History of Present Illness

Statement of Goals

Understand the history of present illness (HPI) component of the medical interview.

Learning Objectives

A. Describe the history of present illness as a coherent and chronological "story" of the patient's active medical problem(s) in the context of the person's life.
B. Distinguish between signs and symptoms of a disease or an illness.
C. List and describe seven content areas investigated for each symptom:

1. Location
2. Quality
3. Quantity or Severity
4. Timing
5. Setting
6. Modifying factors
7. Associated symptoms

D. Distinguish the concepts of disease and illness.
E. Describe patient-centered approaches to understanding illness in the context of the patient's life:

1. How the illness affects day-to-day life (effects on work, family, etc.)
2. The patient's own ideas about the cause and significance of the illness (including personal feelings, prior personal or family experiences)
3. The patient's expectations of the health care provider.

F. Describe current medications, allergies and medication intolerance as components of the HPI, under the subheadings.
G. Obtain a chief complaint and the history of a simple illness demonstrating effective data gathering skills learned previously. Demonstrate appropriate use of a series of open-ended questions early in the interview.
H. Record the HPI in the form of a medical record.

Curriculum Comments

Objective A:

In the ambulatory setting, a patient may visit a physician for an acute illness, follow-up of a chronic illness or for preventive health care. In each of these situations, the History of the Present Illness (HPI) describes the story of the reason for the visit. For a patient with an acute illness, the HPI will give an account of the symptoms and the events of the
illness leading him or her to seek care. For a patient with a chronic illness, the HPI may describe the status of the illness since the last visit.

**Objective B:**

A **symptom** is any departure from normal experienced by the patient. It is a *subjective* description by the patient. In contrast, a **sign** is an abnormality indicative of disease that is observable by physical examination. It is an *objective* finding of disease. For example, a patient may report symptoms of nausea and vomiting. On examination, an enlarged, tender liver could be a **sign** of hepatitis. Fever could be both a symptom and a sign.

**Objective C:**

By exploring these **seven content areas** for each major symptom, you will develop a detailed understanding of the problem. Clinicians use these attributes of symptoms as important clues to establishing a diagnosis.

1. Location – describe primary location, radiation
2. Quality – for example: the character of pain, the color / consistency of diarrhea
3. Quantity or Severity – could be “on a scale from 1-10”, expressed as the effect on daily life or quantify the number of episodes (e.g. 10 episodes of vomiting in the last 24 hours)
4. Timing – onset, duration, frequency of symptoms
5. Setting – place, situation, or events associated with illness
6. Modifying factors – what makes it better and what makes it worse
7. Associated symptoms – other health changes noted by patient

**Objective D:**

"**Disease**" refers to a disturbance in the physical structure or physiologic function of the human organism. It may be present with or without the person's awareness.

"**Illness**" refers to the condition of impaired health recognized and experienced by a person. It may be present with or without discernable disease. It includes the physical, emotional and cultural components of the illness experience.

**Objective E:**

The following approaches may be used to understand the present illness in the context of the person's life:

Ask how this illness has affected day-to-day life. Think about the person's usual roles (worker, parent, spouse, musician, etc.) and how they might be affected.

Ask the patient, “What do you think might be wrong; what do you think caused it?” These questions may reveal a possible diagnosis (“My sister felt like this when they
diagnosed pernicious anemia.”) or may reveal important patient concerns (“I’m really afraid I have cancer”).

Ask the patient: "Is there anything that I can specifically do to help you?" The patient may have specific needs that he would like the provider to fulfill, such as wanting a referral to see a sub-specialist.

**Objective F:**

Current medications and allergies are listed at the end of the HPI. This information may have a significant impact on the patient’s current health. Some physicians record this information in the past medical history of the medical record. For the FCM course, include it with the HPI. Be sure to include a sub-heading so that future readers can locate this important information as efficiently as possible.

Questions about current medications should include prescription medications, over-the-counter medications, herbals, vitamins, and other supplements. Document the name, dose, and dosing interval for each medication (including over-the-counters). If medications are used on an as needed basis ("prn"), document the indication and approximate frequency of use. Try to discern (and document) actual usage as well as the usage prescribed. When listing medication allergies, include the medication and the specific reaction that occurred (hives, wheezing, etc.). In addition to medication allergies, list allergies to foods, insects, or environmental factors including the specific reaction that occurs. Intolerance to specific medications, such as a blood clot attributed to oral contraceptives is noted in this section as well.

Even though Bates lists tobacco, alcohol and drug use in the HPI, they are more commonly listed under social history in current practice. Therefore, in FCM they should be included in the Social History.

**Objective G**

One example of the documentation of an HPI is found in the patient write-up in Bates, pp. 16-17.

**Sample Case**

*Juan Vargas is a 22-year-old man with a chief complaint of "a really bad cold." He felt well until three days ago when he developed a sore throat and sneezing. The next day he had tender, swollen "glands" in his neck, felt alternately warm and chilled and got nasal congestion. Yesterday, he developed a cough productive of thick yellow sputum and an achy chest anteriorly. Yesterday, he was too sick to go to classes; this is the worst cold he has had in years. Two of his college friends have similar symptoms. He has had a stressful semester and relates his illness to lack of sleep. Tylenol has helped the achy feeling, but cough syrup and decongestant don't seem to help. He has no earache or shortness of breath. He is concerned about feeling better for an important job interview.*
Apply Your Skills

Observe your preceptor obtain an HPI from several patients.

Are the seven content areas applicable? What skills does the preceptor use to elicit a coherent story? Focus on the patient’s experience of illness. What skills does the preceptor use to bring out the patient’s story?

If possible, interview one patient yourself. Record one HPI that you observed or that you obtained yourself in your encounter note. If you observed an HPI and would have included additional items, indicate what else you would have asked.

**Turn the encounter note in at your next small group session: (Required Encounter Note #1)**

The encounter note should include:

**Date:**

**Hx:** ID information (HIPPA Compliant Please)

**Source and reliability:**

**Chief Complaint (CC):**

**HPI: Include 7 content areas and effect on life; concerns, whenever possible; see checklist that follows**

**Drugs:**

**Allergies:**

**Physical Exam (PE):**
  - Vital Signs
  - General Appearance

**Discussion:***

**Signature:**

*Discussion can include what the diagnosis was and if possible why your preceptor thought that. It could also include information you learned (from preceptor or looked up) about a disease. At this point in your education, it can be brief---several several sentences.*
HPI Checklist

☐ location
☐ quality of symptoms
☐ severity
☐ timing
☐ setting
☐ modifying factors - better
☐ modifying factors - worse
☐ associated symptoms
☐ effect on patient's day-to-day life
☐ patient's concerns
☐ medications
☐ dose and frequency
☐ allergies to medications
☐ type of reaction

Study Questions:

1. What is the difference between a symptom and a sign?

2. What is the difference between a disease and an illness?

3. What are the seven content areas that are included (if possible) in the description of a symptom?

4. What are the patient-centered approaches to understanding an illness in the context of a patient’s life?

5. How and where should you record a patient’s current medications and medical allergies?