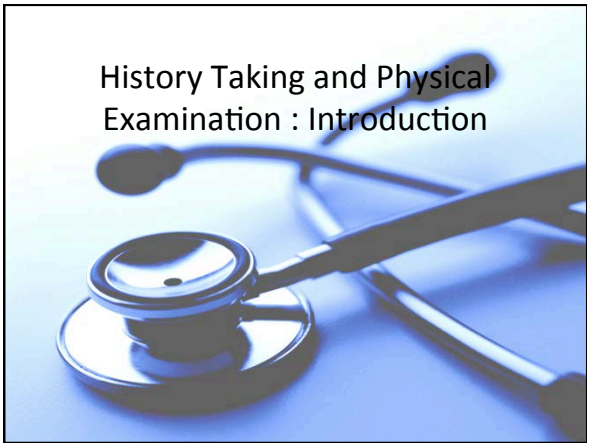
History Taking and Physical Examination : Introduction



Your ability to gather a sensitive and detailed history and to perform a thorough and accurate examination deepens your relationships with patients, focuses your assessment, and sets the direction of your clinical thinking.

The quality of your history and physical examination governs your next steps with the patient and guides your choices from the initially bewildering array of secondary testing and technology.

- Systematic Approach
- History shortens the differentials
- Clinical examination shortens the list further
- Investigations might be required at times for accurate diagnosis
- We begin with History, then Examination and then the required lab tests and investigations.

Presenting Illness

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D/D s: **********

↓ History Taking

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↓ Physical examination

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↓ Investigations

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Final Diagnosis

Effective communication skills positively influence health outcomes

- Active listening helps the doctor recognize what is wrong
- Patient satisfaction is improved if patients understand what is wrong and what they can do to help.
- Treatment of patients is not the order-sheet from the doctor. Rather, it's a mutual plan formulated by the doctor and the patient after a thorough discussion (cafeteria approach) ; and, it is the patient who has the final say.
- Patient participation in management is a must. And the importance of good communication and rapport building can not be further emphasized.

BLISS: The stages of consultation

Beginning	**Preparation** **Setting** **Introductions**
Listening	Problems Ideas Concerns Expectations Clarify, Summarize
Information gathering	Systematic enquiry **Clinical examination**
Sharing information	Chunk it Check it Share decisions
Setting Goals	Ending Follow-up

- Where will you see your patient?
- Quite, private space
- Respect privacy and patients' dignity in all circumstances
- Introduce your colleagues to the patient if they are to be present with you during the consultation.

How long should a consultation last?

- New patient: 20-30 minutes
- Old patients:
  - USA : 15 minutes
  - UK : 10 minutes
  - Nepal: It depends
- Students: 30 minutes- 45 minutes
- This generally depends whether it is first visit or a follow-up.
- Best answer: Be flexible. Do as the case warrants

How will you sit?

- Non-confrontational way ("not" at exact opposite ends of the table)
- Can avoid table altogether. If you use one, arrange the seats at the corner of the table.
- Should be at the same level as the patient. That shows equality.
- Good eye contact
- You should have an easy and quick access to the door(way out) ☺

Non-Verbal Communication

- Your attitude
- Demeanour
- Dress

- After you meet a patient, you won't ask the patient immediately to start describing his problems. There are preliminaries that will ease the patient and that begins with non-verbal communication. Begin with a smile (I don't mean that you go the patient and start smiling and laughing at him while he is intense pain/ Just be flexible; But, you should be presentable and approachable), then you introduce yourself.
- Then the patient will introduce himself and you continue further.
- But, before you begin with History Taking and start discussing the problems, you should try your best to make the patient comfortable with you.

http://xnet.kp.org/permanentejournal/fall99pj/habits.html

Four habits model of successful clinician-patient relationship.

