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ADULT HISTORY TAKING MANUAL

A Comprehensive Clinical Guide for Medical Students and Practitioners

Prepared by:

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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:

2026 Clinical Format Version

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.)

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 Structured Symptom Analysis

***O**nset*

"When did it start?" "Did it come on suddenly or gradually?" "What were you doing at the time?"

***C**ourse/**D**uration*

"Is it constant or does it come and go?" "How has it changed since it started?"

***S**everity / **Q**uantity*

"How severe is it?" "How often does it occur?" "How much (e.g., sputum, stool frequency)?"

Character **/ N**ature of Symptom ***(symptom-specific)***

Cough → dry or productive? Diarrhoea → watery, bloody, mucus? Vomiting → bilious, projectile?

***A**ssociated **S**ymptoms*

"Have you noticed any other symptoms?"(e.g., fever, weight loss, shortness of breath)

***E**xacerbating / **R**elieving Factors*

"What makes it worse?" "What makes it better?"

Relevant Negatives **(Rule Out Serious Causes)**

Ask targeted red flags depending on symptom (e.g., haemoptysis in cough, blood in stool in diarrhoea)

Include:

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

"SOCRATES is for pain. Everything else needs symptom-specific thinking."

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?"

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. Family History

“Are there any conditions that run in your family — for example, heart disease, cancer, or diabetes?”

“Did your parents, siblings, or children have any similar symptoms to what you are describing?”

“How old were they when this was diagnosed?”

“Are your parents still alive? If not, what did they pass away from?”

11. 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.)

12. 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?”

Mobility

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

Recreational Drugs

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

13. Travel History

"Have you travelled anywhere recently, either in the UK or abroad?"

"Where did you travel to, and when did you return?"

"Did you take any vaccinations or malaria prophylaxis before travel?"

14. 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.*

15. 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.)

16. 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

01. Introduction

02. Verbal Consent

03. Confidentiality

04. Presenting Complaint (PC)

05. History of Presenting Complaint (HPC)

06. ICE — Ideas, Concerns, Expectations

07. Past Medical History (PMH)

08. Past Surgical History (PSH)

09. Medications

10. Family History

11. Allergies

12. Social History

13. Systemic Review

14. Travel History

15. Anything the Patient Would Like to Add

16. Summary