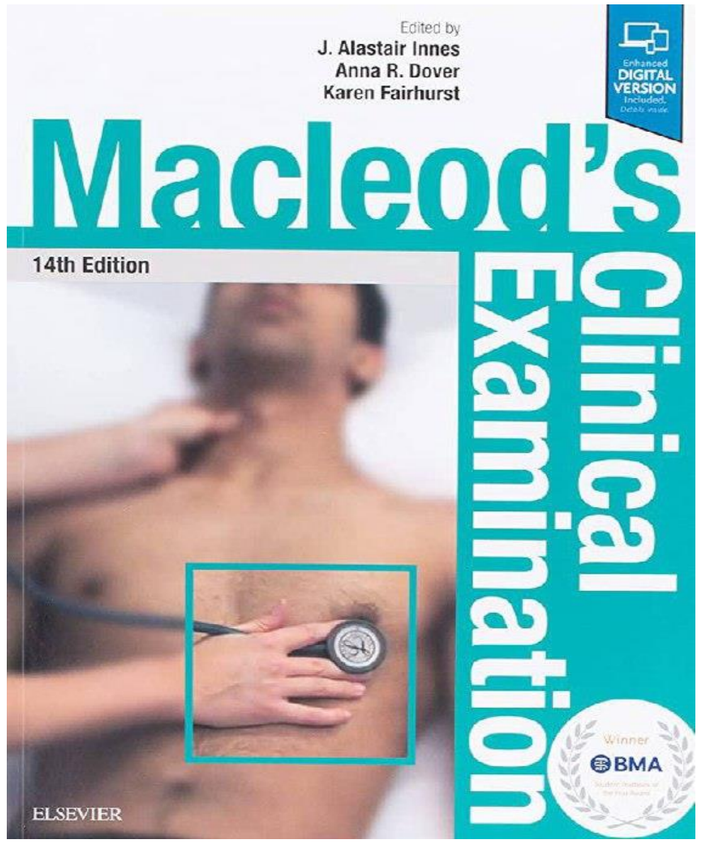


Outlines:

- Gathering Information (Beginning Of The History)
- Complete History Taking
- Difficult Situations

Done By: M. ALALI, MD, PH.
Introductory: Section 1 CH.2 General Aspect Of History Taking.
Note: This summary contains all Macleod's important notes.

For Full Material, please JOIN this WhatsApp Community:

Gathering information (Beginning of the history)

1. Preparation:

- **Read** your patient's past records along with any referral or transfer correspondence before starting.
- **Allowing sufficient time:** In UK general practice the average time available is **12** minutes? In hospital, around **10** minutes is commonly allowed for returning outpatients? For new and complex problems, a full consultation may take **30** minutes or more. For **students**, time spent with patients learning and practicing history taking is highly valuable, but patients appreciate advance discussion of the time students need.

2. Starting your consultation

- **Introduce** yourself and anyone who is with you.
- **Shaking** hands if appropriate.
- **Confirm** the patient's **name** and how they **prefer** to be addressed.
- **If you are a student, inform patients; they are usually eager to help**.
- **Write down facts that are easily forgotten**, such as blood pressure or family tree, but remember that writing notes must not interfere with the consultation.
- **Using different styles of question:**

1. **Begin with open questions** such as 'How can I help you today?' or 'What has brought you along to see me today?'
2. **Listen actively and encourage the patient to talk by looking interested and making encouraging comments**, such as 'Tell me a bit more.'
3. **Always give the impression that you have plenty of time**.
4. **Allow patients to tell their story in their own words, ideally without interruption**. **You may occasionally need to interject to guide the patient gently back to describing the symptoms**.
5. **While avoiding unnecessary repetition**, it may be helpful occasionally to tell patients what you think they have said and ask if your interpretation is correct (reflection).
6. **Showing empathy when taking a history**: Being empathic helps your relationship with patients and **improves their health outcomes**.
   Try to see the problem from their point of view and convey that to them in your questions.
   Empathy Vs. Sympathy:
   Empathy: I Know how you feel, Sympathy: I feel how you feel.

The following history illustrates the mix of question styles needed to elucidate a clear story:

When did you first feel unwell, and what did you feel? (Open questioning).

Well, I've been getting this funny feeling in my chest over the last few months. It's been getting worse and worse but it was really awful this morning. My husband called 999. The ambulance came and the nurse said I was having a heart attack. It was really scary.

