The history taking in Surgery

Dr. Muhammad Shamim

FCPS (Pak), FRCS (UK), FACS (USA), FICS (USA), MHPE (Nl & Eg)

Assistant Professor, Dept. of Surgery

College of Medicine, Sattam bin Abdulaziz University

Email: surgeon.shamim@gmail.com

Web: surgeonshamim.com

General points to remember

- *Keep all your senses on alert.*
- *Always introduce yourself to the patient.*
- *Always ask permission for interviewing & examination.*
- *Ensure patient's dignity & privacy.*
- *Always examine opposite sex patient in the presence of a chaperone.*

History taking

- *Diagnosis can be made based on history alone.*
  - *Communication skills*
    - *an ability to listen*
    - *ask common-sense questions*
  - *Approach patient complaints in a problem oriented fashion to elicit relevant information.*
- *Identify covert disease states in addition to overt disease.*
- *Build rapport with the patient.*
- *Deal with your own discomfort.*

Component of history

1. *Patients data.*
2. *Present complaint.*
3. *History of present complaint.*
4. *Past medical history.*
5. *Past surgical history.*
6. *Drugs, allergies & immunization.*
7. *Substance abuse*
8. *Menstrual & obstetric history (in females).*
9. *Family history.*
10. *Socio-economic history.*
11. *Review of systems.*

Getting Started

- *Begin by recording the patient's particulars;*
  - *Name:*
  - *Age (or date of birth):*
  - *Sex:*
  - *Marital status:*
  - *Occupation:*
  - *Religion:*
  - *Ethnic group:*
  - *Residence:*
- *Also record the date of history & examination, & in cases of inpatients the date, time & mode of admission.*

Presenting complaint (PC)

- *Ask open ended questions.*
- *Don't ask like this: What is the matter?*
- *This must be put in a short statement in patient's own words.*
- *If there is more than one complaint, list them in order of severity or in chronological order.*
  - *Example*
    - *Abdominal pain for 2 days.*
    - *Vomiting for last 24 hours.*
    - *Abdominal distension for 6 hours.*

History of present complaint (HOPC)

- ***Let the patient to tell the story in their own words.***
- ***Explore complaint(s) using general questions:***
  - *Duration?*
  - *Location/Radiation?*
  - *Severity/Character?*
  - *Have you tried any therapeutic maneuvers?*
  - *Pace of illness?*
  - *Are there any associated symptoms?*
  - *Previous history of present complaint(s).*
  - *What do you think the problem is &/or what are you worried it might be?*
  - *Why today?*
- ***Subsequent questions will depend both on what you uncover & your knowledge base/understanding of patients & their illnesses.***

Example

- *If the patient's chief complaint was abdominal pain you might have uncovered the following:*
  - *The pain began 2 days ago in the peri-umbilical area, but for last 24 hours it shifted to the right lower abdomen. It aggravates with movement & coughing, & rapidly goes away by pain killers. It is roughly 5 (on a scale of 1 to 10), & constant. It has never happened before. It is associated with anorexia & low-grade fever, but there is no vomiting, constipation or diarrhea.*

.....HOPC

- *During history, you are continually generating differential diagnoses in minds, allowing the patient's answers to direct the logical use of additional questions.*
- *At the completion of the HOPC, you should have a pretty good idea as to the likely cause of a patient's problem. You may then focus your clinical examination on the search for physical signs that would lend support to your working diagnosis & help direct you in the rational use of adjuvant testing.*
- *You will undoubtedly forget to ask certain questions……*

Past & associated medical history

- *Start by asking the patient if they have any medical problems.*
- *If you receive little/no response, ask:*
  - *Have they ever received medical care? If so, what problems/issues were addressed? Was the care continuous or episodic?*
  - *Have they ever undergone any procedures, X-rays, CT scans, MRIs or other special testing?*
  - *Ever been hospitalized? If so, for what?*
- *Ask specifically about common medical problems:*
  - *hypertension, diabetes mellitus, tuberculosis, arthritis, angina/myocardial infarction, chronic pulmonary disease.*

Past surgical history

- *Were they ever operated on?*
- *Were they ever suffered accident?*

Drugs, allergies & immunization

- ***Drugs***
  - *Do they take any prescribed medicines? If so, what is the dose & frequency? Do they know why they are being treated?*
  - *Don't forget to ask about over the counter or "non-traditional" medications.*
- ***Allergies/Reactions***
  - *Have they experienced any adverse reactions to medications?*
- ***Immunization***
  - *Covid, tuberculosis, polio, diphtheria, pertusis, tetanus, measles, mumps, rubella, typhoid, hemophilus influenza & hepatitis B.*

Substance abuse

- ***Tobacco***
  - *Have they ever smoked cigarettes, cigar, pipe or 'shisha/huqqa'?*
  - *Do they chew tobacco? (tobacco alone, with pan or pan masala)?*
- ***Alcohol***
  - *Do they drink alcohol? If so, how much, what type of drink & the duration?*
- ***Drug abuse***
  - *Do they abuse heroine or any other opioids?*

Menstrual & obstetric history

Menstruation

- *Menarche?*
- *Menopause?*
- *Duration & quantity of the menses?*
- *Dysmenorrhea?*
- *Mittelschmerz?*

