风暴式医学教程 MOSBY'S CRASH COURSE (原版英文医学教程)

病史与查体

History and Examination

James Marsh
with Wilfred Yeo Series Editor

国际医学畅销书

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该丛书是由国外知名医学专家指导、由优秀的医学院校学生执笔的系列教辅书。特殊的编写方式能免去超负荷学习的负担，有助于学生迅速、准确地掌握现代医学课程的核心知识和最新概念。

易学易记——大量生动、形象的图表，有助于摆脱枯燥的学习，轻松了解和记忆复杂的内容。

重点突出——要点栏，提醒关键内容，强化记忆；
检查栏，检测对主题的理解程度；
测试栏，通过模拟考试的方式，测试学习成效。

该丛书囊括了医学基础与临床的主要学科，其简明、系统的英文，能使你全面、快迅地掌握医学专业英语；低价高值的定位将让全国医学生以国内的价格购买到国外的畅销教辅书。

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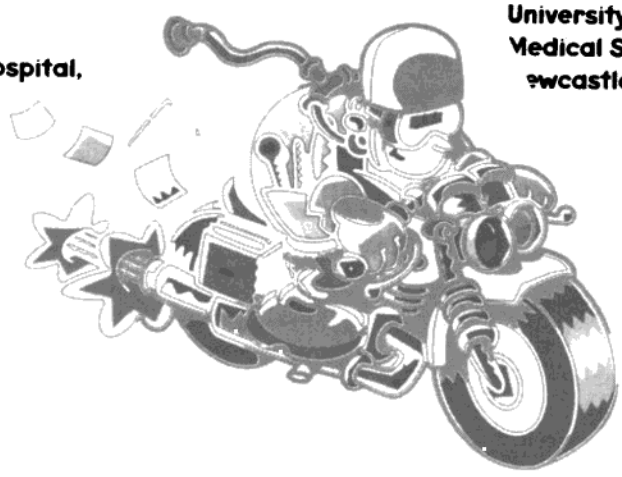

History and Examination

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Preface

The clerking is the cornerstone of medical practice. The aim of this book is to guide the student through the daunting task of collecting and restructuring the vast amount of information obtained from taking a history and the examination. The student is encouraged to develop an enquiring approach within a systematic framework so that all important information will be acquired. Following on from this, the student can formulate a clear path towards a differential diagnosis and management plan.

This book is primarily designed as a revision aid for students approaching examinations. The first two sections cover history taking and examination and are divided into body systems. A basic skeleton clerking is presented at the start of each section so that a structured approach can be adopted. Specific examples of different presentations or pathologies are then presented, illustrating how the history or examination can be adapted to different circumstances. The third section helps the student to collate information in the clerking, so that it can be structured and communicated in a digestible form allowing appropriate further investigations and therapeutic strategies to be implemented. Every patient is different – this is part of the challenge of medicine!

James Marsh

In spite of the vast array of technology now available to assist doctors in their work with patients, the role of the history and examination remains central in both diagnosis and management. A quarter of a century ago George Engel said '...the interview is potentially the most powerful, sensitive instrument at the command of the physician'. The move towards a more patient-centred clinical method in recent years has, if anything, increased the importance of the history and examination. The benefits of good communication go beyond making an accurate diagnosis – concordance with treatment is more likely, patient outcomes are improved, doctors feel more satisfied with their work, and complaints and litigation are reduced. Similarly, the physical examination does more than to help confirm your clinical hunches. It also enables you to make a more discriminating use of diagnostic technology, something that demonstrates a professional approach to the patient and will be appreciated by both your patients and the public purse.

This book offers a comprehensive, user-friendly guide to history-taking and physical examination. A flexible and discriminating approach is encouraged, one that is sensitive to patients' ideas, concerns and expectations. I am sure *Crash Course: History and Examination* will be useful to you not only in passing your exams, but beyond the dreaded long and short cases into 'real life'. James Marsh is to be congratulated for his efforts in authoring this text.

