Guide to Taking a Patient History

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Elements of the Medical Interview

Good history taking is an important first step in treating the patient. Each person will develop their own style and technique, but a good interview will likely include the basic elements discussed below. Remember you are treating a patient, not their condition. The better you understand your patient, the better your treatment plan will be and the more likely you will be to get good patient compliance.

The patient interview can be thought of as having two parts: (i) the setting for the interview and (ii) the interview process itself.

The Setting:

The setting is important because it creates the environment in which you and the patient must interact. The environment will greatly influence how comfortable the patient feels during the process and how complete and informative the patient’s answers will be. It is normal to expect patients to experience some degree of anxiety during an initial interview, if for no other reason than they are about to discuss personal matters with a stranger. If your approach is more like an interrogation, the patient will be closed and unresponsive to your questions. If your tone is judgmental, there is a chance that the patient will disregard you advice and instructions. In either case, the patient is very likely to seek another doctor. Patients want to feel comfortable and at ease when talking to their health care provider. And they have a right to expect a pleasant and professional approach to their problems. If it is the first patient of the day this is easy, on the other hand, if it is the last patient after a horrible day, it may be easier said than done. Within limits you may be able to adjust your physical surrounding to facilitate good interviews. Try to avoid having a table or counter between you and the patient. A cold, sterile room is not conducive to discussing hemorrhoids, while a carnival-like atmosphere may not inspire the level of confidence you are seeking. Check your seating position – make sure your seating is no higher than eye level. Patients are very uncomfortable having to look up while talking and are actually most comfortable while looking slightly down. Be aware of your body language – avoid body positions that are defensive or withdrawn. Be aware of eye contact, too much and too little are both bad. Watch your vocabulary – don’t overwhelm the patient with highly technical terminology they don’t understand; at the same time, don’t talk down to the patient. Lastly, a warm handshake is a very comforting gesture towards a new patient and it’s also a nice way to conclude the visit.

The Process:

The questions are the key to a good interview. You need to use a mix of “open ended questions” and “close ended questions.” Open ended questions leave the door open for the patient to tell you more. Questions like “when did this problem start?,” “have you had any recent health problems?,” and “can you show me where it hurts?” are open ended. The patient feels free to provide additional information. While questions like “does it hurt here?,” “did you have this pain yesterday?,” and “have you had the flu in the past month?” are close ended. Close ended questions seek very specific, often yes or no responses from the patient and don’t encourage the patient to provide any additional information. Good interviews are a mixture of both kinds of questions.

Basic Elements:

1. Greeting
   a. Introduction
   b. Identification of patient and self
   c. Assessment of the patient’s overall appearance and demeanor
2. Personal history
   a. Age
   b. Occupation
c. Sex
d. Height / Weight
e. Marital / Family status
   i. Children
3. Chief complaint (CC) or Presenting complaint
   a. Why is the patient seeking care?
   b. What other problems concern the patient?
4. History of present illness
   a. Location and radiation of complaint
   b. Severity of complaint
   c. Timing of onset
   d. Situation (setting) of onset
   e. Duration of complaint
   f. Previous similar complaints
   g. Exacerbating and relieving factors
   h. Associated symptoms
   i. Patient’s explanation of complaint
5. Past medical history
   a. Systematic questioning regarding previous adult illnesses
      i. Neurological/Psychiatric
      ii. Eye, ear, nose, throat
      iii. Skin/Hair/Nails
      iv. Musculoskeletal
      v. Cardiovascular/Respiratory
      vi. Genital-urinary
      vii. GI tract
   b. Childhood illnesses
   c. Surgeries, injuries or hospital admissions
   d. OB/GYM
      i. Birth control
      ii. Pregnancies / Births
      iii. Menstrual periods
      iv. Pelvic exams / Pap smears
   e. Psychiatric
   f. Immunizations
   g. Screening tests
   h. Allergies
6. Family history
   a. Disease history
   b. Parental health
   c. Children’s health
7. Drug history
   a. Current medications
      i. Prescription
      ii. Over-the-counter
   b. Drug allergies
8. Lifestyle (social history)
   a. Alcohol
   b. Smoking
   c. Recreational drug use
   d. Sexual life style/orientation
   e. Reproductive status
   f. Occupational issues
The doctor / patient interview is something that each person individualizes to meet their own needs. The elements below are intended as a guide for practicing an interview in English. Each element is followed by one or more sample questions which could be used for the interview element.

