Week 2: History Taking - cough

King Saud University
College of Medicine
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Riyadh, KSA

OBJECTIVE: **To conduct history taking on a patient with "cough".**
MATERIALS: **Well illuminated room, examination table or comfortable chair.**

D: Appropriately done PD: Partially done ND: Not done/Incorrectly done

	STEP/TASK	D	PD	ND
	Preparation			
1.	Greet the patient and introduce yourself.			
2.	Explain the procedure, reassure the patient and get patient's consent.			
3.	Make sure the patient is in a comfortable position sitting or lying down.			
4.	Maintain good eye contact and establish rapport with the patient.			
	HISTORY			
	Personal Information			
5.	Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
	Presenting Complaint:			
6.	Ask the patient about the main problem/s that made him/her went to see the doctor. "I have a cough"			
	History of Present Illness			
7.	Allow the patient to provide an account of recent events in his/her own words without interruption.			
8.	Ask the patient when the condition started.			
9.	Ask the patient if there is sputum or not. If it is present ask about its color. Ask if any history of hemoptysis			
10.	Ask to describe throat pain if it found.			
11.	Ask any associated signs and symptoms like fever, headache, runny nose, breathing difficulty, etc. Ask if the patient have history of longstanding heart burn , or post nasal drip			
	Past Medical History			
12.	Ask about any similar episodes in the past.			
13.	Ask about other medical conditions or congenital problems.			
14.	Ask about history of surgery, previous hospitalizations, allergy, blood transfusion, and trauma.			
	Family History			
15.	Ask about significant illness in the family like Diabetes Mellitus, Hypertension, etc.			
	Personal and Social History			
16.	Ask about use of alcoholic beverages, cigarette smoking or illicit drugs.			

17.	Ask politely about emotional problems at home or at work.			
	Obstetric and Gynaecologic History (if patient is female)			
18.	Ask about the LMP (last menstrual period), regularity and quality of menstruation. Ask age of menopause if patient is elderly.			
19.	Ask about number of pregnancy, number of children, and history of complications during pregnancy like Gestational Diabetes.			
	Systemic Review *(inquiry about all the cardinal symptoms in each of the major systems)*			
20.	Cardiac symptoms • Ask about having chest pain, ankle swelling, etc.			
21.	GIT symptoms • Ask about having weight loss or weight gain, nausea or vomiting, diarrhea or constipation, abdominal pain, excessive thirst etc. • Ask about having loss or increase of appetite.			
22.	Neurological symptoms • Ask about having nervousness, irritability, fatigue, or seizures. • Ask about having headache, dizziness, ringing in the ears, changes in hearing, vision, smell or taste, etc.			
23.	Urinary and Reproductive symptoms • Ask about having increased frequency of urination. • Ask about having burning on passing urine, frequency of urination, blood in the urine, etc. • Ask about having penile or vaginal discharge, hesitancy or urgency of urination, poor urine stream or dribbling, etc.			
24.	Dermatologic symptoms • Ask about having skin rashes, redness, or itchiness, etc. • Ask about having skin pigmentation, dryness, or sweating.			
25.	Musculoskeletal symptoms • Ask about having joint pain or stiffness, muscle pain or weakness, etc. • Ask about having overgrowth or shorter stature.			
	Closing			
26.	Make explanations to the patient, answer questions and discuss management plan. If appropriate, order diagnostic investigations *(e.g. CBC).*			
27.	Ensure that the patient is comfortable.			
28.	Thank the patient. Wash hands and document the procedure.			

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Simulated Patient Case Script

Cough

Your role in this session is to role-play a patient with cough.

Trigger

You have applied to your GP with a presenting symptom of "COUGH" you also feel tired Started two days ago.

Wait for the Doctor's (student) questions, and answer them based on the provided list below.
(If you face any unexpected questions, try to skip that question with a suitable phrase like:
"I have not recognized" "I did not pay attention" "I don't know" and inform the faculty about that/those questions). Please do not forget to add the gestures and mimics related to your scenario.

Personal and Social History: name, age, gender, occupation – *Please use as your own*.
Single and living with parents. No tobacco use.

Possible questions and answers about your present complaint:

1- When these complaints started? **It started two days ago.**

2- Do you have sputum? **Yes.**

3- Can you describe its color? **It is yellowish in color.**

4- Do you have any pain in your throat? **Yes. I have sore throat.**

5- Do you have fever or headache? **Yes, I had mild fever last night and no headache .**

6- Do you have any other symptoms (difficulty in breathing, runny nose etc.)? **No.**

7- Was there any change in your appetite? **No.**

8- What triggers or alleviates your complaint? **I did not recognize anything specific except the hot drinks alleviate the sore throat.**

9- Are you on any medication? **I took one paracetamol pill for fever last night.**

10- Do you have any medical problems or condition in the past? **No.**

11 - Does anyone in your family with similar condition? **No**.

Past medical history: Nothing specific, No important disease history, No operation, No current medication, No allergy.
Family history: Parents are healthy and alive, no major history of disease.