John Spencer
Faculty Advisor

Preface

So you have an exam in medicine and you don't know where to start? The answer is easy – start with *Crash Course*. Medicine is fun to learn if you can bring it to life with patients who need their problems solving. This series of books does just that, focusing on learning methods to find the right path through the differential diagnosis, and offering treatment promptly.

The *Crash Course* Series is designed to help you in preparing for exams and includes informative diagrams and Hint and Tip boxes to help you remember concepts. The books are comprehensive, accurate and well balanced, and should enable you to learn each subject well. To check that you did learn something from the book, (rather than just flashing it in front of your eyes!), we have added a self-assessment section in the usual format of most medical exams – multiple-choice and short-answer questions (with answers), and case studies for self-directed learning. Good luck!

Wilf Yeo
Series Editor (Clinical Sciences)

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Figure Credits

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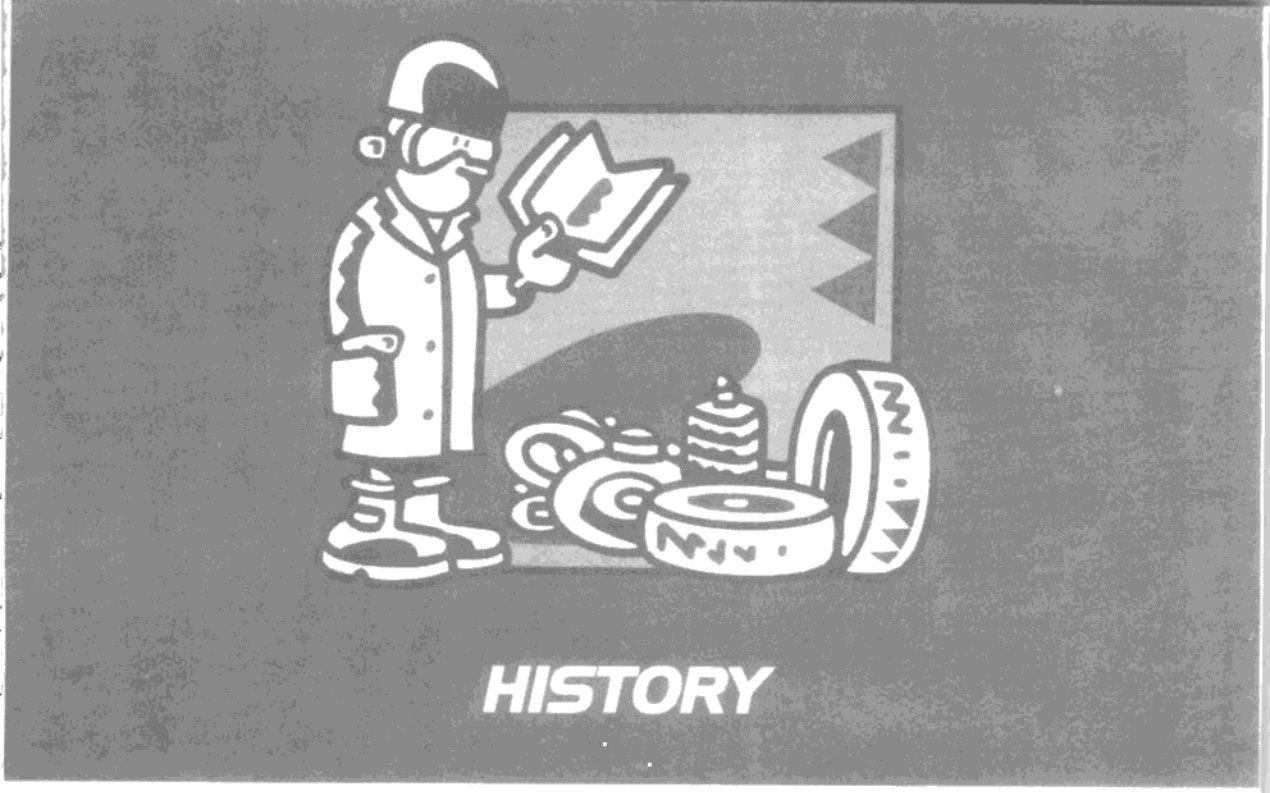

HISTORY

1. Introduction to History Taking

BASIC PRINCIPLES

The principal aims of medical clerking are to establish:

- What is wrong with the patient?
- How do these problems impact on the patient's life?

