GENERAL PATIENT HISTORY-TAKING FORMAT, PRESENTED IN A STEP-BY-STEP

1. Patient's Basic InformationP

- **Name**
- **Age**
- **Gender**
- **Occupation**
- **Address**
- **Marital Status**

2. Chief Complaint (CC)

- **Primary Concern**: What is the main reason the patient has come for consultation?
- **Duration**: How long has this problem been present?
- **Additional Symptoms**: Are there any other symptoms associated with the chief complaint?

3. History of Present Illness (HPI)

- **Onset**: When did the symptoms first begin (sudden or gradual)?
- **Course**: How have the symptoms progressed (improved, worsened, remained the same)?
- **Nature of Symptoms**: Describe the characteristics (e.g., pain, cough, shortness of breath).
- **Aggravating/Relieving Factors**: What makes the symptoms worse or better (e.g., position, activity, medications)?
- **Associated Symptoms**: Any other complaints that have occurred alongside the chief complaint (e.g., nausea, fever)?

4. Past Medical History (PMH)

- **Chronic Diseases**: List any long-term illnesses (e.g., diabetes, hypertension, asthma).
- **Previous Surgeries**: Document any surgeries the patient has undergone.
- **Hospitalizations**: Record previous admissions to the hospital and reasons.
- **Injuries/Trauma**: Note any significant injuries or accidents.

5. Medication History

- **Current Medications**: Include all prescription drugs, over-the-counter medications, herbal supplements, and vitamins the patient is currently taking.
- **Drug Allergies**: Document any drug allergies and describe the type of reaction (e.g., rash, anaphylaxis).
- **Previous Treatments**: Mention past treatments taken for similar issues and their outcomes.

6. Family History (FH)

- **Hereditary Conditions**: Ask about family history of conditions like heart disease, diabetes, cancer, hypertension, and mental illnesses.
- **Immediate Family**: Document health status or cause of death (if deceased) of parents, siblings, and children.

7. Social History (SH)

- **Smoking**: Does the patient smoke? If yes, how much and for how long?
- **Alcohol**: Ask about alcohol consumption (frequency, quantity).
- **Recreational Drugs**: Inquire about the use of any illicit drugs.
- **Dietary Habits**: Assess the patient's typical diet (e.g., vegetarian, high in fats, fast food).
- **Exercise**: Document the patient's physical activity level.
- **Living Situation**: Where does the patient live, and with whom (alone, with family)? Are there any significant stressors?
- **Occupational History**: Ask about the patient's job and any potential exposures to harmful substances or ergonomic challenges.

8. Review of Systems (ROS)

Go through each body system to uncover any additional symptoms the patient might not have mentioned.

General: Weight loss, fatigue, fever, night sweats.
Skin: Rashes, itching, changes in moles.
HEENT (Head, Eyes, Ears, Nose, Throat): Headaches, vision changes, hearing loss, sore throat.
Respiratory: Cough, shortness of breath, wheezing.
Cardiovascular: Chest pain, palpitations, swelling in legs.
Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea, constipation.
Genitourinary: Urination problems, blood in urine, sexual dysfunction.
Musculoskeletal: Joint pain, muscle weakness, back pain.
Neurological: Dizziness, numbness, tingling, seizures.
Psychiatric: Anxiety, depression, mood changes, memory problems.

9. Allergies

- **Drug Allergies**: Any known drug allergies or reactions.
- **Food Allergies**: Any specific food intolerances or allergies.
- **Environmental Allergies**: Allergies to pollen, dust, animals, etc.

10. Immunization History

- **Routine Vaccinations**: Document vaccination status (e.g., tetanus, MMR, flu, hepatitis B).
- **Recent Travel**: If applicable, inquire about recent travel to areas where vaccinations like yellow fever or typhoid might be relevant.

11. Sexual History (if relevant)

- **Sexual Activity**: Ask if the patient is sexually active.
- **Number of Partners**: Inquire about the number of current and past partners.
- **Contraception/Protection**: Ask about the use of contraceptives or protection against STIs.
- **History of STIs**: Any history of sexually transmitted infections.

12. Obstetric and Gynecologic History (for female patients)

- **Menstrual History**: Document details about menstruation (regularity, duration, pain, heavy bleeding).
- **Pregnancies**: Number of pregnancies, miscarriages, and complications during pregnancy.
- **Contraceptive Use**: Ask about the use of birth control methods.
- **Menopause**: Document if the patient has gone through menopause and any symptoms.

13. Mental Health

- **Current Mental State**: Assess if the patient is experiencing anxiety, depression, or any other mental health concerns.
- **Past Mental Health Issues**: Ask about past psychiatric diagnoses, therapy, or medications.

14. Personal & Lifestyle Factors

- **Sleep Patterns**: Ask about sleep quality, duration, and any problems (e.g., insomnia, snoring).
- **Stress Levels**: Assess the patient's current stress level and coping mechanisms.
- **Recreational Activities**: Ask about hobbies and leisure activities.
