GENERAL PRINCIPLES

Overview

Medical students are often told that ‘90% of the diagnosis is in the history’. Although there is a large amount of truth in this statement, this is only the case if your history-taking skills are focused, accurate and relevant. This, in turn, is largely dependent on your bedside manner and your ability to build up a good rapport with your patient.

There is no easy recipe for developing a good bedside manner, but courtesy, patience and letting patients express their ideas, concerns and expectations are essential ingredients. Whenever you meet a patient, introduce yourself politely and do not forget relatives or friends who may also be present. Try to put the patient at ease, as visiting the doctor is very stressful for most people, particularly if they think that they have a serious illness. If you cannot speak the same language, try to get an interpreter. Language Line solutions, a telephone-based translation service, is a useful resource; avoid using members of the family as interpreters. If a patient has hearing difficulties, sit closer or write things down.

The aims of history taking are:

- to establish rapport with the patient;
- to obtain an accurate, sequential account of the patient’s symptoms through open questions and make a differential diagnosis;
- to ask specific questions to focus on the most likely diagnoses;
- to determine risk factors for these possible diagnoses;
- to put this problem or problems into the context of the patient’s life.

This chapter provides a framework for taking a comprehensive history. However, the important thing is that you develop an approach with which you are comfortable and then practise it. In this way, you will not miss things, and you will be able to concentrate more on what the patient is telling you rather than what comes next. With experience, you will recognize patterns and explore different avenues in the history.

Make sure not to miss nonverbal clues, as facial expression and body posture can sometimes tell you more than the words themselves. If you are looking up, patients will also feel that you are genuinely listening to what they are saying. It is important to strike a good balance between recording the history accurately and maintaining eye contact.

As a general principle, start the consultation by asking very open-ended questions, such as ‘How are you?’ or ‘What problems have made you come to the clinic today?’ This gives patients the opportunity to say what they want. Then ask more specific questions to clarify important aspects.

Try to take the history and then write it down afterwards; this enables you to listen and appear to be listening without distraction, plus you can organize your thoughts before committing them to paper. However, when you are learning, it may be easier to make notes as you go along; you can also have prompts on your paper to enable you to fill in all sub-sections of this history detailed below. As you gain experience, you will find it easier to memorize the patient’s history and write it down later.

THE HISTORY

At the start of every history you should always:

- Document the date, time and place of the consultation. This should be done on both sides and each subsequent sheet of paper (remember that the clinical record is a legal document).
- Document your name, grade and role.
- Record the age, sex and occupation of the patient.
- Document who referred the patient and if the patient was seen as an emergency.

CLINICAL NOTES

With the move to electronic notes, some of these steps will be done for you. It is important that you use only your own computer log-in details, and if you move away from your computer you lock the screen so no patient information is on display.

A comprehensive medical history is detailed below. The separate headings help ensure a good flow and that information is not missed. Depending on the situation, the importance of each part of the history will differ; for instance, family history is crucial with genetic conditions, and a detailed social history is particularly relevant in the elderly. The history needs to be adapted to the situation; it is obviously unsafe and inappropriate to take a detailed history from an acutely unwell patient in the resuscitation unit of the emergency department.

Presenting complaint (PC)

This is a sentence or short list explaining the reason the patient has seen you today. Resist the temptation to write the entire history in this section, particularly when there are multiple symptoms; however, mentioning an obvious background condition can be helpful (e.g. ‘One week increasing
shortness of breath and productive cough. Background: 10-year history of COPD').

