

Week 5

CNS History Taking

- **OBJECTIVE:** To take an ideal history related to CNS signs and symptoms.
- MATERIALS:** there will be standardized patient to take the history from him.

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

STEP/TASK	D	PD	ND
Introduce yourself to the patient.			
1. Personal data			
Name, Age, Gender, Nationality, Occupation.			
2. Chief complain			
Short statement of the problem that brought the PT, better recorded in the patient's own words.			
3. History of presenting illness.			
Symptom Onset (acute, subacute, chronic and insidious), Duration, Course of the condition (static, progressive, or relapsing and remitting), Aggravating & Reliving Factors , and Associated symptoms: such as Pain (back, neck, muscular), Headache, Syncope, Vertigo, SEIZURES, Paresthesia or Numbness, Fever, Nausea, Vomiting, Motor Difficulties (weakness, Atrophy, ataxia, bradykinesia & involuntary movement's), Visual Disturbance (diplopia, blurring, scotoma), Auditory Disturbance (hearing loss, tinnitus, dizziness) Dysphagia, Speech & Language Symptoms (dysarthria, dysphonia, comprehension problem), Mental Symptoms (memory difficulty, disorientation in the environment, confusion, lethargy, insomnia, forgetfulness anxiety, depression, hallucination, paranoid thoughts, personality change) Autonomic Dysfunction (bowel, bladder, sexual, postural hypotension). Pain should be further defined in terms of the following: Location, Radiation, Quality, Severity, and Aggravating & Reliving Factors.			
4. Past Medical History			
Same situation before, head trauma, toxic exposure.			
Chronic disease (DM, HTN, hyperlipidemia , renal or cardiac diseases , connective tissue diseases ...)			
History of hospitalization : Admission, Surgery			
5. Family & Social History			
Same situation in the family, chronic disease (DM, HTM), congenital & hereditary diseases, history of stroke or transient ischemic attack.			
Marital status, No. of children, housing status, job status & environment / conclude: socioeconomic status. History of travelling.			
Habits: smoking, drinking Alcohol, using prohibited substances. Blood transfusion			
6. Drug history:			
Any recent medication, long term medication, Allergies, Herbal Medication.			
7. Systemic review:			
CNS , CVS&RES, GIT, UT, MS			
SUMMARY			