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 demonstrate at a later date that they were.

If, on the other hand, there is a clear answer – 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 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 there is little or no opportunity to obtain 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 usually require a ‘Because...’ answer, and such answers can provide a useful insight into the patient’s attitudes, priorities, preferences and behaviour.

‘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

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NEW EVIDENCE FOR THE BENEFITS OF INCREASING BRUSHING TIME

To motivate behavioural change, it helps if patients understand the benefits of brushing for at least 2 minutes twice a day with fluoride toothpaste, compared to an average brushing time of around 46 seconds.1

New research results from Aquafresh show that increasing brushing time:

**Significantly increases plaque removal**

![Graph showing plaque removal vs brushing time]

- 26% more plaque removal was observed with brushing for 120 seconds compared with 45 seconds.*

**Significantly increases fluoride uptake and enamel strengthening**

![Graph showing enamel recovery vs brushing time]

- Surface microhardness (SMH) increased in a linear fashion over the period 30–180 seconds.*

References


Aquafresh is a registered trade mark of the GlaxoSmithKline group of companies.
worse?... is it hot things?... or cold things?... or biting on the tooth?... and so on. 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 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 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 medication they are taking along to the next visit, so that the precise drugs and dosages 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 heart murmurs, or other 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 permanent damage which has 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.

Other recent 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 postoperative bleedings, or to recognise the potential for drug interactions.

Cases such as these often reveal the fact that although a practising surgeon might have taken a comprehensive medical history when the patient first attended as a new patient, this process has either not been repeated, or has been much more superficial, when the patient has returned for successive courses of treatment. In the majority of cases, no further written medical history questionnaire is ever undertaken, and indeed there is rarely any note on the record card to confirm what (if any) further questioning has taken place to update the patient’s medical history. This can be a considerable embarrassment when the patient has attended the same practice over a large number of years, and the practitioner is apparently still relying upon the patient’s original medical history details.

It is self-evident that a patient’s medical status is not static, and indeed, a patient’s medical record prescribed by others may change from visit to visit – it is prudent, therefore, to ensure not only that changes in medical history (including medication) are regularly checked and updated, but also that this fact is clearly recorded as a dated entry in the patient’s clinical notes.
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 given. Clearly, a well-structured medical history questionnaire form, which is completed, signed and dated by the patient, and subsequently updated when necessary, perhaps at regular intervals (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 the patient a regular or irregular attender?
• What treatment has been provided in the last five years?
• Is there a history of fractured teeth/fillings?
• Are any teeth painful or sensitive?
• If so, what causes any such sensitivity?
• Do any symptoms blunted on tooth brushing or spontaneously?
• Is the patient apprehensive about receiving dental care?
• If so, do these concerns 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?

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 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 interests have also been known to have an impact on treatment:

For example:
• Bruxism in air traffic controllers, marathon runners and certain other sports players
• keratolentalgia in (pilots and cabin crew)
• Stress and its relation to periapical disease (including episodes of pericoronitis 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 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 linguo 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 less likely that critical information will be overlooked, or lost.

Later in the treatment planning process, when it becomes a little clearer what treatment possibilities are under consideration, it may be necessary to explore some aspects of the history in greater depth, in order 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.