

GENERAL SCHEME OF CASE TAKING

DR KRIPAL SINGH

ASSISTANT PROFESSOR

P.G DEPT. OF SHALYA TANTRA

PROGRAMME OUTCOME, COURSE OUTCOME & LEARNING OBJECTIVES

Programme Outcome (PO):

- Understand systematic case taking in clinical practice.
- Develop skills of history taking, diagnosis, and evaluation.

Course Outcome (CO):

- Explain components of history taking.
- Differentiate past, present, family, drug & allergy history.
- Demonstrate correct method of case recording.

Learning Objectives (LO):

- Define case taking and its importance.
- List steps of history taking.
- Apply systematic approach for diagnosis and management.

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

Q1. CASE TAKING BEGINS WITH –

- a) Family history
- b) Chief complaints
- c) Patient particulars
- d) Past history

Answer: c) Patient particulars

Q2. IN CHIEF COMPLAINTS, SYMPTOMS SHOULD BE RECORDED IN –

- a) Random order
- b) Order of severity
- c) Chronological order
- d) By system-wise approach

Answer: c) Chronological order

Q3. NEGATIVE ANSWERS IN CASE HISTORY ARE –

- a) Useless
- b) Sometimes more valuable
- c) To be avoided
- d) Recorded only if patient insists

Answer: b) Sometimes more valuable

Q4. HISTORY OF ALLERGY SHOULD BE WRITTEN –

- a) In green ink
- b) In red type
- c) In blue ink
- d) Can be omitted

Answer: b) In red type

Q5. WHICH OF THE FOLLOWING MUST BE INCLUDED IN PAST HISTORY?

- a) Previous illnesses
- b) Previous operations
- c) Accidents and dates
- d) All of the above

Answer: d) All of the above

Q6. WHICH OF THE FOLLOWING IS NOT PART OF PERSONAL HISTORY?

- a) Smoking
- b) Alcohol intake
- c) Diet
- d) Family illnesses

Answer: d) Family illnesses

Q7. FAMILY HISTORY IS IMPORTANT BECAUSE –

- a) Some diseases are hereditary
- b) It helps to know patient's occupation
- c) It gives marital status
- d) It is part of immunization history

Answer: a) Some diseases are hereditary

Q8. IMMUNIZATION HISTORY IS ESPECIALLY RELEVANT IN –

- a) Adults only
- b) Children
- c) Geriatrics
- d) Pregnant women only

Answer: b) Children

**Q9. WHICH OF THE FOLLOWING IS AN
EXAMPLE OF A DISEASE WITH FAMILIAL
TENDENCY?**

- a) Tuberculosis
- b) Diabetes mellitus
- c) Hypertension
- d) All of the above

Answer: d) All of the above



Q10. CASE TAKING ENDS WITH –

- a) Treatment
- b) Provisional diagnosis, progress, and follow-up
- c) Patient's social history
- d) Termination of examination only

Answer: b) Provisional diagnosis, progress, and follow-up