HISTORY TAKING SEQUENCE

Presenting Complaint/Principal Symptom (record in patient's own words) - Use standard format: e.g., 20 y.o. woman presents with 2/7 history of ″a sore tummy″.
History of Presenting Complaint - Details of current illness (S- site, O-onset, C-character, R-radiation, A-associated symptoms, T-time, E-exacerbating/relieving factors, S-severity) - Details of previous similar episodes - Extent of functional disability
Past History - Past illnesses and operations - Medications and allergies - Blood transfusions - Reproductive history
Social History - Occupation, education - Smoking, alcohol, drugs - Overseas travel - Marital status, social support, living conditions - Exercise, diet
Family History (parents, siblings- significant illnesses if alive, cause of death if deceased)
Systems Review As well as detailed questioning in the system likely to be affected, a quick review of possible important symptoms and disorders in other systems is essential; otherwise important diseases may be missed. When recording the systems review, list important negative answers.
Round up consultation Before completing the history, it is often valuable to ask what the patient thinks is wrong with him or her, and what he/she is most concerned about.