GENERAL SCHEME OF CASE TAKING

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P.G SCHOLAR 2020 BATCH

P.G DEPT. OF SHALYA TANTRA

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GENERAL SCHEME OF HISTORY TAKING

- IT MEANS HOW TO FOLLOW A PATIENT FROM HIS ARRIVAL AT THE HOSPITAL OR CLINIC UP TO HIS NORMAL CONDITION.
- IT IS A GENERAL SCHEME AND APPLIED TO ALL PATIENTS WHOEVER COME TO THE PHYSICIAN/SURGEON.

THE GENERAL SCHEME INCLUDES-

1. HISTORY TAKING
2. PHYSICAL EXAMINATION
3. PROVISIONAL DIAGNOSIS
4. SPECIAL INVESTIGATION
5. CLINICAL DIAGNOSIS
6. TREATMENT (MEDICAL & SURGICAL)
7. PROGRESS
8. FOLLOW-UP
9. TERMINATION

1. HISTORY TAKING-

A. PARTICULARS OF THE PATIENT-

BEFORE INTERROGATING ABOUT THE COMPLAINTS OF THE PATIENT

FOLLOWING HEADINGS SHOULD BE NOTED IN THE HISTORY-SHEET :

a) NAME

b) AGE

c) SEX

d) RELIGION

e) SOCIAL STATUS

f) OCCUPATION

g) RESIDENCE

B. CHIEF COMPLAINTS-

THE COMPLAINTS OF THE PATIENT ARE RECORDED UNDER THIS HEADING IN A CHRONOLOGICAL ORDER OF THEIR APPEARANCE.

AS FOR EXAMPLE-

- SWELLING IN THE NECK- 1 YEAR
- FEVER (MOSTLY IN THE EVENING)- 6 MONTHS
- SLIGHT PAIN IN THE SWELLING- 5 MONTHS
- SINUS IN THE NECK- 1 MONTH

- IF A FEW COMPLAINTS START SIMULTANEOUSLY, WE SHOULD LIST THEM IN ORDER OF SEVERITY.
- AS VERY OFTEN THE PATIENT MAY NOT MENTION SOME OF HIS PREVIOUS COMPLAINTS AS

  HE/SHE CONSIDERS THEM INSIGNIFICANT OR UNRELATED TO HIS PRESENT TROUBLE.

- BUT ON THE CONTRARY , THIS MAY GIVE A VERY IMPORTANT CLUE TO ARRIVE AT A DIAGNOSIS.

AS FOR EXAMPLE, A PATIENT WITH RIGIDITY AND TENDERNESS IN RIGHT HYPOCHONDRIAC REGION OF THE ABDOMEN MAY NOT HAVE TOLD DOCTOR OF ‘HUNGER PAINS’ A FEW MONTHS BACK. BUT THIS COMPLAINT HINT AT ONCE THAT THIS A CASE OF PEPTIC PERFORATION.

C. HISTORY OF PRESENT ILLNESS-

THIS HISTORY COMMENCES FROM THE BEGINNING OF THE FIRST SYMPTOM AND EXTENDS TO THE TIME OF EXAMINATION.

IT INCLUDES-

i. **MODE OF ONSET OF SYMPTOMS**- WHETHER SUDDEN OR GRADUAL.

ii. **PROGRESS –** WITH EVOLUTION OF SYMPTOMS IN THE EXACT ORDER OF THEIR OCCURRENCE.

iii. **TREATMENT-** WHICH THE PATIENT MIGHT HAVE RECEIVED.

- SOMETIMES NEGATIVE ANSWERS ARE MORE VALUABLE IN ARRIVING AT A DIAGNOSIS AND SHOULD NEVER BE DISREGARDED.
- IT SHOULD BE RECORDED IN THE PATIENT'S OWN LANGUAGE AND NOT IN SCIENTIFIC TERMS. PATIENTS SHOULD BE ALLOWED TO DESCRIBE HIS OWN STORY OF SYMPTOMS.

