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13th Edition

CHAMBERLAIN’S

SYMPTOMS AND SIGNS IN CLINICAL MEDICINE
An Introduction to Medical Diagnosis

Edited by

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The student of medicine has to learn both the ‘bottom up’ approach of constructing a differential diagnosis from individual clinical findings, and the ‘top down’ approach of learning the key features pertaining to a particular diagnosis. In this textbook we have integrated both approaches into a coherent working framework that will assist the reader in preparing for academic and professional examinations, and in everyday practice. In so doing, we have remained true to the original intention of E Noble Chamberlain who, in 1936, wrote the following in the preface to the first edition of his textbook:

As the title implies, an account has been given of the common symptoms and physical signs of disease, but since his student days the author has felt that these are often wrongly described divorced from diagnosis. An attempt has been made, therefore, to take the student a stage further to the visualisation of symptoms and signs as forming a clinical picture of some pathological process. In each chapter some of the commoner or more important diseases have been included to illustrate how symptoms and signs are pieced together in the jigsaw puzzle of diagnosis.

E Noble Chamberlain
Symptoms and Signs in Clinical Medicine, 1st edition (1936)

We have split this textbook into three sections. The first section introduces the basic skills underpinning much of what follows – how to take a history and perform an examination, how to devise a differential diagnosis and select appropriate investigations, and how to record your findings in the case notes and present cases on ward rounds.

The second section takes a systems-based approach to history taking and examining patients, and also includes information on relevant diagnostic tests and common diagnoses for each system. Each chapter begins with the individual ‘building blocks’ of the history and examination, and ends by drawing these elements together into relevant diagnoses. A selection of self-assessment questions pertaining to each chapter is also available on the companion website so you can test what you have learnt.

The third and final section of the book covers ‘special situations’, including the assessment of the newborn, infants and children, the acutely ill patient, the patient with impaired consciousness, the older patient and death and the dying patient.

We are grateful to all of our contributors for sharing their expertise in the chapters they have written. We hope that today’s reader finds the 13th edition of Chamberlain’s Symptoms and Signs in Clinical Medicine to be as useful and informative as previous generations have done since 1936.

Andrew R Houghton
David Gray
2010
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Chamberlain and his textbook of symptoms and signs

The first edition of *Symptoms and Signs in Clinical Medicine: An Introduction to Medical Diagnosis* was published in 1936 by John Wright & Sons (Bristol). It was written by Ernest Noble (‘Joey’) Chamberlain and included a chapter on ‘The Examination of Sick Children’ by Norman B Capon.

At the time his textbook was published, Chamberlain was working at the Liverpool Royal Infirmary as a lecturer in medicine and as assistant physician to the cardiologist Henry Wallace Jones. Prior to this he had served in the Royal Naval Air Service and also as a ship’s surgeon, before becoming a physician to outpatients and to the new cardiology department at the Royal Southern Hospital, Liverpool, where he studied for an MSc, his thesis being on *Studies in the Chemical Physiology of Cholesterol* (Munk’s Roll, vol. VI, p. 97 © Royal College of Physicians of London).

Chamberlain’s textbook was advertised in the *Quarterly Journal of Medicine* (Fig. 1), at a cost of 25 shillings (the equivalent of over £60 today!), and a favourable review appeared in the *Journal of the American Medical Association* (JAMA):

> The text is well written and there are numerous splendid illustrations. The chapters on diseases of the heart and vessels and the digestive system are complete and deserve special commendation.
>

© 1936 American Medical Association.

The textbook rapidly became popular, requiring a reprint within the same year, and a second edition was soon published in 1938. Further editions followed, including special Commonwealth and Japanese editions, and by the time of the eighth edition Chamberlain’s textbook had expanded to over 500 pages and was attracting great praise from a reviewer in the *Archives of Internal Medicine*:

> It is a remarkable course in diagnosis with the eyes; if well studied, it would almost convert a recent medical school graduate into a good diagnostician. The reviewer has never seen anything to equal it.
>

Chamberlain retired from his post as senior physician at the Royal Southern Hospital, Liverpool, in 1964. He died on 9 February 1974, aged 75, the day after he had completed the proofreading of the ninth edition of his textbook. His obituary in the *British Medical Journal* described him as:

> a consultant physician of the old school. A man of great kindliness and courtesy, he dedicated most of his time to medicine, and equally he lived a full and gracious professional life. We have yet to feel the full impact of losing men of his type.
>
> *British Medical Journal* 1974, i: 464, with permission from BMJ Publishing Group.

