Learning Objectives

• Describe the purpose of effective history taking in prehospital patient care.
• List components of the patient history as defined by the National EMS Education Standards.
• Outline effective patient interviewing techniques to facilitate history taking.
Learning Objectives

• Describe how the paramedic uses clinical reasoning.
• Outline the process to determine differential diagnoses.
• Identify strategies to manage special challenges in obtaining a patient history.

History Taking

• Details gathered during interview with patient
• Provides account of medical, social events in patient's life
• Indicates environmental factors that have an impact on the condition

History Taking

• Gives structure to patient assessment
• Crucial to establish priorities in patient care
Patient History Components

- History obtained in prehospital setting
  - Focused on problem or reason EMS was summoned, problem-based history

Patient History Components

- Several purposes
  - History places emphasis on identifying life-threatening conditions requiring immediate intervention
    - Gives full attention to “needs of moment”
    - Patient provides information, leads, appropriate care for urgent, emergent, and nonemergent patient
    - Identifies potential life threats, existence of current life threat

Patient History Components

- Can be expanded when appropriate
  - Allows patient education
  - Opportunities to provide service referrals to agencies, organizations, help with specific health care needs
Patient History Content

• Each part has specific purpose
  – Offers “snapshot” of patient condition
  – Date, time obtained
  – Identifying patient information
    • Age
    • Sex
    • Race
    • Occupation (can be key to identifying problem)

Patient History Content

• Documentation should include source of referral, patient history
  – Who requested EMS assistance
  – Paramedic decides whether source of referral, patient history are reliable

Patient History Content

• Chief complaint is main part
  – Reason why EMS was summoned
  – After identifying chief complaint, obtain history with description of present illness, injury
    • Provides chronological account of patient symptoms
  – Next, question about past medical history, current health status
  – Perform body systems review, appropriate to patient’s symptoms, complaint
History Taking Techniques

- Set stage for good encounter, establish good first impression, make environment conducive to free-flowing communication
  - Establish professional demeanor with patient
  - Ensure patient comfort, provide safe environment
  - Greet patient by name, surname
    - Avoid demeaning terms such as “Granny,” “Pop,” or “Hon”

- Avoid entering patient’s personal space
- Inquire about patient’s feelings
- Be sensitive to patient’s feelings, experiences
- Watch for signs of uneasiness
- Use appropriate, easily understood language

- Ask open-ended questions, direct questions (if needed)
  - Opening questions determine why patient is seeking medical care, advice
  - Facilitation
    - Use posture, positive actions, words to encourage patient to say more
    - Maintain eye contact
    - Use phrases like “go on,” “I’m listening” to encourage continued talking
History Taking Techniques

• Clarification
  – Ask questions to better grasp vague statements, words

• Empathy
  – Ask about patient’s feelings, show empathy, interpret patient’s feelings
  – Helps gain patient’s trust

• Confrontation
  – Some issues may call for confronting patients about feelings
  – Asking severely depressed patient, “Have you ever thought about killing yourself?”

• Interpretation
  – When appropriate, go beyond confrontation, make inference from patient’s response
  – Draw inference from patient who says, “I think I’m going to die”; you may infer patient may be gravely ill
  – Ask patients about their feelings, use therapeutic techniques
  – Therapeutic communication encourages patients to explain how they feel
Chief Complaint

- Patient’s primary complaint
- Usually reason for EMS response
- May be verbal or nonverbal

Chief Complaint

- Most are characterized by
  - Pain
  - Abnormal function
  - Change in patient’s normal state
  - Unusual observation made by patient

Chief Complaint

- May be misleading
  - Problem may be more serious than complaint indicates
    - Patient who has fallen down steps may complain of injured ankle
    - Physical examination may reveal possible internal injuries
    - May have fallen from stroke
Chief Complaint

