Breathlessness History Checklist

1. Introduction:

- Introduce yourself
- Gain permission for the interview
- Patient profile (usually skip)

5.2 Medical Research Council breathlessness scale

Grade	Degree of breathlessness related to activities
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying on the level or walking up a slight hill
3	Walks slower than most people on the level, stops after a mile or so, or stops after 15 min walking at own pace
4	Stops for breath after walking about 100 yards or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when undressing

Used with the permission of the Medical Research Council.

2/a. Chief Complaint+ HPI: (modified Socrates)

- Duration – How long has this been going on?
- Onset – Sudden or gradual?
- Timing – Constant or intermittent?
- Character– Improving, stable, or worsening over time?
- Exacerbating factors – e.g., exertion, lying flat, allergens
- Relieving factors – e.g., rest, medications, positioning
- Severity – Use MRC Dyspnea Scale (1 to 5)
- Previous similar episodes of breathlessness

2/b. Associated Symptoms: Socrates for any associated pain

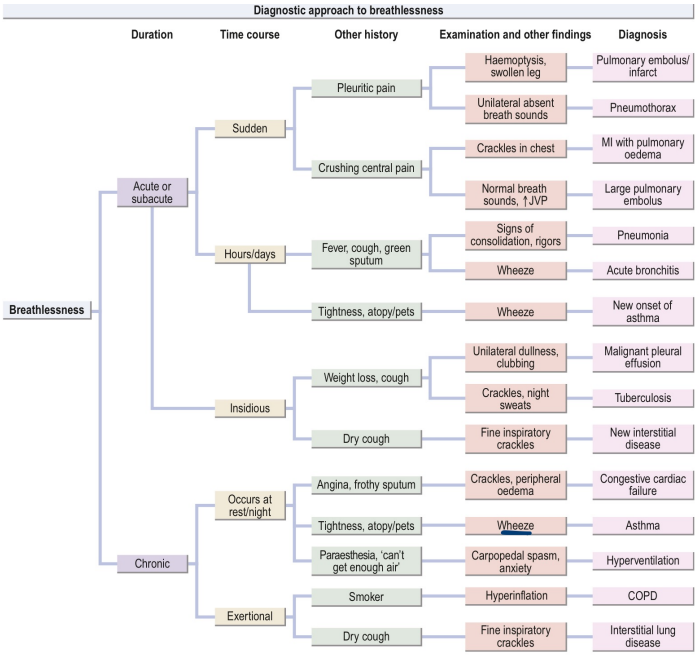
Cardiac:	Respiratory:	MSS/Other:	Signs of DVT/PE:	Fluid Overload/ others :	GI
Chest pain	Cough (productive? color? volume)	History of trauma	Calf pain/swelling	Peripheral edema	Gastroenteritis?
Palpitations	Recent URTI or lower respiratory tract infection	Rib or chest wall pain	Recent long travel or immobilization	Ascites	
Paroxysmal nocturnal dyspnea (PND)	Noisy breathing wheeze: High-pitched, musical, mostly on expiration. Rattling: loose upper airway secretions. Stridor: loud, harsh sound from large airway blockage. Seen in: Asthma, COPD, bronchitis, bronchiectasis, heart failure. during/after exercise? During = COPD, After = asthma Night wheeze? Asthma Allergy/hay fever? Atopy/asthma Family history?Supports asthma	Reduced mobility	Sudden pleuritic chest pain	Scrotal swelling	
Orthopnea (how many pillows?)				Anemia?	
Syncope or presyncope					

3. Systemic / General Symptoms

- Associated (secondary)-symptoms (systemic & red flags):
    - Fever / Night sweats
    - Weight loss (how many kg? over how long?)
    - Appetite changes
    - Stress, Psychological (hypocapnia)?

