

## Clinical History and Physical Examination

### Why do we do a history and physical exam?

- The history and physical examination are at the heart of the diagnostic and treatment process.
- The history is the first step in developing a relationship with the patient.
- It is your chance to make a good “first impression” and sets the stage for your role in the patient’s health.
- Do you know what percentage of the diagnosis comes from the history?

### Questioning: The basics

- **The most important part of questioning is listening!** Many people are too involved constructing their next question instead of listening to the answers.
- Determine the reasons for asking the questions. Be sure it is known what is to be gained by asking questions.
- Do not ask too many questions.

### Closed questions

- The doctor controls the conversation with fixed and limited number of responses
- Can be used at the beginning of an interview to “break the ice”
- You **can** ask too many closed-ended questions
- **Health professionals who ask closed questions to which the patient responds with one-word answers find themselves asking more and more questions and paying less and less time listening to the answers**

### Open questions

- Open-ended questions give the respondent the opportunity to respond in any way they wish
- There is often no right or wrong answer and elaboration is encouraged
- Advantages:
  - The respondent is free to discuss what he views as relevant
  - The doctor can participate in active listening
- Disadvantage:
  - People can ramble! (But don’t stereotype about the elderly)
  - Well-timed closed questions can bring rambling to an end

- You will most likely (naturally) use a combination of open and closed questions, allowing the patient to predict the “direction” of the conversation
- Beginning and interview with an open question and gradually becoming more specific is termed “funneling”, and is an appropriate technique
- By not providing a logical sequence of questions, the patient can become disoriented and confused

## Setting the Stage

- What should the interview space look like for this intimate experience?
- What are the vital pieces of equipment for this process?
- Who should sit? Who should stand?
- How should you place yourself with reference to the patient?
- How do you manage time?

## The History/Clinical Interview

- Introduce yourself (clinic vs. practice)
- Address the patient properly (don't patronize)
- Begin by letting the patient "spill it", but then refine the details

## History/Clinical Interview

- **Patient Name:** Name, middle name, last name, maiden name; previous names, aliases, etc.
- **Patient Age:** Stated age versus chronological age; supporting documents.
- **Date of Birth**
- Also document the place of birth (city/county, state/province, and country).

## History/Clinical Interview

- **Patient Gender:** If appropriate, document genetic sex, physical sex, and psychological sex; history of sex change (surgeries?).
- **Marital/Relationship Status:** Is the patient single, married, partnered, widowed, divorced, etc.?
- **Address:** Update current address.
- **Telephone:** Area code and telephone number of home and office, cellular phone, and email address if applicable.

## History/Clinical Interview

- **Patient Race:** Document the patient's race and cultural and/or religious background
- **Occupation:** Document occupation and physical and emotional demands of occupation

## History/Clinical Interview

- The next step is the **Chief Complaint (CC)**
- This section covers data about the main problem, the reason the patient seeks your help. The problem (s) that bring the patient to the physician should be recorded in the patient's own words ("use quotation marks liberally").
- **CC** should include:  
"This xx-year-old, race, sex, ...complaint"
- What are some good phrases to use to elicit this information?

## History of Present Illness (HPI)

- In this section, you get more information about the CC
- There are several memory aids (mnemonics) to help remember the steps
- Traditionally, we use “OPQRST” to help us remember what we need to cover, but this doesn’t get us all the information (use as a back-up method)

## HPI

- **Onset:** How did this happen or what caused it?
- **Provocation:** What makes it worse?
- **Quality:** What does it feel or how does it feel?
- **Remission:** What makes it better?  
– (also seen as **Radiation:** Does it travel?)
- **Severity:** How bad is the pain?
- **Temporal Factors/Time:** When did this occur?  
Has it changed over time?

## HPI 18 specifics

- There are 18 questions that you may ask about a complaint that helps you cover the “OPQRST”
- This is our **preferred** method of history-gathering
- You should memorize these 18, but understand that modification of them may be necessary per patient and per “complaint”
- Also, when you can’t remember the 18, the OPQRST will get you through

## What if the patient has more than one CC?

- You will need to document the HPI for **EACH** chief complaint
- Should you use separate forms?
- Do you have to handle them all at once?
- Remember that you may need to modify the 18 questions as appropriate for the CC  
– (HA vs. LBP)

- When or approximately when did it start?
- Did it begin gradually or suddenly?  
If gradually, over what period of time? How long to develop?
- Did anything cause or contribute to the onset?
- Have you ever had anything like this before?  
If yes, did it feel the same? What was the outcome?
- Can you point to the exact location of your symptom(s)? Describe.
- Does it travel (radiate) to any other part of your body. Describe.
- Do you have symptoms in any other part of your body?
- Can you describe the sensation? (dull, sharp, burning, aching, gnawing, throbbing, shooting, constricting, other)
- How would you describe the intensity? (mild, moderate, severe, other; 1-10 scale)
- Has it been constant or does it come and go? (Constant, intermittent, episodic)
- Has it been getting better, worse, or staying about the same?
- Have you found anything that makes it better? (rest, morning, evening, certain position, other)
- Have you found anything that makes it worse? (Positions, activities, morning, evening, coughing, sneezing, straining, other)
- Has there been a change in any bodily functions? (Urination, defecation, respiration, digestion, vision, sexual, other)
- Has it affected your daily activities in any way?
- Have you tried store bought or home remedies?  
If yes, what was the effectiveness?
- Have you sought other professional care for this condition?  
If yes, what was the effectiveness?
- Is there anything else you would like to discuss or that would be important for me to know?

