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Medical history-taking in psychiatry

Michael Phelan & Grant Blair

Abstract A good medical history is an essential starting point in ensuring that the physical health needs of people with severe mental illness are addressed. Psychiatrists have an important role in helping to tackle the general ill health, excess of undiagnosed physical illness and reduced survival rates among their patients. To do this they need to use their medical training, communication skills and regular contact with patients. Assessments should include family history, past and current physical health, medication, lifestyle, healthcare and physical symptoms. Some groups of patients will need more detailed assessments.

Previous articles in this journal have highlighted the poor physical health of many people with mental disorders (Santhouse & Holloway, 1999) and intellectual disabilities (Kerr, 2004), the need for mental health services to address physical health issues (Cormac *et al*, 2004) and the requirement for physical examinations in psychiatric practice (Garden, 2005). We believe that any attempts to improve the physical healthcare of psychiatric patients will, above all, be dependent on relevant and comprehensive history-taking, and that this must underpin all other strategies to tackle the problem. In this article we offer a realistic approach to medical history-taking within the constraints of routine psychiatric practice.

If you don't ask you'll never know

Medical students are taught on the first day of their clinical studies that history-taking must come before any physical examination or investigations, and that in many cases a physical examination and subsequent investigation will simply confirm a diagnosis. It has been estimated that, among medical out-patients, 83% of medical diagnoses could be made from history alone, compared with 9% from examination (Hampton *et al*, 1975). For example, people in the early stages of diabetes or lung cancer are more likely to have symptoms suggesting their diagnosis, rather than any clear-cut physical abnormalities detectable on examination. This fundamental medical principle is often forgotten in psychiatric practice, where traditionally the emphasis has been on ensuring that patients receive a physical examination on admission. Osborn & Warner (1998) examined the case notes of 48 in-patients, and found evidence of physical history-taking for only one patient.

Specific medical disorders can first present with psychiatric symptoms. Although all psychiatrists must always consider a physical cause for any psychiatric symptoms, in practice such presentations are rare. What is far more common, especially in patients with a severe and enduring mental illness, is general ill health and undiagnosed physical disorders. Overall, the physical health of people with mental disorders is not characterised by any unusual or rare physical illnesses and common medical conditions are generally just more common. Jeste *et al* (1996) have highlighted that, in comparison with the rest of the population, people with schizophrenia, despite having higher rates of physical disorders, are less likely to mention physical symptoms spontaneously or to complain about them. Various reasons have been suggested to explain this difference, but it is clear that mental health staff and others are often unaware of patients' physical disorders (e.g. Koran *et al*, 1989). One consequence of this lack of awareness would appear to be the excess of late presentations of medical conditions and avoidable deaths reported by Brown *et al* (2000). The Disability Rights Commission (2006) recently concluded that the 5-year survival rates for virtually all major illnesses are lower in people with mental health problems.

Many factors contribute to the poor physical health associated with severe mental illness. Social deprivation is one, but it does not fully explain the excess. Many patients, especially those with schizophrenia (Brown *et al*, 1999), have unhealthy lifestyles, with smoking and obesity being especially damaging. Psychotropic medications have well-recognised

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short- and long-term adverse physical effects. Reports that second-generation antipsychotics are associated with various components of metabolic syndrome (obesity, dyslipidaemias, glucose intolerance, insulin resistance and hypertension) have received recent attention (Thakore, 2005).

Despite higher rates of physical illness, research suggests that people with severe mental illnesses do not necessarily receive the physical healthcare that they require. Burns & Cohen (1998) examined the primary care notes of such patients and found that they were less likely to have basic health promotion data recorded than patients without a mental illness, despite higher consultation rates. It is to be hoped that the new General Medical Services (or GP) contract, introduced in 2004, will improve the situation. Under the new contract, National Health Service general practices in the UK are financially rewarded for achieving a variety of quality indicators.[†] One of these includes an annual physical health review of patients with severe long-term mental illness.

Practicalities of assessment

At times it is inappropriate, or even impossible, for psychiatrists and other mental health professionals to ask patients about their physical health, but for the most part many opportunities do present themselves and should be taken. When a patient is admitted to hospital in the UK it is standard practice that the admitting doctor will conduct a physical examination as soon as possible. Osborn & Warner (1998) reported that 71% of patients in their study had undergone such examinations, a rate similar to those found by one of us (M.P.) in local audit studies. A full physical history should be taken at the same time. If a history cannot be taken because the patient is too disturbed or uncooperative it is essential that this fact is documented and further attempts are made when the patient is more settled.