- Greet the patient and introduce yourself.
  - Good afternoon, my name is Dr. Morgan
- Personal History
  - Patient’s name
    - Please tell me your first and last name.
    - Could you please tell me your first and last name?
    - Can you spell your last name for me please?
  - Determine the patient’s age, height and weight
    - How old are you?
    - When were you born?
    - How much do you weigh?
    - What is your height?
  - Determine the patient’s occupation.
    - What do you do for a living?
    - How long have you worked in your present job?
    - What did you do before your present job?
    - Is your work stressful?
    - Is there much physical activity associated with your work?
    - How long have you been retired?
- Determine the patient’s chief complaint (CC).
  - How can I help you today?
  - What seems to be the problem?
  - What brings you in to see me today?
- Determine the duration of the CC.
  - When were you last feeling perfectly well?
  - When did this problem start?
  - How long have you had this problem?
  - Have you taken any kind of medicine for your problem?
    - What kind of medicine did you take and how much have you taken?
    - Did the medicine help?
- Assess any aggravating or relieving factors.
  - Is there anything that makes this problem worse?
  - Is there anything that makes this problem better?
- Determine the onset of the CC.
  - Did this problem start slowly or did it come on quite suddenly?
- Assess any pain associated with the problem.
  - Is this problem causing you any pain?
  - Can you describe the pain for me?
    - Is it stabbing or burning?
    - Is it constant or intermittent?
    - Is it throbbing or pounding?
    - Is it sharp or dull?
  - On a scale of one to ten, how would you rank the pain?
  - Is the pain disrupting your daily activities?
  - Does the pain radiate to any other part of your body?
  - Does the pain keep you awake at night?
- Current and past medical history.
  - Do you have any current health problems, things such as diabetes or high blood pressure?
    - If the patient answers yes, ask follow up questions.
• How long have you had this condition?
• Are you seeing a doctor for this condition?
• Are you taking any medications for this condition?
  • Can you tell me the name of the medication?
  • Do you know what doses you take?
  • How often do you take this medication?
• When did you last see a doctor for this condition?
  o Have you had any recent illnesses or health problems other than the one that brought you in today? Things like a sore throat or a cold or flu.

Family history.
  o Do your parents have any health problems? How old are they.
  o I'm sorry to hear that, what was the cause of your mother's (father's) death? How old was she (he) when she (he) died?
  o Do you have any brothers or sisters? How old are they? Do they have any health problems?
  o Are you married? Do you have any children? How old are they? Do they have any health problems?
  o Is there a history of (high blood pressure, cancer, asthma, diabetes ...etc.) in your family?

Drug history
  o Are you taking any prescription medications?
    • Pills
    • Injections
    • Inhalers
  o Do you use any alternative treatments or remedies for any health problems?
  o Are you taking any over-the-counter (OTC) medicines?

Lifestyle (social) history.
  o Do you smoke?
  o How much do you smoke?
  o How old were you when you started smoking?
  o Do you drink beer, wine or spirits?
  o How often do you drink? How often do you drink alone?
  o How much do you drink?
  o Have you notice a recent increase or decrease in your weight?
  o Do you have any allergies; things like food allergies or allergies to medications?

Depending on the CC of your patient you will need to ask a few additional questions related to specific symptoms.

These are just a FEW examples of CC specific questions you might ask depending on the CC of your patient. Questions marked with an OE are open ended examples, while questions marked with an CE are close ended examples.

Respiratory
  o Is your cough worse in the morning, in the evening or at night? CE
  o When is your cough at its worst? OE
  o Do you cough up any blood? CE
  o Do you cough anything up? OE
  o Is you cough dry or productive? CE
  o Are you short of breath? CE
  o Do you have any difficulty breathing? CE
  o How is your breathing? OE

Cardiovascular
  o Can you show me where the pain is located? OE
  o Does the pain radiate to any other part of your body? OE
- Do you get short of breath when you are active? CE
- How long does the pain last? OE
- What were you doing when the pain started? OE
- Have you ever had this pain before? CE

**GI**
- Can you show me where the pain is located? OE
- Are there any foods that make the problem worse? OE
- Do you have diarrhea? CE
  - How many times per day? CE
- Have you noticed any blood in your stools? CE
- Have you noticed any fat or mucus in your stools? CE
- Have you noticed anything unusual in regard to your stools? OE
- Do you have regular bowel movements? CE
- Can you describe your bowel movements to me? OE

**GU**
- How often do you urinate each day? CE
- Can you describe the appearance of your urine? OE
- Do you feel any pain when you urinate? CE
- Can you tell me about your urination habits? OE
- Do you have any difficulty starting to urinate? CE
- How often do you urinate during the night? CE
- What is the color of your urine? CE
- Does your urine appear to be dark or cloudy? CE
- Can you describe your monthly cycles for me? OE
- When did you have your last period? CE
  - Was your last period normal? CE
  - Are your periods regular? CE

**Headaches**
- Can you show me where your head hurts? OE
- When you have your headaches are you sensitive to bright light? CE
- Can you describe the pain? Is it sharp and intense or dull and not so intense? OE
- Do you feel any pressure? OE
- How long have you been having headaches? CE
- How do the headaches start? CE
  - Do they start slowly or suddenly? CE
- How severe is the pain – can you rank it for me on a scale of 1 – 10? CE
- Do your headaches make you nauseous? CE
- Describe how you feel when you are having a headache, OE
- Do any position help you headaches – lying down, standing, etc.? OE