The standard approach is to obtain the history before conducting a physical examination and requesting appropriate investigations. Despite being discussed as separate chapters, these components of the clerking interlock with each other in a dynamic fashion from the moment that the doctor meets the patient.

The medical history has a traditional format, but it should not be considered as a rigid interrogation and checklist of questions. Although a structured approach is needed, it is important to adopt a flexible attitude, adapting your questions and differential diagnosis as information is received. The process of formulating a differential diagnosis starts as soon as the patient describes his or her presenting complaint. The symptom should be explored in detail so that possible diagnoses can be excluded, others can be introduced, and the relative probability of each assessed. Once the patient has described his or her main symptoms, specific questions should be asked to refine the differential diagnosis. Thus the process of history taking is an active skill, and not one of passive listening.

OBTAINING AND ASSESSING INFORMATION

Gleaning the important information is a fine art and takes years to master. Every medical student has experienced the frustration of taking a garbled, incoherent history from a rambling patient, only to see a consultant ask one or two seemingly simple questions that make the underlying diagnosis become embarrassingly straightforward.

The traditional approach is to start by asking 'open' questions, for example:

- "Tell me about your pain!"
- "Why have you come to hospital today?"

This gives patients the opportunity to tell you how they perceive their problems before the agenda is taken out of their hands, and your own prejudices take over. (It is surprising how often the doctor and patient focus on different problems.) By careful steering and gentle coaxing, even the most garrulous patients can usually give full, clear, and reasonably concise descriptions of their current symptoms. It is also necessary to ask 'closed' questions for further clarification, for example:

- "Does your abdominal pain get worse after eating?"
- "Did you black out completely or just feel lightheaded?"

It is a matter of judgement when to start interrupting and asking closed questions, but as a general rule, think twice before interrupting a patient in full flow. If specific questions are introduced too early, vital information may never come to light.

It is also important to obtain information on the impact the patients' illness has, not only physically but also in a wider context, psychologically and socially. A given pathological process affects individuals in very different ways, depending upon factors such as lifestyle, social circumstances, attitude to illness, and other medical problems. This information is vital for a full assessment and also reassures patients that the doctor is taking a genuine interest in them and not just their chest pain, arthritis, etc. Information to explore includes:

- Ideas. What does the patient think is wrong?
- Concerns. What is the patient worried might be wrong?
- Expectations. What does the patient think is going to happen in the consultation and regarding his or her future health? What might happen following the consultation? (e.g. investigations, operations).

RELATIONSHIP WITH THE PATIENT

The atmosphere and setting is important when taking a history. Patients should feel free to express their fears and concerns without fear or embarrassment. An absolute air of confidentiality should be tacitly created. At the same time, take note of any non-verbal signs (e.g. hostility, embarrassment). Often the most crucial information needs to be coaxed out of the patient. Never appear to be in a rush. Patients expect and deserve full attention and sympathy for their problems. It is not unusual for patients to express their real concerns just as they are leaving the consulting room.

However tempting, do not ignore throwaway comments from the patient. They often carry the key to the whole problem. Never be in a rush. Time invested in taking a good history pays dividends in the long term.

It is often useful (even if potentially time-consuming), to ask patients at the end of a consultation if there is anything else they wish to discuss. If patients feel at ease with you, they will talk more freely. They should feel confident not only in your diagnostic abilities, but also in your empathy, understanding, and motivation. After all, you are acting as their advocate. This process should start as soon as you greet patients.