• Patients often modify or substitute
  – Hide problem they find embarrassing, difficult to discuss
  • Vaginal bleeding may be modified as heavy period, actually bleeding was abrupt hemorrhage, occurred during intercourse
  • Frequent headaches may be substituted for feelings of depression with suicidal thoughts

Chief Complaint

• Determining true reason for patient’s concern is one skill of history taking
• After identifying chief complaint
  – Manage life-threatening situations
  – Obtain history of present illness, relevant medical history

What single question would you ask a patient in order to identify the priority chief complaint when he or she has given you a list of problems?
History of Present Illness

• Identifies chief complaint, provides full, clear, chronological account of patient’s symptoms

• Obtaining takes skill
  – Asking proper questions related to chief complaint
  – Interpreting patient’s response
  – Low back pain complaint suggests muscle strain
  – Direct questioning reveals history
  – May be more crucial than obvious chief complaint

History of Present Illness

• Mnemonic OPQRST helps define patient’s complaint, focuses on essential elements of assessment
  – Helps lead paramedic through thorough a series of questions, better understand chief complaint
  – Take notes while obtaining health history
    • Most patients realize it is difficult to remember all details, accept note taking

History of Present Illness

• Onset/origin
  – Identify what patient was doing when pain began
  – Also notes whether patient has history of similar episodes
  – Questions to ask
    • Did the pain/discomfort begin suddenly or occur gradually over time?
    • When did you last feel well?
    • What were you doing when the pain started?
    • Did the pain begin during a period of activity or while you were at rest?
    • Have you ever had this pain or type of discomfort before? If so, is it the same or different than what you’re experiencing now?
History of Present Illness

• Provoke/palliation
  – Refer to precipitating factors associated with patient’s complaints
    • Ask questions, identify precipitating factors
    • What makes the pain/discomfort better?
    • What makes the pain/discomfort worse?
    • Does pain increase or decrease when you take a breath?
    • Does lying down or sitting up affect your discomfort level?
    • Have you taken any medication for symptoms? If so, did the medications make you feel better?

• Quality
  – Refers to how patient perceives pain, discomfort
  – Ask questions to obtain pain quality
    • What does the pain feel like?
    • Can you describe the pain?
    • Is the pain sharp or dull?
    • Is the pain constant, or does it come and go?

• Region/radiation
  – Refer to pain location, whether localized, associated with pain elsewhere in body
  – Ask questions to identify
    • Where is the pain?
    • Can you point with one finger to the exact location of the pain?
    • Does the pain stay in the same place or move?
    • If the pain moves, where does it go? Does the pain go to more than one area?
History of Present Illness

• Severity
  – Refers to how patient rates pain/discomfort level
  – Provides baseline for future pain evaluation
  – Ask questions
    • On a scale of 0 to 10, with 0 being least, 10 being worst, how would you rate the pain/discomfort?
    • How bad is the pain?
    • Does the pain intensity vary or stay same?
    • Have you had this type of pain before? If so, how is the pain different, or is it exactly the same?

• Time
  – Refers to duration of pain/discomfort
  – Ask questions to clarify duration of pain/discomfort
    • How long have you been feeling this way?
    • Have you had this same type of pain before? If so, how long did it last?
    • When did the pain/discomfort start?
    • How long did the pain/discomfort last?
    • When did the pain/discomfort end?
Past Medical History

• Obtain after gaining good grasp of chief complaint
• May include diabetes, cardiac/respiratory disorders
• May add insight into current state

Past Medical History

• Important past medical history may include
  – General health state
  – Medications
  – Allergies, nature of allergic reactions
  – Childhood illnesses
  – Adult illnesses
  – Psychiatric illnesses
  – Previous injuries
  – Physical disability due to previous illness, injury
  – Surgeries
  – Hospitalizations

Past Medical History

• Variety of memory devices used to recall key questions, gather medical history
  – SAMPLE survey
• Regardless of past medical history, direct questions should be asked to every patient
  – Answers can be significant in development of field impression
  – Pertinent positives, pertinent negatives can help build complete picture
Current Health Status