When the ninth edition (co-authored by Colin Ogilvie) was published, it brought the total number of copies sold to over 100,000. Further editions, still bearing Chamberlain’s name, have continued to be published at regular intervals up to the present day.
Recently Published. Large 8vo. 436 pp., with 282 Illustrations, of which 17 are in colour.
25s. net, postage 6d.

SYMPTOMS AND SIGNS IN CLINICAL MEDICINE
An Introduction to Medical Diagnosis.
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With a Chapter on the Examination of Sick Children.
By NORMAN B. CAPON, M.D., F.R.C.P., Lecturer in Diseases of Children, University of Liverpool.

The aim of this book is to help the student and young practitioner to master the technique of medical examination and to apply it to the problems of diagnosis and practice.

* The volume must be counted a fine achievement. . . . The illustrations are well chosen and, together with the rest of the volume, excellently produced. — The Practitioner.
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Finally, we would like to thank Dr Joanna Koster (Head of Health Science Textbooks), Jane Tod (Senior Project Editor), Lotika Singha (Freelance Editorial Consultant) and the rest of the team at Hodder Arnold for their encouragement, guidance and support throughout this project.
INTRODUCTION
To this day, history taking forms the basis of medical practice worldwide. After all, in the majority of cases, the correct diagnosis can be made from the history alone. Viewed simplistically, the medical history is an exercise in data gathering. This dataset can not only help formulate diagnoses but also ascertain possible causes, assess the impact of illness on patients and guide more focused examination, investigation and subsequent management.

Current practice (see Box 1.1), however, dictates that we adopt a different approach to the history compared with traditional models. We now require a greater volume and quality of information than ever before in order to manage our patients more holistically. Moreover, healthcare professionals are dealing with more demanding and knowledgeable patients with access to masses of information via the internet and other media outlets. Healthcare professionals, in turn, are under different pressures to obtain data. As examples, consider the busy hospital on-call doctor and 10-minute general practitioner (GP) consultations, not to mention medical exams!

This chapter deals with the art of deriving these data effectively through good communication and the concept of set, dialogue, closure.

On the topic of history taking, the Foundation Programme Curriculum (2007) states that the following knowledge is required of foundation doctors:

- symptom patterns
- incidence patterns in primary care
- alarm symptoms
- the appropriate use of open/closed questions.

The Curriculum goes on to say that foundation doctors must develop the following attitudes/behaviours. Foundation doctors must consider the impact of:

- physical problems on psychological and social well-being
- physical illness presenting with psychiatric symptoms
- psychiatric illness presenting with physical symptoms
- psychological/social distress on physical symptoms (somatization)
- family dynamics
- poor nutrition.

Foundation doctors must be able to show empathy with patients when:

- English is not the patient’s first language
- the patient is confused
- they have impaired hearing
- they are using complementary/alternative medicines
- they have psychiatric/psychological problems where there are doubts over the informant’s reliability
- they have learning disabilities
- the doctor asks appropriate questions on sexual behaviour and orientation
- the patient is a child and the informant is the child and/or carer
- there is a possible vulnerable child/elder protection issue.

BOX 1.1 GENERAL MEDICAL COUNCIL – GOOD MEDICAL PRACTICE (2006)
Good clinical care must include:

- adequately assessing the patient’s conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient’s views, and where necessary examining the patient
- providing or arranging advice, investigations or treatment where necessary
- referring a patient to another practitioner, when this is in the patient’s best interests.
The core competencies and skills listed in the Curriculum are listed below.

**F1 level:**
- demonstrates accomplished, concise and focused (targeted) history taking and communication, including in difficult circumstances
- includes the importance of clinical, psychological, social, cultural and nutritional factors, particularly those relating to ethnicity, race, cultural or religious beliefs and preferences, sexual orientation, gender and disability
- takes a focused family history, and constructs and interprets a family tree where relevant
- incorporates the patient’s concerns, expectations and understanding
- takes a history from patients with learning disabilities and those for whom English is not their main language.

**F2 level:**
- encourages and teaches the above
- checks on patients’ understanding, concerns and expectations
- begins to develop skills to manage three-way consultations, for example with children and their family/carers.