D. PAST HISTORY-

- ALL THE DISEASES SUFFERED BY THE PATIENT, PREVIOUS TO THE PRESENT ONE, SHOULD BE NOTED AND RECORDED IN CHRONOLOGICAL ORDER.
- THEIR SHOULD BE MENTION OF DATES OF THEIR OCCURRENCE AND THEIR DURATION.
- PAST DISEASES MAY NOT HAVE ANY RELATION WITH THE PRESENT DISEASE.
- PARTICULAR ATTENTION SHOULD BE PAID TO THE DISEASES LIKE DIABETES MELLITUS, DIPHTHERIA ,RHEUMATOID FEVER, BLEEDING TENDENCIES, TUBERCULOSIS, SYPHILIS, GONORRHOEA, TROPICAL DISEASES, ASTHMA ETC.
- THEIR SHOULD ALSO TO MENTION ANY OF THE PREVIOUS OPERATIONS OR ACCIDENTS.
- THE DATES AND THE TYPES OF OPERATIONS SHOULD BE MENTIONED IN A CHRONOLOGICAL

E. DRUG HISTORY-

- PATIENT SHOULD BE ASKED ABOUT ALL THE DRUGS HE WAS TAKING
- IT WILL HELP TO GIVE A CLUE TO THE PRESENT ILLNESS OR IN THE SUBSEQUENT TREATMENT.
- IT IS IMPORTANT FROM ANAESTHETIC POINT OF VIEW.
- SPECIAL ENQUIRY SHOULD BE MADE ABOUT STEROIDS, INSULIN, ANTIHYPERTENSIVE, DIURETICS, HORMONE REPLACEMENT THERAPY, NSAIDS, CONTRACEPTIVE PILLS ETC.

F. HISTORY OF ALLERGY-

- IT IS VERY IMPORTANT AND SHOULD NOT BE MISSED UNDER ANY CIRCUMSTANCES, WHILE TAKING HISTORY OF A PATIENT.
- THE PATIENT SHOULD BE ASKED WHETHER HE/SHE IS ALLERGIC TO ANY MEDICINE OR DIET.
- IT SHOULD BE NOTED WITH RED TYPE ON THE COVER OF HISTORY SHEET.
- WE SHOULD MAKE IT A PRACTICE AND THIS PRACTICE WILL DEFINITELY SAVE MANY CATASTROPHIES (MISHAP, CASUALTY).

G. PERSONAL HISTORY-

UNDER THIS HISTORY, THESE SHOULD BE NOTED-

- SMOKING (CIGARETTES, CIGAR, AND BEEDI ETC WITH THE FREQUENCY.)
- ALCOHOL INTAKE (FREQUENCY, QUANTITY ETC).
- DIET- REGULAR/ IRREGULAR, VEGETARIAN/NON-VEGETARIAN FOOD, SPICY FOOD INTAKE OR NOT ETC.
- PATIENT'S MARITAL STATUS LIKE SINGLE, MARRIED, WIDOW/WIDOWER SHOULD ALSO BE NOTED.
- IN WOMEN, THE MENSTRUAL HISTORY MUST BE RECORDED.

H. FAMILY HISTORY-

IT IS ALSO VERY IMPORTANT BECAUSE MANY DISEASES DO RECUR

IN FAMILIES, LIKE-

- ❖ HAEMOPHILIA
- ❖ TUBERCULOSIS
- ❖ DIABETES
- ❖ HYPERTENSION
- ❖ PEPTIC ULCERS
- ❖ MAJORITY OF THE CANCERS PARTICULARLY BREAST CANCER
- ❖ PILES ETC.

- ➢ WE SHOULD ENQUIRE THE SUFFERINGS OF ANY MAJOR AILMENTS OF THE FAMILY MEMBERS.
- ➢ IF THEY ARE DEAD, THEN THE CAUSES OF THEIR DEATHS SHOULD ALSO BE ENQUIRED.

I. IMMUNIZATION HISTORY-

PARENTS SHOULD BE ASKED WHETHER THEIR CHILDREN HAVE BEEN IMMUNISED AGAINST THESE DISEASES-

- DIPHTHERIA
- TETANUS
- WHOOPING COUGH
- POLIOMYELITIS
- TUBERCULOSIS
- HEPATITIS A
- HEPATITIS B
- ROTA VIRUS
- INFLUENZA
- VARICELLA VIRUS ETC.

THANK YOU