Getting to know you

A detailed history is an essential element in understanding the background to a patient's oral health and planning effectively for their present and future treatment - Dental Protection

Before providing any treatment, it is a clinician’s responsibility to ask the right questions, in the right way, and to listen carefully to the patient’s responses. If an important aspect of a patient's history does not come to light in the consultation process, and problems arise as a result of this, attention tends to focus upon the clinical records and what they do (and do not) contain. In the absence of any evidence that certain key questions were ever asked, it is extremely difficult to attribute at a later date that they were.

If, on the other hand, there is failure to elicit, perhaps in a medical history questionnaire, which has been completed (and preferably, signed and dated) by the patient on a particular day, then there can be no doubt that the clinician asked the relevant question and was entitled to work from the assumption that the answer(s) given were correct.

Four specific areas of the patient's history are worthy of particular consideration in this brief overview:

- Medical history
- Dental history
- Personal/social history
- History of the presenting complaint (if any)

General observations

Creating any history about a patient is essentially an information gathering exercise. Specific techniques can usefully be employed to maximise the effectiveness of the process. The experienced clinician will choose between the available techniques according to the communication abilities of the individual patient that they are dealing with.

Closed questions

There are times when you need a specific question. The first stage of medical history screening may be one such occasion. Such questions are sometimes called ‘closed’ questions because this is exactly what you are looking for. Closed questions can also be useful when dealing with patients whose answers tend to stray from the purpose of the question.

Open questions

These questions tend to begin with... What? Why? When? How? etc and because of this, they require the patient to provide more information for you in their reply. This is often helpful when dealing with less communicative patients, or when you are hoping to gather more information about a particular topic. Sometimes this highlights areas where further information needs to be gathered – perhaps by contacting the patient's medical practitioner, perhaps by asking the patient to bring any medical records they are taking along to the next visit, so that the precise accuracy of these can be identified with certainty.

In several recent cases, the patient's medical history has been at the heart of negligence claims brought against dentists and other dental team members. It is crucially important, for example, to investigate the nature of hereditary or familial heart disease, in order to decide whether prophylactic antibiotics are indicated to prevent the risk of infective endocarditis. Infective endocarditis is a serious and life-threatening disease, and most patients are left with little or no prospect of continuing to their employment, for example, to investigate the nature of hereditary or familial heart disease, in order to decide whether prophylactic antibiotics are indicated to prevent the risk of infective endocarditis. Infective endocarditis is a serious and life-threatening disease, and most patients are left with little or no prospect of continuing to their employment.

Some cases have involved, for example, a failure to take into account certain allergies to drugs (especially penicillin and other antibiotics), or to recognise the significance of long-term aspirin medication predisposing to a serious risk of bleeding, or of anticoagulation, or to recognise the potential for drug interactions.

Many practices take medical histories verbally and if no positive or significant responses are elicited, an entry such as ‘MH nil’ is made in the records. While better than nothing at all, this approach carries the disadvantage that it can be difficult or impossible to establish precisely what questions were asked of the patient, in what terms, and what answers were provided. Clearly, a well structured medical history questionnaire, which is completed, signed and dated by the patient, and subsequently updated on a regular basis (ideally, during each successive course of treatment), is not only in the patient's best interest, but is also the best platform for the success of treatment approaches that have been tried in the past. If this knowledge helps the clinician to avoid repeating the previous mistakes of other clinicians, it can also help to avoid claims and complaints that might otherwise have resulted.

Social history

The social history should include details of employment (and interests, hobbies, etc) as well as other social and family related information. The patient's occupation should be included in the consideration of relevant factors affecting diagnosis, treatment planning, consent and treatment, bearing in mind the fact that this is an aspect of a patient's history that may change as time passes. It is worth establishing a routine of checking the patient's contact details and employment, when carrying out a periodic update of the patient's medical history.

The ability to attend for appointments could affect the success of complex or extensive treatment, eg crown and bridgework, implants, long term periodontal treatment and orthodontics. Certain occupations can place severe constraints on a patient's ability to attend regularly for appointments.

Issues relating to a patients employment or recreational activities can have an impact on treatment:

For example:
- Bruxism in air traffic controllers, marathon runners and certain other sports players
not collected and recorded in a clear and logical fashion. Having a structured and systematic approach to history taking and record keeping makes it easier to ensure that the patient is aware of any way in which their treatment (and its prognosis) might be affected by some aspect of their history.

The outcome of treatment can have a general effect or a more specific effect on a given patient. For example, chronic severe pain, which can arise from some form of nerve damage, or TMJ/muscle disturbance associated with dental procedures, or perhaps a facial paralysis, or permanent loss of sensation in the lip or tongue, would all be likely to reduce the quality of life for most patients.

On the other hand, the loss of ability to articulate clearly when speaking or singing, because of a change in anterior tooth shape, position or angulation, or perhaps because of lingual or inferior alveolar nerve damage, would have a more profound affect on an opera singer, lecturer or telephonist than for an agricultural worker who did not depend upon singing for his livelihood. Similarly, there are many jobs in which appearance is important and an adversely altered appearance can either lose a patient a job or severely affect a patient’s confidence, particularly if they have to face the public in their working life. Awareness of information such as this is critical when contemplating any aesthetic/ cosmetic procedures.

History of present complaint
When a patient attends with a specific problem it is helpful to know how long the problem has existed, when it was first noticed, whether it has ever occurred before, whether any previous treatment has sought to resolve the problem and if so, with what success.

If the patient is complaining of pain, for example, it is helpful to know what kind of pain it is (dull ache, or throbbing, or acute bursts of pain), or how long it lasts, and what makes it worse or better and whether it has occurred previously and if so under what circumstances.

Each of these findings needs to be recorded carefully in the notes to demonstrate this important part of the diagnostic process. The significance of this becomes apparent on occasions when a mistaken diagnosis is made. If, however, the diagnosis is supported by the information which was available to the clinician at the time, as noted in the records, such situations can often be defended successfully.

Summary
It will be appreciated that there is very little value in gathering information from the above sources if the responses are not collected and recorded in a clear and logical fashion. Having a structured and systematic approach to history taking and record keeping makes it easier to ensure that the patient is aware of any way in which their treatment (and its prognosis) might be affected by some aspect of their history.