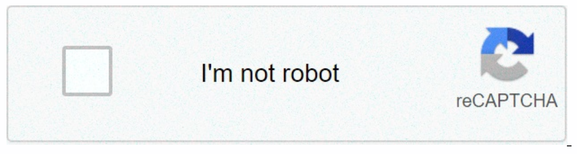

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Medical anamnesis form

Patient information obtained by a doctor Not to be confused with history of medication. See Medical History (journal). A patient's medical history, case history or anamnesis (from Greek: ἀνά, aná, open and μνσις, mnesis, memory) are information obtained by a physician by asking specific questions, either by the patient or by other persons who know the person and may provide appropriate information, with the aim of obtaining information that is useful in formulating a diagnosis and providing medical care to the patient. The medically relevant complaints reported by the patient or others familiar with the patient are referred to as symptoms as as opposed to clinical signs as detected by direct examination by medical staff. Most health meetings will result in some kind of history being taken. Medical histories vary in their depth and focus. For example, an ambulance paramedic will typically limit their story to important details, such as name, story presenting complaint, allergies, etc. On the other hand, a psychiatric history is often long and in-depth, as many details about the patient's life are relevant to the preparation of a management plan for a psychiatric illness. The information obtained in this way, together with the physical examination, allows the doctor and other health professionals to form a diagnosis and treatment plan. If a diagnosis cannot be made, a preliminary diagnosis may be formulated and other options (differential diagnoses) may be added, as indicated in the probability of convention. The treatment plan may then include further studies to clarify the diagnosis. The method by which doctors collect information about a patient's past and present medical condition in order to make informed clinical decisions is called history and physical (a.k.a. H&P). The story requires a clinician to be adept at asking appropriate and relevant questions that can give them some insight into what the patient may be experiencing. The standardized format of the story starts with the biggest concern (why is the patient in the clinic or hospital?) followed by the history of current illness (to characterize the nature of symptom (e) or concern (s)), the previous medical history, the previous surgical history, family history, the social history, their medications, their allergies, and a review of systems (where a comprehensive examination of symptoms that potentially affects the rest of the body is briefly performed to ensure something serious has been seriously missed). [1] After all the important story questions have been asked, a focused physical exam (meaning one that only implies what is relevant to the main concern) is usually done. Based on the information provided by H&P, laboratory and imaging samples are ordered and medical or surgical treatment is administered as needed. Process ecple A GP typically provides for the following information on whether patient: Identification and demographics: name, age, height, weight. The main complaint (CC) – the biggest health problem or concern, and its time lapse (e.g. chest pain for the last 4 hours). History of the current disease (HPI) - details of the complaints listed in CC (also often called history to present complaint or HPC). Previous medical history (PMH) (including major illnesses, previous surgery/surgeries (sometimes excellent as previous surgical history or PSH), any current ongoing illness, e.g. diabetes). Review of systems (ROS) Systematic interrogation on different organ systems Family diseases – especially those relevant to the patient's main complaint. Childhood diseases – This is very important in pediatrics. Social history (medicine) – including living events, occupations, marital status, number of children, drug use (including tobacco, alcohol, other recreational drug use), recent foreign travel, and exposure to environmental pathogens through recreational activities or pets. Regular and emergency medications (including those prescribed by doctors, and others obtained over-the-counter or alternative medications) Allergies – for medications, food, latex, and other environmental factors Sexual history, obstetric/gynecological history, and so on, as needed. Conclusion & Completion History-taking can be comprehensive storytelling (a fixed and comprehensive set of questions asked, which are only practiced by health students such as medical students, medical assistant students or nursing students) or iterative hypothesis tests (questions are limited and adapted to exclude in or out likely diagnoses based on information already obtained as practiced by busy clinicians). Computer history-taking could be an integral part of clinical decision support systems. A follow-up procedure is initiated at the onset of the disease to record details of future progress and results after treatment or printing. This is known as a catamnesis in medical terms. Review of systems Main article: Review of systems Regardless of system a particular condition may