Physical history-taking and assessments should be viewed as a continuous process throughout a patient's contact with services. After an initial screening, in-patients should be regularly asked about physical symptoms, especially when medication is being changed or if they have an underlying medical condition. Out-patients should routinely be asked about their general physical health, with more specific and detailed questioning when appropriate.

Many people with severe and enduring mental illness have infrequent and limited contact with a psychiatrist. They are likely to have far more face-to-face contact with community psychiatric nurses or other community mental health professional. Regardless of their professional background, care coordinators play a vital role in assessing physical health needs.

You do not need to be a doctor to ask people about their physical health.

The Physical Health Check (PHC) was developed specifically to help non-medical mental health professionals ask appropriate physical questions (Phelan *et al*, 2004). A completed PHC provides a brief systematic record of the patient's lifestyle, current physical health and recent receipt of healthcare. The aim of the PHC is to stimulate a dialogue about physical health and help staff and patients to agree on a plan of action to address problem areas. One community mental health team that used the tool with patients on the enhanced care programme approach found that it revealed extensive physical health needs and improved the routine recording of physical health information (Phelan *et al*, 2004).

Standard physical health history

Medical textbooks provide many templates for systematic physical health review. There will always be a balance to be reached between brevity and completeness. In most general psychiatric assessments the items listed in Box 1 should be considered.

Family history

History of mental illness in families is routinely asked about, but physical health should also be included. Patients should be specifically asked about disorders known to have a significant genetic component, for example ischaemic heart disease, diabetes, hypertension and autoimmune disorders. Answers may identify patients who have an increased risk of specific conditions, as well as bringing to light fears that patients have about their own health, if relatives have died young.

Box 1 Key items for physical health review of psychiatric patients

- Family history
- Past medical history
- Current illnesses and disabilities
- Current medication
- Habits and lifestyle
- Health screening
- Symptoms

[†]The new contract and its quality and outcomes framework are discussed in: Cohen, A. (2008) The primary care management of anxiety and depression: a GP's perspective. *Advances in Psychiatric Treatment*, **14**, 98–105. Ed.

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Medical history

This may have relevance to current symptoms and disabilities. It can also help staff to understand how the individual responds to physical illness, and any relationship between their physical and mental disorders. Patients should be specifically asked about any allergies. Importantly, taking a medical history can reveal long-standing conditions or recurrent disorders, such as hypertension or tuberculosis, which may have been untreated because of the individual's poor mental health.

Current illnesses and disabilities

Doctors tend to ask about diagnosed illnesses and ignore disabilities. Questions about eyesight, hearing, swallowing difficulties and mobility may highlight important needs that can be met relatively easily, for example with replacement glasses or dentures.

Current medication

It is vital that prescribed and over-the-counter medication is recorded, not only so that the numerous potential interactions with psychotropic medication can be avoided, but also to identify long-standing medical conditions that the patient has not reported and inappropriate medication that is no longer required. Patients need to be asked about their adherence to prescribed treatment; erratic adherence is a problem not limited to psychiatric drugs.

Habits and lifestyle

Initial screening questions should ask about smoking habits, alcohol consumption, recreational drug use, diet, exercise, sexual activity/dysfunction and safe sex practices and, if relevant, contraception. For most patients such questions will reveal at least some areas where interventions have the potential to improve their physical health.

Health screening

Many patients struggle to gain access to recommended routine health screening, and mental health staff have an important role to play in helping them to do so. All should be asked when they last visited the dentist and optician, and when they last had their blood pressure measured and lipids tested. Women should be asked about cervical screening (recommended every 3 years for ages 25–65) and mammography (recommended every 3 years for ages 50–64). Patients at risk (with a history of diabetes, ischaemic heart disease, stroke, chronic obstructive pulmonary disease, asthma, those immunocompromised or over 65 years of age) should be asked whether they have had immunisation against influenza.

Symptoms

Patients may not spontaneously mention physical symptoms, especially if these are long-standing or perceived as embarrassing. It is therefore important to ask specific questions about each body system.

Documentation

The standard psychiatric history usually covers some of the above areas but not all. Past medical history is usually asked about, as are smoking and alcohol consumption. It is far less likely that patients will be asked in detail about physical symptoms and when they last went to the dentist. To encourage and remind doctors to ask about areas that have traditionally been neglected it can be helpful to introduce standardised forms. This helps to ensure that all relevant questions are asked, and that the answers are clearly documented. One such form, designed to be used on admission to an acute adult ward, is shown in the online supplement to this article.

Regardless of whether specific forms are used it is essential that physical health issues are clearly documented in the patient's records. For clarity this should be in a specific section of the patient's file. It should include the outcome of what patients have been told and action plans that have been agreed. If patients are unhappy to answer questions or refuse further examination or investigation this needs to be recorded.

