What is History?

- A chronological record of significant events often including an explanation of their causes
- An account of a patient’s family and personal background and past and present health

Components of History

- Includes
  - Description of patient
  - Chief complaint
  - HPI
  - Medical problems (current and past)
  - Medications
  - Allergies
  - Surgical history
  - Family history
  - Social history

Importance of Histories

- Helps you learn about your patient
- Allows insight into patient’s problem
- Opportunity to observe behaviors
Patient Description

- Age
- Gender
- Race/ethnicity
- Occupation

Chief Complaint (CC)

- Primary reason the patient seeks help
- Often a single symptom or issue
- Best to document in patient’s own words
- In self-care, may learn before description
- How can I help you? What brings you here? What seems to be the problem?

- "My shoulders and back are really hurting."

Willie Pannik
- 23 years old
- College student

History of Present Illness (HPI)

- Elaborate on chief complaint
  - Duration
  - Aggravation factors
  - Relieving factors
  - Relevant associated symptoms

"It's been going on for a couple of weeks. I also have been peeing a lot...I'm irritable and not sleeping well."

"My heavy book and laptop bag seem to make the pain worse."

"I haven't taken anything for this."

"This happens to me every quarter for at least a couple of weeks! It never lasts past exam week, though."
Medical Problems

- Medical problems
- Diagnoses
- Things a doctor is treating the patient for

Medications

- Current medications
  - Prescription
  - Non-prescription
  - Supplements/complementary therapies
- Dose
- Frequency
- Effects (positive and negative)

Allergies

- Medications
- Foods
- Stings
- Substance (latex, adhesive, etc)

"I don’t go to the doctor…I’m pretty healthy!"
"I don’t take any medications, either."
"I feel sick on my stomach when I take aspirin."

Surgical History

- Procedures
- Date

"I had my wisdom teeth removed when I was 19."

http://www.believinginserendipity.com/2010/06/wisdom-teeth-extraction.html
Family History

- Any disease or condition that runs in family
  - Include mental health
  - Cancers
  - Cardiovascular issues
  - Etc
- Important for risk assessment

“"I think my grandmother has high blood pressure, or something.”

Social History

- Occupation
- Marital Status
- Illicit drug use
- Alcohol use
- Tobacco use
- Living situation
- Religious background
- Diet

“I live by myself in campus housing.”
“I don’t drink beer and stuff, and I hate the smell of cigarettes.”
“I drink about 5 cups of coffee a day, and usually a lot of Mountain Dew too.”

How to Take a History

- Introduce yourself
- Try to make the patient comfortable
- Try to see the patient’s point of view
- Ask clear questions
  - OPEN ENDED

How to Take a History

- Avoid jargon
- Avoid leading questions
- Stay organized
  - Forms
  - Mnemonics
CC/HPI
- S symptoms
- C characteristics
- H history
- O onset
- L location
- A aggravating factors
- R remitting factors

Medications
- D drug
- A amount
- T timing
- A action

SH
- T tobacco
- I Illicit drugs
- A alcohol
- S sexual
- H home life
- O occupation
- E eating (diet)

SOAP

Importance of Documentation
- Facilitates next encounter
  - You
  - Other healthcare provider
- Used to justify payment for services provided
- Legal implications

“If it wasn’t documented, it wasn’t done”
Different Ways of Documenting

- SOAP note
- SOAP grid

SOAP notes

- Widely used format
- Organized information
- Easily understood
- Information presented top-to-bottom on page

SOAP grid

- Used in conference and therapeutics
  - Possibly some practice settings
- Organized information
  - Multiple prompts
- Shows complete thought process
- Information presented left-to-right on page

“S” – Subjective

- What the patient tells you
- Information FROM the patient
- Usually includes components of collected history
  - Review of systems

“O” – Objective

- What you find on your own
- Your observations
- Physical assessment
- Data from a medical chart
  - Laboratory results
  - Xrays and other studies
  - Information from other healthcare professionals

“A” – Assessment

- What you think is going on
- Why you think that
- Rationalization
- Goals of therapy
  - MAY ALSO BE INCLUDED IN PLAN
“P” – Plan
- What you want to do
- Pharmacologic therapy
- Non-pharmacologic therapy
- Counseling points
  - THREE PRIME QUESTIONS
- Monitoring parameters
- Follow-up

THREE PRIME QUESTIONS
- What is the medication for?
- How should the medication be taken?
- What should be expected from the medication?

Writing SOAP Notes
- Professional communication
  - Legal document
  - Part of the medical record
- Complete
- Concise
- Legible

Self-care Issues
- Setting
  - Be cognizant of privacy
  - Counseling room or area
- Information availability
  - Often no medical charts
- Limited resources

Triage
- Determine level of care necessary for patient
- Self-care may not be appropriate

Times to Triage
- Generally, symptoms for > certain number of days
- Severe symptoms
- Worsening symptoms
- When to triage immediately:
  - Myocardial Infarction symptoms
  - TIA or stroke symptoms
  - Loss of consciousness episodes
  - Head injuries; obvious fractures; excessive bleeding
Evaluate SOAP notes...

What about Willie Pannik?

Questions?

http://thebiggestnews.com/tag/waves