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 determine at a later date that they were.

If, on the other hand, there is evidence that 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 consultation. 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 to the communication abilities of the clinician will choose between the process. The experienced clinician will be aware of the need to maximise the effectiveness of the information gathering exercise. Specific techniques can usefully be employed to maximise the effectiveness of the consultation. The experienced clinician will choose between the available techniques according to the communication abilities of the individual patient that they are dealing with.

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 information of a better quality, and in greater detail.

‘Why’ questions

These questions, which are a specific kind of open question, can be extremely useful. They are looking for the patient’s reasons for the answer(s) given were correct.

‘Shopping list’ questions

This approach is a little like a multiple-choice test, where you give the patient several possible answers to choose from. For example ‘What makes the pain worse?...? It is hot things?... or cold things?... or biting on the tooth?... and so on. They can be useful when dealing with patients who seem not to understand the meaning of open questions and can thereby speed up the information gathering process.

Leading questions

These questions tend to be worded in such a way as either to suggest the answer or to invite a specific reply. For example ‘You have been wearing your appliance, haven’t you? They can be useful when trying to establish confidence and communication with a nervous, quiet, or uncommunicative patient who are of limited value when seeking specific accurate informa

Medical history

One of the first principles one learns at dental school is that of the importance of taking a detailed medical history before treating any patient. Most dental schools have their own design of medical history questionnaire, and this shapes the format, style and extent of any further questioning of the patient on particular points arising from the medical history.

Many practices, in similar fashion, take commendable care in designing and using their own medical history questionnaires which patients are asked to complete when attending the practice for the first time. In most cases the design provides for the patient to answer yes or no to a set of specific predetermined questions, and then to sign and date the completed questionnaire. The dental surgeon then ensures that the patient has properly understood all of the questions (for example, where patients leave one or more answers blank), and where ‘yes’ answers have been given, further questioning of the patient will allow the details of any response to be clarified and expanded upon. 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 record they are taking along to the next visit, so that the precise nature of the issue can be identified clearly.

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 a patient’s general medical history in order to establish 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 the realisation which has the potential to shorten their life and/or restrict its quality. Damage in such cases is therefore very high indeed, often including a lifetime’s loss of earnings.

Other recent cases have involved, for example, a failure to take into account certain allergies to drugs (especially penicillins and other antibiotics), or to recognise the significance of long-term aspirin medication precipitating a serious risk of gastrointestinal bleeding, or to recognize the potential for drug interactions.

Cases such as these often reveal the fact that although a practit

Many practices take medical histories verbally and if no positive or significant responses are elicited, an entry such as ‘M/H 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 given. Clearly, a well-structured medical history questionnaire form, which is completed, signed and dated by the patient, and subsequently updated, provides a lot of useful basic information. The patient’s oral health and planning effectively for their present and future treatment - Dental Protection

Not only will questions like those above help to inform the clinician regarding areas which may or may not need treatment, or which should be kept under review, they will also guide the clinician regarding the success (or failure) 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 an appointment could affect the success of complex or extensive treatment, eg crown and bridge work, implants, long term periodontal treatment and orthodontics. Certain occupations can place severe constraints on a patient’s attendance to attend regularly for appointments.

Issues relating to a patients employment or recreational activities might otherwise have resulted.

For example:

• Bruxism in air traffic control
• Marathon runners and certain other sports players

If, so what, why causes such sensitivity?

• Does the patient’s gums bleed on tooth brushing or spontaneously?

• How is the patient apprehensive about receiving dental care?

• Do these questions relate to any particular dental procedure(s) or to the experience in general?

• Has the patient experienced any particular problems associated with treatment procedures experienced in the past?

If so, what?

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• aerodontalgia in (pilots and cabin crew)
• Stress and its relation to peri-
odontal disease (including epi-
sodes of periconisms involving
young adults in the armed forces, or
studying for examinations)

The outcome of treatment can have a general effect or a
more specific effect on a given patient. For example, chronic se-
vere 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, be-
cause of a change in anterior
tooth shape, position or angula-
tion, or perhaps because of lin-
gual or inferior alveolar nerve
damage, would have a more pro-
found affect on an opera singer,
letrnir 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 al-
tered 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 criti-
cal when contemplating any aes-
thetic/ cosmetic procedures.

History of present complaint
When a patient attends with a spe-
cific problem it is helpful to know
how long the problem has existed,
when it was first noticed, whether
it has ever occurred before, wheth-
er 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 oc-
curred previously and if so un-
der what circumstances.

Each of these findings needs
to be recorded carefully in the
notes to demonstrate this im-
portant 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 informa-
tion which was available to the clini-
cian at the time, as noted in the
records, such situations can of-
ten 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. Hav-
ing a structured and systematic
history taking and record keep-
ing in mind that critical information
will be overlooked, or lost.

Later in the treatment plan-
ning process, when it becomes
a little clearer what treatment
possibilities are under consid-
eration, it may be necessary to
explore some aspects of the his-
ory in greater depth, in order to
ensure that the patient is aware
of any way in which their treat-
ment (and its prognosis) might
be affected by some aspect of
their history.