When you say a 'funny feeling', can you tell me more about what it felt like? (Open questioning, steering away from events and opinions back to symptoms).

Well, it was here, across my chest. It was sort of tight, like something heavy sitting on my chest.

And did it go anywhere else? (Open but clarifying)

Well, maybe up here in my neck.

What were you doing when it came on? (Clarifying precipitating event)

Just sitting in the kitchen, finishing my breakfast.

How long was the tightness there? (Closed)

About an hour altogether.

So, you felt a tightness in your chest this morning that went on for about an hour and you also felt it in your neck? (Reflection)
Yes that's right.
Did you feel anything else at the same time?
(Open, not overlooking secondary symptoms)
I felt a bit sick and sweaty.
So, it's 3 weeks since your operation. How is your recovery going?
OK, but I still have to put drops in my eye.
And what about the swelling under your eye?
That gets worse during the day, and sometimes by the afternoon I can't see that well.
And how does that feel at work?
Well, it's really difficult. You know, with the kids and everything. It's all a bit awkward.
I can understand that that must feel pretty uncomfortable and awkward. How do you cope? Are there are any other areas that are awkward for you, maybe in other aspects of your life, like the social side?

Complete History Taking

- **Patient profile**
- **Chief complaint**
- **History of present illness**
- **Past medical and surgical history**
- **Family history**
- **Drug and allergy history**
- **Social history**
- **Systemic enquiry "Review"**

Patient profile

- **Patient's name, age, marital status, address, job.**
- **Source of history:** patient, relative …. etc.
- **Source & time of referral/admission.**
- **Who took the history?**
- **Date & time of history taking.**

Note:

- Name should be **full and accurate** in order to communicate with patient and for medico-legal issue.

Example:

- Mrs. Aseel Khaled Ali is a 30-year-old married lady.
- She works as a teacher and lives in al-Zarqa city.
- She was admitted on the 2nd of July 2022 on 3:15 a.m. through the ER.
- History was taken from the patient herself by me__, 4th year medical student on the 4th of July 2022 at 10:00 a.m.

Chief complaint

- **The major problem** in the patient's own words **plus** its duration (prior to admission).
- Use **patient's words**
- **Avoid** medical terminology.

✓ Use ✓	✗ Don't use ✗
Difficulty in swallowing	dysphagia
Shortness of breath	dyspnea
Abnormal movement	Seizure
Chest pain	angina

- **Many complaints?**
  - **Use the** first symptoms that caused patient to seek medical advice.
  - Or the most concerning symptom to the patient.

- **Note:**
  1. you **can use two or three main symptoms said by patient**.
  2. **Clarify exactly what patients mean by any specific term they use; common terms can mean different** things to different patients and professionals (Box 2.1).

2.1 Examples of terms used by patients that should be clarified

Patient's term	Common underlying problems	Useful distinguishing features
Allergy	True allergy (immunoglobulin E-mediated reaction) Intolerance of food or drug, often with nausea or other gastrointestinal upset	Visible rash or swelling, rapid onset Predominantly gastrointestinal symptoms
Indigestion	Acid reflux with oesophagitis Abdominal pain due to: Peptic ulcer Gastritis Cholecystitis Pancreatitis	Retrosternal burning, acid taste Site and nature of discomfort: Epigastric, relieved by eating Epigastric, with vomiting Right upper quadrant, tender Epigastric, severe, tender
Arthritis	Joint pain Muscle pain Immobility due to prior skeletal injury	Redness or swelling of joints Muscle tenderness Deformity at site
Catarrh	Purulent sputum from bronchitis Infected sinonasal discharge Nasal blockage	Cough, yellow or green sputum Yellow or green nasal discharge Anosmia, prior nasal injury/polyps
Fits	Transient syncope from cardiac disease Epilepsy Abnormal involuntary movement	Witnessed pallor during syncope Witnessed tonic/clonic movements No loss of consciousness
Dizziness	Labyrinthitis Syncope from hypotension Cerebrovascular event	Nystagmus, feeling of room spinning, with no other neurological deficit History of palpitation or cardiac disease, postural element Sudden onset, with other neurological deficit

History of presenting illness:

- **Analyzing** the **main symptom**(s).
- Identifying **risk factors**.
- Possible serious **complications**.
- Exploring the **differential diagnosis**.
- Recognizing **patterns of symptoms**.