**History of the presenting complaint (HPC)**

This is where the presenting complaint is explored in detail. It is impossible to describe a system that will work for all complaints in every situation. You will need to develop your own techniques, likes and dislikes. Inadequate relevant detail in this section is the commonest problem in medical student histories:

- Aim to obtain a coherent, sequential chronological description of the events leading to the consultation.
- Ask the questions relevant to the symptoms (e.g. for pain, 'Where is it?', 'What is its character?')
- Keep the differential diagnoses for a symptom in your mind and seek evidence to confirm or refute them.
- Use the review of symptoms questions for the system you suspect to fill in extra detail (e.g. if the complaint is a cough, ask about dyspnoea, pain, sputum, etc. and record it in the presenting complaint section).
- Ask about the relevant risk factors (e.g. if pulmonary embolus is suspected, ask about immobility, travel, etc.).
- Recapitulate the history to the patient, as this helps cement the story in your mind and reassures the patient that you are listening.
- If the history is long, or vague, using the opening question 'So when did you last feel well?' gives a platform to begin from.
- Seek collateral history from witnesses, friends or family where necessary (e.g. after a seizure). It is always worth asking patients first whether they mind you speaking to family or friends.
- With chronic complaints, it is vital to ask about how the symptoms are affecting the patient's life.
- Document relevant negative findings (e.g. headache, but no photophobia or neck stiffness).

Finally, ask if the patient has any thoughts or worries as to what the diagnosis might be; this can be very enlightening and will help you build a good working relationship as you will be addressing the patient's concerns. What the doctor is interested in and what the patient is interested in can be diametrically different.

**Past medical history (PMH)**

Ask the patient if he or she has had any previous operations or medical problems. It is prudent to probe a little about each illness and how the diagnosis was made. Previous histories are sometimes incorrect and can be carried forward from one hospital visit to the next. Record the history in chronological order and, where possible, record the year, hospital and consultant involved for each episode. Many patients may forget past illnesses, particularly if they are anxious, and it is worth developing a routine to ask them specifically about diabetes, hypertension, angina or heart disease, rheumatic fever, tuberculosis, epilepsy, asthma/emphysema/bronchitis, jaundice, stroke or transient ischaemic attacks.

**HINTS AND TIPS**

**MJTHREADS is a useful mnemonic for remembering to ask about specific medical conditions:** myocardial infarction, jaundice, tuberculosis, hypertension, rheumatic fever, epilepsy, asthma, diabetes, stroke.

**Medications and allergies (DHX)**

Record which medications the patient is currently taking, how often and at what dose. If the prescribed medications are not being taken, ask why. Ask if there have been any recent changes in medication. Always ask what drugs the patient has taken in the past. For example, a patient with pulmonary fibrosis caused by amiodarone may well have stopped taking it years before! Ask about any nonprescription medications or herbal remedies that the patient may be taking. Ask about illicit drug use, and whether the patient smokes or injects the substance.

Does the patient have any allergies to any medications or anything else at all, no matter how trivial? If yes, what was the exact nature of the reaction? Was it anaphylaxis or did the patient experience a rash? It is worth asking about penicillin directly as many patients state they have a penicillin allergy, but on being questioned more closely they may describe a nonspecific symptom, and a β-lactam antibiotic can be given safely if the need is there.

If the patient says he or she has no allergies, it is traditional to write ‘No known drug allergies’ (NKDA).

**Family history (FHX)**

Do any diseases run in the patient’s family—in particular, ischaemic heart disease, cancer, diabetes and autoimmune disorders? Record illnesses in close relatives, including age of death where relevant. Generally speaking, family members affected before the age of 60 years are deemed to be relevant. Drawing a family tree can be helpful in some patients.
Social history (SHX)

The importance of this part of the history is to establish how the illness affects the patient’s life and whether the patient is coping at home. It can provide important information on the patient’s baseline functional status, and this is key when one is considering whether it will be safe for the patient to return home. Ask:

