[IMAGE]

Help Your Doctor Help You

By K. Jeffrey Miller, DC, MBA

In health care, a patient’s history is divided into five categories: history of the present illness (HPI), review of systems, past history, family history and social history. Each category plays a role in your health to varying degrees based on your health presentation at the time of the visit.

The order of these categories is important because the history is recorded from "now" and then moves backward. The History of the Present illness (HPI) is the "now" portion of the history and the basis for all health histories. This category seeks several pieces of information:

Items to Include in a History of Present Illness

- Location of symptoms (where it hurts)
- How and when the symptoms began
- Quality of symptoms (what it feels like: achy, sharp, burning etc.)
- Severity of symptoms (usually listed as the degree of pain on a scale of 0 through 10)
- Duration of the symptoms (when it started)
- Timing of the symptoms (how much of the day are symptoms present, what times of day)
- Context of the symptoms (circumstances associated with the symptoms)
- Modifying factors for the symptoms (what makes the symptoms better or worse)
- Associated signs and symptoms for the current problem (any other problems)

It is important to start with the HPI because your doctor wants to help you with the current complaint, and previous events may or may not be related to current problems. Also, it is usually easier to provide your doctor with information about "now."

It is often difficult for a doctor to work from the distant past forward. Many patients cannot remember details about previous doctors, hospitals, testing facilities, diagnoses, medications or procedures. This limits the accuracy of the information provided and makes it difficult to access previous records.

Previous history information is important, but many doctors obtain the information utilizing paperwork completed by patients as they initially enter the office. This allows the doctor to spend more time focusing on "now."

After the information is gathered, the doctor can review the information prior to entering the exam room. Once in the room, the doctor can focus on the HPI and then cover information emphasized on the forms you have already completed.

Most health care providers request that patients come in prior to their scheduled appointment time to complete paperwork. For example, a doctor might schedule a new patient from 10:00 to 10:30 a.m., but ask that the patient be at the office by 9:30 am.

If a patient does not arrive when requested or shows up at the actual appointment time or later, everything is delayed. The patient's appointment runs behind and this carries over to other patient appointments.

To avoid this scenario, many doctors often mail paperwork to patients prior to their appointment or post the forms on their website. Under some circumstances, a nurse or assistant may call and obtain the information over the phone. These processes are a tremendous help to the doctor and ultimately the patient.

There are other techniques that can help with initial paperwork. With the availability of computers, tablets, smartphones etc., it is easy for *you* to keep a detailed personal medical history at your fingertips. Here are the categories of information contained in a personal health history. This information can be printed to give to your doctor at the time of the appointment or transferred to the doctor electronically:

<u>Items to Include in Your Personal Health History</u>

- Diagnosed ongoing medical conditions (usually permanent conditions such as diabetes, heart disease etc.)
- Current medications and supplements (name, dosage, number of times per day, prescribing doctor)
- Previous surgical procedures with approximate dates
- Previous hospitalizations
- Previous injuries
- Allergies
- Blood type

- Demographic information (full name, phone, address, e-mail, emergency contact etc.)
- Insurance information (employer, company name, group number, policy number, ID number, effective date, phone numbers)

It must be noted that there is one piece of information from your History of Present Illness that is often difficult for patients to list properly. It is the "how and when" related to the beginning of symptoms.

When a doctor reads the initial paperwork and the patient described the onset of their problem as, "Falling out of a truck in 1994," the doctor knows they may have difficulty obtaining the patient's history accurately in a timely manner. The accident described is a major point to consider but, as stated earlier, a previous injury may or may not have something to do with current symptoms.

Because there may not be a direct relationship between previous and current symptoms, it may be best to list the beginning of your "current" complaints in one of these time frames; when the symptoms appeared, when the symptoms became worse, when the symptoms became bad enough to seek help or as the day of the appointment. This usually establishes the onset within a reasonable time frame and any links to previous episodes can be traced back as needed.

So, before your next appointment, record your own health history and history of present illness. Be prepared to provide it in print or electronically to the doctor, be early to the appointment as requested and complete the necessary paperwork. Once the doctor has this information, they can address your current complaints in a faster and more efficient manner.

K. Jeffrey Miller, DC, MBA,is an assistant professor of chiropractic at the University of Missouri Orthopedic Institute, a branch of the University of Missouri Health System. He is a graduate of Palmer College of Chiropractic and the author of several practitioner and patient texts.