Patient

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History and physical examination

Introduction

It is said that over 80% of diagnoses are made on history alone[1] . In recent times the focus (and the funding) has shifted towards technological advances in investigations, but there is no doubt that history and examination skills remain the cornerstone of clinical practice. This record will aim to provide you with some helpful tips; your patients will teach you the rest.

As this has the potential to be a very broad topic, see also the following separate articles: Consultation Analysis, Clinical Negligence, Electronic Patient Records and Telephone Consultations

Most articles on clinical topics will include the relevant aspects of history and examination for that subject.

Preparation

This is a frequently neglected area but it can be very important.

- Clear your mind of the last patient as you wash your hands to prepare for the next.
- Glance through the records before seeing the patient. Patients expect you to know their past medical history, even if it is the first time that they have consulted with you, because they know that you have the records. It is certainly worth noting the last consultation and the major problems as displayed on the screen.

- Think about your timing. Hospital consultants may allow up to an hour for new patient consultations, whereas general practice generally allocates a total of 10 minutes for history, examination and explanation (you are doing very well if you manage to fit in some health promotion). Secondary care also benefits from a referral letter, whereas if you have a patient who is unfamiliar to you, you may have to extract a clear and concise story in a brief duration. So it is important to be efficient and focused. If the consultation is over-running you will need to decide whether this is permissible (bearing in mind your obligations to other patients waiting to see you) or whether you need to ask the patient to return for another consultation. There are risks and benefits to both these approaches, and you will need to rely on your clinical judgement in coming to a decision.

History

Important information
"Always listen to the patient, they might be telling you the diagnosis." *Attr. William Osler* [2]

Communication skills

Remember that these are non-verbal as well as verbal [3] . Your manner, your physical position with regards to the patient's (this may not be within your control), and your body language all contribute to the outcome of the consultation. Be relaxed and smile to radiate confidence. If they have had to wait a long time, a comment addressing this with an apology at the outset is often appreciated; it will give you a much better start and shows respect for their individuality.

Avoid writing whilst the patient is talking to you; if they are saying a lot of relevant things - or there is importance in the temporal order of the narrative - and you need to jot them down, mention it to the patient so that they understand that you are still listening to them: "I'll just make a note of your symptoms as you go along so that I get the order right."

Extracting the information

Patients vary greatly in how they present[4] . Many will be anxious. This may manifest itself in a number of ways:

- The quiet patient from whom only monosyllabic answers can be extracted by direct questioning.
- The apparently over-confident patient who addresses (or adds to) their anxiety by turning up with an armful of internet printouts, concerned that they have been fatally afflicted by Von Noodles' disease.
- The angry patient whose wait for the appointment or in the waiting room has given them time to mull over the worst.
- The returning patient who needs endless reassurance.

We are encouraged to ask open questions and avoid leading questions. This may pose a challenge in the time-pressed clinic when confronted with a chatty patient who finds it difficult to give a clear history - in these cases, gentle steering phrases may be helpful:

- "That sounds tough. Tell me which one of these problems is troubling you most?"
- "Perhaps we can come back to that. Tell me a little more about the shortness of breath ..."

Note that the first addresses the patient's concern, whereas the second addresses yours. The two may not be the same but each is important. If their greatest concern is not worrying you, jot it down and make sure you address it at the end of the consultation (even if it is just to reassure them). It is worth noting that research has shown that on average, physicians tend to interrupt a patient within 16 seconds of asking an opening question, whereas allowing them to speak uninterrupted may take an average of just six seconds longer[5] .

Staying focused

In a patient-led interview, staying focused can be a challenge. Time will force you to do this. Ask yourself, "Why did this patient come?" There may be hidden anxiety such as a concern about cancer that needs to be explored and addressed. Patients sometimes open the consultation with, "I hope I'm not wasting your time." This may mean, "I hope I am wasting your time and this is not serious but I am worried." If the patient enters anxious and leaves reassured, the doctor's time was not wasted.

Sometimes, but less often nowadays, a patient may present with what they regard as an acceptable opening gambit such as a cold, although the doctor may think otherwise; whereas, really the patient wants to discuss erectile dysfunction or fear of cancer. This is usually introduced with, "While I'm here doctor."

The consultation is an opportunity to explore the patient's needs and expectations and to educate - all this inside 8½ minutes (1 minute for patient changeover, 30 seconds for hand-washing). Deciding what can safely be omitted for each patient as the consultation is truncated from an hour to 10 minutes and what must be included is a matter at great art and skill. Such matters as the patient's real agenda and health promotion within the consultation are discussed in the separate Consultation Analysis article.

