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 clear evidence of a past experience, 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 be used to maximise the effectiveness of the information gathering. 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 definite ‘yes’ or ‘no’ answer to a specific question. The first stage of medical history screening may be one such occasion. Such questions are sometimes called ‘closed’ questions because they are essentially yes/no questions. Specific techniques can be used to elicit a more detailed reply from the patient. A direct ‘yes’ or ‘no’ 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 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 also called ‘closed’ questions because they are essentially yes/no questions. Specific techniques can be used to elicit a more detailed reply from the patient. A direct ‘yes’ or ‘no’ 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.

‘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?... is it hot stuffs... or cold things... or hitting 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 but are of limited value when seeking specific accurate information, or a more detailed reply.

Medical history
One of the first principles one learns at dental school is that 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, no or both of 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 records they are taking along to the next visit, so that the precise nature of the medical history can thereby 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 functional 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 the potential to shorten their life and/or restrict its quality. Damages in such cases are therefore very high indeed, often including a lifetime’s loss of earnings.

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 a very high risk 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 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 successful defence of cases where failure to elicit or act upon a relevant aspect of medical history leads to avoidable harm to the patient.

In all cases, the taking and confirmation of a medical history is the role of the dental surgeon and is certainly a key part of a dentist’s duty of care. If in doubt, it may be sensible to defer treatment pending clarification of any areas of uncertainty in a patient’s medical history.

Dental history
However thoroughly it is carried out, any clinical examination is still only a snapshot of a patient’s dental and oral tissues at a moment in time. While it will provide a lot of useful basic information, the clinician’s understanding of the patient’s presenting condition is greatly improved by knowing how the patient reached the present position.

• Is there a history of fractured teeth/fillings?
• Are any teeth painful or sensitive?
• If so, what causes any such sensitivity?
• Do the patient’s gums bleed on tooth brushing or spontaneously?
• Is the patient apprehensive about receiving dental care?
• Do the patient’s dental problems relate to any particular dental procedure(s) or to the experience in general?
• Has the patient experienced any particular problems associated with treatment provided for them in the past?

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 may also help to identify any special needs that the patient might otherwise have resulted.
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 im- not collected and recorded in a clear and logical fashion. Having a structured and systematic process to history taking and record keeping through all the process is necessary 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.

Later in the treatment planning process, when it becomes a little clearer what treatment possibilities are under consider- ation, it may be necessary to explore some aspects of the history in greater depth, in order to be recorded carefully in the notes to demonstrate this im-

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