How to Use the History Form

In the beginning of ones clinical experience, the use of a history form with typical patient questions is an excellent method to develop ones “history taking” skills. Think of it as a crutch while developing the patient interviewing skills. Mastery of these questions takes approximately 50 new patient encounters. Once you are comfortable with these questions and are an experience practitioner, use of this form is no longer needed and may be replaced by a blank sheet of paper.

Patient's Name _____ Date _____

History (OPQRST and FAOMASH)

Identification: Age _____ Race _____ Gender _____

Chief Complaint

1. _____ **3. _____**

2. _____ **4. _____**

Current History:

Onset/Occurrence: When did it happen? How did it happen? How often is it present? How long does it last when it is present? What is the intensity of the pain? Have you had this before? When was the last time?

Palliative/Provocative: What makes it better? What makes it worse? Is there a change in position (lying, sitting or standing)? Is there a change in activity (walk, run, squat, rise)? Have you tried heat, cold, massage, stretches or exercises or medications?

Quality/Quantity: What is the sensation like (Sharp, Dull, Throbbing, Achy, Numbness, Tingling, Electrical, etc.)? On a zero to 10 scale, zero being no pain, 10 being the worst imaginable, what does it feel like in general? Does it restrict or stop your activities?

Radiation: Does the pain travel? If so, from where to where? How often is the radiation present and how long does it last?

Site: Does the pain change with patient's location (work, home, car, etc.)?

Time: Is there a change related to any time of day: morning, late morning, afternoon, evening or night time?

Past Medical History

Family History: How is the age and health of your mother, father, sisters, brothers, grandparents, aunts and uncles? Include a genogram (with at least three generations).

Accidents: Any past motor vehicle accidents, severe falls, major injuries like fractures or dislocations? If so, when did they happen, what treatments were you given, and are there any residual problems from the injuries?

Patient's Name _____ Date _____

Other Doctors: Who have you seen for this condition and what have they done for it? Who is your primary healthcare provider?

Medications/Vitamins/Herbs: Are you taking any medications, vitamins or herbs? What conditions are you taking them for? Who prescribed them for you?

Allergies: Do you have any allergies? Are you allergic to any medications? No Know Drug Allergies (NKDA)

Surgeries: Have you had any surgeries? Give examples if the patient does not recall.(Tonsils, appendix, gall bladder, hernia, uterus, ovaries?)

Hospitalization: Have you ever been hospitalized? When and what for?

Usual ChildHood Diseases (UCHD): Have you had measles, mumps, chicken pox or other childhood diseases?

Social History:

Married or single? Any children?

Your present and past employer?

Any exposure to environmental agents?

Your religion? Any hobbies?

Recreational activities? What is your living condition?

Where do you get your water supply? Do you smoke, drink, use IV drugs,

Any blood transfusions Multiple sex partners?

For veterans, include military service history question. For pediatric patients, include sleep, play habits and pets.

Patient's Name _____ Date _____

System Review: **Do you have any problems with....**

General Weight loss, weight gain, weakness, fever, chills, fatigue, sweats, night sweats.

Skin Rashes, pruritus, lesions, bruising.

Head Trauma, headache, tenderness.

Eyes Vision, changes in the visual field, glasses, last prescription change, photo phobia, blurring, diplopia, spots, discharge, inflammation.

Ears Hearing changes, tinnitus, pain, discharge, vertigo.

Nose Sinus problems, nosebleeds, obstruction, polyps.

Throat Teeth, tongue, gums, dentures, lesions, hoarseness, sore throats.

Respiratory Chest pain, sneezing, dyspnea, cough, amount and color of sputum, hemoptysis, history of pneumonia, history of influenza or pneumococcal vaccinations.

Cardiovascular Chest pain, orthopenea (number of pillows used at night), dyspnea on exertion, paroxysmal nocturnal dyspnea, murmurs, hypertension, leg cramps.

Gastrointestinal Appetite, dysphagia, nausea, vomiting, hematemesis, indigestion, abdominal pain, diarrhea, constipation, melena, bloating, and anal discomfort, hemorrhoids, change in stool shape and color, jaundice.

Genitourinary Frequency, urgency, hesitancy, dysuria, hematuria, polyuria, nocturia, incontinence, venereal disease, discharge, sterility, impotence.

Gynecologic Gravida/para/abortions, menarche, last menstrual period (frequency, duration, flow), dysmenorrhea, spotting, menopause, contraception, last pelvic and Pap smear.

Endocrine Polyuria, polydypsia, polyphagia, temperature intolerance, thyroid difficulties, glycosuria, hormone therapy, changes in hair or skin texture.

Musculoskeletal Arthritis, trauma, joint swelling.

Hematology Anemia, bleeding tendency, easy bruising, lymphadenopathy.

Neuropsychiatric Syncope, seizures, weakness, coordination, sensations, memory, mood, sleep pattern, emotional disturbances, drug and alcohol problems.

Inquiring (TCM paradigm)

Chills and Fever
Perspiration
Food and Drink, Appetite and taste
Defecation and Urination
Pain
Sleep
Menses and Leukorrhea