Common problems

Certain presentations are so common that the doctor should have a protocol to follow for such consultations. This includes presentations of chest pain, breathlessness, dysuria, vaginal discharge and abdominal pain. It is focused and efficient. There are standard questions for rheumatology conditions or wheezing in children or diagnosing asthma in adults. Direct questioning may be helpful in narrowing down the diagnosis, but introduced too early it may lead the doctor down a number of blind alleys. Open-ended questions, followed by some specific questions to fill in the gaps, may be more productive [6] .

Nurses have shown themselves able to provide a great range of safe care by following protocols. Some doctors are less comfortable with protocols, aware that following them blindly is no defence against allegations of clinical negligence. A balance needs to be struck. Much of the time, protocols are a swift, efficient and effective way to cover the ground with risk management in that they reduce the chance of forgetting or overlooking something important However, doctors must continue to use their clinical judgement, and tailor their approach to the individual patient and the individual clinical scenario. Care must be patient-centred, not protocol-centred, but if variation from a protocol occurs, the healthcare professional must be prepared to justify their approach, and importantly, document their reasons.

Past medical history

Patients assume that the doctor has their medical records and is fully conversant with their past medical history. Although major events should be displayed on the screen, some may be incomplete and it is worth checking both for completeness and to assure the patient of one's thoroughness. The habitual loss of medical records means that most records are of remarkably short duration. As mentioned above, unless you are familiar with the patient, it is worth looking at past history and recent consultations before the patient enters.

Drugs

Note current medication - this is important not only as a indication of what they are on but also a reminder of other existing conditions they might have but have forgotten to mention. Drugs may contribute to the current problem or influence choice of medication for it. The constipated patient may be taking co-codamol. The computer will record if medication is overused or underused and the date of last issue. Enquire about over-the-counter (OTC) remedies and possible herbal or other treatments. The latter are just as likely as prescription-only medicines (POMs) to have toxic effects or drug interactions, perhaps more so as they have not been so thoroughly tested.

Family history

Patients also assume that their family doctor is aware of their family history. Many conditions do have a genetic component, including coronary heart disease, diabetes, atopic eczema, autoimmune disease, glaucoma and some cancers. So if you are reviewing a patient with one of these diagnoses, it may be worth noting the genetic component to them so that family members can be assessed.

Social history

Similarly, patients assume that their doctor knows their social situation. It may be relevant, such as the middle-aged spinster caring for disabled and demanding parents, the single mother with a handicapped child, or the child with asthma who lives in a smoky, damp and overcrowded environment. Occupation may be very relevant to the aetiology of the disease and its management. It also indicates the person's level of education and hence ability to comprehend certain issues.

Examination[7]

Important information
"Just remember one thing. Whether the patient is a patient in real life, or a patient in an exam, they are a human being. A person. At some point, they'll be you."[8]

There is no real dividing line between history and examination. During the course of the history, you will gather a wealth of information on the patient's education and social background, and to a lesser extent, there will be physical signs to pick up. Examination needs to be as focused as history. Try to learn and apply good technique. Quite simply, good technique is more likely to give a correct result than poor technique. The yield from examining systems that are not obviously relevant is too low to justify in such limited time.

The first part of any examination is to observe. Learn to observe. Look before you lay on hands. Examination of the cardiovascular or respiratory system does not start with the stethoscope. You may get valuable information from the facies, skin colouration, gait, handshake and personal hygiene (reflective of physical, psychological and social background). Note the red eye, the freckles on the lips of Peutz-Jeghers syndrome or the white forelock of Waardenberg's syndrome. A number of endocrine disorders may be immediately apparent.

The doctor should have a protocol for each system. Many forms of examination have their own article covering appropriate topics listed below. All general practitioners should have competence in:

- Examination of the cardiovascular system, including auscultation of the heart.
- Examination of the respiratory system.
- Examination of the abdomen.
- Checking for hernia and lumps in the groin and scrotum.
- Examining lumps.
- Neurological history and examination.
- Competence at orthopaedic examination, which should include back examination, neurological examination of the lower limbs for knee and hip history and examination purposes, shoulder examination, and assessment of ankle injuries.
- Examination of tender, hot swollen joints.
- Gynaecological history and examination.
- Breast lumps and breast examination.
- Peripheral pulses.
- ENT examination.
- Examination of the eye.
- Mental state examination.

