**History Taking Template**

Wash your hands
Introduce yourself, and ask permission to take a history

**General information**

Name:
Age:
Sex:
Occupation:

**Presenting Complaint:**

A short phrase describing the presenting complaint in the patients own words

**History of Presenting Complaint:**

Mnemonic - **SOCRATES** for pain

- **Site** - Where is the pain?
- **Onset** - When did the pain start, and was it sudden or gradual?
- **Character** - What is the pain like? An ache? Stabbing?
- **Radiation** - Does the pain radiate anywhere?
- **Associations** - Any other signs or symptoms associated with the pain?
- **Time course** - Does the pain follow any pattern?
- **Exacerbating/Relieving factors** - Does anything change the pain?
- **Severity** - How bad is the pain?

Need to explore the presenting complaint chronologically and incorporate relevant systems enquiries.

For example - Chest pain - need to explore cardiovascular, respiratory and GI systems enquiry in the history of presenting complaint as pathology from all of these systems could cause chest pain.

**Systems Enquiry**

Specific questions for each system – must be asked for every patient

<table>
<thead>
<tr>
<th>CARDIOVASCULAR</th>
<th>RESPIRATORY</th>
<th>GASTROINTESTINAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>SOB</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Palpitations</td>
<td>Cough</td>
<td>Diarrhoea/ Constipation</td>
</tr>
<tr>
<td>SOB/ SOBOE – quantify</td>
<td>Sputum production</td>
<td>Dyspepsia/ heartburn</td>
</tr>
<tr>
<td>Orthopnoea</td>
<td>Chest pain</td>
<td>Dysphagia</td>
</tr>
<tr>
<td>Paroxysmal Nocturnal</td>
<td>Haemoptysis</td>
<td>Haematemesis/ melaena</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermittent claudication</td>
<td>Wheeze</td>
<td>Rectal bleeding</td>
</tr>
<tr>
<td>Oedema</td>
<td></td>
<td>Jaundice</td>
</tr>
<tr>
<td>GENITOURINARY</td>
<td>NEUROLOGICAL</td>
<td>LOCOMOTOR</td>
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<tr>
<td>---------------------</td>
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<td>-----------------</td>
</tr>
<tr>
<td>Haematuria</td>
<td>Headache</td>
<td>Falls</td>
</tr>
<tr>
<td>Dysuria</td>
<td>Dizziness</td>
<td>Arthralgia</td>
</tr>
<tr>
<td>Increased freq micturition</td>
<td>Visual disturbance/ diplopia</td>
<td>Joint stiffness</td>
</tr>
<tr>
<td>Nocturia</td>
<td>Speech disturbance</td>
<td>Rashes</td>
</tr>
<tr>
<td>Hesitancy/ dribbling</td>
<td>Hearing disturbance</td>
<td>Mobility</td>
</tr>
<tr>
<td>Polyuria</td>
<td>Weakness</td>
<td>Functional deficit</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>Paraesthesia</td>
<td></td>
</tr>
<tr>
<td>Intermenstrual bleeding</td>
<td>Numbness</td>
<td></td>
</tr>
<tr>
<td>Menstrual cycle</td>
<td>Numbness</td>
<td></td>
</tr>
</tbody>
</table>

**Past Medical/Surgical History**

Mnemonic – JAM THREADS

- J - jaundice
- A - anaemia & other haematological conditions
- M - myocardial infarction
- T - tuberculosis
- H - hypertension & heart disease
- R - rheumatic fever
- E - epilepsy
- A - asthma & COPD
- D - diabetes
- S - stroke

**Drug History/Allergies**

Names and doses of all drugs
Compliance
Allergies – nature of allergy very important

**Family History**

First degree relatives
Any significant medical problems
If deceased – Age at which deceased and cause of death

**Social History**

Smoking:
- Current/ Ex-smoker
- Pack years – Age started smoking, number of cigarettes per day
Alcohol:
- CAGE questionnaire
- Quantify number of units per day/week
- Any episodes of alcohol withdrawal

Home circumstances:
- Independent/dependent for activities of daily living – washing/eating/shopping/cleaning
- Stairs/toilet on ground floor/bedroom on ground floor
- Mobility – with/without aids
- Carers
- Social support – who do they live with? Family close by?

**Examination**

See separate sheet

**Tests**

Document systematically

- Bedside investigations i.e. urine dipstick/ECG/BM
- Blood test results
- Radiology

**Impression**

What is your overall impression and list your differential diagnoses?

**Plan**

Further investigations:
- Bedside tests
- Blood tests
- Radiology
- Specialist investigations

Management:
- A clear plan of management for the next 24 hours including interventions (i.e. antibiotics, fluids)
- You should also outline a longer term management plan (i.e. further investigations that may be required)
- Clear parameters for aims of treatment – BP/PR/RR.
- Clear indications of when the nursing staff should contact doctors
- A clear plan for what to do in the event of deterioration
- Document any discussions about management with senior colleagues and colleagues from other specialities
- Document discussions with the patient and their relatives about the patients management
To complete your documentation:

- Sign and date your history at the bottom and clearly (and legibly) document your grade and your name