Chapter 2

The clinical consultation

Most diagnoses are reached from the case history alone. The use of physical examination is to confirm your hypothesis or to fully qualify and quantify the extent of the patient's problem.

As the practitioner you must be able to put the patient at ease so that they feel comfortable enough to talk freely and openly. It is important to keep questions as open as possible to elicit the maximum amount of information from the patient. Record the patient's story accurately, but at the same time maintain good eye contact.

You must be able to evaluate what the patient is saying and follow up the information with more appropriate and focused questions directed towards your differential diagnoses. The questioning and language you use should be adapted to the age, sex and background of the individual patient. Avoid using too many technical terms or jargon.

It is useful to break down the case history into a number of identifiable sections. These will help to ensure your history progresses in a logical manner and to ensure that vital details are not omitted:

I. **The patient's personal details**
II. **The Presenting complaint**
III. **The onset and history of the presenting complaint**
IV. **Past medical history**
V. **Medications – present and previously**
VI. **Family history**
VII. **Personal and social history, and**
VIII. **Systems inquiry**

Before starting the case history there are a few clerical details that must be obtained from the patient:

1. **Patients full name**
2. **Address & telephone number**
3. **Date of birth**
4. **Date of the consultation**
5. **GP's name & address**
6. **Occupation**
7. **Weight & height**
8. **Marital status (and any children)**
9. **Who referred them to you**

Introduce yourself by shaking the patient's hand, and go on to tell the patient who you are, and what the consultation will involve. Tell them what is likely to happen at the end of the consultation and ask them whether 'this is O.K.?'.

With regards to the presenting problem you must first identify the:

- **The location of symptoms**
- **The timing: that is the onset, duration, and frequency.**
- **The character or quality of symptoms.**
- **Perceived intensity or severity.**
- **Any identifiable patterns.**
- **Aggravating & relieving factors.**
- **Associated manifestations, such as co-existing signs and symptoms.**

A good way of memorising the nature of the presenting complaint is using the acronym of **SOCRATES**. This stands for:

S – Site
O – Onset
C – Character
R – Radiation
A – Associated manifestations
T – Time
E – Exacerbating and Relieving factors
S – Severity

Patients past medical history:
In this section enquire about general events in the patient's health, including childhood if appropriate.

- **Any investigations? If so when, why, and what was the outcome?**
- **Any significant illnesses? If so when were these, have they resolved, and how?**
- **Any operations? If so when were these, were there any complications and what were their outcome?**
- **Any accidents, traumas or fractures? If so what kind of injuries were sustained and how might they have affected their health?**
- **Also ask if they had any additional hospitalisations and if so when, and for what reasons?**
- **Do they have any allergies?**

DRUG HISTORY

1. **What drugs are they taking now?**
2. **What have they been taking in the past?**
3. **Drug reactions and sensitivities.**
4. **Immunisations?**
5. **Non-prescribed / over-the-counter medicines?**
6. **Complementary medicines?**
7. **Recreational drugs?**

FAMILY HISTORY

What is their parent's age? Inquire about their state of health and if they are deceased, what were the cause(s) of death. Ask if there are any hereditary diseases within their family.

PERSONAL AND SOCIAL HISTORY

Do not underestimate the importance of understanding the patient's lifestyle as in some cases it may play an important predisposing or maintaining role. Ask them to give you a rundown of a typical day's diet beginning with breakfast, lunch, dinner and any snacking in between. Pay particular attention to fluid intake – including water, tea/coffee and alcohol. With regards to alcohol, ask when they started drinking and the level of past consumption. Ask them about smoking, when they started and how much on a typical day.

SYSTEMS INQUIRY

This is often considered as a quick scan into each of the body's systems in order to ensure that you do not miss any conditions that relate to the patient's presenting complaint. This is especially important if this is the first time you have seen this particular patient or if there are insufficient records to rely upon. This is in order to help you evaluate any co-existing pathologies and how these may be influencing the patient and their presenting complaint.

The systemic inquiry is classically divided into:

1. **Cardiovascular system**
2. **Respiratory system**
3. **Gastrointestinal system**
4. **Genitourinary system**
5. **The peripheral and central nervous systems**
6. **The musculoskeletal system**
7. **Endocrine system**
8. **The skin**

References, Bibliography and Recommended reading

Jamison J R (2007), Differential Diagnosis for primary Practice, 2nd edn., Churchill Livingstone. (ISBN-13: 978-0443102875)

Goodman C G, Snyder T K (2007), Differential Diagnosis for Physical Therapists: Screening for Referral, 4th edn, Saunders. (ISBN: 978-0721606194)

Seller R H, Differential Diagnosis of Common Complaints, Saunders, 3rd edn, 1996 ISBN: 978-1416029069

Beck R, et al (2003), Tutorials in Differential Diagnosis, 4th edn., Churchill Livingstone. ISBN: 978-04430615-7-8

DVD-VIDEO recordings
Syrimis A (2007), Clinical Examinations DVDs, Bloomsbury Educational Ltd,
ISBNs:

- Respiratory system examination: 978-0-9551291-0-0
- General system examination: 978-0-9551291-1-7
- Cardiovascular system examination: 978-0-9551291-2-4
- Abdominal system examination: 978-0-9551291-3-1
- Peripheral nervous system examination: 978-0-9551291-4-8
- Cranial nerves examination: 978-0-9551291-5-5
- Musculoskeletal examination: 978-0-9551291-6-2
- Case History Taking: 978-0-9551291-7-9
- Clinical Examinations: Complete DVD series: 978-0-9551291-9-3

http://www.clinicalexams.co.uk/student-resources-section.htm
(For additional lecture notes, Q&As and images, Username & Password provided in class)

Boon N A, Colledge N R, Walker, B & Hunter J A A (2006), Davidson's Principles and Practice of Medicine. 20th Edition, Churchill Livingston ISBN: 978-0-4430703-5-8

Bickley, L. S.; Szilagyi, P. G.; 2003; ***Bates' Guide to Physical Examination and History Taking****;* (8th Ed); Lippincott; New York.

Epstein, O.; et al.; 1997; *Clinical Examination;* (2nd Ed.); Mosby; London. (similar to Bates but presents the information in a different but equally good way. Some very good photographs and is user friendly).

Marsh J; 1999 *History and Examination;* Mosby London. (a great 'crash course' book with sample questions. Very user friendly. I recommend it).

Forbes, C. D.; Jackson, W. F.; 1998; *Color Atlas and Test of Clinical Medicine;* (2nd Ed.); Mosby; London. Excellent reference book for photographs of various pathologies.

Haslett, C.; et al.; 1999; *Davidson's Principles and Practice of Medicine;* (18th Ed.); Churchill Livingstone; Edinburgh. (Use to put your clinical findings into context of general medicine).

Bradley J, Rubenstein D, Wayne D, The Clinical Manual, Blackwell Scientific publications. ISBN 0-632-03312-6. This is another very good pocket size book but you may have to order it. I find this book very useful because it also had a summary of the main pathologies and their signs and symptoms.