- ROS (Review of Systems) : brief screen of other systems (almost skip unless relevant)

4. Past History



Medical Conditions:

- Hypertension, Diabetes, anemia
- Heart diseases (MI, CHF, valvular disease)
- Lung diseases (Asthma, COPD, CF, bronchiectasis)
- past DVT or PE history
- ◆ Procedures & (past surgical):
  Coronary angiography (any stents?)
  Bronchoscopy
  Recent major surgeries (e.g., C-section, hip/knee replacement, valve/CABG)
- Drug History: Meds for chronic illnesses
  Important drugs: (2B 2N O+T):
    - Beta-blockers
    - Thyroxine
    - NSAIDs
    - Oral contraceptives
    - Nitrates
    - β2-agonists

- Family History: Family and patient's hx of cardiac or respiratory diseases
- Social History:
  Smoking: (Number of cigarettes smoked per day x Number of years smoking)/20
  Occupation: Exposure to dust, fumes, chemicals, and asbestos
  Alcohol use
  Recent travel history
  Blood transfusions (esp. if relevant to PE/infectious cause)

Mnemonic to Remember Sections: (If your brain suddenly undergoes a mental blockage during an OSCE)

D.O.C.T.O.R. BREATHE S.P.E.C.I.A.L

- Duration
- Onset
- Course
- Timing
- Orthopnea/PND
- Relieving & Risk Factors
- B-symptoms
- Review of Systems
- Edema/DVT signs
- Associated symptoms
- Trauma
- History (past medical/surgical)
- Exacerbating Factors
- Smoking
- Procedures
- Exposure (Occupation)
- Current meds
- Infections (URTI, gastro)
- Alcohol
- Lifestyle (travel, transfusion, family hx)

Internal Monologue History-Taking Scenario for Breathlessness

"Okay, deep breath….. It's just an examiner, I've survived worse. Smile. Pretend that you've been practicing all week and not crying over YouTube videos of OSCE tips at 2am……time to take a proper history of breathlessness, Start from the top."

1." Introduce yourself. Confirm the patient's name and get permission to ask a few questions."

2. "Alright, breathlessness, First (Modified Socrates): how long has it been happening? Was the onset sudden or gradual? Is it constant or does it come and go? Has it been getting worse or better over time or staying the same? "Now, let's explore what makes it better or worse (walking, lying down, climbing stairs)? And what relieves it? Medications? Rest?", "How bad is it? Use the MRC dyspnea scale, can they walk a few meters, climb stairs, or not even get out of bed?"

3. " Associated symptoms. Think heart, lungs, and beyond."

- Cardiac: palpitations? Chest pain? Orthopnea? PND? Fainting?
- Respiratory: cough? noisy breathing? recent infection?
- MSS: Trauma? Rip or chest wall pain? Reduced mobility?
- GI: Gastroenteritis?
- Signs of fluid: leg swelling? ascites? scrotal edema?
- DVT/PE? Leg pain? Immobility? Recent travel?

4. check for general red flags (systematic)… fever, night sweats, appetite or weight loss. Ask: how many kilos lost and over how many months?"

5. Past medical history, "any chronic diseases? Hypertension, diabetes, asthma, COPD, PE, CF, Anemia cardiac conditions, procedures: any stents? C-section, hip/knee replacement, valve/CABG?"

6. Surgical history? "Any heart surgeries, stents, valve replacements, recent major surgeries like hip/knee/C-section?"

7. "What about medications: (2N 2B O+T) chronic meds? Anything that could worsen breathlessness like beta-blockers, NSAIDs, thyroxine, or oral contraceptives?"

8. Family history: "Any heart or lung conditions run in the family or the patient has ever suffered from?"

9. Social history: "Do they smoke? How many packs per day and for how long? Let me calculate pack-years. Ask about occupation: "Do they work with dust, chemicals, or fumes? Alcohol? Recent travel or blood transfusions?"

10."Alright full circle. Did I miss anything? Think SPECIAL: Smoking, Procedures, Exposure, Chronic meds, Infections, Alcohol, Lifestyle. Let's summarize back to the patient."