History Taking

- 2 ways:
  - Ask the patient to describe his problems.
  - First get some background information (preferred one)

Components of history taking:

1) Observing
2) Listening
   - ICE : **I**deas , **C**oncerns, **E**xpectations
3) Questioning
4) Note taking
   - Try to keep eye contact as much as possible

Observing

- Observe at patients:
  - General Demeanour
  - Presentation (Is he well presented ?)
  - Intelligence
  - Dressing, etc
- Disabilities : Physical or Mental

Listening

- First, listen to patients own story in his own words.
  - Ask him : "How can I help you taday?" or "What brings you here today?" and then let him describe everything.
  - As far as possible, do not interrupt when the describe their problem.
- "Active Listening" : Encourage patient to talk by
- Looking interested (have eye contact/ nod your head)
- Making comments like " tell me bit more", "uhuh", etc.
- **ICE: I**deas, **C**oncerns and **E**xpectations
  - Knowing these is important for better patient response and follow up.

Questioning

- Always begin with open ended questions
  - Eg: "Always ask What is the problem- can you describe it?"
  - Rather than "Are you having headache?"
  - "Tell me more about your headache " is preferred over individual questions like "What aggravates your problem?", "Where exactly is the pain?".
  - Then the missed information can specifically asked afterwards.
- Avoid leading questions as much as possible.
  - Eg: "Have you noticed any diurnal variation?" preferred over "Do you have more headache in the evening?"
  - Remember: Specific/closed ended questions/ Leading questions can always be asked to clarify your doubts. But, avoid them as much as possible.
  - In fact, direct/leading questions are essential component of sensitive history taking

Note Taking

- Make as much eye contact as possible
- Note down relevant things (asking the same question time and again can irritate the patient)
- Make the full account of what the patient says after listening to him properly is the best rather than noting everything as soon as the patient says.
- And then, the question is how much you can recall afterwards. Missing out on something is detrimental.
- So, again, "Flexibility" is the key

Contents of History taking:

1) Particulars of the patient
   - Name
   - Age
   - Sex
   - Religion
   - Social Status
   - Occupation
   - Residence
   - Mostly this information is gained from record sheets, patient files. But first hand information is invaluable. And you have no options at the first visit. Even at follow ups, things can change.

Presenting Illness

- Ask about the duration of the complaint. (For how long has the patient had the complaint)
- List them in chronological order if there are many presenting problems.

History of Presenting illness

- From the beginning of the symptoms till the time of examination

1) The mode of onset
2) The progression of the disease
3) Precipitating factors/ Aggravating factors/ Relieving factors, if any
4) Describes how each symptom developed

5) Includes patients thoughts and feelings about the illness.
6) Associated complaints
7) Treatment history

Past History

- All the diseases suffered by the patient, irrespective of whether you think it is relevant to the presenting illness.
- Should be listed in chronological order
- Past medical and surgical history both should be included

Drug History

- Any treatment he is on for the current illness
- Any drugs the patient taking for any other illness (more important in elderly)

History of Allergy

- Drug allergy
- Allergy to anything else (latex, food, danders, etc)

Personal History

- Smoking (cigarettes, cigars, pipes)
  - Duration of consumption, frequency
- Alcohol
  - Duration of consumption, amount of consumption, frequency
- Any other illicit drug consumption
- Diet – Vegetarian, Non-veg
- Marital History
- Sexual History
- Menstrual History in females
- Weight loss??
- Appetite
- Occupational History

Family History

- Similar illness in the family
- History of any chronic illness in the family
- Many illness run in families: Diabetes, Hypertension, certain cancers, hemophilias, etc.

At times, further information from third party may be required.

PHYSICAL EXAMINATION

Physical Examination

1) General Examination
2) Specific/ Systemic Examination

General Examination : Nutshell

- Mental and emotional state
  - Agitated, cheerful, distressed, confused
- Physical Appearance
  - Frail, drowsy, breathless
  - Undernourished, cachectic, obese
- Physique
  - Height, weight, waist

