patients who test your history taking skills and not the intelligent ones. Remember also that occasionally patients might not reveal some facts are as they are embarrassed or think those facts are irrelevant. Some patients might have gone to other doctors before seeing you and may not reveal it as they feel it might offend you. It is up to the watchful clinician to ferret out all such useful information that the patient might have. Others may suppress some facts as they fear that if they tell everything they will be diagnosed to have a serious disease! At the other end of the spectrum are malingerers and oversmart patients who knowingly give false history. These are usually patients who want to shirk work and hence are looking for a gullible doctor to get a medical illness certificate. Well, sickness absenteeism is already a problem plaguing the economy of the country. Try not to add to it! With experience, it will be possible to spot them as their history will not conform to any known disease pattern. And of course, there will be an occasional patient who genuinely believes he has a problem in spite of not having any. In the face of such varied patient profile a clinician has to wear a detective's hat also, from time-to-time.

How do we start collecting history then? You can start by simply asking questions like "Mr Ramappa, what bring you to the

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Pocket Manual on

The Art of History Taking

Salient Features

- A concise but informative text
- This edition is thoroughly revised and updated
- Presents the art of history taking from surgeon's and clinician's points of views
- Gives clear indication as to the potential areas of impediments to communication within an hospital set-up, allowing planning of corrective measures
- Develops good communication skills amongst the readers
- Useful for the medical students, teachers, budding as well as practicing clinicians and surgeons.

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