History Taking Worksheet

1. Why is history taking important?
2. Do you use any acronyms for history taking?

Top tip- 70% of the time you will make a diagnosis based on the history taking alone.

1. How do you open a consultation?
2. A patient profile- What do you want to know that’s non-medical?
3. How would you ask the patient for the chief complaint?
4. Do you want to ask open ended, closed or leading questions? Are these appropriate?
5. What does SOCRATES stand for?
6. How would you determine the severity of pain?

What about with a child?

1. Map out your history taking process…
2. Make a list of each system- what would you assess?

For example- Respiratory- SOB, Cough, Sputum production, Chest pain, Haemoptysis, Wheeze, sputum colour, thickness time of when sputum is produced.

1. Reflection- Use the Gibbs cycle to reflect on a time where you have taken a history- would you change anything you did now?

If you haven’t taken a history before map out a history for a patient attending with SOB- What questions would you ask?

12. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3661386/>

Read this article and make notes.