It is vital that there is good communication between the mental health team and the patient's general practitioner (GP), so that the GP is made aware of any relevant issues and that unnecessary duplication is avoided. Information about physical health should be included in discharge summaries and out-patient letters.

Interview technique

The principles of good interviewing technique are just as relevant to physical history-taking as to any other part of the history. In addition to gathering important knowledge about physical health, history-taking is an opportunity to explore patients' understanding of their illnesses and their attitudes to health promotion.

Open-ended questions should initially be used, with subsequent closed questions to clarify replies and get more detail when needed. Leading and

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multi-thematic questions should always be avoided, for example 'You don't have any problems with your breathing, do you?' It is also better not to ask questions with more than one theme, such as 'Any headaches or pain in your chest?' Jargon must be avoided, and patients asked to clarify vague terms such as 'indigestion' or 'nerves'. Answers should be summarised, so that they are checked and the patient feels understood, for example 'You told me that you occasionally have pains in your left knee when you walk, and you need glasses to read, but otherwise you have no other physical symptoms or disabilities'. Clinical discretion is needed when delicate or potentially embarrassing questions need to be asked, and a flexible approach should be taken. For instance, it may be appropriate for a female nurse rather than the male ward doctor to discuss contraceptive arrangements with a female patient.

Carers can also be an important source of information. If the patient gives permission for them to be approached they may be able to give additional history about physical health, especially gradual changes such as loss of weight or mobility, which the patient has not noticed. If there are uncertainties about the patient's physical health, or they are known to have complex medical needs, their GP should be contacted.

Special patient groups

The general principles and approach discussed so far are relevant to all patients, but some factors (Box 2) indicate that a more detailed or specific approach is needed.

Diabetes

The prevalence of diabetes is increasing in the general population and in people with schizophrenia it is estimated to be 15–18% (Expert Group, 2004). Particular risk factors include:

- South Asian descent
- a history of gestational diabetes
- family history of diabetes
- a personal or family history of other auto-immune disease (thyroid disease, Addison's disease, pernicious anaemia)
- being overweight (especially after age 50)
- atypical antipsychotics.

Although many young people with type 1 diabetes present with a 2- to 6-week history of polyuria, polydypsia, weight loss and sometimes ketoacidosis, the onset of type 2 diabetes is often insidious and the symptoms may be non-specific. Many individuals are undiagnosed for years. This results in significant risks of serious medical complications and denies them the well-established health gains obtained from effective treatment. It is recommended that people with severe mental illness are screened with a blood glucose test (ideally fasting) at least annually. More frequent testing should be considered for patients on atypical antipsychotics, especially if other high-risk factors are present. In addition, basic screening questions should be asked. Such questions are particularly important for patients who refuse a blood test. As well as the classic symptoms of thirst, polyuria and weight loss, a history should look for tiredness, visual blurring, and skin and candidal infections.

It is important to ensure that patients with established diabetes receive the same level of care as they would if they did not have a mental illness. Box 3 lists the key points that need to be covered in the history.

Box 2 Factors indicating the need for a more detailed history-taking

- Diabetes
- Smoking
- Risk of infections
- Heavy drinking
- Hypertension
- Intellectual disability

Box 3 Diabetes

For people with established diabetes, history-taking should include:

- an exploration of their understanding of diabetes
- diet and lifestyle (especially smoking)
- the pattern of their care (primary, secondary or shared care)
- frequency and appropriateness of testing
- date and outcome of most recent annual check (including bloods)
- date and outcome of most recent retinal screening
- general well-being
- presence of polyuria and/or polydypsia
- changes in weight
- medication and adherence
- skin and foot care

For those on insulin:

- check for any episodes of hypoglycaemia or ketoacidosis

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Smoking

Given the high prevalence of smoking among psychiatric patients[†] and its damaging consequences it is no longer sufficient just to ask whether patients smoke or not. A full smoking history should be taken as well as a motivational assessment of the desire to quit. For patients who express some motivation to stop smoking, appropriate support and advice should be made easily accessible. If patients do stop smoking, doctors need to be aware of the likely increase in blood serum levels of antipsychotics, and ask should about any increase in side-effects. Clozapine and olanzapine are the most likely drugs to be affected. Particular attention should be given to possible symptoms of smoking-related diseases (Box 4).

High risk of infections

Certain factors confer increased risk of infections: homelessness, intravenous drug use, working in the sex industry, a compromised immune system, and recent arrival in the UK, especially from the African continent. Patients should be asked about anything that might put them at particular risk, for example sharing needles, infected partners, unsafe sex or a history of tuberculosis.