Cough History Checklist

5.3 Causes of chronic cough and accompanying clues in the history	
Pathophysiology	**Suggestive features in history/ examination**
Airways inflammation	
• Asthma – 'cough-variant asthma'	Affects children and some adults Often present at night Associated wheezing, atopy
• Chronic obstructive pulmonary disease	History of smoking and intermittent sputum
• Persisting airway reactivity following acute bronchitis	Cough persisting after recent infection
• Bronchiectasis	Daily purulent sputum for long periods Pneumonia or whooping cough in childhood Recurrent haemoptysis
Lung cancer	Persistent cough, especially in smokers Any haemoptysis Pneumonia that fails to clear in 4–6 weeks
Rhinitis with postnasal drip	Chronic sneezing, nasal blockage/ discharge
Oesophageal reflux	Heartburn or acid reflux after eating, bending or lying Nocturnal and daytime cough
Drug effects	Angiotensin-converting enzyme inhibitors
Interstitial lung diseases	Persistent dry cough Fine inspiratory crackles at bases
Idiopathic cough	Long history with no signs and negative investigations – diagnosis of exclusion

1. Introduction

- Introduce yourself.
- Ask for permission to take the history.
- Patient profile (usually skip).

2/a. Chief Complaint + HPI : (cougHS Too PAD that's SAD)+++

- Duration of the cough.
- Associated symptoms: Socrates/modified for any pain
- Smoking?
- ACE inhibitors
- Daily?
- Pattern: Constant, worse at night, early morning, etc
- Trigger
- Sputum: Sputum color (white, yellow, green, pink, bloody),(frothy for weeks/ months: Bronchoalveolar cell carcinoma), Volume, Consistency any noticed change in it (firm plugs: allergic bronchopulmonary aspergillosis) & Smell (foul? Anaerobic infection)
- Haemoptysis: coughing blood, red color?
- Onset: Sudden or gradual?
- Character: Dry, productive, barking, whooping, paroxysmal?
- Exacerbating/Relieving factors: Exercise, cold air, lying flat, Is the throat clearing something you can control, or does it happen on its own? And does coughing up sputum make you feel better or relieved?.
- Previous similar episodes of cough

2/b. Associated Symptoms:

Cardiovascular	Respiratory	Gastrointestinal	DVT &Edema
Chest pain	Shortness of breath	Heartburn (GERD) appears with food ingestion? relived by antacids?	Symptoms of DVT (unilateral leg pain, swelling)
Palpitations	Noisy breathing (wheezes or stridor)	Appetite changes	Lower limb edema
Orthopnea	History of respiratory diseases (asthma, COPD, cystic fibrosis, bronchiectasis)	Alerted voice or swallowing	scrotal swelling, ascites
Paroxysmal nocturnal dyspnea (PND)	History of TB	History of Gastroenteritis	
Syncope			

3. Systemic / General Symptoms

- B (secondary)-symptoms (systemic & red flags):
  - Fever
  - Night sweats
  - Weight loss (how many kg? over how long?)
  - Appetite changes
- ROS (Review of Systems): brief screen of other systems (almost skip unless relevant)

4. Past history:

- Past medical conditions: HTN, DM, cardiac disease, PE, DVT, asthma, COPD, CF, bronchiectasis
- History of procedures: Coronary catheterization, stent, bronchoscopy
- Surgical history: CABG, valve replacement, major surgeries (e.g., C-section, hip/knee replacement)
- Drug history:
  - Drugs for Chronic diseases
  - Specific drugs (2b + 1n + Ace): Beta-blockers, ACE inhibitors, NSAIDs, B2-agonists
- Family history of cardiac or respiratory illnesses
  Make sure to ask about patients and family history of diseases
- Social history:
  - Smoking (calculate pack years)
  - Ask about PETS !!
  - Allergies, atopy and eczema !!
  - Occupation (dust, fumes, exposure)
  - Alcohol use
  - Recent travel
  - Blood transfusion
  - Diet (only if relevant)