- Who is at home? Do you have a partner? Is your partner fit and well?
- What is the home like? Is it a flat or are there stairs? Can you manage these? Do you leave the house, and how often? If the patient is in a home, clarify if this is a warden-controlled flat, a residential home or a nursing home as these offer different levels of support.
- Do you need help with daily tasks, such as washing, dressing, feeding, cleaning or shopping? Do you have carers or a nearby relative who helps? How often do they come, and what do they help with?
- Do you have dependent children? Who is looking after them now?
- Do you have any other responsibilities, such as caring for an infirm parent or pets?
- What is your occupation? Details of the patient’s past and present occupation can be important (e.g. industrial lung disease).
- Are you still able to work despite the current problem? Some diagnoses can be particularly important in relation to work, such as heavy goods vehicle drivers and epilepsy.
- Do you, or did you, smoke? Smoking is a significant cause of many diseases. Record smoking in pack-years.
- How much alcohol do you drink (past and present)? Record the number of units per week (Fig. 1.1).
- Have you recently been abroad, and if so, where? Was this urban or rural? Were you vaccinated?
- Do you have pets (particularly budgerigars, pigeons and parrots)?

Sexual history is not appropriate in every history but may be important (e.g. for hepatitis or human immunodeficiency virus infection).

Systems review (SR)

Patients occasionally focus on one minor symptom while omitting to tell you of another more significant symptom. In fact, this can be a deliberate act, asking the doctor to deal with a simple problem (e.g. sore throat) while deciding whether to ask for help with the real worry such as impotence or rectal bleeding. Performing a quick systems review will prevent you from missing other important diseases.

Some of these you will have covered in the history of the presenting complaint, and you do not need to ask about them again.

General symptoms

Fatigue

This is a nonspecific symptom that can accompany many organic as well as psychiatric diseases. Look particularly for evidence of anaemia or hypothyroidism.

Appetite

Anorexia is a feature of many diseases, again organic and psychiatric; increased appetite despite weight loss is seen in hyperthyroidism. Distinguish between reduced appetite, nausea and dysphagia.

Weight change

Weight loss can be deliberate (dieting) or due to chronic disease. The causes are discussed in detail in Chapter 13.

Weight gain is seen in pregnancy, hypothyroidism, Cushing syndrome, polycystic ovary syndrome and ‘comfort eating’ due to anxiety or depression.

Sweats

Drenching sweats occurring at night are seen in lymphoma, chronic leukaemia and tuberculosis. These are commonly referred to as B symptoms (including also weight loss and fever).

Pruritus (itching)

Pruritus can be due to local skin disease or systemic disease, as shown in Table 1.1.

Sleep pattern

If there is difficulty in sleeping, ask if the problem is in going to sleep or in waking early. Difficulty in getting off to sleep is often due to worry or anxiety, whereas early morning waking is a feature of depression. Sleep apnoea is common, and can be debilitating as excessive sleepiness limits daytime function. The commonest medical condition affecting sleep is obstructive sleep apnoea (see Chapter 28). Ask about snoring, whether sleep is refreshing, morning headaches and restless leg movements. The patient’s partner is often the best source of information.

Fig. 1.1 Units of alcohol. These refer to a standard pub measure of wine (12% alcohol by volume), a small pub measure of spirits (40% alcohol by volume) and standard strength beer (3%–4% alcohol by volume) and standard strength beer (3%–4% alcohol by volume) and standard strength beer (3%–4% alcohol by volume). An easy way to work out the units for a drink is to remember that the alcohol percentage is equivalent to the number of units in 1 L of the drink (e.g. 1 L of 40% whisky contains 40 units, and a 330-mL bottle of 6% lager contains 2 units).

1 unit = 2/3 small glass of wine

1/2 pint of beer, lager or cider

1 small measure of spirit

Units of alcohol

1 unit = 2/3 small glass of wine

1/2 pint of beer, lager or cider

1 small measure of spirit

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Cardiovascular symptoms

Chest pain
Establish the site, radiation, character, exacerbating and relieving factors and severity; this is discussed in detail in Chapter 4.

Shortness of breath (dyspnoea) and exercise tolerance
Exertional dyspnoea can be due to poor left ventricular function, pulmonary oedema, arrhythmia or valvular disease (see Chapter 27).

