Taking a Medical History
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Most medical diagnoses are made on the basis of the medical history.
The physician-patient relationship develops from the medical history.
History taking is the most important clinical skill.

Objectives
• Describe the characteristics of an effective interview
• Describe patient-centered interviewing
• Describe the content of the medical history
• Describe the process of a taking a medical history, with attention to appropriate use of interview techniques.

Understanding Exactly – the effective interview
• Objectivity – validity
  - remove one’s own beliefs and biases;
  - requires active listening and feedback to patient
  - avoid premature interpretation
• Precision – words are the basic measurement of measurement in an interview. The data obtained from the interview is only as good as the understanding of the meaning of the words used.
• Reproducibility – the history obtained by one interviewer should be equivalent to that obtained by another. This is often not the case (as you will experience).

Working to develop and demonstrate the following attitudes will help you become a more effective interviewer.
• Respect
  – Value an individual’s traits and beliefs
• Genuineness
  – Be yourself, both personally and professionally
• Empathy
  – Understanding and sensitive appreciation of another person
  – Communication of that understanding back to the patient

Biomedical model
Understands disease and aberrant behavior as deviations from normal physiological functioning. Ignores psychological, social, cultural, spiritual context.

Patient-Centered Model
Integrates the biomedical model and the biopsychosocial model. Understands disease in the broader context of an individual’s unique experience of illness. This includes an
understanding of the patients psychological, social, cultural and spiritual values and beliefs, and how these influence, and are influenced by, the patient’s disease.

**Patient-Centered Interviewing**

- Parallel search of two frameworks – both equally important
- Illness framework (Patient)
  - ideas, concerns, expectations, feelings, thoughts, effects
  - understanding patient’s experience of illness
- Disease framework (Physician)
  - symptoms, signs, investigations, underlying pathology
  - differential diagnosis
- Integration of two frameworks leads to finding COMMON GROUND
  - Nature of problems and priorities
  - Goals of treatment
  - Roles of Doctor and Patient
  - *SHARED UNDERSTANDING AND DECISION-MAKING*

**Who Controls the Interview?**
Interview progresses from patient centered (and controlled) to physician centered
The control of the interview may revert back and forth between physician an patient over course of the interview
Dysfunctional interviews – eg, rambling patient, or highly controlling physician.

**Patient-centered Interview**

- Associated with:
  - Patient satisfaction
  - Better patient outcomes
    - symptom resolution
    - fewer follow-up visits for symptoms
  - Patients less likely to switch physicians
  - Lower chance of malpractice suits

**Content of Medical Interview**

- Chief Complaint
- History of Present Illness
- Past Medical History
- Family History
- Social History (Patient Profile)
- Review of Systems
Setting the Stage

• Common courtesies show respect for patient
  – Knock
  – Introduce yourself, and purpose of interview
  – Be friendly, but courteous - use the patient’s name

• Attend to the patients comfort and privacy

Chief Complaint

• The main reason patient presents for care
• Identifying the patient’s agendas
• Be alert for hidden agendas
• Defining the “iatrotropic stimulus” can help clarify purpose of visit
  – What motivated the patient to come to the office/ ER today?

• In only 23% of office visits were patients allowed to complete their opening statement
  – On average, physicians interrupted 4 times, used closed questions 46% of time, interchangeable responses 35% of time.
  – Only 1 of 51 patients who were interrupted completed opening statement
  – Order in which patients present complaints not related to clinical importance

Let the patient do the talking

• Minimal facilitators “uh huh,” “mm hmm”, “OK”
  – most likely to allow patient to complete opening statement
  – use of non-verbal communication techniques also important

Chief Complaint - Defining agendas

• Screening
  – Checking with patient if there are other issues.
  – “Is there anything else you wish to discuss today?”

• Confirmation
  – Confirm and clarify understanding of patients concerns for the patient.

• Negotiate agenda for session
  – Allows patient to prioritize problems
  – Helps to establish therapeutic partnership

History of Present Illness

• Thorough elaboration of the chief complaint and other current symptoms
• Patient-centered interview
  Develop thorough understanding of the patient’s illness
  Focus on the context and patient’s understanding of the illness, in addition to the “disease.”
- Exploration of the disease
  - What are patient’s feelings about the disease?
    - ie, what is patient’s emotional response to illness – fear, distrust, anger, sadness, ambivalence?
  - What are patient’s ideas about illness?
    - Patient’s understanding of disorder and its cause. Patient’s ideas about reasonable treatment.
  - How does the patient experience this illness?
    - How has illness affected patient functionally? How has it affected relationships? What is its symbolic meaning?
  - What are patients expectations?
    - What does the patient want from the physician. What are values and fears? What does patient want today? In long run?

- Who is this patient?
  - What are the patient’s interests, work, important relationships, values, major concerns?

- Obtained using combination of open-ended and directive questions
- Simultaneously develops information about patient’s life setting and the symptoms

- Physician-centered interview
  – Chronological account of disease
  – Thorough symptom description
    • Qualitative and quantitative description
  -- Leads to differential diagnosis

- Open ended questions
- Directive open-ended questions - seven “Wh” questions
  - Where is it on your body? Where does it go? (location)
  - What does it feel like? (quality)
  - How bad is it? (severity)
  - When did it start? (timing)
    - Does it come and go, or does it stay?
    - How long does it last? How often does it come?
  - When does it occur? (setting/context)
  - What makes it better or worse? (modifying factors)
  - What other symptoms do you have with this? (associated symptoms)

- Describing pain
  - Quality – nature of pain gives underlying clue about underlying pathology
  - Severity – useful to use semi-quantitative or quantitative scale
    Mild, moderate, severe, excruciating
    On a scale of 1 to 10, where 1 is very mild pain, and 10 is the worst pain imaginable, how bad is your pain?
• Laundry list/menu questions
  Useful when patient has difficulty describing symptom. Be careful to avoid too many choices. Avoid forcing patient to use description that may not be accurate. “Is your dizziness more like you feel you are about to faint, the room is spinning around, or something else?”

• Directive or close-ended questions
  – Clarification of unclear meaning
  – Provide additional detail
  - Hypothesis testing – interviewer develops hypotheses about cause of illness, why patient responds to illness a certain way, etc., uses directive questions to explore hypotheses.

• Avoid leading questions - your head doesn’t hurt, does it?
• Avoid multiple questions – do you have stomach pain or diarrhea?

• Clarify uncertainties/ambiguity
• Summarize
  – Feedback to patient your understanding of story
    • you have story straight
    • provides focus
    • provides organization
    • allows for transition
• Confrontation
  – Pointing out discrepancies
    • in the story, behavior, verbal/non-verbal communication
    • clarifies discrepancies

References


