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ADULT HISTORY TAKING MANUAL

A Comprehensive Clinical Guide for Medical Students and Practitioners

Prepared by:

Dr. Raheel Azhar

About This Manual:

This manual provides a concise, structured framework for taking and recording a comprehensive adult medical history.
It is designed to help medical students, interns, and clinicians ensure that no key aspect of patient assessment is missed and that history taking remains systematic, efficient, and clinically focused.

Includes:

- Standardized Adult History Template
- Headings and Subheadings for Each Section
- Logical Sequence for Clinical Documentation

Edition:

2025 Clinical Format Version
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Comprehensive Adult History Taking Manual

I. Pre-Consultation & Introduction:

Knock, enter, wash hands, and ensure a respectful approach.

Greet the patient:

"Good morning, I am Dr Raheel, one of the doctors today."

Confirm patient's identity:

"Could I confirm your full name and date of birth, please?"

Explain your role and purpose:

"I have been asked to take your history to better understand what's been happening."

2. Verbal Consent

Obtain permission before proceeding:

"Would that be alright with you?"

3. Confidentiality

Reassure the patient:

"Everything we discuss will remain confidential within the medical team looking after you."

4. Presenting Complaint (PC)

Open question to begin the consultation:

"What's brought you in today?"
"Can you tell me what's been going on?"

(Allow the patient to explain freely before narrowing down.)

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5. History of Presenting Complaint (HPC)

Chronological exploration *of the symptom.*

Use appropriate framework depending on the nature of the complaint:

A. If Pain Is the Complaint—› ***Use SOCRATES***

S*ite* – Where is the pain?
O*nset* – When did it start?
C*haracter* – What does it feel like? (sharp/dull/burning)
R*adiation* – Does it spread anywhere?
A*ssociated symptoms* – Any vomiting, fever, or rash?
T*ime course* – Constant or intermittent?
E*xacerbating/relieving factors* – What makes it better or worse?
S*everity* – On a scale of 1–10, with 10 being the worst pain imaginable, how bad is it?

B. If non-pain symptom ***(e.g., cough, diarrhoea)*** —› ***Use OPQRST***

O*nset-*

"When did it start?" "Did it come on suddenly or gradually?" "What were you doing when it started?"

P*rovocation / Palliation*

"What makes it worse?" "What makes it better?" "Does movement, position, or breathing affect it?"

Q*uality*

"Can you describe what the pain feels like?" (Sharp, dull, stabbing, crushing, burning, throbbing etc.)

R*egion / Radiation*

"Where exactly is the pain?" "Does it move or spread anywhere?"

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***S**everity*

"On a scale of 1 to 10, with 10 being the worst pain imaginable, how bad is it?"

***T**ime / Timing*

"How long have you had it?" "Is it constant or does it come and go?" "How has it changed since it started?"

Include:

Impact on daily life (e.g., "How has this affected your usual activities?").

6. Ideas, Concerns, and Expectations (ICE)

Ideas:

"What do you think might be causing your symptoms?"

Concerns:

"Is there anything in particular that's worrying you?"

Expectations:

"What were you hoping we might do for you today?"

(This shows empathy, patient-centred communication, and insight.)

7. Past Medical History (PMH)

"Do you have any medical conditions such as diabetes, hypertension, or heart disease?"

"Have you ever been admitted to hospital?"

"Any chronic conditions under treatment?"

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8. Past Surgical History (PSH)

"Have you had any operations or procedures before?"

"When and why?"

"Any complications with surgery or anaesthesia?"

9. Medication History

"Are you taking any prescribed medications at the moment?"

"Any over-the-counter or herbal supplements?"

"How regularly do you take them?"

"Any recent changes?"

10. Allergy History

"Do you have any allergies to medications, food, or anything else?"

If yes, ask: "What happens when you take it?" (rash, anaphylaxis, etc.)

11. Social History

Occupation

"What kind of work do you do?"

Alcohol

"Do you drink alcohol? How often and how much?"

Smoking/Vaping

"Do you smoke or use any tobacco products?" (Pack-year if applicable)

Home Situation

"Who do you live with? Any support at home?"

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Mobility

"How do you usually get around? Are you independent or use aids?"

Recreational Drugs

"Do you use any recreational or non-prescribed substances?"

(Add travel history, diet, or hobbies when relevant to the presentation.)

12. Systemic Review

Screen other body systems briefly for associated or alternative pathology:

General: *weight loss, fever, night sweats, fatigue*.

Cardiovascular: *chest pain, palpitations, orthopnoea, leg swelling.*

Respiratory: *cough, sputum, dyspnoea, haemoptysis.*

Gastrointestinal: *nausea, vomiting, abdominal pain, bowel changes.*

Genitourinary: *dysuria, frequency, haematuria.*

Neurological: *headache, weakness, numbness, seizures.*

13. Patient's Additional Input

"Is there anything else you'd like to mention that we have not discussed?"

(Always offer the patient a final opportunity to contribute, OSCE examiners value this highly.)

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14. Summary

Summarize key points concisely:

"To summarize, Mr John is a 58 year old man presenting with… [duration, main symptom, relevant associated features, background conditions]."

Offer the patient a chance to correct or add details:

"Does that sound accurate to you?"

History-Taking Flow

1. *Introduction*
2. *Verbal Consent*
3. *Confidentiality*
4. *Presenting Complaint (PC)*
5. *History of Presenting Complaint (HPC)*
6. *ICE — Ideas, Concerns, Expectations*
7. *Past Medical History (PMH)*
8. *Past Surgical History (PSH)*
9. *Medications*
10. *Allergies*
11. *Social History*
12. *Systemic Review*
13. *Anything the Patient Would Like to Add*
14. *Summary*

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