Orthopnoea is breathlessness on lying flat, usually from increased pulmonary venous congestion. This symptom can be present in diaphragmatic weakness and even in chronic obstructive pulmonary disease, as diaphragmatic input to ventilation is less efficient when the patient is lying flat.

Paroxysmal nocturnal dyspnoea is waking during the night because of severe breathlessness (pulmonary oedema).

Sudden onset of breathlessness, irrespective of body position or exercise, is often due to arrhythmia, pneumothorax or pulmonary embolism (see Chapter 5).

Taking a relevant exercise tolerance history is important. Ask the patient whether they can walk up a set of stairs (in one go, without being out of breath once upstairs) and how far they can walk on the flat. Remember that joint problems rather than cardiorespiratory reserve may be the limiting factor.

Loss of consciousness (syncope)
Syncope is the transient loss of consciousness and motor tone, which may be due to arrhythmia, valvular heart disease, postural hypotension or vertebrobasilar insufficiency (see Chapter 18).

Palpitations
Palpitations mean different things to different people, and they should be explored carefully as they may be insignificant or they may be life threatening. Most commonly they refer to awareness of one’s heart beating (see Chapter 7).

Respiratory symptoms

Dyspnoea
Clarify the degree of dyspnoea and its consequences for everyday tasks; try to separate respiratory dyspnoea from cardiac causes, although there is much overlap (see Chapter 5).

Cough
The causes of cough are multiple. Associated features will help in developing a sensible differential diagnosis (see Chapter 6).

Sputum
How much sputum is produced? Ask about its colour, texture and time course:

- yellow/green: usually infection, acute asthma (due to eosinophils);
- frothy: pulmonary oedema;
- rusty: lobar pneumonia (pneumococcal);
- blood: pulmonary embolism, lung cancer, pneumonia (see Chapter 6);
- taste: foul in bronchiectasis and abscess;
- smell: foul in bronchiectasis.

Chest pain
This needs a careful assessment of character, position, precipitating factors, etc. Chest pain is usually pleuritic in respiratory disease (see Chapter 4), and is potentially due to pneumonia, pneumothorax or pulmonary embolus.

Wheeze
Patients with airway obstruction sometimes notice an audible expiratory wheeze.

### Table 1.1 Causes of pruritus

<table>
<thead>
<tr>
<th>Cause</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin disease</td>
<td>Scabies, eczema, lichen planus, urticaria, dry skin (elderly, hypothyroidism)</td>
</tr>
<tr>
<td>Systemic disease</td>
<td>Hepatic (biliary obstruction, pregnancy)</td>
</tr>
<tr>
<td></td>
<td>Malignancy (particularly lymphoma)</td>
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<tr>
<td></td>
<td>Haematological (polycythaemia, iron deficiency)</td>
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<td></td>
<td>Chronic renal failure</td>
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<td></td>
<td>Drugs (sensitivity, opiates)</td>
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<td></td>
<td>Endocrine (diabetes mellitus, hyperthyroidism/hypothyroidism, carcinoid syndrome)</td>
</tr>
<tr>
<td></td>
<td>Parastic (trichinosis)</td>
</tr>
<tr>
<td></td>
<td>Neurological (multiple sclerosis)</td>
</tr>
<tr>
<td></td>
<td>Psychogenic</td>
</tr>
</tbody>
</table>

### Ankle and calf swelling
This can be due to right ventricular failure, low plasma oncotic pressure (e.g. decreased albumin levels) or drugs (e.g. calcium channel blockers), or it can be gravitational.

Calf swelling can be due to:

- deep vein thrombosis: consider underlying risk factors such as – recent travel, immobility or surgery, pregnancy, combined oral contraceptive pill use, family history, malignancy;
- ruptured Baker cyst: more common in the elderly and can be secondary to osteoarthritis of the knee;
- muscle trauma;
- cellulitis.

### Calf, thigh or buttock pain on exertion (claudication)
Intermittent claudication due to peripheral vascular disease causes calf, thigh or buttock pain on exercise. The amount of exercise required to cause pain tends to be consistent although it often deteriorates slowly. Pain is relieved within a predictable period of rest.