- Head and Neck
  - Facies:
    - Masked: Parkinsonism
    - Adenoid facies : Adenoid hypertrophy
    - Moon face: Cushing Syndrome
    - Risus Sardonicus: Tetanus
  - Head shape and size:
    - Hydrocephalus
  - Sinuses:
    - Sinusitis
    - Mastoiditis
  - Lymphatics and Salivary glands
    - Distended Lymphatics : Lymphatic blocks (cancers)
    - Salivary Gland tumors
  - Thyroid gland
    - Hyperthyroidism, Thyroid tumors
  - Venous congestion
    - Superior Vena Caval Syndrome
  - Webbed neck with Lymphatic congestion: Turner syndrome

- Skin:
  - Cyanosis, pallor, jaundice,
- Chest:
  - Breast: Mastalgia, supernumerary nipples, any mass
  - Shape :
    - Pectus excavatum : Marfan Syndrome
    - Pectus carinatum : Marfan, Noonan, Trisomy 18, etc.
- Abdomen :
  - Ascitis
  - Hepatomegaly
  - Hernias

- Pelvis and Genitalia :
  - Hydrocele
  - Hernias
  - Prostatomegaly
- Limbs:
  - Upper limbs:
    - Finger clubbing
    - Abnormalities of skin and nail
    - Polydactyly : Patau syndrome (Trisomy 13)
    - Simian crease: Down's syndrome (Trisomy 21)

- Lower Limbs:
  - Bow legs: Rickets
  - Distened veins: Varicose veins
  - Warm red legs: DVT (?)
- Lymph Nodes:
  - Characteristics and site
  - Matted and generalised: Tuberculosis
  - Rubbery and generalised: Lymphomas
  - Localized tender: Infectious, acute
  - Localized hard: Rule out carcinomas

Systemic

- Cardiovascular System
- Respiratory System
- Abdominal System
- Central Nervous System
- Musculo Skeletal System
- Genito Urinary System

Cardiovascular System

- Pulse: Rate, Rhythm, character and volume
- Blood Pressure
- Jugular Venous Pressure (JVP) height and character
- Ankle edema : +nt/-nt ; level of edema
- Apex beat position, character, presence of thrills
- Heart sounds : any added sounds/ murmurs/ type of murmurs and their grades
- Peripheral pulses and bruits

Respiratory System

- Any chest wall deformity
  - Barrel chest in COPD
- Trachea central or deviated
  - Mass effect, lung collapse, tension pneumothorax
- Signs of hyperinflation
  - Emphysema
  - Foreign body aspiration
- Chest expansion and its symmetry
  - Nerve damage, Lung collapse, Pneumothorax
- Breath sounds
  - Symmetrical
  - Any added sounds
  - Type of added sounds
  - Location of added sounds

- Percussion note :
  - If any abnormalities
  - Type of abnormalities (hyper-resonant or dull – stony/woody)
  - Site of abnormalities
- Vocal Resonance
  - Any abnormalities
  - Type of abnormalities
  - Site of abnormalities

Abdominal System

- Abdominal system is not a system as such. Kept together for convenience.
  - Gastro intestinal System
  - Hepatobiliary System and Spleen
  - Renal System
  - Genitourinary System

Gastro intestinal System and Hepatobiliary System:

- Begins from mouth and ends at anus
- Mouth:
  - Teeth/ dentures, caries – Ludwig's angina/ Cause of sinusitis (!!)
  - Ulcers : Aphthous ulcers, Crohn's ulcer
  - Salivary gland problems : Duct obstruction, sub-lingual gland problems, dry mouth
- Pharynx : Not much to examine under GI.
- Esophagus: Can't be examined clinically. (Esophagoscopy, Barium meal/follow through)

- Abdomen:
  - Inspection:
    - Fetor Hepaticus (in fact, comes under observation and not examination)
    - Scars , if any. Site of scars.
    - Shape of abdomen : distended or scaphoid
    - Hernial orifices
    - Ascitis, if present
    - Distended veins of the abdomen
    - Persitaltic waves if there is severe obstruction (early in the process)
    - Stretch marks in cushing's

- Auscultation
  - Normal bowel sounds
  - Hunger pangs/ borborygmi
  - Increased bowel sounds in obstruction (in partial, initially in full obstruction)
  - Absent bowel sounds : peritonitis
  - Bruits present (vascular system)