---

**COMUNICATION SKILLS**

Most patients are only too willing to volunteer information. After all, many patients think that the more they talk, the more you will be able to help. The key is getting the relevant information through effective communication.

**Language**

Keep it simple and talk clearly. Study the patient’s speech and body language. Matching these can help build rapport quickly. Avoid medical jargon. If it is obvious the patient doesn’t understand you, try rephrasing the question, preferably using lay terms.

**Active listening**

Don’t just listen; show the patient you are interested in what they have to say! Adopt an attentive posture, maintain good eye contact, gesture with your hands or nod your head accordingly. Avoid unnecessary interruptions. Summarizing salient points not only suggests you have been listening but can quite often evoke further points that may otherwise have been missed.

**Questioning**

Begin with a series of ‘open’ questions, those that are likely to provide a long response:
- ‘Why have you come to hospital today?’
- ‘Tell me more about these chest pains.’

As the interview proceeds use more ‘closed’ questions, those that are likely to provide a shorter response:
- ‘Any difficulty breathing?’
- ‘Any problems with your waterworks?’

**Control**

Manage the pace and direction of the interview. Patients prefer a doctor who is slightly authoritative. Appearing too laid back or aloof rarely instils confidence.

**Signposting**

This is the process of telling patients where the interview might go next. As a doctor, use it to steer the patient towards the questions that you want answered. ‘Mrs X, that was very useful, thank you. But moving on, could you tell me if you are on any regular medications?’ This also ensures a smooth dialogue without any awkward pauses.

**Cues**

Cues can be verbal or non-verbal and are a way in which patients signpost their real concerns unintentionally and should be explored further.
- ‘I’m not going to get admitted am I doctor? I cannot afford to be off work’ says Mr Y, constantly looking at his watch
- ‘Could it be cancer doctor?’ asks Mrs Z, whose mother recently died of colonic carcinoma.
Taking a history

CLINICAL PEARL
A useful mnemonic for focusing a history is I C E, which reminds you to establish your patient’s:
* Ideas about their health (i.e. what do they think is the cause of their symptoms?)
* Concerns about their health (i.e. what are they most concerned about?)
* Expectations about their diagnosis and treatments (i.e. what do they expect from you?).

SET, DIALOGUE, CLOSURE

In simple terms, this means knowing what to do before, during and after a consultation. This approach provides a clear structure to the interview, acts as an aide memoire for reference, maximizes information and ensures salient points are not overlooked. In fact, the format can be applied to almost any communication skills exercise in medical practice, be it teaching, breaking bad news or even practical procedures!

SET: setting the scene

As stated in the introduction, history taking is ultimately a data-gathering exercise. Even before engaging the patient in medical dialogue, it pays to be well prepared and organized. A few simple steps can get the patient on your side and maximize this information.

Ensure privacy – draw the curtains and make the surroundings as quiet as possible. Read accompanying correspondence (GP/clinic letters), and look through old notes. This provides valuable objective and subjective information from other healthcare professionals. Dress appropriately and in line with local infection control policy.

Introduce yourself and ask the patient how they would prefer to be addressed. Explain your aims, seek consent to proceed and reiterate that all information provided will be handled with confidentiality. These assurances should quickly establish rapport and instil confidence. Patients are more likely to provide intimate personal details if they know your specific role in their care. Note the GP’s details in case certain points need to be clarified later (e.g. drug history).

A few moments spent observing the patient and establishing ethnicity, occupation and the spoken language can be extremely useful. Remember, many diseases have associations with particular ethnic groups and occupations (for example: Middle Eastern background – thalassaemia; Caucasian – cystic fibrosis; publicans – alcoholic liver disease; shipbuilders – asbestosis). Would you need a translator? General inspection can provide insight into the patient’s functional status. Are they on oxygen, or in a wheelchair?

DIALOGUE: the actual content of the medical history

PC – presenting complaint(s)

The presenting complaint(s) are the main symptom(s), in the patient’s own words, that have brought him/her forwards for medical attention. The patient presents with ‘passing black motion’ not ‘melaena’. Simple ‘open’ questions such as ‘What has brought you to hospital today?’ or ‘What has been troubling you recently?’ are often all that is needed to generate this information.

Many patients see this opening gambit as a cue to express all of their symptoms and concerns in a seemingly illogical and disconnected manner. The key is not to fear and not to interrupt! Instead, be attentive and formulate a list of the patient’s chief concerns. Contrary to popular belief, this may actually save you time.