Spinal claudication due to spinal stenosis also causes calf, thigh or buttock pain on exertion, possibly by causing occlusion of the spinal arteries. However, the claudication distance tends to be variable.
Hoarse voice
This may be caused, for example, by recurrent laryngeal nerve palsy in bronchial carcinoma.

Gastrointestinal disease

Abdominal pain
Establish the site, radiation, character, exacerbating and relieving factors and severity. This is discussed in detail in Chapter 9.

Dysphagia
Dysphagia means difficulty in swallowing. Ask about:
• The onset and progression of symptoms.
• Where things get stuck. This may give a clue as to the site of the lesion.
• If there is difficulty with solids, fluids or both.
Neuromuscular disorders tend to present with dysphagia for fluids at onset, whereas mechanical obstruction results in dysphagia for solids at onset.

The causes of dysphagia are outlined in Table 1.2.

Nausea and vomiting
What does the vomitus look like?
• Yellow-green: upper gastrointestinal (GI) tract contents plus bile.
• Brown (feculent): lower small bowel contents.
• Bright-red blood: active upper GI tract bleeding (see Chapter 11).
• ‘Coffee grounds’: ‘old’ upper GI tract bleeding.

How ‘violent’ was the vomiting? Projectile vomiting indicates pyloric stenosis, most commonly seen in infants, but may arise because of duodenal ulceration in adults.

Indigestion
Heartburn or dyspepsia is due to reflux of the gastric contents into the oesophagus. Be aware that heartburn can easily be confused with cardiac chest pain. Always explore these symptoms carefully.

Change in bowel habit or stools
Has there been a change? Ask about diarrhoea and constipation, or the presence of one alternating with the other (see Chapter 12).

Is there any rectal bleeding? Is the bleeding with or without mucus? The causes of rectal bleeding are summarized in Box 1.1. Anal and rectal lesions result in fresh blood on the outside of the stool, on the paper on wiping or in the pan. Higher lesions result in blood intermixed with the stool. Melaena implies upper GI tract bleeding and the passage of altered blood originating proximal to the hepatic flexure.

Inquire about tenesmus. Tenesmus is the painful desire to defecate when there is no stool in the rectum. This is due to a lesion in the lumen or wall of the rectum mimicking faeces.

Jaundice and itch
Jaundice can be insidious or acute, and the patient may therefore not have noticed it. Ask the patient’s family or friends whether they have noticed a change in skin colour. Itching is caused by build-up of bile salts in the skin and is a feature of obstructive jaundice (see Chapter 14). It can be asked about directly and may even be evident on clinical examination through scratch marks. Jaundice may indicate liver function impairment and bruising, and should therefore be asked about directly as clotting factor biosynthesis may be impaired.

<table>
<thead>
<tr>
<th>Table 1.2 Causes of dysphagia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorder</td>
</tr>
<tr>
<td>Oropharyngeal lesions</td>
</tr>
<tr>
<td>Intrinsc oesophageal and gastric lesions</td>
</tr>
<tr>
<td>Extrinsic oesophageal compression</td>
</tr>
<tr>
<td>Neuromuscular disorders</td>
</tr>
<tr>
<td>Psychological</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BOX 1.1 CAUSES OF RECTAL BLEEDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemorrhoids</td>
</tr>
</tbody>
</table>
Abdominal swelling
Ask whether the patient has noticed a change in the size of the abdomen. Remember the seven F’s: foetus, flatus, fat, fluid, flipping great mass, faeces and full bladder.

Genitourinary symptoms

Dysuria
This is discomfort during or after micturition due to urinary tract infection or recent urethral instrumentation (cather or cystoscope).