Many infections, including hepatitis, tuberculosis and HIV, can have vague, minimal or no physical symptoms in the early stages. All at-risk patients should be asked about history of night sweats, malaise, fever, weight loss, cough and jaundice. Patients should be counselled before HIV testing, in most cases by a specialist clinic.

Heavy drinking

Alcohol can have a detrimental effect on every organ of the body, and heavy drinkers will always be at increased risk of a wide range of medical conditions.[‡] Susceptibility to alcohol damage varies, and those at most risk include women and older people. Gastrointestinal, neurological, cardiovascular and endocrine conditions all need to be considered. A focused history should explore the broad range of possible physical illness associated with excessive alcohol consumption, including a past history of (or symptoms suggestive of) liver disease and jaundice, dyspepsia and gastrointestinal bleeding, pancreatitis, diarrhoea, night sweats, epilepsy, hypertension, heart failure and accidents at home or work.

[†]See pp. 217–228, this issue.
[‡]See Barclay, G., Barbour, J., Stewart, S, *et al* (2008) Physical effects of long-term alcohol misuse. *Advances in Psychiatric Treatment*, **14**, 139–151. Ed.

Box 4 Symptoms of smoking-related diseases

Carcinoma of the bronchus (>30 000 deaths a year in the UK)
- Cough
- Chest pain
- Unexplained weight loss
- Haemoptysis
- Shortness of breath
- Hoarse voice

Chronic obstructive pulmonary disease (>30 000 deaths a year in the UK)
- Cough (often productive)
- Shortness of breath on exertion
- Intercurrent chest infections

Ischaemic heart disease (>1.4 million people affected in the UK)
- Central chest pain on exertion
- Breathlessness

Peripheral vascular disease
- Intermittent claudication

Hypertension

About 15% of all adults are hypertensive, with the proportion increasing with age, especially after age 50. As with any other long-standing disorder patients should be asked about their general understanding of their condition and their views about treatment. More specific questions can then be asked about diet (should be low in salt and fats), exercise, smoking, adherence to treatment and the frequency of review by their GP.

Intellectual disability

The general health needs of people with intellectual disability have been highlighted by Kerr (2004). Many of the problems are similar in nature to, but often more frequent than, those common in people with mental illness. Rates of sensory deficits and epilepsy are high. Collateral history from a friend, carer or GP will often be especially important because of communication difficulties.

Conclusions

All psychiatrists need to make use of their medical training, communication skills and regular contact with patients to contribute to physical healthcare. Although psychiatrists cannot and should not be a substitute for a GP, they will always have an

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important contribution to helping patients live healthy lives and receive the medical care that they need. Although the new GP contract encourages physical assessments to be made in the community, it would be wrong to assume that these checks are always completed, especially for the small number of disturbed patients who avoid contact with primary healthcare teams. Asking appropriate questions about physical health and lifestyle should be a routine part of any psychiatrist's job.

Psychiatrists who feel daunted by the prospect of medical history-taking should consider using lists or forms that can act as useful prompts, and remember that the task can be shared with other professions. Finally, although it may often not be possible to cover everything mentioned in this article, it is always better to get some history than none.

Declaration of interest

None.

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MCQs

1 Increased rates of diabetes are associated with:
a a family history of Huntington's disease
b being underweight
c being female
d a diagnosis of schizophrenia
e South American descent.

2 When a patient is admitted to a psychiatric ward:
a it is important to ask how many cigarettes they smoke a day
b there is little point in assessing their motivation to give up smoking
c it is best to avoid asking potentially embarrassing questions about physical health
d the admitting doctor should have sole responsibility for physical health issues
e they should be encouraged to continue to smoke their normal number of cigarettes to avoid sudden changes in plasma drug levels.

3 People with schizophrenia:
a are more likely to complain about their physical health than people without schizophrenia
b have reduced rates of ischaemic heart disease
c have 5-year survival rates for most conditions that are similar to those for the general population
d are more likely to smoke, and to smoke more, than people without schizophrenia
e are less likely to develop diabetes if they are over the age of 50.

4 Psychiatrists:
a should avoid routinely asking patients about their physical health
b should always do physical examinations when patients are admitted to hospital
c should sometimes ask other members of staff to ask patients about their physical health
d can assume that GPs will have completed a full physical check
e are more likely to take a full medical history than do a physical examination.

5 People who are at high risk of infections:
a include prostitutes
b should automatically be screened for HIV
c can be assumed not to have TB unless they have had a recent cough
d include all psychiatric patients
e should not be admitted to a psychiatric ward.

MCQ answers

1	2	3	4	5
a F	a T	a F	a F	a T
b F	b F	b F	b F	b F
c F	c F	c F	c T	c F
d T	d F	d T	d F	d F
e F	e F	e F	e F	e F

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