•The patient was doing well until.. OR
•The patient was relatively doing well until …..

Pain:

- **Pain** is a very important symptom common to many areas of practice.
- A general scheme for the detailed characterization of pain is outlined in **(Box 2.2).**

2.2 Characteristics of pain (SOCRATES)

Site
- Somatic pain, often well localised, e.g. sprained ankle
- Visceral pain, more diffuse, e.g. angina pectoris

Onset
- Speed of onset and any associated circumstances

Character
- Described by adjectives, e.g. sharp/dull, burning/tingling, boring/stabbing, crushing/tugging, preferably using the patient's own description rather than offering suggestions

Radiation
- Through local extension
- Referred by a shared neuronal pathway to a distant unaffected site, e.g. diaphragmatic pain at the shoulder tip via the phrenic nerve (C_3, C_4)

Associated symptoms
- Visual aura accompanying migraine with aura
- Numbness in the leg with back pain suggesting nerve root irritation

Timing (duration, course, pattern)
- Since onset
- Episodic or continuous:
  - If episodic, duration and frequency of attacks
  - If continuous, any changes in severity

Exacerbating and relieving factors
- Circumstances in which pain is provoked or exacerbated, e.g. eating
- Specific activities or postures, and any avoidance measures that have been taken to prevent onset
- Effects of specific activities or postures, including effects of medication and alternative medical approaches

Severity
- Difficult to assess, as so subjective
- Sometimes helpful to compare with other common pains, e.g. toothache
- Variation by day or night, during the week or month, e.g. relating to the menstrual cycle

Felt at the affected organ and extended to nearby organ (tissue).

Pain is felt far from the affected organ because of the same neuronal supply.

- The questions required at this point will **vary according to the system involved**. A **summary** of useful starting questions for each system is shown in (Box 2.3).
- **Learn to think**, as you listen, **about the broad categories of disease that** may present **and how these relate to the history**, particularly in relation to the onset and rate of progression of symptoms (Box 2.4).

2.3 Questions to ask about common symptoms

System	Question
Cardiovascular	Do you ever have chest pain or tightness? Do you ever wake up during the night feeling short of breath? Have you ever noticed your heart racing or thumping?
Respiratory	Are you ever short of breath? Have you had a cough? If so, do you cough anything up? What colour is your phlegm? Have you ever coughed up blood?
Gastrointestinal	Are you troubled by indigestion or heartburn? Have you noticed any change in your bowel habit recently? Have you ever seen any blood or slime in your stools?
Genitourinary	Do you ever have pain or difficulty passing urine? Do you have to get up at night to pass urine? If so, how often? Have you noticed any dribbling at the end of passing urine? Have your periods been quite regular?
Musculoskeletal	Do you have any pain, stiffness or swelling in your joints? Do you have any difficulty walking or dressing?
Endocrine	Do you tend to feel the heat or cold more than you used to? Have you been feeling thirstier or drinking more than usual?
Neurological	Have you ever had any fits, faints or blackouts? Have you noticed any numbness, weakness or clumsiness in your arms or legs?

2.4 Typical patterns of symptoms related to disease causation			
Disease causation	**Onset of symptoms**	**Progression of symptoms**	**Associated symptoms/pattern of symptoms**
Infection	Usually hours, unheralded	Usually fairly rapid over hours or days	Fevers, rigors, localising symptoms, e.g. pleuritic pain and cough
Inflammation	May appear acutely	Coming and going over weeks to months	Nature may be multifocal, often with local tenderness
Metabolic	Very variable	Hours to months	Steady progression in severity with no remission
Malignant	Gradual, insidious	Steady progression over weeks to months	Weight loss, fatigue
Toxic	Abrupt	Rapid	Dramatic onset of symptoms; vomiting often a feature
Trauma	Abrupt	Little change from onset	Diagnosis usually clear from history
Vascular	Sudden	Stepwise progression with acute episodes	Rapid development of associated physical signs
Degenerative	Gradual	Months to years	Gradual worsening with periods of more acute deterioration

Past medical history & Surgical history:

- Past medical history **may be relevant to the presenting symptoms**: for example, previous migraine in a patient with headache, or hematemesis and multiple minor injuries in a patient with suspected alcohol abuse.
- It **may reveal predisposing past or underlying illness**, such as diabetes in a patient with peripheral vascular disease, or childhood whooping cough in someone presenting with bronchiectasis.
- The referral letter and case records often contain useful headlines **but the patient is usually the best source**.
- **Chronic illness.**
- **Previous hospital admissions.**
- **History of blood transfusions.**
- **Past procedures** (endoscopies, bronchoscopies, Catheterization).
- For **surgeries**: (date, hospital, emergent or elective, complications).