CLINICAL PEARL
Ask patients what they think is the cause of their problem(s). This makes them feel involved and can unmask hidden agenda(s) or cues. ‘I am worried I may have cancer, doctor. It runs in the family, you know!’

HPC – history of presenting complaint(s)

Symptoms are a consequence of dysfunction of an organ system. In most cases, the organ involved gives rise to a classic cluster of symptoms, e.g. pneumonia can cause breathlessness, cough and purulent sputum. The extent of dysfunction largely determines
the breadth and severity of the symptoms. At the same time, we know that disease can involve more than one system, similar symptoms can arise from different organs (chest pain – cardiac versus respiratory versus musculoskeletal), and patients can present with multiple diseases. It is the evaluation of these symptoms, through careful questioning, that is dealt with here.

The combination of history of presenting complaints and systems enquiry (dealt with later) should answer the following questions:

- Which system do the symptoms come from?
- How severe are the symptoms?
- How many systems are involved?

As a general guide, explore the following.

- The patient’s interpretation of that symptom:
  - ‘Exactly what do you mean by palpitations?’
- Duration and onset:
  - ‘When and how did it start?’
  - ‘Was it sudden or gradual?’
  - ‘What were you doing at the time?’
- Severity and functional status:
  - ‘What sort of things can you not do now compared with when you were last well?’
- Precipitating, exacerbating and alleviating factors:
  - ‘What seems to bring it on?’
  - ‘What makes it worse?’
  - ‘What makes it better?’
- Previous similar episodes and if so, find out the outcome:
  - ‘What was the diagnosis?’
  - ‘What investigations and treatments were carried out?’
- Associated symptoms from that system:
  - If the patient has dysuria, ask about polyuria, nocturia and haematuria.
- In addition, if the presenting complaint is pain, determine the:
  - site
  - character (stabbing, squeezing, crushing, etc.)
  - severity (no pain = 0, worst ever = 10)
  - radiation
  - temporal relationship (worse at certain times, continuous or intermittent?)

**CLINICAL PEARL**

A useful mnemonic when taking a pain history is **SOCRATES**:

- Site
- Onset (sudden or gradual)
- Character
- Radiation
- Associations (other symptoms or signs)
- Time course
- Exacerbating and relieving factors
- Severity

**IMPORTANT**

‘Red flag symptoms’ – these are alarm symptoms which, by their very presence, pattern of behaviour or association with other elements in the history, indicate potentially serious underlying medical conditions such as carcinoma. These symptoms warrant prompt assessment and management. Examples include:

- Haemoptysis alone (?carcinoma, tuberculosis, pulmonary embolism)
- Back pain that is getting worse, lasts longer than 6 weeks, is associated with neurological symptoms such as sphincter disturbance, loss of perianal sensation or progressive motor weakness (?cauda equina syndrome)
- Tight central chest pain lasting longer than 15 minutes, with no relief following glyceryl trinitrate spray, in a patient who has diabetes, hypertension and a history of previous percutaneous coronary intervention (?acute coronary syndrome).

**PMH/PSH – past medical and surgical history**

In chronological order, for each condition specifically enquire about:

- diagnosis – when, where and how?
- complications
- treatment details
- any active problems
- follow-up arrangements (hospital, GP).
DH – drug history

The reasons for conducting a detailed drug history are numerous and include:

- assessment of the patient’s treatment response to date
- the patient’s symptoms may be related to drug side effects or interactions
- a medication list can provide valuable clues about the medical history that the patient may have forgotten to mention.

Enquire about current and past treatments. Details should include:

- indications (what was the medical reason?)
- response to treatment
- monitoring (e.g. warfarin and international normalized ratio (INR) checks)
- dosage and frequency (and any recent changes)
- side effects
- compliance:
  - does the patient know the doses and have they ever missed any?
  - do they get any help taking their medications?
  - district nurse administered medications or dosette boxes?
- do they take any over-the-counter preparations (e.g. aspirin) or herbal remedies?
- any illicit drug usage (for recreational or medical purposes)?

Allergies and adverse reactions – drugs, chemicals, food

Document any previous allergies and adverse reactions, severity (mild, moderate, severe or life-threatening) and management. This reduces future risk from prescribing errors. Try to ascertain if what the patient had was a true allergy, simple intolerance or troublesome side effects.

