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...’

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

  ![](Image 597x58 to 785x130)

  • 26% more plaque removal was observed with brushing for 120 seconds compared with 45 seconds**¹

  Recommend a great tasting fluoride dentifrice to encourage your patients to brush for longer, for increased fluoride protection and plaque removal

- Significantly increases fluoride uptake and enamel strengthening

  ![](Image 227x188 to 803x852)

  • Surface microhardness (SMH) increased in a linear fashion over the period 30–180 seconds**²

  * p<0.05

References


AQUAFRESH is a registered trade mark of the GlaxoSmithKline group of companies.
worse?... is it hot 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.

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, or uncommunicative patient. 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 practitioner 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.

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Many practices take medical histories verbally and if no posi- 
tive 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 disad- 
vantage 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 up- 
dated when regular reviews are undertaken (ideally, during each successive course of treatment), is not only in the patient’s best interest, but is also the best platform for the success- 
ful defence of cases where failure to elicit or act upon a relevant as- 
pect of medical history leads to avoidable harm to the patient.

In all cases, the taking and 
confirmation of a medical his- 
tory is the role of the dental sur- 
gon 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 pa- 
tient’s dental and oral tissues at a moment in time. While it will provide a lot of useful basic in- 
formation, the clinician’s under- 
standing of the patient’s present- 
ing 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?
• Does the patient grum- 
lle about 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?
• If so, what?
• Has the patient experienced 
a particular problem 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 ap- 
proaches 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 in- 
teres, hobbies, etc) as well as 
other social and family related information. The patient’s occu- 
pation 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 an update of the 
patient’s medical history.

The ability to attend for ap- 
pointments could affect the 
success of complex or exten- 
sive treatment, eg crown and 
bridgework, implants, long term 
periodontal treatment and ortho- 
dontics. Certain occupations 
can place severe constraints on a pa- 
tient’s ability to attend regularly for 
appointments.

Issues relating to a patients employment or recreational in- 
teres have also been known to 
have an impact on treatment:

For example:
• Bruxism in air traffic control- 
ers, marathon runners and 
certain other sports players
• Aerodontalgia in (pilots and 
cabin crew)
• Stress and its relation to peri-
codontal disease (including epi- 
sodes 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 se- 
vere pain, which can arise from 
some form of nerve damage, or 
TMJ/muscle disturbance asso- 
ciated 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, be- 
cause of a change in anterior 
tooth shape, position or angula- 
tion, or perhaps because of ling- 
gual or inferior alveolar nerve 
damage, would have a more pro- 
found affect on an opera singer, 
lecturer or telephone worker 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 al- 
tered 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 criti- 
cal when contemplating any aes- 
thetic/cosmetic procedures.

History of present complaint
When a patient attends with a spe- 
cific problem it is helpful to know 
how long the problem has existed, 
when it was first noticed, whether 
it has ever occurred before, wheth- 
er 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 oc- 
curred previously and if so un- 
der what circumstances.

Each of these findings needs 
to be recorded carefully in the 
notes to demonstrate this im- 
portant 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 cli- 
cian at the time, as noted in the 
records, such situations can of- 
ten be defended successfully.

Summary
It will be appreciated that there 
is very little value in gather- 
ing information from the above 
sources if the responses are not 
collected and recorded in a 
clear and logical fashion. Hav- 
ing 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 plan- 
ning process, when it becomes 
possible to know which treatment 
possibilities are under consider- 
ation, it may be necessary to 
explore some aspects of the his- 
tory in greater depth, in order 
to ensure that the patient is aware 
of any way in which their treat- 
ment (and its prognosis) might 
be affected by some aspect of 
their history.

Web: www.dentalprotection.org.

For details of Carl Zeiss and our wide range of other 
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