Change in urine appearance
What does the urine look like?
- Cloudy: infection, precipitated urates or phosphates.
- Frothy: proteinuria.
- Orange: very concentrated urine, bilirubin, rifampicin.
- Red/smoky: haematuria, haemoglobinuria, myoglobinuria, rifampicin, blackwater fever due to haemolysis in Plasmodium falciparum malaria, eating beetroot.
- Dark on standing: porphyria.
- Green: drugs containing methylene blue (commercial analgesics).

See Chapter 15 for the causes of haematuria and proteinuria.

Frequency and nocturia
Increased frequency of micturition can be due to:
- bladder irritation: infection, stones, tumour;
- outflow obstruction: prostatic hypertrophy, urethral stricture;
- neurological causes: multiple sclerosis, cauda equina syndrome.

In polyuria there is an increased volume of urine as well as increased frequency of micturition.

Nocturia can be due to any of the causes of polyuria (see Chapter 15) and increased frequency.

Hesitancy
Hesitancy followed by a poor stream with terminal dribbling is a feature of prostatic enlargement. These symptoms are often associated with benign prostatic hypertrophy, but could indicate carcinoma of the prostate.

Loin pain
This can be associated with a renal calculus or a pyelonephritis (see Chapter 15).

Incontinence
This can be either urge incontinence (e.g. detrusor instability) or stress incontinence (e.g. weak pelvic musculature following childbirth). It can be functional, as people with mobility problems may not be able to get to the toilet quickly enough.

Menstruation
Determine the pattern of the normal cycle. Then ask about flow (heavy or light), intermenstrual bleeding, postcoital bleeding and dysmenorrhoea.

Discharge
Vaginal or penile discharge can indicate infection.

Neurological symptoms

Headache
This is a difficult symptom for the doctor, with the diagnosis ranging from the trivial to the fatal. Ask about red flag symptoms (see Chapter 16).

Dizziness and vertigo
Ask about any perceived movement of the room. Establish when it is occurring, in bed (classically benign positional vertigo) or with a change in posture; that is, going from sitting to standing (i.e. orthostatic hypotension). Is there any associated tinnitus or recent coryzal symptoms, suggesting a vestibular cause? Be aware that the patient may refer to unsteadiness as a sensation of feeling dizzy; consider peripheral neuropathy and visual/hearing impairment (see Chapter 23).

Loss of consciousness
Establish the situation, when it occurred (at rest, on sitting to standing or on exertion), any warning symptoms, any seizure activity and the postictal period. See Chapter 18.

Visual disturbance
Vision can be affected by lesions of the optic pathway and lesions of the nerves controlling eye movements (third, fourth and sixth).

Altered hearing
Ask about deafness, tinnitus and vertigo (see Chapter 23).

Altered smell
Anosmia can result from head injury, nasal polyps, following viral upper respiratory tract infections or frontal lobe tumours and can be a feature of Parkinson disease.

Speech disturbance
There are three types of disordered speech:
- dysarthria: difficulty in articulating speech but language content is completely normal;
- dysphonia: difficulty in voice production;
- dysphasia: difficulty in understanding or expressing language, caused by lesions affecting the dominant cerebral hemisphere (usually the left).

Table 1.3 shows the characteristic speech abnormalities that result from lesions at specific anatomical sites.

Limb weakness, paraesthesiae and sensory loss
This may result from a stroke leading to negative symptoms of weakness or sensory loss. Positive features of paraesthesiae or pins and needles are referred to as positive symptoms, seen in migrainous conditions or with seizures. These are covered in detail in Chapter 32.
Metabolic and endocrine symptoms

Symptoms associated with metabolic and endocrine problems are varied and multiple—these symptoms are described in detail in Chapter 33. The two commonest endocrine conditions to consider and ask about are disorders of the thyroid (Table 1.4) and diabetes (Table 1.5).

Musculoskeletal symptoms

Pain

Pain can arise in the muscles, joints (see Chapter 24) or bones (see Table 1.6).

