PUO History Taking

	INTRODUCTION	
1	Introduces themselves	
2	Confirms patient details	
3	Establishes presenting complaint using open questioning	
	HISTORY OF PRESENTING COMPLAINT	
4	Asks about fever	
5	Onset of fever	
6	Duration of fever	
7	Severity of fever	
8	Course of fever	
9	Exacerbating or relieving factors	
10	Recent infections	
11	Local exposure	
12	Elicits patient’s ideas, concerns and expectations	
	ASSOCIATED SYMPTOMS	
13	Malaise	
14	Nausea/vomiting	
15	Night sweats	
16	Rigors	
17	Weight loss	
18	Pain	
19	Swellings	
20	Skin changes (e.g. rash)	
21	Joint pain/stiffness	
22	Dry eyes/mouth	
23	Cough / shortness of breath	
24	Change in bowel habit	
25	Haemoptysis / haematuria	
	PAST MEDICAL HISTORY	
26	Immunisation history	
27	Previous infectious diseases	

28	Autoimmune conditions	
29	Malignancy	
30	Surgical history (e.g. splenectomy, heart valves, metallic implants)	
DRUG HISTORY		
31	Prescribed medication	
32	Antibiotics	
33	Immunosuppresants	
34	Chemotherapy	
35	Over the counter medication	
36	ALLERGIES	
FAMILY HISTORY		
37	Malignancy	
38	Autoimmune conditions	
39	Infectious disease (e.g. TB)	
SOCIAL HISTORY		
40	Occupational exposure to disease	
41	Hobbies	
42	Home environment	
43	Smoking history	
44	Alcohol history	
45	Recreational drug use (IV particularly important)	
46	Level of functional independence	
SYSTEMIC ENQUIRY		
47	Screens for symptoms in other body systems	
CLOSING THE CONSULTATION		
48	Thanks patient	
49	Summarises salient points of the history	
KEY COMMUNICATION SKILLS		
50	Active listening	
51	Summarising	
52	Signposting	

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