SH – social history

Exploring the social welfare of patients is perhaps the least well-practised section (and often the most relevant to the patient) in the traditional history-taking model. Yet, a detailed enquiry can provide the most useful insight(s) into the patient’s problems. Often, failure of social well-being and support networks can contribute to illness. Conversely, physical ailments can have detrimental effects on the quality of day-to-day life. Pay particular attention to:

- family and friends (including marital status):
  - their health and relationship well-being
  - frequency of visits.
- accommodation:
  - flat or house
  - nursing or residential home
  - flights of stairs or chair lift
  - toilet location – upstairs versus downstairs
  - modification to appliances – bathroom rails, door handles.

Help

- Who?
  - Family, friends, neighbours
  - Social services, district nurses
  - Meals on wheels
  - Carers
- What with?
  - Cooking, cleaning, dressing, shopping
  - Mobility – any walking aids?
- How often?
  - Once a day, twice a day, etc.

Occupation

- Nature of work – is the illness due to the patient’s occupation (e.g. asthma)?
- Consider the effects of illness on work (e.g. any absences)?
Leisure

- Hobbies (e.g. pet birds – psittacosis)
- Smoker? If so, what, and current or previous? Calculate the number of pack-years (see Box 1.2).
- Alcohol? Calculate the average units per week (current recommended weekly allowance is 21 units for men and 14 units for women).

**BOX 1.2 SMOKING PACK-YEAR CALCULATION**
Assumption: 1 pack contains 20 cigarettes
Pack-years = packs smoked per day × years of smoking
So, 40 cigarettes smoked per day for 15 years = 2 packs per day × 15 years = 30 pack-year smoking history.

FH – family history
The FH provides valuable insight into whether the patient’s symptoms are related to a familial condition. Enquiries should be ‘open’ questions and serve as a screen.

- ‘Is the family well?'
- ‘Are there any illnesses that run in the family?'

If the answers are positive, construct a detailed family tree (see Fig. 22.2, p. 393). In particular, find out who is affected, the age, health and the cause of death, if known. Remember to be empathetic when discussing these potentially sensitive matters.

SE – systems enquiry
The systems enquiry is sometimes called the systems review, functional enquiry or review of systems. This is a brief review of symptoms from other systems and therefore a screen for illness elsewhere. Ask about:

- general:
  - weight
  - appetite
  - lethargy
  - fever
  - mood
- cardiovascular:
  - chest pain
  - exercise tolerance
  - breathlessness
  - paroxysmal nocturnal dyspnœa
  - orthopnoea
  - ankle swelling
  - palpitations
- respiratory:
  - cough
  - sputum
  - breathlessness
  - haemoptysis
  - wheeze
  - chest pain
- gastrointestinal:
  - abdominal pain
  - indigestion
  - dysphagia
  - nausea
  - vomiting
  - bowel habit
- neurological:
  - fits
  - faints
  - ‘funny turns’
  - headaches
  - weakness
  - altered sensation
  - speech problems
  - blackouts
  - sphincter disturbance
- genitourinary:
  - urinary frequency
  - dysuria
  - polyuria
  - nocturia
  - haematuria
  - impotence
  - menstruation
- musculoskeletal:
  - aches and pains
  - joint stiffness
  - swelling.

If any of the answers are positive, explore them in further detail.

Patient’s concerns, expectations and wishes
As you take the history, explore how the patient perceives their symptoms and the treatment they
Table 1.1 Example of history taking in a patient with jaundice

