

History Taking

Introduction to the Patient

History taking is a most important process and must be rehearsed well. No matter how efficient and skilled the surgeon is, he or she must make the patient feel confident.

hand-shake, a smile, a pleasant introduction and a caring gesture will make the remainder of contact with the patient much easier and more pleasant.

Introduction to the patient is a most important moment, this allows a rapport to develop with the patient that will facilitate the rest of the interview and enhance the possibility of achieving an appropriate diagnosis and treatment plan.

Premature physical examination of a lesion may not only reduce the patient's confidence but also unnerve the surgeon if the diagnosis is not immediately apparent with visual examination.

History of the presenting Complaint

This is the patient's opportunity to tell the surgeon about the problem and it is important to avoid leading questions.

many will also have difficulty in remembering the timescale of the illness. A good initial beginning with history taking is to ask the patient to think back to the start of the problem to ensure that he or she gives an account in chronological order. It is also important, while the patient is giving the history, to ensure that he or she gives a clear account of what has happened, and does not discuss what he or she thinks is the cause of the problem.

Patients wishing to avail themselves of the best medical attention will usually wish to please and will therefore tend to agree, using a positive response, to any direct question asked.

This problem can be overcome by providing the patient with alternatives: 'Is the pain constant?' is more likely to be answered accurately if the patient is asked 'Is the pain constant or not?'

Several features of the presenting problem should then be elicited:

- When was the problem first noted?
- What is the location?
- Are the symptoms continuous or intermittent?
- Does anything make the problem better or worse?
- Is the problem getting better or worse?

Relevant medical history

This is the surgeon's chance to take a history from the patient. This part has two aspects: first, the opportunity to elaborate on any points in the history that the surgeon felt were unclear; second, to enquire from the patient any aspect of his or her health that might otherwise influence the treatment plan.

Family history

Two main items are worth enquiring regarding family history:

- (1) is there a genetic family problem, especially any blood-related problem such as hemophilia?
- (2) has any member of the family had any problem with anesthetics.

Drug therapy

As outlined above, it is critical to know about certain drugs prior to performing any surgery. Dosage of corticosteroids and anticoagulants need to be controlled and monitored carefully.

Social history

Knowledge of tobacco smoking and alcohol consumption will not only inform the surgeon of the potential risks for general anesthesia and surgery but also the patient's likelihood of smoking- and alcohol-related diseases

Allergies

A history of asthma and anaphylaxis is important. The surgeon must know about drug allergies

Common surgical symptoms

Pain

Pain anywhere should have the same features elicited. These can be summarized by the acronym SOCRATES.

- **Site.** Where is the pain, is it localized, in a region, or generalized?
- **Onset.** Gradual, rapid, or sudden? Intermittent or constant?
- **Character.** Sharp, stabbing, dull, aching, tight, sore?
- **Radiation.** Does it spread to other areas? (From loin to groin in ureteric pain, to shoulder tip in diaphragmatic irritation, to back in retroperitoneal pain, to jaw and neck in myocardial pain.)
- **Associated symptoms.** Nausea, vomiting, dysuria, jaundice?
- **Timing.** Does it occur at any particular time?
- **Exacerbating or relieving factors.** Worse with deep breathing, moving, or coughing suggests irritation of somatic nerves either in the pleura or peritoneum; relief with hot water bottles suggests deep inflammatory or infiltrative pain.
- **Surgical history.** Does the pain relate to surgical interventions?

Terms used in General Surgery and History Taking

Dyspepsia (epigastric discomfort or pain, usually after eating) What is the frequency? Is it always precipitated by food or is it spontaneous in onset? Is there any relief, especially with milky drinks or food? Is it positional?

Dysphagia (difficulty during swallowing) Is the symptom new or longstanding? Is it rapidly worsening or relatively constant? Is it worse with solid food or fluids? (Worse with fluids suggests a motility problem, rather than a stenosis.)

Oesophageal reflux (bitter or acidic tasting fluid in the pharynx or mouth) How frequently? What colour is it? (Green suggests bile whereas white suggests only stomach contents). When does it occur (lying only, on bending, spontaneously when standing)? Is it associated with coughing?

Haematemesis (the presence of blood in vomit) What colour is the blood (dark red-brown 'coffee grounds' is old or small-volume stomach bleeding; dark red may be venous from the oesophagus; bright red is arterial and often from major gastric or duodenal arterial bleeding)?

Bleeding per rectum What colour is the blood? Is it pink-red and only on the paper when wiping? Does it splash in the pan? (Both suggest a case from the anal canal.) Is it bright red on the surface of the stool (suggests a lower rectal cause)? Is the blood darker with clots or marbled into the stools (suggests a colonic cause)? Is the blood fully mixed with the stool or altered (suggests a proximal colonic cause)?

Haematuria (blood in the urine) Does the blood occur at the start (suggests bladder origin), during, or end (suggests prostatic or penile origin) of the stream? Is there associated pain (suggests infection or stone disease)?

Dyspnoea (difficulty in or increased awareness of breathing) When does the dyspnoea occur—quantify the amount of effort. Is it positional?

- *Orthopnoea*. Difficulty in breathing that occurs on lying flat; quantify it by asking how many pillows the patient needs at night to remain symptom-free.
- *Paroxysmal nocturnal dyspnoea*. Intermittent breathlessness at night. Both orthopnoea and paroxysmal nocturnal dyspnoea suggest cardiac failure.