Management

In the 1980s, handing over a prescription indicated the end of the consultation. It is now recognised that educating the patient in their condition and involving them in management decisions is likely to both improve patient satisfaction and clinical outcomes.

Investigations

If you want to carry out investigations, think why you are doing so:

- To exclude or confirm a diagnosis.
- To reassure the patient.
- To satisfy the priorities and local protocols of the hospital doctor to whom you may refer the patient.

Clearly, investigations should be justified in terms of costs and of potential risks they may pose for the patient. One of these risks is actually increasing patient anxiety (a well-established risk) - particularly in the event of an ambiguous or false positive result. It is better to establish what exactly a patient's fears are rather than going on to perform more tests or referring where there may not be the need.

Health promotion

Note the health template on the screen. It should be complete and reasonably contemporary. Just mentioning smoking, alcohol consumption or BMI will remind the patient and make them think about the issue. Linking specific lifestyle advice to the current illness is far more effective so pick your issue[9] . However, be careful not to swamp the patient's agenda with your own. Health promotion may also affect your practice's performance under the Quality and Outcomes Framework.

Management should include health education and advice. This is not simply a move away from paternalism but aids compliance and may reduce unnecessary attendance. Twin-tray laser printers enable printed patient information leaflets to be given to the patient to take away.

Records

When considering what to include and leave out when writing your records, ask yourself three things:

- Will the next doctor who sees this patient follow my train of thought and understand my management plan?
- Would this stand up in a court?
- Would I be happy for the patient to read these notes?

In the 1950s, history, examination and medication seldom exceeded one line of Lloyd George records. Be concise but do not skimp. Record thoughts such as "could be psychosomatic" or "may need endoscopy" and plans such as "if not better soon, refer". The notes may be a useful tool for you later and if the patient is seen for the same event by another doctor, they need to be able to understand what your thinking was and what management plan you had in mind. Ideally each patient contact should contain a mini management plan. The notes may also be subject to scrutiny in the case of complaint or litigation. The quality of notes can be fundamental to the defensibility of a case. Use abbreviations, but only those that other doctors would readily recognise.

Never record derogatory statements that would cause embarrassment if the patient were to read them or they were to be read out in a formal situation but do not avoid factual statements such as "smells of urine". Patients now have right of access to their notes.

Poor keyboard skills slow consultations and may tempt some to be more brief than they should. A few hours' training in keyboard skills is a sound investment.

Potentially tricky situations

The 'difficult historian'[6]

Not everybody can reliably give an historical account of their problem[4] . It is not enough simply to write 'difficult historian' (is this a withdrawn elderly lady or a drunken axeman?). State why and, depending on the problem, it may be useful, for example, to put in a comment of the patient's mental state via a mini mental state examination. Almost every patient can make some some sort of comment on their well-being, and asking a few very general questions ("Does it hurt anywhere?") can provide some useful pointers. Where possible, obtain the history from relatives, carers or friends. Where you suspect that there is a mental health problem, try to corroborate the information you are obtaining. If the patient is violent or intoxicated, describe the situation you are in and document verbatim what is said. Try to remain calm under fire. Make sure that the patient is not seriously ill before calling security or the police.

The child[10]

Children vary widely in their ability to communicate: the neonate's subtle signals may only be perceived by its mother, whereas the teenager communicates as an adult. The child's account should not be assumed to have any less credence than the adult's[11] . Children are capable of quite complex thought structures from a very early age[12] . Ask how the child prefers to be addressed and introduce yourself. Eye contact is reassuring for older children but not for younger ones. Have toys handy for the child ± siblings and note, throughout the consultation, how the child interacts with the family. Make sure you know what prompted the referral and what the parent or carer fears or thinks is the matter. Address this[13] .

Relatives

Generally, relatives are there to help and support the patient. Obvious cases are parents of young children or children of elderly parents. They are helpful sources of additional information. However, beware that their agenda may be different from the patient's one. For example, family denial or collusion is a problem that may be encountered in general practice. The relatives may even attempt to involve the doctor in the subterfuge[14] . The family's difficulty in dealing with a person's distress at the news of advanced cancer, or their desire to protect them from the news, may be subconsciously masked in statements such as: "Don't tell him, doc - it would kill him." This may serve to isolate the patient further who may be fully aware of the condition and unable to share this burden with the family who don't want him to know. The family's interpretation of events may not always be the same as the patient's in some situations where perhaps social events interplay with illness (as with mental health problems, for example).