COUGH NOTES:

- Productive? Yellow or green: bronchial infection?
- Large volumes over long periods: Bronchiectasis
- Cough fails to settle over weeks: bronchial carcinoma. (X-RAY required)
- Viral bronchitis resolves in less than 3 weeks by itself.
- Absence of initial explosive glottal opening: bovine cough, possible hilar malignancy

Internal Monologue History-Taking Scenario for cough

"Begin by introducing urself. Confirm the patient's profile, then get straight to the story.
Okay, the patient is complaining of a cough, a smile and being confident will help, let's break this down clearly.
When approaching a patient with cough, I first ask about duration: is it acute, subacute, or chronic? Then I explore onset (sudden or gradual) and character (dry, productive, barking, whooping, paroxysmal). I check for daily patterns (worse at night, morning, or constant) and ask about any triggers like exercise, cold air, or lying flat. I inquire if the cough is productive, then characterize sputum by its color, amount, consistency, and smell, and ask about any blood (Haemoptysis). I also explore exacerbating or relieving factors. Do you clear your throat because you feel you have to, or is it more of a habit? and don't forget to ask about smoking habit, ACE inhibitors, ask about previous episodes and any chest pain, using a SOCRATES-like approach if pain is present.

Think broadly: Could this be from the lungs, heart, upper airway, or GI tract?
Check associated features:

- Cardiac signs like orthopnea and edema.
- Respiratory signs like SOB and noisy breathing.
- GI: GERD/ recurrent laryngeal dysfunction (voice/swallowing)
- DVT/Edema
- Systemic signs like weight loss, fever, night sweats.

Don't forget past diseases & surgical proccedures, relevant medications(2B + 1N +ACE inhibitors), and smoking history & family hx of cardiac, respiratory and Gi diseases (take the patient's hx too).
Always end with exposures, lifestyle, and travel/transfusion/occupational risks."

Hemoptysis History-Taking Checklist

1. Introduction

- Greet and introduce yourself
- Ask for permission to take history
- Patient profile (usually skip)

2/a. Chief Complaint + HPI: " BAD SALT made u cough blood "

- Breathlessness (Ask very fast about DOCTOR BREATH SPECIAL)
- Associated symptoms
- Diseases that the pt knows about (rs, cvs & gi)

- Source: Was the blood truly coughed up (not vomited or swallowed from a nosebleed)? Is it associated with each cough? Any similar previous episodes?
- Amount: Volume and measurement (spoonful, cupful, streaks, clots? Volume and measurement (spoonful, cupful, streaks, clots? Fresh or old blood?, blood on clear sputum? Lung cancer)
- Length: since when?
- Trigger: what make u suffer from Haemoptysis more?
- Previous history of hematemesis or epistaxis?!

2/b. Associated symptoms: If you can, briefly ask about associated symptoms or relevant special questions (e.g. SOCRATES, DOCTOR BREATH SPECIAL , etc).

cardiovascular	Respiratory	Gastrointestinal	other
Chest pain	cough(dry, productive?)	Heartburn?	Easy bruising? bleeding disorder
Palpitations	noisy breathing	gum disease?	Edema: leg, scrotal, ascites
orthopnea	Breathlessness(MRC)	jaundice	DVT
PND	Pulmonary embolism		
syncope	Lung cancer?		

3. Systemic / General Symptoms

- Associated (secondary)-symptoms (systemic & red flags):
  - Fever/ Night sweats
  - Weight loss (how many kg? over how long?)
  - Appetite changes
- ROS (Review of Systems): brief screen of other systems (almost skip unless relevant)

4. Past History: Medical History

- Cardiac diseases
- Chronic respiratory conditions (asthma, COPD, bronchiectasis)
- Lung cancer
- Bleeding disorders or liver disease
- History of PE, DVT, or recent URTI/gastroenteritis
- Procedural: Cardiac cath or bronchoscopy?

