MEDICAL HISTORY:

Structured study material for ICM II placement case study

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Taking medical history

I. BASIC DATA

(they are usually already available in the patient documentation, must be verified and supplemented in the interview)

Personal data:

Name, surname, academic title:

Date and time of admission/examination

II. REASON FOR ADMISSION TO THE HOSPITAL:

Patient arrived/was brought by ambulance car/recommended by for:

(brief information about the problem: pain, shortness of breath, fever, cough, rash, ……)

III. FAMILY HISTORY: (FH)

Father, mother: if they are alive, what diseases do they have; in case of death when did they die, at what age, what was the cause of death

Siblings: dtto

Children: dtto

Focused questions on diseases in the family: hypertension, heart attack, strokes, diabetes, tuberculosis, infectious diseases, malignancies, hepatitis, neurological diseases, psychiatric diseases.

IV. PERSONAL HISTORY (PH):

(Chronologically, with the year, eventually where he/she was treated. Let the patient talk and then clarify with specifically targeted questions)

Past illnesses: in childhood, in adolescencence, adult age
Target questions: hypertension, heart attack, pulmonary embolism, thrombosis, strokes, infectious diseases, tuberculosis, peptic ulcer disease, liver and kidney diseases, endocrinopathy (thyreoidea), diabetes, seizure disorders, neurological diseases (ask explicitly, even if the patient denies them).

Previous hospitalisation: reason, where he/she was hospitalised, year

Injuries:

Operation: procedure, where it was done, complications occured, year

Habbits and abusus: Smoking, use of alcohol, addictive substances, illegal drugs (also in the past)

Dietary habits:

V. PHARMACOLOGICAL HISTORY (PH):
Prescription and over the counter medications. Name, strenght and dosage.

VI. ALLERGIC HISTORY (AH):

Drug allergies (describe), food, contrast dyes (agents), contact allergies, hay fever, etc.

VII. GYNECOLOGICAL HISTORY (GH):

Menses (from - to), character, date of last period, methods of contraception. Pregnancies, how many? Number of births and abortions?

VIII. SOCIAL HISTORY (SH):

Marital status, with whom he/she lives, whom he/she takes care of, who takes care of him/her, financial security, housing conditions

IX. CURRENT DISEASE (CD):

The reason for hospitalizayion/chief medical complaints. The onset, circumstances of the onset, course of the disease. Previous tests and examinations. Previous and current findings, treatment.

Current symptoms: pain, shortness of breath, aktivity tolerance, appetite, feeling of hunger/thirst, weight gain ir weight loss, loss of strenght, mood and motivation changes, pattern of stool and urine elimination.

date, time, signature