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

- **S**ite - Where is the pain?
- **O**nset - When did the pain start, and was it sudden or gradual?
- **C**haracter - What is the pain like? An ache? Stabbing?
- **R**adiation - Does the pain radiate anywhere?
- **A**ssociations - Any other signs or symptoms associated with the pain?
- **T**ime course - Does the pain follow any pattern?
- **E**xacerbating/Relieving factors - Does anything change the pain?
- **S**everity - 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

CARDIOVASCULAR	**RESPIRATORY**	**GASTROINTESTINAL**
Chest pain	SOB	Abdominal pain
Palpitations	Cough	Diarrhoea/ Constipation
SOB/ SOBOE – quantify	Sputum production	Dyspepsia/ heartburn
Orthopnoea	Chest pain	Dysphagia
Paroxysmal Nocturnal Dyspnoea	Haemoptysis	Haematemesis/ melaena
Intermittent claudication	Wheeze	Rectal bleeding
Oedema		Jaundice

GENITOURINARY	NEUROLOGICAL	LOCOMOTOR
Haematuria	Headache	Falls
Dysuria	Dizziness	Arthralgia
Increased freq micturition	Visual disturbance/ diplopia	Joint stiffness
Nocturia	Speech disturbance	Rashes
Hesitancy/ dribbling	Hearing disturbance	Mobility
Polyuria	Weakness	Functional deficit
Vaginal discharge	Paraesthesia	
Intermenstrual bleeding	Numbness	
Menstrual cycle	Cramps	

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 (ie 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