. Past Surgical History

- Especially thoracic or abdominal surgeries

. Drug History

- Chronic medications
- Anticoagulants: Warfarin, heparin
- NSAIDs

. Family History

Make sure to ask about patients and family history of diseases:

- Cardiac, respiratory, or hematological illnesses
- Thrombocytopenia
- Vitamin K deficiency

. Social History

- Occupation
- Smoking and pack-year calculation
- Alcohol use
- Recent travel or blood transfusion
- Diet

Internal Monologue History-Taking Scenario for Haemoptysis

"Okay, let's not panic, coughing up blood doesn't always mean tuberculosis and tears. First, I'll start with the usual: greet, introduce, and ask for permission. Skip the profile unless something stands out.

Now for the complaint, blood with a cough? That's hemoptysis, not hematemesis or epistaxis. Let me start by confirming this is true hemoptysis and not vomited or swallowed blood? Ask if it came with coughing, and whether it's happened before. Ask about any gum diseases?

Use BAD SALT to remember the key points:

- Breathlessness: a quick check using DOCTOR BREATH SPECIAL
- Associated symptoms from other systems
- Diseases the patient already knows about
- Source of bleeding: confirm it's pulmonary
- Amount: streaks, spoon, cup? Fresh or clotted?
- Length: since when?
- Trigger: what makes it worse?

Next up: associated symptoms. I'll hit cardio (chest pain, palpitations, orthopnea), respiratory (SOB, noisy breathing), GI (heartburn, jaundice, gum disease), and some general clues like edema or bruising. syncope?

I won't forget red flags: fever, night sweats, appetite loss, and that mysterious unexplained weight drop. If they lost 5kg in two weeks, I'm raising my eyebrow.

Time for past history. I'll ask about anything chronic: asthma, COPD, TB, cancer, DVT, bleeding or liver disorders. Any cath or bronchoscopies? Surgeries? I'll also check for risky meds, anticoagulants (heparin? warfarin?) or NSAIDs.

Last step: family and social history. Anyone at home coughing blood too? Any weird blood disorders (experienced by the fam or the patient, ask about both)? Smoker? (Time to calculate those pack-years like a mathematician with a stethoscope). What do they eat, drink, and do for a living?

Chest Pain & Syncope History Checklist

1. Introduction

- Introduce yourself
- Ask permission to take history
- Patient profile

2/a. Chief Complaint + History of Present Illness (HPI): SOCRATES

- Duration: How long has the chest pain/syncope lasted?
- Site: Where exactly is the chest pain?
- Onset: Sudden or gradual?
- Character: Describe the pain (sharp, crushing, burning, etc.)
- Radiation: Does the pain move anywhere? (jaw, arm, back)
- Timing: Constant or intermittent?
- Course: Better, same, or worse over time?
- Exacerbating factors: What makes it worse? (exertion the Canadian cardiovascular society classifications, stress, deep breath, food, position)
- Relieving factors: What makes it better? (rest, meds) eased by simple analgesia or settles spontaneously? MSS
- Severity: Ask patient to rate pain severity (0-10 scale)
- Previous episodes: Any similar past chest pain or syncope?

2/b. Associated Symptoms, ask about:

- Cardiac: palpitations, orthopnea, paroxysmal nocturnal dyspnea (PND), edema
- Respiratory: shortness of breath (SOB)(Use MRC scale), cough, noisy breathing
- Gastrointestinal: heartburn, dysphagia, odynophagia
- Musculoskeletal: trauma, muscle spasm, rib fracture
- Neurological: syncope or presyncope
- Dermatological: any rash (e.g., shingles)
- Signs of deep vein thrombosis (DVT)

3. Systemic Symptoms (Red Flags)

- Fever, night sweats
- Appetite changes
- Weight loss (how much & duration), BMI
- Review of systems (brief unless relevant)