Drug history:

- **Begin** by checking any written sources of information, such as the drug list on the referral letter or patient record. It is useful to **compare** this with the patient's own recollection of what they take.
- **Should always be translated to generic** pharmaceutical **names** and **quantitative doses** for the patient record.
- Ask about **prescribed drugs** and other medications, including **over- the-counter remedies**, **herbal and homeopathic remedies**, and vitamin **or mineral supplements**.
- Do not forget to ask about **inhalers and topical medications**, as patients may assume that you are asking only about tablets.

2.5 Example of a drug history				
Drug	**Dose**	**Duration**	**Indication**	**Side-effects/patient concerns**
Aspirin	75 mg daily	5 years	Started after myocardial infarction	Indigestion
Atenolol	50 mg daily	5 years	Started after myocardial infarction	Cold hands (?adherence)
Co-codamol (paracetamol + codeine)	8 mg/500mg, up to 8 tablets daily	4 weeks	Back pain	Constipation
Salbutamol MDI	2 puffs as necessary	6 months	Asthma	Palpitation, agitation
MDI, *metered-dose inhaler.*				

1. Concordance and adherence:

- **Half of all patients** do not take prescribed medicines as directed.
- **Adherent** (taking drugs but not necessarily understanding why).
- **Concordant** (taking the drug and understanding why).
- Patients who take their medication as prescribed are said to be adherent.
- Concordance implies that the patient and doctor have negotiated and reached an agreement on management, and adherence to therapy is likely (though not guaranteed) to improve.

2. Drug allergies/reactions

- **Ask if your patient has ever had an allergic reaction to a medication or vaccine.**
- **Clarify** exactly what patients **mean** by allergy, as intolerance (such as nausea) is much more common than true allergy.
- **Drug allergies are over-reported** by patients: for example, only **1 in 7** who report a rash with penicillin will have a positive penicillin skin test.
- Note **other allergies**, such as **foodstuffs or pollen**.
- **Record true allergies** prominently in the **patient's case records, drug chart and computer records.**
- If patients have had a **severe or life-threatening allergic reaction**, advise them to wear an **alert necklace or bracelet**.

3. non-prescribed drug use:

- **Ask all patients who may be using drugs about non-prescribed drugs**.
- In Britain about **30**% of the adult population **have used illegal or non- prescribed drugs (mainly cannabis) at some time**.
- Useful questions are summarized in Box (2.6).