Weakness

This can be either secondary to a neurological condition or from nutritional deficiency, medications (e.g. long-term

### Table 1.3 Causes and features of abnormalities of speech arising from lesions at specific anatomical sites

<table>
<thead>
<tr>
<th>Site of lesion</th>
<th>Causes</th>
<th>Features of speech</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dysarthria</strong></td>
<td>Mouth Ulcers, macroglossia</td>
<td>Slurred</td>
</tr>
<tr>
<td>Lower cranial nerve lesions (9th to 12th)</td>
<td>Bulbar palsy (stroke, poliomyelitis, motor neurone disease, syringobulbia, malignancy)</td>
<td>Nasal quality, slurred Associated features such as dysphagia</td>
</tr>
<tr>
<td>Upper cranial nerve lesions (9th to 12th)</td>
<td>Pseudobulbar palsy (stroke, motor neurone disease, multiple sclerosis)</td>
<td>Spastic speech, like 'Donald Duck' Associated features such as dysphagia and emotional lability</td>
</tr>
<tr>
<td>Cerebellum</td>
<td>Multiple sclerosis, stroke, tumour, hereditary ataxias, alcohol, hypothyroidism</td>
<td>Scanning (staccato) speech Flow is broken Syllables explosive</td>
</tr>
<tr>
<td>Extrapyramidal</td>
<td>Parkinsonism</td>
<td>Difficulty initiating speech Monotonous and slightly slurred</td>
</tr>
<tr>
<td><strong>Dysphonia</strong></td>
<td>Acute alcohol intoxication</td>
<td>Slurred</td>
</tr>
<tr>
<td>Neuromuscular junction</td>
<td>Myasthenia gravis</td>
<td>Weak, nasal speech Deteriorates on repetition</td>
</tr>
<tr>
<td>Vocal cord disease</td>
<td>Tumour, viral laryngitis, tuberculosis, syphilis</td>
<td>Weak volume, husky quality</td>
</tr>
<tr>
<td>Vocal cord paralysis</td>
<td>Recurrent laryngeal nerve palsy (mediastinal carcinoma, intrathoracic surgery or trauma, aortic aneurysm)</td>
<td>Weak volume, husky quality</td>
</tr>
<tr>
<td><strong>Dysphasia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broca area (inferior frontal gyrus)</td>
<td>Infarction, bleeding, space-occupying lesion</td>
<td>Expressive dysphasia Comprehension intact Difficulty in finding appropriate words and so speech nonfluent</td>
</tr>
<tr>
<td>Wernicke area (superior temporal gyrus)</td>
<td>Infarction, bleeding, space-occupying lesion</td>
<td>Receptive dysphasia Fluent speech but words are disorganized or unintelligible Comprehension impaired</td>
</tr>
<tr>
<td>Frontotemporoparietal lesion Posterior part of superior temporal/ inferior parietal lobe</td>
<td>Infarction (left middle cerebral artery), bleeding, space-occupying lesion and raised intracranial pressure, dementia</td>
<td>Global dysphasia Marked receptive and expressive dysphasia Nominal aphasia Unable to name specific objects Other aspects of speech preserved</td>
</tr>
</tbody>
</table>

### Table 1.4 Differences in the history between hyperthyroidism and hypothyroidism

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Hyperthyroidism</th>
<th>Hypothyroidism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature intolerance</td>
<td>Heat</td>
<td>Cold</td>
</tr>
<tr>
<td>Weight</td>
<td>Decreased</td>
<td>Increased</td>
</tr>
<tr>
<td>Appetite</td>
<td>Increased</td>
<td>Decreased</td>
</tr>
<tr>
<td>Bowel habit</td>
<td>Diarrhoea</td>
<td>Constipation</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Anxiety, irritability</td>
<td>Poor memory, depression</td>
</tr>
<tr>
<td>Menstruation</td>
<td>Oligomenorrhoea</td>
<td>Menorrhagia</td>
</tr>
<tr>
<td>Other symptoms</td>
<td>Palpitations, sweating, eye changes, pretibial myxoedema, acropaechy</td>
<td>Dry skin, brittle hair, arthralgia, myalgia</td>
</tr>
</tbody>
</table>
History taking and communication

steroid use) or underlying arthritis or myositis leading to muscle wasting and atrophy; this is covered in detail in Chapter 34.