<table>
<thead>
<tr>
<th>Set</th>
<th>Data</th>
<th>Possible implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection</td>
<td>Yellow discoloration, Unkempt, Tattoos</td>
<td>Jaundice, Not coping, Hepatitis B and C</td>
</tr>
<tr>
<td>Language</td>
<td>Confused, slurred speech</td>
<td>Encephalopathy</td>
</tr>
<tr>
<td>Age</td>
<td>Young, Elderly</td>
<td>Hepatitis more likely, Malignancy</td>
</tr>
<tr>
<td>Occupation</td>
<td>Farm worker</td>
<td>Weil’s disease</td>
</tr>
<tr>
<td>Dialogue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenting complaint</td>
<td>‘I’ve been turning yellow doctor’</td>
<td></td>
</tr>
<tr>
<td>History of presenting complaint(s)</td>
<td>Longstanding symptoms, Travel abroad, Pale stools, dark urine, Blood transfusions, Previous similar episodes</td>
<td>Chronic liver disease, Shellfish, hepatitis A, Obstructive jaundice, Hepatitis C, Haemolysis, Gilbert’s syndrome</td>
</tr>
<tr>
<td>Past medical and surgical history</td>
<td>Liver disease, Gallstones, Diabetes mellitus, Recent abdominal surgery</td>
<td>Decompensation of chronic disease, Common bile duct stone, Haemochromatosis, Injury to biliary tract</td>
</tr>
<tr>
<td>Drug history</td>
<td>Intravenous drug use, Contraceptive pill, General anaesthetic</td>
<td>Hepatitis C, human immunodeficiency virus (HIV), Hepatocellular</td>
</tr>
<tr>
<td>Allergies</td>
<td>Any new medications</td>
<td></td>
</tr>
<tr>
<td>Social history</td>
<td>Relationship problems, unemployment, Smoking</td>
<td>Alcohol excess, Malignancy</td>
</tr>
<tr>
<td>Family history</td>
<td>Autosomal recessive</td>
<td>Haemochromatosis, Wilson’s disease</td>
</tr>
<tr>
<td>Closure</td>
<td>30-year-old man with jaundice</td>
<td>Problem – hepatitis, Cause – viral, Examination focus – tattoos etc., Investigations – hepatitis screen etc.</td>
</tr>
</tbody>
</table>

Table 1.1 Example of history taking in a patient with jaundice
anticipate. Ascertain their health-related goals. This is also a suitable point at which to enquire whether they are happy for information about their illness to be shared with family or friends.

CLOSEUP: concluding

Use this opportunity to summarize the main points from the history. Ask about any outstanding issues. Then thank the patient by name. Create a mental list of the patient’s problems and the possible causes. Use closure to plan the next few steps: confirming or refuting diagnoses and tackling these problems through focused examination, investigation and treatment.

DIFFICULT SCENARIOS

Despite the best efforts of this chapter, history taking is not always plain sailing! Occasionally, you will face patients from whom data gathering is difficult. This does not mean that the patients themselves are difficult. Do not be prejudiced or judgemental. Their conduct during the consultation could in itself be explained by their underlying problems.

- Are they having difficulties at home, e.g. financial, relationships?
- Is the problem with the hospital itself, e.g. long waiting times, perceived poor previous experience?
- Are there any medical problems, e.g. psychiatric illness, alcohol or drug misuse?

The key to dealing with these scenarios is prompt recognition so that appropriate action can be taken.

The reserved patient

**Key points**

- Remain patient.
- Use ‘open’ questions. (‘Headaches? Tell me more.’)
- Actively encourage the patient. Show an interest; gesture approvingly, smile, echo what is being said ‘Okay, right, yes’.
- Take control. (‘I can’t help you as much, without your help.’)

Avoid:

- Rushing the patient. Remember – only they know their symptoms.

The ‘rambling’ patient

**Key points**

- Use ‘closed’ questions.
- Summarize.
- Interrupt politely.
- Signpost (re-direct) questions (‘I am sorry to interrupt you. I can see you feel strongly about that and I shall try to come back to that later, but for the moment I would like to move on and ask you about your bowels’).
- Ask the patient to prioritize symptoms.
- Make them aware of time constraints.

Avoid:

- showing frustration or anger.
The elderly patient

Key points

- The social history is of vital importance in this vulnerable population. Are they at risk from neglect or confusion? Are they coping?
- Visual and hearing loss is common. Ensure adequate lighting is present and hearing aids are working. (If not, move closer.) Speak clearly and perhaps at a slower pace. Write down questions if needed.
- Polypharmacy is frequently encountered with resultant issues of compliance and side effects.
- Dementia may present problems with confusion and memory recall. Look for other sources to corroborate the history (relatives, carers, GP, etc.) and document this.

Avoid:

- making prejudicial statements or judgements. Not all elderly patients are the same!
- patronizing language such as ‘dear’.

SUMMARY

Use the principles of:
- set
- dialogue
- closure

to structure your medical history-taking.

Cover the following aspects in taking the medical history:

- PC – presenting complaint(s)
- HPC – history of presenting complaint(s)
- PMH/PSH – past medical/surgical history
- DH – drug history
- Allergies and adverse reactions
- SH – social history
- FH – family history
- SE – systems enquiry
- Patient’s concerns, expectations and wishes.

FURTHER READING