• Focuses on patient’s current health state
  – Considers personal habits, environmental conditions
  • Details regarding allergies, medications, last oral intake, family history can be critical
  • Question females with abdominal pain about last menstrual period if of child-bearing age
  • All patients with abdominal pain should be asked about last bowel movement
  • Identify events occurring before emergency

• Medications
  – Ask whether taking on regular basis, if so, for what reasons, frequency
  – Also ask about over-the-counter medicines, herbs, naturopathic, homeopathic medications
  – Determine adherence to medication regimen

• Medications
  – History may offer clues of chief complaint
    • Diabetic may have taken insulin but may have eaten at odd intervals
    • Patient with chest pain who takes various cardiac drugs
    • Irrational patient who takes prescribed sedatives
    • Trauma patient who takes blood-thinning drugs
Current Health Status

• Medications
  – Sometimes helpful to examine prescription fill date, determine whether patient has been taking medications as prescribed
  • Older adults with dementia may neglect to take medications, take more often than prescribed
  – History may not always be relevant to problem at hand
  • Can point to potential problems that may be seen during care episode
  • Sometimes wise to directly ask if patient has taken specific drugs
  • Administration of some medications can cause life-threatening conditions

What would you do if you couldn’t recognize the names or indications for the patient’s home medications?

Current Health Status

• Last oral intake
  – Important when considering potential airway problems in patient who loses consciousness, whose condition deteriorates
  – May help rule out some problems, such as food poisoning, food allergies
  • Certain types of food poisoning do not appear for several hours
  • Sensitivity to certain foods would develop allergic reaction immediately after eating the foods (peanut oil, shellfish)
Current Health Status

• Last oral intake
  – Can point to some illnesses
    • Undiagnosed, uncontrolled diabetic may report excessive hunger, thirst
    • Some older adults may have inadequate food intake, inability to procure, prepare food

• Family history
  – May be relevant to chief complaint
  – Establish whether family history of heart disease, high BP, cancer, tuberculosis, stroke, diabetes, kidney disease, current contagious illness, other ailments exists
  – Note presence, absence of hereditary diseases during interview
  – Through experience, will develop “personal line” of questioning that further analyzes patient’s particular symptoms

• Last menstrual period
  – Obtain history when interviewing females ages 12 to 55 who have abdominal pain
  – Ask when last period was, if it was normal
    • May prompt discussion of other significant symptoms
    • Response determines need to pursue additional questions regarding contraceptive use, venereal disease, urinary tract infections, ectopic pregnancy
Current Health Status

• Last bowel movement
  – Ask about habits to determine whether they have been normal, abnormal
    • Patient with abdominal pain may describe recent history of diarrhea, constipation, bloody bowel movements
  – Information helpful for receiving physician to assess bowel obstruction, dehydration, lower GI bleeding

Current Health Status

• Last bowel movement
  – Also ask about symptoms of abnormal urinary function
    • Blood in urine
    • Urethral discharge
    • Pain, burning with urination
    • Frequent urination
    • Inability to void

Current Health Status

• Events before emergency
  – Ask patient, bystanders about events that occurred before emergency
    • Fainting episode preceded by exertion, straining
    • Loss of consciousness before, after fall
  – Attempt to correlate any event with progression of illness, injury
Getting More Information

• With experience, will learn to communicate with more skill
  – Get more complete picture of patient’s illness, injury
  – Able to obtain more information about symptoms, complaints
  – Use clinical reasoning to evaluate associated problems, possible effects on body systems

Getting More Information

• With experience, will learn to communicate with more skill
  – Defining attributes of symptom may require asking direct questions
  – May involve obtaining history of sensitive topics
    • Alcohol use
    • Drug use
    • Physical abuse, violence
    • Sexual issues

