Allergy (previous): ① substance abuse ② social (occupation, marriage, hobbies, hobbies, functions and participation) ③ psychological assessment ④ previous seek of help

History of low back Pain:

history goals:
① assess fully pattern of pain
② determine functional impairment
③ identify alarm symptoms

SOCRATES:

* all time frame questions: ① how long? ② progression ③ continuity ④ ~~A~~cuteness ⑤ previous episode/experience

Alleviating factors: ① medical specialist visit, ② rest/activity/special positions

* Associated Symp.
* Red flags
* risk factors

S: lower back including: sudden/gradual

O: i) acuteness: acute (<6 weeks) Vs chronic (>12 weeks), if pain hyperacute: fractures/trauma
ii) Continuity: most pains remit with alleviating factors
* constant pain in old people: malignancy
* constant pain in young: ankylosing spondilitis
iii) Progression: vide supra
iv) previous episodes/experiences

C: electrical shock: disk herniation, colicky: other visceral pain

R: radiating below the knee → sciatica
if in the abdomin → other visceral causes

A/E: better: rest, activity, special positions? eg. leaning forward: spinal stenosis
worse: rest, activity
with coughing/~~straining~~ standing: neurogenic claudication

T: at night: malignancy
at awakening
any other specific time

* previous seek of help

S: functional impairment, from 1o

Associated symptoms:

- fever / constitutional symptoms: weight loss, fatigue, anorexia
- weakness Neurological symptoms: weakness / sensory disturbances → possibly on the same distribution

alarm symptoms:

- Urinary / defecation problems
- pain that radiates to foot, esp. if both legs
- anesthesia of pelvic area / perineal area
- progressive weakness / sensation problems
- fever

*Past Medical: history of cancer (ask the question!), DM, immunosupressives, osteoprosis, trauma

*drugs: corticosteroids

*previous surgery

*family history: cancer, osteoprosis, DM

* Social: • substance abuse: IV drugs
• smoking • occupation • other social

*! indicate that you want to evaluate patient's psychosocial history, esp. if pain is persisting with no obvious findings

Diarrhea History:

1) * Establish the presence of diarrhea: • how many times?
   • are they watery and loose?
   • how many ~~times~~ times did you used to defecate before the appearance of symptoms?
   ~~* Character of stools:~~
   ~~Excessively watery~~
   ~~•~~

2) * Onset and other time frame questions:
   ① onset/duration
   ② progression
   ③ continuity
   ④ acuteness: acute Vs gradual onset
   ⑤ previous episodes/experiences

3) * Character of stools:
   ① amount of stools
   ② watery
   ③ blood / mucous
   ④ other changes of color: black, white, etc...
   ⑤ offensive smell/difficult to flush

4) * Associated symptoms:
   ① fever ② nausea/vomiting ③ abdominal pain ④ other constitutional symptoms
   ⑤ other GI symptoms ⑥ other related systemic symptoms

5) * Associations: gluten milk
   • Comes with: eating, with certain foods, recent food from outside, recent travel/ antibiotics with meals
   Relieved by: not eating

6) * Severity: if functional impairment