- Palpation
  - Tenderness- Rule: If tenderness is present, begin from the area exact opposite and come to the tender area at last. Be gentle always.
    - Localised : Appendicitis, mesenteric lymph adenitis (shifting)
    - Generalised: Perforated abdomen, peritonitis (types)
  - Rebound tenderness
    - Guarding
  - Distension
  - Hernial orifices
  - Masses and description of the masses, if any

- Palpation contd…
  - Liver span (combination of palpation of abdomen and percussion of chest !!)
  - Liver tenderness in hepatitis
  - Spleen enlargement
  - Cholecystitis (murphy's sign)
  - Ascitis:
    - Shifting dullness
    - Fluid thrill

- Percussion
  - Distension
    - Gaseous : Resonant
    - Fluid: Dull
  - Ascitis:
    - Shifting dullness
    - Fluid thrill

Specific organs

- Stomach : Generally not palpable
  - Palpable in cases of:
    - Gastric outlet obstruction
    - Gastric masses
    - Palpable pylorus in Hypertrophic Pyloric Stenosis
    - In gastric outlet obstruction, we can even palpate the waves of contraction.
- Small bowel :
  - Palpable like a sausage : intussesception
  - Distension
  - Appendicitis : signs of appendicitis

- Rectal examination :
  - Examination of prostate
  - No abdominal examination is complete without rectal examination
  - Fecal occult blood testing
  - Empty rectal vault? Filled?
- Genitalia examination (will be covered seperately)

- Renal System : We do not have much to do with examination.
  - Kidney masses : tumors, hydro nephrosis
  - costo-phrenic angle tenderness.
  - Palpable bladder
  - Renal bruit (as a cause of secondary hypertension)

- Genito-urinary:
  - Hydrocele,
  - Penile disorders – balanitis, phimosis, paraphimosis, any disorder of shape, etc
  - Cancers : penile carcinoma, vulvar carcinoma, seminoma, etc
  - Discharges: vaginitis, balanitis, etc
  - Prostatomegaly

Musculo Skeletal System

- Gait
- Any obvious deformities
  - Amputations
  - Deformities in the joints and bones
  - Rheumatoid arthritis
  - Fractures/ malunion/ malalingment
  - Dislocation of joints
- Muscle or soft tissue changes
  - Swellings
  - Inflammations
  - tenderness
  - muscle atrophy/ hypertrophy

- Spine
  - Range of motion
  - Any deformities/ dislocation
  - Tenderness
- Joints:
  - Obvious deformities
  - Dislocations
  - Range of motion
  - Crepitus
  - Tenderness
  - Inflammed

Central Nervous System

- Mini-mental score
- Glasgow-Coma Scale (GCS)
- Intelligence
- Mood
- Speech
- Orientation (time, place and preson in sequence)
- Memory
- Judgement and reasoning

- Cranial nerves
- Pupils : ARP, Marcus gunn pupil, PERLA (pupils equal and react to light and accomodation)
- Fundoscopy
- Tremors – intention, resting
- Fasciculations
- Gait – waddling (myopathic gait) , high stepping, narrow, antalgic
- Handedness (can be in history as well)

- Sensory:
  - Touch, pain, temperature
  - Vibration
  - Two point discrimation
  - Joint position
  - Sterognosis
- Motor
  - Bulk
  - Power
  - Tone: altered tone, clonus
  - Involuntary movements
  - Reflexes
- UMN lesion Vs Lower motor lesion

Cerebellum

- Tone
- Romberg's sign (in fact not a cerebellar sign)
- Co-ordination :
  - Finger nose test
  - Heel-shin test
  - Dysdiadokinesia

Cerebellar signs

- Nystagmus
- Staccato speech
- Dysmetria
  - Finger nose test
  - Heel- shin test
- Dysdiadochokinesis (it's a test that will be +ve in cerebellar diseases)
- Ataxia

- Intention tremors
- Spasticity
- Pronator drift