Stroke & TIA History Taking

INTRODUCTION		
1	Introduces themselves	
2	Confirms patient details	
3	Establishes presenting complaint using open questioning	
HISTORY OF PRESENTING COMPLAINT		
4	Onset / Duration	
5	Severity	
6	Intermittent / Continuous	
7	Exacerbating / Relieving factors	
8	Associated symptoms	
9	Dominant hand	
10	Recent head or neck trauma	
11	Ideas / Concerns / Expectations	
KEY SYMPTOMS		
12	Weakness	
13	Sensory disturbance	
14	Visual disturbance	
15	Co-ordination problems	
16	Speech disturbance	
17	Dysphagia	
18	Headache	
19	Nausea/vomiting	
20	Reduced level of consciousness	
21	Pain	
STROKE RISK FACTORS		
22	Ischaemic heart disease	
23	Hypertension	
24	Atrial fibrillation	
25	Hypercholesterolaemia	
26	Diabetes	
27	Previous stroke or TIA	

28	Smoking	
29	Excessive alcohol intake	
30	Family history of stroke	
PAST MEDICAL HISTORY		
31	Stroke risk factors as above	
32	Previous stroke or TIA	
33	Other neurological diagnoses	
34	Other medical conditions	
35	Surgical history	
DRUG HISTORY		
36	Anticoagulants	
37	Antiplatelets	
38	Antihypertensives	
39	Cholesterol-lowering medication	
40	Other prescribed medications	
41	Over the counter medication	
42	ALLERGIES	
FAMILY HISTORY		
43	Stroke or TIA (including age of onset)	
SOCIAL HISTORY		
44	Smoking history	
45	Alcohol intake	
46	Recreational drug use	
47	Housing	
48	Home situation (e.g. who do they live with)	
49	Level of functional independence	
50	Occupation	
51	Driving status	
SYSTEMIC ENQUIRY		
52	Screens for symptoms in other body systems	
CLOSING THE CONSULTATION		
53	Thanks patient	
54	Summarises salient points of the history	

KEY COMMUNICATION SKILLS		
55	Active listening	
56	Summarising	
57	Signposting	