seem limited to, all the other systems are usually reviewed in a comprehensive history. The review of systems often includes all the main systems in the body that may provide the opportunity to mention symptoms or concerns that the individual may have failed to mention in history. Health care professionals can structure the revision of systems as follows: Cardiovascular system (chest pain, dyspnea, ankle swelling, palpitations) are the main symptoms and you can ask for a brief description of each of the positive symptoms. Respiratory system (cough, haemoptysis, epistaxis, wheezing, pain localized to the chest that can increase with inspiration or expiration). Gastrointestinal system (weight change, flatulence and heartburn, dysphagia, odynophagia, hematemesis, melena, haematochezia, abdominal pain, vomiting, intestinal habit). Genitourinary system pain with micturition (dysuria), urine color, any urethral discharge, altered bladder control as urgent in urination or incontinence, menstruation and sexual activity). Nervous system (Headache, loss of consciousness, dizziness and dizziness, speech and related functions such as literacy and memory). Cranial nerve symptoms (Vision (amaurosis), diplopia, facial numbness, deafness, oropharyngeal dysphagia, limb motor or sensory symptoms and loss of coordination). Endocrine system (weight loss, polydipsia, polyuria, increased appetite (polyphagia) and irritability). Musculoskeletal system (any bone or joint pain accompanied by joint lift or tenderness, aggravating and soothing factors for the pain and any positive family history of joint disease). Skin (skin rash, recent change in cosmetics and use of sunscreen when exposed to sun). Inhibitory factors Factors that inhibit taking a proper medical history include a physical inability of the patient to communicate with the doctor, such as unconsciousness and communication disorders. In such cases it may be necessary to record such information that can be obtained from other people who know the patient. In medical terms this is known as a heteroanamnesis, or collateral history, as opposed to a self-reporting anamnesis. Medical history taking can also be impaired by various factors that hinder proper physician-patient conditions, such as transitions to doctors that are unknown to the patient. History of ingesting issues related to sexual or reproductive medicine can be hampered by a reluctance of the patient to disclose intimate or unpleasant information. Although such a problem is on the patient's mind, he or she often does not start talking about such a problem without the doctor initiating the topic on a specific issue of sexual or reproductive health. [2] Some knowledge of the doctor generally makes it easier for patients to talk about intimate topics such as sexual subjects, but for some patients, a very high level of confidentiality can make the patient reluctant to disclose such intimate issues. [2] When visiting a healthcare provider about sexual problems, it is often necessary to have both partners in a few present, and this is typically a good thing, but can also prevent publication of certain topics, and according to one report increases stress levels. [2] Computer-assisted history that takes computer-assisted storytelling systems has been available since the 1960s. [3] However, their use continues to vary across health systems. [4] One advantage of using computer systems as a helping or even primary source of medically related information is that patients may be less susceptible to social desirability bias. [4] For example, patients may be more likely to report that they have engaged in unhealthy lifestyle behaviors. Another advantage of using computer systems is that they provide easy and portable to a one electronic health record. Also an advantage is that it saves money and paper. One drawback of many computer medical history systems is that they cannot detect non-verbal communication, which can be useful for elucidating concerns and treatment plans. Another drawback is that people may feel less comfortable communicating with a computer as opposed to a human. In a sexual history-taking setting in Australia using a computer-assisted self-interview, 51% of people were very comfortable with it, 35% were comfortable with it, and 14% were either uncomfortable or very uncomfortable with it. [5] The evidence for or against computer-assisted history that takes systems is sparse. As of 2011, there were no randomized control trials comparing computer-assisted versus traditional oral and written family history takes to identify patients with an elevated risk of developing type 2 diabetes mellitus. [6] See also Genogram Medical record Medicine Physical Examination Psychoanalysis (Freud uses the term anamnesis to describe neurotics' recounting of their symptoms) References ^ Patient responsibility. American Medical Association. Downloaded October 24, 2020. ^ 1.0 1.1 Quilliam, S. (2011). 'Cringe Report': Why patients don't dare ask questions and what we can do about it. 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