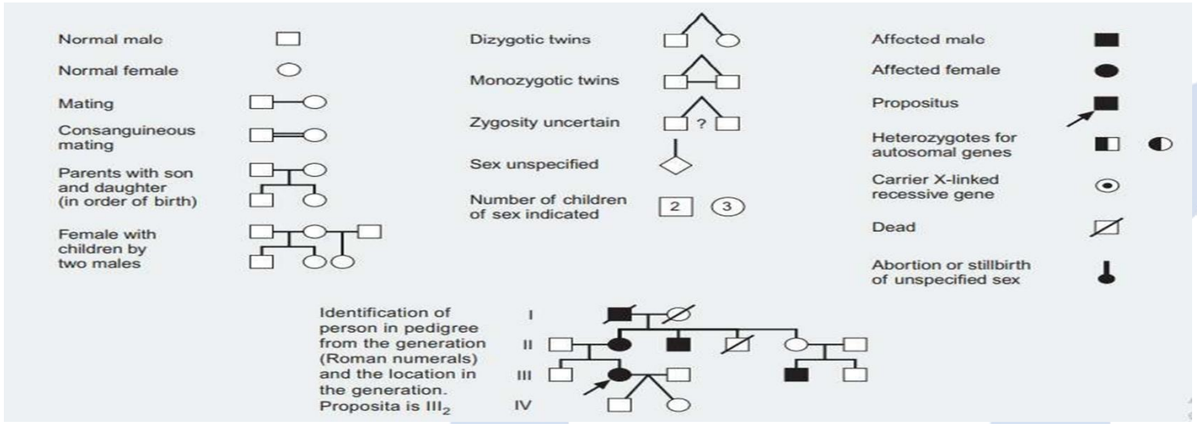
2.6 Non-prescribed drug history

- What drugs are you taking?
- How often and how much?
- How long have you been taking drugs?
- Have you managed to stop at any time? If so, when and why did you start using drugs again?
- What symptoms do you have if you cannot get drugs?
- Do you ever inject? If so, where do you get the needles and syringes?
- Do you ever share needles, syringes or other drug-taking equipment?
- Do you see your drug use as a problem?
- Do you want to make changes in your life or change the way you use drugs?
- Have you been checked for infections spread by drug use?

Family history:

- **Start** with open questions, such as '**Are there any illnesses that run in your family**?'.
- **Follow up** the presenting symptoms with a question like '**Have any of your family had heart trouble**?'.
- **Single-gene inherited** diseases are relatively **uncommon** in clinical practice. **Even when present, autosomal recessive diseases such as cystic fibrosis usually arise in patients with healthy parents who are unaffected carriers**.
- **Many other illnesses are associated with a positive family history but are not due to a single-gene disorder**.
- A further complication is that some illnesses, such **as asthma and diseases caused by atheroma**, are so common in the UK population that their presence in family members may not greatly influence the risk to the patient.
- **Document illness in first-degree relatives:** that is, parents, siblings and children.
- If you suspect an **inherited disorder** such as hemophilia, construct a **pedigree chart** (Fig. 2.1), noting whether any individuals were adopted.

- **Ask about the health of other household members,** since this **may suggest environmental risks** to the patient.



Social history and lifestyle:

- **No medical assessment is complete without** determining **the social circumstances of your patient.**
- **Occupation;** current & previous (exposure to hazards: chemicals, dust, asbestos).
- **Relationships, sexual history**
- **Type of home, stairs**.
- **Pets.**
- **Smoking** (cigarettes, cigars, pipe) duration & amount expressed by pack years, passive smoking).
- **Alcohol**.
- **Travel history.**

2.7 Calculating pack-years of smoking

A 'pack-year' is smoking 20 cigarettes a day (1 pack) for 1 year

$$\frac{\text{Number of cigarettes smoked per day} \times \text{Number of years smoking}}{20}$$

For example, a smoker of 15 cigarettes a day who has smoked for 40 years would have smoked:

$$\frac{15 \times 40}{20} = 30 \text{ pack-years}$$

Smoking

1. We calculate it **to estimate the risk of tobacco-related health problems**.
2. Ask **if they have smoked only tobacco or also cannabis**.
3. **Never miss the opportunity during history taking to encourage smoking cessation**, in a positive and non- judgmental way, as a route to improved health.
4. **Do not forget to ask non-smokers about** their exposure to environmental tobacco smoke (**passive smoking**).

Alcohol

- Alcohol **causes extensive pathology**, including not only hepatic cirrhosis, encephalopathy and peripheral neuropathy but also pancreatitis, cardiomyopathy, erectile dysfunction and injury through accidents.
- **Always ask** patients if they drink alcohol but **try to avoid appearing critical**, as this will lead them to underestimate their intake.
- **If they do drink**, ask them to **describe how much and what type (beer, wine, spirits) they drink in an average week**.
- The **quantity** of alcohol consumed each week **is best estimated in units**; 1 **unit (10 mL of ethanol)** is contained in one small glass of wine, half a pint of beer or lager, or one standard measure (25 mL) of spirits.

- %Ethanol in **beer** = **4%**.
- % Ethanol in **wine** = **12 %**.
- %Ethanol in **spirit** = **40 %.**
- **Calculate units based on the ethanol concentration.**

- E.g., 500 ml of beer alcohol = 20 ml pure ethanol = 2 units.
- E.g., 300 ml of wine alcohol = 36 ml pure ethanol = 3.6 units.