## Past Health History (PHH)

- 1. How would you rate your overall health? (Poor, good, excellent, other)
- 2. Have you gained or lost weight in the last year? (Amount and why)
- **MEDICATIONS:**
- 3. Do you take any medications or supplements?
  - a. Over the counter (aspirin, decongestants, vitamins)
  - b. Prescription (birth control, blood pressure)
  - c. Other drugs (alcohol, tobacco, recreational drugs)
- **ILLNESSES:**
- 4. Have you had the measles, mumps, chicken pox, or any other childhood disease?
- 5. Have you had any other significant diseases or allergies **in the past**?
- 6. Do you suffer from any diseases or allergies **currently**?
- **SURGERIES:**
- 7. Have you had any surgical procedures? (tonsils, appendix, hernia, Caesarian, transfusions)
- **TRAUMAS:**
- 8. Have you had any injuries, accidents, broken bones, bad falls or blows to the head or body?
- 9. Do you use any supports, braces, wraps, heel lifts?
- Mnemonic: MIST (or 2+MIST)

## Occupational History (OH)

- 1. Does your current job require you to primarily sit, stand, walk, other?
- 2. Does your current job require lifting and/or twisting?
- 3. Does your job involve jarring or jolting forces to the spine or extremities? Vibrating machinery?
- 4. Does your job require your head or body to be bent forward, backward, to the side or twisted repeatedly or for extended periods?
- 5. Do you currently or have you ever worked or lived somewhere where you were exposed to toxic metals, gases, fumes, dusts, radioactive material or chemicals?

## Social History (SH) & Habits (mnemonic--BRED)

- 1. Is your job stressful? How would you rate it on a scale of 1-10?
- 2. Is your home or personal life stressful? How would you rate it on a scale of 1-10?
- 3. How do you use your spare time? (sports, reading, hobbies, etc.)
- **BEVERAGES:**
- 4. Do you drink any of the following on a regular basis – coffee, tea, alcohol, sweetened juices, carbonated beverages, milk, water? (Frequency and amount)
- **REST:**
- 5. Are you getting adequate sleep? How much?
- 6. What type of sleeping surface do you use?
- 7. Do you sleep primarily on your back, side or stomach?
- 8. Do you read, watch TV, or relax with your neck or back bent?
- **EXERCISE:**
- 9. Do you have a regular exercise program? (What and frequency)
- **DIET:**
- 10. Do you have a balanced diet of fruit, vegetables, meat, roughage, fish, fowl, dairy products?
- 11. Are any of the following a main part of your diet? Sugar, oils, fats, salt? (Frequency and amount)

## Family History (FH) & Marital History (MH)

- **FAMILY HISTORY (FH):**
- 1. Is your father in poor, fair, good, excellent health? If deceased, why?
- 2. Is your mother in poor, fair, good, excellent health? If deceased, why?
- 3. Are your siblings in poor, fair, good, excellent health? If deceased, why?
- 4. Do any of your family members have any diagnosed conditions? Explain.
- **MARITAL HISTORY (MH):**
- 1. Are you married, single, divorced, with or without children?
- 2. Is your spouse in poor, fair, good, excellent health?
- 3. Are your children in poor, fair, good, excellent health?
- 4. Do any of your children suffer from diagnosed conditions?

## Review of Systems (ROS)

- The ROS is usually a checklist or questionnaire that the patient completes to give the doctor an overall impression of the patient's general health and to highlight symptoms in other systems of the body not uncovered by the history
- The doctor should inquire about any positive symptoms the patient indicated on the form
- **It is not a form to be completed and then ignored by the doctor**
- Can be very valuable to tie together multiple system involvement by a disease process
- Remember, the patient doesn't have the knowledge to tie together her onset of back pain with changes in gastrointestinal function, but the doctor does!

## Probing questions

- Sometimes it is necessary to encourage or prompt patients into talking when they fail to do so spontaneously
- Probes and prompts are verbal tactics used to spur on conversation or to clarify situations
- Probing questions are okay, but...
  - be sure they don't result in leading questions

## Leading questions

- There are 3 main types of leading questions:
  - Conversational lead: reflects common opinion or views already held
  - Pressurized agreement: puts pressure on people to agree with the questioner
  - Hidden subtleties: leads the patient without his or her knowledge
    - Loftus (1975): headaches
    - Loftus & Zanni (1975): "the" and "a"