Getting More Information

• Questioning sensitive issues guidelines
  – Remember privacy is essential with all, regardless of age, sex
  – Be direct, firm, do not apologize for asking
  – Avoid confrontation
  – Be nonjudgmental
  – Use easily understood language that is not patronizing
  – Encourage relevant questions
  – Document carefully, use patient’s words (note with quotation marks), when possible
Clinical Reasoning

- Depth, focus of interview based on case at hand
  - Still gather as much information as possible at scene, during transport
  - Select questions based on chief complaint, present problem
  - Use answers, think about associated problems, body system changes related to complaint
  - Requires integrating history with physical assessment findings

Clinical Reasoning

- Depth, focus of interview based on case at hand
  - Requires knowledge of anatomy, physiology, pathophysiology to direct appropriate questions to patient
  - Answers to questions analyzed as they are received
  - Be prepared to change track of questions based on careful evaluation of answers

Clinical Reasoning

- Process
  - Begin with broad possibility of systems that could contribute to complaint
  - Requires consideration of current symptoms, past medical history, abnormal symptoms, physical findings
    - Findings then analyzed by anatomical location
    - Must consider all systems found in that location that may cause, contribute to problem
    - Findings interpreted in terms of pathological process
Clinical Reasoning

- Process
  - Possible body systems involved must be narrowed down, ruled out
  - Allows development of working hypothesis of nature of problem
  - Differential diagnosis
    - Process of weighing probability of one disease versus that of other diseases possibly accounting for illness
    - Tested with questions, assessments relating to systems with similar types of signs, symptoms

Clinical Reasoning

- Process
  - Competing possibilities considered, paramedic selects most likely problem to treat
    - Pay careful attention to signs, symptoms that do not fit with working diagnosis

Review of Body Systems

- Identifying abnormal symptoms and signs
- Analyzing findings by anatomical location
- Assessing systems function by location that may contribute to the problem
- Identifying the findings in terms of the pathophysiologic process
- Developing a working hypothesis
- Selecting the most likely problem to treat

Note: This is a sample example of a differential diagnosis for chest pain. It illustrates what a paramedic considers in treating patients in terms of what they see. The data presented above was prepared by the author with the assistance of a professional physician and is intended for educational purposes. It should not be used as a substitute for professional medical advice. The physician should be consulted for any medical condition when necessary. The information presented is accurate as of the latest data available.
Special Challenges

• Each patient is unique
  – Each encounter is slightly different
  – Must adapt quickly to special requirements of each encounter
  – Can obtain needed information quickly

Special Challenges

• Silence
  – Often uncomfortable, has many meanings, uses
    • Collect thoughts
    • Recall details
    • Decide whether they trust paramedic
    • Can defuse emotionally tense event

Special Challenges

• Stay alert for nonverbal clues of distress, anxiety
  – Worried expression
  – Loss of eye contact
  – When patient is ready to talk again, will express feelings more clearly
  – May also result from paramedic’s lack of sensitivity, understanding, compassion
  – Appropriate, caring “bedside manner” is key to good care

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Special Challenges

- Overly talkative patients
  - Can be frustrating when there is limited time
  - No perfect solutions or helpful techniques
  - Accept less comprehensive history
  - Give free rein for first several minutes
  - Ask questions that invite brief “yes” or “no” answers when appropriate
  - Summarize comments frequently
  - Refocus discussion as needed

- Patients with multiple symptoms
  - Some, especially the elderly, have longer history because of age, chronic illness, medication use
  - Elderly more likely to suffer from more than one illness
  - Expect longer interview
  - Use therapeutic communication techniques, focus on most relevant aspects of chief complaint

- Anxious patients
  - Normal for patient, family, bystanders to be anxious
  - Be sensitive to nonverbal clues of anxiety, be supportive in calm, confident way
  - Professional, caring attitude often helps reduce anxiety
  - Be aware anxiety may not be related directly to illness, injury
  - Elderly on fixed income may worry about hospital stay cost
  - Car crash victim may worry about liability, losing car insurance
False Reassurance