Remember that first impressions really do matter. Appear friendly, but professional. Patients must have confidence in your abilities to act on their behalf.

DIFFICULT CONSULTATIONS

In certain circumstances the history can be considerably more difficult to obtain, for example if:

- There is a language barrier.
- The patient is confused, hostile, or unconscious.

There is, however, rarely any justification for resorting to a veterinary approach. Remember that the history is the most important part of the clerking. If there is a language barrier, help the patient to relax, do not rush, explain everything clearly, and if necessary obtain an interpreter. If the patient is confused or unconscious, history taking is still vital. A relative, carer, nursing home worker, or other witness is usually available to provide information. This process is time consuming, but worthwhile. Most doctors have learned from bitter experience!

The history is the most important part of the patient's assessment as it provides 80% of the information required to make a diagnosis.

OVERVIEW OF HISTORY SECTION

The first section of this book focuses on the history. Chapter 2 outlines the basic structure of a medical history, detailing the bare skeleton of the history. It is important to adopt a systematic approach so that all relevant information is obtained. The following chapters are used to illustrate the need to be flexible within that basic format, adapting your questions to different circumstances, so that differential diagnoses can be explored. The examples of medical histories are not intended to provide a rigid checklist of questions. History taking is a highly individual skill, and students will need to adopt their own style. The examples provided are only a framework, and should be adapted to suit your own preferences and the individual patient.

2. The History

INTRODUCTORY STATEMENT

Before taking a detailed history it is essential to obtain some background information from the patient. This should include the patient's:

- Name.
- Age.
- Sex.
- Occupation.
- Presenting complaint.

Ideally, try to use the words that the patient has used (e.g. people rarely complain of 'dyspnoea', but will say that they feel 'short of breath'). This statement should be short and pithy, for example "John Smith is a 56-year-old electrician complaining of chest pain".

This information is vital as it helps you (and any listeners) focus interest during the course of the subsequent history, so that appropriate questions can be anticipated if the patient does not volunteer the information. The process of forming a differential diagnosis should have already begun, but at this stage, it will by necessity be broad.

HISTORY OF PRESENTING COMPLAINT

This is the main component of the history. A detailed, thorough investigation into the current illness is performed. This is usually composed of two sequential (but often overlapping) stages:

- The patient's account of the symptoms.
- Specific, detailed questions by the doctor.

The relative proportion of each component depends upon the underlying problem, the communication skills of the patient, and the often underestimated listening skills of the doctor. Listening should be an active process. Ideally, the patient should be given every opportunity to talk freely at the start of the consultation with minimal interruption. A common mistake made by most students (and doctors) is to intervene too early.

Patients must feel that they are getting a fair hearing and have had an adequate opportunity to express themselves. They should be made to feel that the doctor is listening carefully and has a genuine concern for their problems. Subtle nuances are often missed if the doctor seizes the agenda too early.

A combination of art, experience, and patience determines when and how to interrupt a patient in full flow. It is prudent to allow the patient to drift a little (especially if you are inexperienced at taking histories). Make a mental note of the most important features of the narrative and issues that require clarification.

The full circumstances surrounding a single event or symptom need to be explored in a systematic manner so that a complete mental image can be obtained.

An example of this approach is illustrated below.

A patient complains of pain

Explore in detail the circumstances surrounding the episode so that a complete picture can be obtained.

What was the patient doing immediately before the episode?

Ascertain exactly what the patient was doing at the time of the onset of the pain (e.g. running, arguing with partner, sitting in chair).

Speed of onset

Determine the rate of development of pain (e.g. seconds, minutes, hours, days). It may be helpful to draw a graph of symptoms versus time (Figs 2.1 and 2.2).

Time of onset

Try to obtain exact times and dates if appropriate.

Subsequent time course

Map out the fluctuations in symptoms with time.

Duration

How long did the pain last? Patients often *overestimate* the duration of symptoms.