The angry patient[15]

Patients may get angry if:

- There has been excessive delay in appointment times or in the waiting room.
- There are perceived medical failings.
- They do not feel that they have been taken seriously (or they have not received the treatment they felt entitled to).
- There is guilt (eg, with regards to a sick relative).
- There is grief following a diagnosis.
- There is a simple misunderstanding.

It is important to recognise the anger, both in the patient and in yourself [16] . Do not leave it unexplored. Recognising when the consultation is dysfunctional and addressing this with the patient can provide insight, and may save time in the long run. Try questions such as "Can you explain in your own words what is upsetting you?", or "Can we start from the beginning again?" then listen attentively (particularly to any grievances) and negotiate subsequent actions/plan with the patient. Maintain non-threatening eye contact, breaking this off intermittently when you speak. Deal with the main issue first, summarise the remaining points and then deal with each. Acknowledge honestly any faults (self, system) and work on how to resolve the issues. Often, just airing the problems will have done a lot to diffuse the situation.

> If you feel that there is a real threat of violence, get away or use the panic button.

Handling sensitive issues [17]

These are difficult to deal with, especially within a short time frame [18] . They may arise, for example, if the patient you are seeing clearly has symptoms and signs relating to chronic liver disease: you will need to ask questions relating to risk factors ('She thinks I'm an alcoholic'). If an elderly, bereaved man has lost weight, you may have to explore the possibility of depression and want to refer to psychiatrists ('He thinks I'm mad'). There is no textbook way of dealing with these and, over time, you may develop your own set phrases. If you are lucky enough to know in advance what you are going to have to say, plan it. Establish a rapport, cover all other aspects first and then deal with the issue gently but explicitly.

Bad news [19]

This is not easy to do, as it is distressing to us to cause distress in somebody else. First of all, allow time and make sure (to the best of your ability) that you can be in a private place where you will not be interrupted. You will have to gauge from the patient quite what they are prepared to hear; as a rule of thumb, honesty is the best policy. Make sure that when you are explaining the problem, you frequently check the patient's understanding (see below). You will develop your own style but here are some tips. Avoid:

- Not doing it or leaving it to somebody else.

- Putting it off ("Let's do a few more investigations").
- Baffling the patient:
  Surgeon: "I'm sorry Mrs J, we found a mitotic growth."

  Grateful patient: "Thank goodness, doctor, I thought you were going to tell me I had cancer!"
- Deliberately not picking up on patient cues.
- Excessive solemnity or gloom. Do not remove all hope.

Always take care when talking about a prognosis and never give a specific time period. Follow-up after breaking bad news is particularly important. See also the separate Breaking Bad News article.

Somatising patients [20]

Difficulties may emerge as a patient repeatedly presents with ongoing physical symptoms for which no cause can be found. Whilst some of these may be the harbingers of something sinister, common things are common and there may be an element of normal problems of daily living being turned into symptoms by an anxious patient. There is a risk of medicalising the patient in an attempt to answer their question, "What are you going to do about my [symptom], doc?" These patients may get dissatisfied with their own doctor and present to others. At some point the system cracks under the pressure of their demands and a test leads to a procedure which leads to a complication and a fresh round of presentations. Whilst following well-established paradigms of managing these patients (eg, be on your guard against manipulative behaviour, avoid referral or multiple doctor input, keep good records, communicate with colleagues), be aware of the new emergence of an actual disease entity and also of the underlying message ('I am depressed following my divorce and miss the attention I used to get'). See the separate Somatic Symptom Disorder article.

Further reading

- Lemon TI, Smith RH; Consultation Content not Consultation Length Improves Patient Satisfaction. J Family Med Prim Care. 2014 Oct-Dec;3(4):333-9. doi: 10.4103/2249-4863.148102.

- Hitawala A, Flores M, Alomari M, et al; Improving Physician-patient and Physician-nurse Communication and Overall Satisfaction Rates: A Quality Improvement Project. Cureus. 2020 Apr 22;12(4):e7776. doi: 10.7759/cureus.7776.
- Asif T, Mohiuddin A, Hasan B, et al; Importance Of Thorough Physical Examination: A Lost Art. Cureus. 2017 May 2;9(5):e1212. doi: 10.7759/cureus.1212.

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