• May be tempting in certain cases to say “It’s alright” or “Everything’s going to be ok”
  – May comfort ill, injured but should be avoided until they can be given with confidence
  – May block open dialog

False Reassurance

• Reassure medical condition is understood, good patient care is available
  – Comfort to know outcome is hopeful (if appropriate) and that the patient will be treated with dignity, respect during care
  – Verbal reassurances generally work well in most situations

Anger, Hostility

• Not too different from anxious behavior
• Natural response to some emergency situations
• Expect at times to be displaced toward EMS crew
Anger, Hostility

• Always ensure personal, scene safety
• Never appropriate toward patient
• More effective approach is to maintain calm, confident manner, set limits on acceptable behavior

Crying

• Can reduce tension, may help reestablish patient’s emotional stability during emergency
• If excessive, uncontrollable, be patient
  – Show compassion using direct eye contact, helps control crying
  – Reducing exhaustive crying conserves energy, promotes comfort

Depression

• Communication can be difficult
• Many types, causes
• Depression seen in emergency often due to moderate, high anxiety
• May also be enhanced by alcohol, substance use
Depression

- Use communication techniques for anxious patients
- If possible, identify seriousness of patient’s state
- Physician’s evaluation is encouraged

Sexually Attractive, Seductive

- Paramedics and patients may be sexually attracted to each other
  - Paramedic should accept that such feelings are normal
  - Feelings should not affect paramedic’s behavior
  - If patient becomes seductive, makes sexual advances
    - Paramedic should firmly set limits of what is acceptable
    - Should be made clear that relationship is a professional one
  - Providing same-sex care, often best practice
    - If not possible, extra caregiver should stay with patient

Confusing Behavior, Histories

- Emergency situations often intense, emotions can run high
- Expect confusing histories, inappropriate, abnormal behaviors
Confusing Behavior, Histories

• Contributing factors
  – Mental illness
  – Delirium
  – Dementia
  – Drug use
  – Illness
  – Injury

Confusing Behavior, Histories

• Identifying pattern of behavior may be difficult
  – Still try to identify one with signs, symptoms consistent with a certain disorder
• Attempt to lead patient in appropriate line of questioning

What illness or injury could cause a chief complaint of confusion?
Developmental Disabilities

• Do not overlook aptitude of patients with intellectual disabilities to provide adequate information
  – Interview just like other patients, using easily understood words, phrases
  – Obvious omission in answers reveals need for more questioning
  – Questions may need to be stated more clearly
  – Severe mental retardation, obtain information from family, friends

Communication Barriers

• May result from social, cultural differences, sight, speech, hearing impairments
• Seek assistance if possible
• Family members, translators, specially trained may be helpful

Family, Friends

• Talking with family, friends
  – Often at scene, good information source
  – If unavailable, try to locate third party (neighbor) who can help supply missing details
Summary

- Obtaining patient history offers structure to patient assessment, often identifies life threats and sets priorities in patient care
- Content of patient history includes date and time, identifying data, source of referral, history, reliability, chief complaint, present illness, past medical history, current health status, and review of body systems

Summary

- Paramedic should ensure patient comfort using several methods
  - Avoid entering patient’s personal space
  - Be sensitive to patient’s feelings, watch for signs of uneasiness
  - Use appropriate language and ask open-ended and direct questions
  - Use therapeutic communication techniques

Summary

- Clinical reasoning requires integrating patient’s history with physical assessment findings, also requires knowledge of anatomy, physiology, and pathophysiology to direct appropriate questions to patient
- Differential diagnosis is process of weighing probability of one disease versus other diseases as accounting for patient’s illness
Summary

• Many challenges can affect history taking
  – Silent or talkative patients
  – Patients with multiple symptoms
  – Anxious, angry, or hostile patients
  – Intoxicated, crying, depressed, and sexually attractive or seductive patients
  – False reassurance
  – Patient presenting confusing behaviors and histories
  – Developmental disabilities and communication barriers
  – Talking with family and friends can be complex

Questions?