Pregnancies

- *Number*
- *Outcome (eg full term vaginal delivery, caesarian section, spontaneous abortion, therapeutic abortion)*
- *Complications.*

Family History

- *Your aim is to search for heritable illnesses among first or second degree relatives.*
- *Enquire about the health & age, or cause of death (if not alive) of the patient's parents, grandparents, brothers, sisters & children.*

Socio-economic history

- *Sexual Activity*
- *Accommodation*
- *Work*
- *Hobbies*
- *Other*

Review of systems (ROS)

- *Pts might have associated or concomitant disease states, which yet do not generate overt symptoms. These have important influence on surgical decision making.*
- *These are direct questions that you must ask every patient.*
- *Remember, negative answers are as important as positive answers.*

Alimentary System Review

- *Appetite*
- *Diet*
- *Weight*
- *Teeth & taste*
- *Swallowing*
- *Regurgitation & reflux*
- *Heartburn*
- *Vomiting*
- *Hematemesis*
- *Flatulence*
- *Indigestion or abdominal pain*
- *Abdominal distension*
- *Defecation*
- *Change of skin color*

Respiratory system review

- *Cough : Is it a dry or productive cough?*
- *Sputum*
- *Hemoptysis*
- *Dyspnea*
- *Pain in the chest*

Cardiovascular system review

Cardiac symptoms

- *Breathlessness*
- *Pain in the chest*
- *Palpitations*
- *Cough & sputum*
- *Dizziness & headaches*
- *Ankle swelling*

Peripheral vascular symptoms

- *Does the patient get pain in the leg muscles on exercise (intermittent claudication)?*
- *Is there any pain in the limb at rest?*

Urogenital system review

Urinary tract symptoms

- *Pain*
- *Edema*
- *Thirst*
- *Micturition*
- *Urine*
- *Headache, drowsiness, visual distrubance, fits & vomiting (uremia).*

Genital tract symptoms

In males

- *Any pain in the penis or urethra at rest, during micturition or intercourse?*
- *Any urethral discharge?*
- *Any swelling of the scrotum?*
- *Can he achieve an erection & ejaculation?*
- *When did secondary sexual characters appear?*

In females

- *Menstrual & obstetric history?*
- *Is intercourse painful (dyspareunia)?*
- *Do the breasts change during the menstrual cycle? Any pain or swelling? Did the patient breast feed her children?*
- *When did secondary sexual characters appear?*

Nervous system review

- ***Mental state***
- ***Brain & cranial nerves***
  - *Does the patient ever become unconscious or stuporous?*
  - *Does he ever have fits?*
  - *Has there been any change in the senses of smell, vision & hearing?*
  - *Is the face ever weak or paralyzed?*
- ***Peripheral nerves***
  - *Are any limbs or part of a limb weak or paralyzed?*
  - *Is there ever any loss of cutaneous sensation?*
  - *Does the patient experience any paraesthesiae tingling, pins & needles in the limbs?*

Musculoskeletal system review

- *Ask if the patient suffers from pain, swelling, or limitation of the movement of any joint?*
- *Are any limbs or groups of muscles weak or painful?*
- *Can he walk normally?*
- *Has he any congenital deformities?*

Metabolism

- *Weight & appetite.*
- *Ask if growth has been normal in rate & quantity. Has the patient noticed any abnormality of body growth & development?*

ANALYSIS OF SEVERE ABDOMINAL PAIN

	Peptic ulcer perforation	Appendicitis	Acute pancreatitis	Gall-bladder colic	Renal colic	Large bowel obstruction	Small bowel obstruction
Site	Epigastrium	Umbilical	Epigastrium or RHC	RHC & epigastrium	Loin	Hypogastric	**Umbilical**
Radiation/shift	Whole abdomen & left shoulder	Right iliac fossa	Back & whole abdomen	Right scapula	Towards groin	Flanks	**Nil**
Nature	Sharp	Colicky, becoming constant	Constant	Colicky or continuous	Colicky	Colicky	**Colicky**
Severity	Very severe	Severe	Very severe	Very severe	Very severe	Severe	**Severe**
Onset & duration	Sudden & persistent	Fairly rapid onset, many hours	Sudden & persistent	Sudden, lasting hours	Sudden, minutes to hours	Slow onset, lasting days	**Fairly rapid onset, hours to days**
Aggravating factors	Movement	Walking, coughing	Movement	Nil	Jolting	Nil	**Nil**
Relieving factors	Nil	Nil	Sitting or leaning forward	Nil	Nil	Nil	**Nil**
Associated symptoms	Shock & vomiting	Vomiting, fever	Vomiting & shock	Vomiting & sometimes fever with rigors	Vomiting, frequency, hematuria	Constipation, distension, vomiting	**Vomiting, constipation, distension**
Physical signs	Board like rigidity	Tenderness & guarding in right iliac fossa	Abdomen rigid after initial softness	Tenderness in RHC	Nil	Flank distension, increased bowel sounds. Rectum ballooned & empty	**Central distension. Bowel sounds increased, Rectum ballooned & empty**
Investigations	**Air under diaphragm seen on x-rays**	TLC CT scan	**Increased serum & urinary amylase**	**Ultrasound may show calculus**	**X-rays may show calculus**	**Intestinal fluid levels on x-rays**	**Intestinal fluid levels on x-rays**

The End!