- The UK Department of Health now defines **hazardous drinking as anything exceeding 14 units per week** for both men and women.
- **Binge drinking**, involving a **large amount** of alcohol causing acute **intoxication**, is more likely to cause problems than if the same amount is consumed over four or five days.
- Most authorities recommend at **least two alcohol-free days per week.**
- **Alcohol dependence** occurs **when alcohol use takes priority over other behavior** that previously had greater value.
- **Warning signs** in the history are summarized in Box (2.8).

2.8 Features of alcohol dependence in the history

- A strong, often overpowering, desire to take alcohol
- Inability to control starting or stopping drinking and the amount that is drunk
- Drinking alcohol in the morning
- Tolerance, where increased doses are needed to achieve the effects originally produced by lower doses
- A withdrawal state when drinking is stopped or reduced, including tremor, sweating, rapid heart rate, anxiety, insomnia and occasionally seizures, disorientation or hallucinations (delirium tremens); this is relieved by more alcohol
- Neglect of other pleasures and interests
- Continuing to drink in spite of being aware of the harmful consequences

Occupational history and home environment

- **Unemployment** is associated with increased morbidity and mortality while **some occupations are associated with particular illnesses** (Box 2.9).
- **Ask all patients about their occupation.**
- Clarify **what the person does at work**, especially about any **chemical or dust exposure.**
- If the patient has worked with **harmful materials.**
- Symptoms that **improve over the weekend or during holidays** suggest **an occupational disorder.**

2.9 Examples of occupational disorders

Occupation	Factor	Disorder	Presents
Shipyard workers, marine engineers, plumbers and heating workers, demolition workers, joiners	Asbestos dust	Pleural plaques Asbestosis Mesothelioma Lung cancer	>15 years later
Stonemasons	Silica dust	Silicosis	After years
Farmers	Fungus spores on mouldy hay	Farmer's lung (hypersensitivity pneumonitis)	After 4–18 hours
Divers	Surfacing from depth too quickly	Decompression sickness Central nervous system, skin, bone and joint symptoms	Immediately, up to 1 week
Industrial workers	Chemicals, e.g. chromium Excessive noise Vibrating tools	Dermatitis on hands Sensorineural hearing loss Vibration white finger	Variable Over months Over months
Bakery workers	Flour dust	Occupational asthma	Variable
Healthcare workers	Cuts, needlestick injuries	Human immunodeficiency virus, hepatitis B and C	Incubation period >3 months

Travel history:

- Returning travelers commonly present with illness.
- They risk **unusual or tropical infections**, and air travel itself can precipitate certain conditions, such **as middle-ear problems or deep vein thrombosis**.
- The **incubation period may indicate** the **likelihood of many illnesses** but some diseases, such as vivax malaria and human immunodeficiency virus, may present **a year or more after travel**.
- **List the locations visited and dates**.
- **Note any travel vaccination and anti-malaria prophylaxis** taken if affected areas were visited.

Sexual history:

- Take a **full sexual history only if the context or pattern of symptoms suggests this is relevant**.
- Ask questions **sensitively and objectively**.
- **Signal your intentions**: 'As part of your medical history, I need to ask you some questions about your relationships. Is this all right?'.

Systematic enquiry (Review):

- **Systematic enquiry uncovers symptoms that may have been forgotten.**
- **Start with** 'Is there anything else you would like to tell me about?' Box (2.10) lists common symptoms by system.
- Asking about all of these is **inappropriate and takes too long**, so judgement and context are **used to select areas to explore in detail**. For example:
- **With a history of repeated infections**, ask about nocturia, thirst and weight loss, which may indicate underlying uncontrolled diabetes.
- In a patient **with palpitation** are there any symptoms to suggest thyrotoxicosis or is there a family history of thyroid disease? Is the patient anxious or drinking too much coffee?
- If a **patient smells of alcohol**, ask about related symptoms, such as numbness in the feet due to alcoholic neuropathy.

