Obtaining a history

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Presenting complaint To establish the presenting complaint one should start with - an open question inviting the patient to explain the reason for seeking medical advice. The patient must be allowed to explain the presenting complaint without interruption, after which carefully directed questions are used to further refine the history (Osler). Clues from these will allow identification of a which then guides subsequent clinical examination and inves tigation to arrive at a probable diagnosis. History taking can be forwards and backwards, but its record should be structured. In the acute situation, pain is the most common presenting feature. The classic features of site, nature, onset, duration, radiation and aggrav ating or relieving features of the pain should be established. In non-acute presentations, anorexia, weight loss, jaundice, altered bowel habit, blood loss and fatigue are all features that should be questioned. Past medical history The past history is important because it may have a bearing on the diagnosis and management. A history of previous similar episodes or past abdominal surgery often guides the diagnosis; for example, adhesive small bowel obstruction in a patient with a history of laparotomy or recurrent left iliac fossa pain in a patient with a past history of diverticulitis. Some symptoms and signs may be due to cardiac, respiratory , haematological conditions, such as abdominal pain in sickle cell crisis or acute epigastric pain in diabetic ketoacidosis. Recurrent right iliac fossa pain may suggest a past history of appendicitis, Crohn’s disease or in some regions amoebic typhlitis or ileocaecal tuberculosis. A positive history of tuber culosis can help in di ff erential diagnoses in many patients. E ff orts should be made to obtain pr evious medical records and investigations. Drug history and allergies Some drugs will have an e ff ect on the symptoms and signs or may have to be discontinued before surgery . For example, a patient with bleeding who is taking a β -blocker will not have tachycardia proportionate to the blood loss; a patient taking long-term corticosteroids will need intravenous steroid supple mentation to prevent an adrenal crisis in the perioperative period; a patient taking anticoagulant drugs may require reversal of the e ff ects before surgical intervention. Patients with diabetes will require strict g lycaemic control with sliding scale insulin in the perioperative period. Detailed enquiry about adverse reactions to anaesthetics or medications can prevent such problems later on. Social history The use of alcohol and illicit drugs, smoking and occupation are important. A history of family background and domestic support will guide the planning of discharge after surgery . Family history It is important to establish a family history of similar or related conditions, particularly cancer, inflammatory bowel disease, endocrine disease (e.g. hyperparathyroidism causing hyper calcaemia or renal calculi) and genetic disorders, including adverse reactions to anaesthetics or medications. Review of the systems A systems review should highlight any comorbid disease, such as cardiac, vascular, respiratory or endocrine problems; these have grave implications for the safety of any surgical inter vention. - Principles of history taking /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

Identify the reason for consultation – the presenting complaint Determine the onset, duration and evolution of the symptoms Deduce the most likely organ or system affected Re /f_i ne the history with relevant direct questions Establish relevant past, social, family, drug and allergy history

Complete with a thorough review of other systems Devise a list of differential diagnoses

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