# OUTLINES OF MEDICAL DIAGNOSIS. PREPARED FOR THE USE OF STUDENTS, AT THE HARVARD MEDICAL SCHOOL, BOSTON

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HARVARD MEDICAL SCHOOL

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# INDEX.

# THE HISTORY.

NOTE the name of the patient, state (married or single), age, residence (town, street and number) and birthplace (malaria, hydatid, etc.), occupation (eye strain, writer's cramp, painter's colic, etc.) and the date on which he is seen.

The family history and personal history should be taken, and the progress of the present illness obtained in detail. If the patient is very ill, depend largely on the friends for data and obtain other necessary information during later visits. Avoid embarrassing questions in the presence of a third person.

As a rule, let the patient tell his story, simply guiding his narrative into profitable channels. Avoid leading questions. Do not be misled by his medical expressions. Lay diagnoses of meningitis, influenza, gastric catarrh, rheumatism and dysentery are untrustworthy and must not be allowed to interfere with a correct diagnosis on the part of the examiner. Note the difference between chilliness and a true chill. Sometimes the history obtained is incorrect because of the dulness of the patient, either natural or due to the disease. Here repeated questioning may finally secure a satisfactory story.

Histories obtained from hospital patients are proverbially untrustworthy. Such persons are for the most part ignorant and unobservant. No matter what methods are employed to obtain the history, it is well to be sceptical about its accuracy, especially when the physical examination furnishes contradictory evidence. In children this is particularly important. Most children are unable to furnish information about themselves, and their histories must be obtained from the people in charge. Their symptoms are

not likely to be accurately stated by themselves, perhaps from fear, embarrassment or misunderstanding.

General questions as to heredity are frequently unsatisfactory. Definite interrogations must be put, and where one is in doubt of the truthfulness of an answer, the desired information may be obtained in a roundabout way,—*e.g.*, patients will admit that parents have had "nerve trouble" or "brain trouble," although they might deny the presence of insanity. Family tendency to tuberculosis should be asked for, but it is of greater importance to know whether the patient has been in close relation, either at home or in the workshop, with a tuberculous individual.

Important diseases often are forgotten by patients in giving the personal history, therefore, it is well to ask specifically regarding the exanthemata, rheumatic fever, pneumonia, St. Vitus' dance, jaundice, etc. Inquiries always should be made concerning the use of alcohol, tobacco, tea, coffee, diet in general, the times and the methods of eating, drinking and sleeping. Inquiries about pregnancy and menstruation should be simple and straightforward and as a rule the same applies to venereal disease. Occasionally indirect questions with regard to venereal diseases are often best. A patient will admit having had a "strain" or frequent or scalding urine, who will deny gonorrhea.

**Present Illness.** The first question should always relate to the first symptom and the time of its occurrence. The sequence of subsequent symptoms should be carefully investigated. The patient's answers often suggest other subjects important in the differential diagnosis, and the doctor or student then can show the extent and accuracy of his medical knowledge by asking enough but not too much. Individual symptoms (*e. g.*, abdominal pain, etc.) should be analyzed according to their situation, time and mode of onset, frequency, duration, character and severity. The mere fact that a patient vomits or expectorates is of little value. It is important to note the quantity, color, presence of blood and mucus. Always consider the temperament of the patient and his customary use of lan-