2.10 Systematic enquiry: cardinal symptoms

General health

- Wellbeing
- Appetite
- Weight change
- Energy
- Sleep
- Mood

Cardiovascular system

- Chest pain on exertion (angina)
- Breathlessness:
  - Lying flat (orthopnoea)
  - At night (paroxysmal nocturnal dyspnoea)
  - On minimal exertion – record how much
- Palpitation
- Pain in legs on walking (claudication)
- Ankle swelling

Respiratory system

- Shortness of breath (exercise tolerance)
- Cough
- Wheeze
- Sputum production (colour, amount)
- Blood in sputum (haemoptysis)
- Chest pain (due to inspiration or coughing)

Gastrointestinal system

- Mouth (oral ulcers, dental problems)
- Difficulty swallowing (dysphagia – distinguish from pain on swallowing, i.e. odynophagia)
- Nausea and vomiting
- Vomiting blood (haematemesis)
- Indigestion
- Heartburn
- Abdominal pain
- Change in bowel habit
- Change in colour of stools (pale, dark, tarry black, fresh blood)

Genitourinary system

- Pain passing urine (dysuria)
- Frequency passing urine (at night: nocturia)
- Blood in urine (haematuria)
- Libido
- Incontinence (stress and urge)
- Sexual partners – unprotected intercourse

Men

If appropriate:

- Prostatic symptoms, including difficulty starting (hesitancy):
  - Poor stream or flow
  - Terminal dribbling
- Urethral discharge
- Erectile difficulties

Women

- Last menstrual period (consider pregnancy)
- Timing and regularity of periods
- Length of periods
- Abnormal bleeding
- Vaginal discharge
- Contraception

If appropriate:

- Pain during intercourse (dyspareunia)

Nervous system

- Headaches
- Dizziness (vertigo or lightheadedness)
- Faints
- Fits
- Altered sensation
- Weakness
- Visual disturbance
- Hearing problems (deafness, tinnitus)
- Memory and concentration changes

Musculoskeletal system

- Joint pain, stiffness or swelling
- Mobility
- Falls

Endocrine system

- Heat or cold intolerance
- Change in sweating
- Excessive thirst (polydipsia)

Other

- Bleeding or bruising
- Skin rash

Closing the interview:

- Using **simple language**, **briefly explain your interpretation** of the patient's history and **outline the likely possibilities**.
- **Be sensitive to their concerns and body language**.
- **Ask** the patient **if** they already **have ideas and concerns about the diagnosis,** so these may be addressed directly.
- Always **give the patient a final opportunity to raise additional concerns** ('Is there anything else you would like to ask?').
- **Make sure patients are involved in any decisions** by suggesting possible actions and encouraging them to contribute their thoughts.
- **Tell them that you will communicate this plan to other professionals involved in their care**.

Difficult situations:

1. Patients with communication difficulties

- If your patient **does not speak** your language, arrange to have an **interpreter**.
- If your patient has **hearing or speech difficulties** such as dysphasia or dysarthria, consider the following:

1. **Write things down** for your patient if they **can read**.
2. **Involve someone** who is used to communicating with your patient.
3. **Seek a sign language interpreter** for a **deaf** patient skilled in sign language.

2. Patients with cognitive difficulties:

- Be alert for **early signs of dementia**.
- **Inconsistent or hesitant responses** from the patient **should always prompt you to suspect and check for memory difficulties**.
- If you do suspect this, assess the patient using a **cognitive rating scale**.
- You may have to **rely on a history from relatives or careers**.

3. Sensitive situations:

- Doctors sometimes need **to ask personal or sensitive questions and examine intimate parts**. If you are talking to a patient who may be suffering **from sexual dysfunction, sexual abuse or sexually transmitted disease, broach the subject sensitively**. Indicate that you are going to ask questions in this area and **make sure the conversation is entirely private.**
- For example: Because of what you're telling me, I need to ask you some rather personal questions. Is that, OK?

4. Emotional or angry patients

- **Never respond with anger or irritation** and resist passing comment on a patient's account of prior management.
- **Recognize** that your patient is **upset**, **show empathy and understanding,** and **ask them to explain why:** for example, 'You seem angry about something' or 'Is there something that is upsetting you?'
- If, despite this, their anger escalates, **set boundaries** on the discussion, **calmly withdraw,** and **seek the assistance and presence of another healthcare worker** as a witness for your own protection.
- **Talkative patients or those who want to deal with many things at once may respond to** 'I only have a short time left with you, so what's the most important thing we need to deal with now?'
- **If patients have a long list of symptoms**, suggest 'Of the six things you've raised today, I can only deal with two, so tell me which are the most important to you and we'll deal with the rest later.'
- **Set professional boundaries if your patient becomes overly familiar**: 'Well, it would be inappropriate for me to discuss my personal issues with you. I'm here to help you so let's focus on your problem.