### Stiffness

Stiffness, particularly after inactivity (e.g. early morning stiffness), is a feature of inflammation.

### Joint swelling

This can be caused by infection, inflammation, blood (haemarthrosis) or crystal deposition.

### Disability

How do the symptoms affect lifestyle? This is extremely important in patients with rheumatological diseases. Consider if the disability is affecting the patient’s work.

### Skin symptoms

### Rash

The distribution and character of the rash may be very helpful in determining the diagnosis (see Chapter 25).

### Pruritus

For the causes of pruritus, see Table 1.1.

### Precipitants

Has there been any recent change in detergents, soap, shampoo, etc. used?

<p>| Table 1.5 Symptoms of diabetes mellitus |</p>
<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to hyperglycaemia</td>
<td>Polyuria, Polydipsia, Fatigue, Blurred vision, Recurrent infections, e.g. <em>Candida</em>, Weight loss (type 1)</td>
</tr>
<tr>
<td>Due to complications</td>
<td>Peripheral neuropathy, Retinopathy, Vascular disease</td>
</tr>
</tbody>
</table>

<p>| Table 1.6 Causes of bone pain |</p>
<table>
<thead>
<tr>
<th>Cause</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour</td>
<td>Primary tumour (benign or malignant), metastases</td>
</tr>
<tr>
<td>Infection</td>
<td>Osteomyelitis (<em>Staphylococcus</em>, <em>Haemophilus influenzae</em>, <em>Salmonella</em>, tuberculosis)</td>
</tr>
<tr>
<td>Fracture</td>
<td>Traumatic, pathological</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Paget disease, pathological</td>
</tr>
</tbody>
</table>

### Haematological symptoms

#### Fatigue

This may point towards an underlying anaemia. Ask about any breathlessness, palpitations or chest tightness particularly on exertion.

#### Excessive bleeding or bruising

Has the patient been aware of easy bruising, prolonged bleeding with minor injury, such as bleeding gums, or menorrhagia? This may suggest an underlying platelet abnormality.

#### Recurrent infections

Has the patient been getting more frequent infections which are harder to recover from, suggesting an underlying immunosuppressive state?

### Glandular swelling

Ask how long the patient has noticed the swelling. Is it enlarging? Is there any tenderness or B symptoms such as weight loss or night sweats? Has the patient had a recent systemic illness? The differentials here are between normal reactive lymph node following infection and lymphoma. See Chapter 21.

### CONCLUSION OF HISTORY TAKING

The way to become skilled in history taking for both clinical practice and examinations is to try to record as many patients as you can with the range of listed presentations. It is important to write these up with a list of diagnoses and a plan, then practise presenting them to other people. Then ask yourself how you could do it better next time.

### COMMUNICATION

At the end of the history, use ‘ICE’; this stands for ideas, concerns and expectations. Has the patient got any ideas as to what the problem is? What is the patient concerned about it being? Has the consultation met the patient’s expectations? Use of these questions can help ensure a patient-centred approach and address what is most important to the patient.

### COMMON PITFALLS

Be careful not to label a patient’s symptoms as ‘functional’. All organic causes must be ruled out before making this diagnosis – it is a diagnosis of exclusion.
A good history is the key to getting the correct diagnosis.
To achieve this, it is important to try to put the patient at ease and establish a good rapport.
Good history taking is a skill which doctors develop and improve on throughout their career.
There is a structure to taking the history which helps ensure all details are covered; this needs to be adapted to the situation and the patient.
A thorough history is more likely to lead to the correct diagnosis, but it is not appropriate in a time-critical emergency.
Good history taking is a skill; with more experience the clinician learns to take a concise history adapted to the situation.