4. Past history: Medical History

- Hypertension (Ask if th HTN is controlled or not), diabetes, dyslipidemia
- Cardiac diseases (MI, CHF, valvular diseases)
- Chronic respiratory diseases (asthma, COPD, CF, bronchiectasis)
- Gastroesophageal reflux disease (GERD) increased by food ingestion?
- History of cardiac catheterization (stents?), bronchoscopy

. Past Surgical History

- Cardiac surgeries (CABG, valve replacement)
- Recent major surgeries (C-section, hip/knee replacement)

. Drug History (1b +2n + T + O)

- Chronic medications
- Specific drugs: Beta-blockers, thyroxine, NSAIDs, oral contraceptives (OCPs), nitrates

. Family History:

- Cardiac, respiratory, or relevant diseases
- Marfan syndrome?
- Familial pulmonary hypertension?

. Social History

- Occupation (exposure to risk factors)
- Smoking status & pack years
- Alcohol consumption
- Recent travel history
- Blood transfusion history
- Diet

Thinking of a differential diagnosis, helps u in asking good questions

4.4 Cardiovascular causes of chest pain and their characteristics

	Angina	Myocardial infarction	Aortic dissection	Pericardial pain	Oesophageal pain
Site	Retrosternal	Retrosternal	Interscapular/retrosternal	Retrosternal or left-sided	Retrosternal or epigastric
Onset	Progressive increase in intensity over 1–2 minutes	Rapid over a few minutes	Very sudden	Gradual; postural change may suddenly aggravate	Over 1–2 minutes; can be sudden (spasm)
Character	Constricting, heavy	Constricting, heavy	Tearing or ripping	Sharp, 'stabbing', pleuritic	Gripping, tight or burning
Radiation	Sometimes arm(s), neck epigastrium	Often to arm(s), neck, jaw sometimes epigastrium	Back, between shoulders	Left shoulder or back	Often to back sometimes to arms
Associated features	Breathlessness	Sweating, nausea, vomiting, breathlessness, feeling of impending death (angor animi)	Sweating, syncope, focal neurological signs, signs of limb ischaemia, mesenteric ischaemia	Flu-like prodrome, breathlessness, fever	Heartburn, acid reflux
Timing	Intermittent, with episodes lasting 2–10 minutes	Acute presentation; prolonged duration	Acute presentation; prolonged duration	Acute presentation; variable duration	Intermittent, often at night-time; variable duration
Exacerbating/ relieving factors	Triggered by emotion, exertion, especially if cold, windy Relieved by rest, nitrates	'Stress' and exercise are rare triggers, usually spontaneous Not relieved by rest or nitrates	SpontaneousNo manoeuvres relieve pain	Sitting up/lying down may affect intensity NSAIDs help	Lying flat/some foods may trigger Not relieved by rest; nitrates sometimes relieve
Severity	Mild to moderate	Usually severe	Very severe	Can be severe	Usually mild but oesophageal spasm can mimic myocardial infarction
Cause	Coronary atherosclerosis, aortic stenosis, hypertrophic cardiomyopathy	Plaque rupture and coronary artery occlusion	Thoracic aortic dissection rupture	Pericarditis (usually viral, also post myocardial infarction)	Oesophageal spasm, reflux, hiatus hernia

NSAIDs, Non-steroidal anti-inflammatory drugs.

Chest Pain notes:

- Causes: chest wall, parietal pleura, mediastinum, tracheobronchial tree, pericardium, oesophagus, subdiaphragmatic organs.
- Not from lung parenchyma or visceral pleura (no pain nerves).
- Character: sharp = pleural pain (worse with inspiration/cough).
- Associated symptoms: breathlessness, fever, cough = infection.
- Important causes:
    - Pneumonia, infarcts, pneumothorax, lung cancer (pleural irritation).
    - Pneumonia → Gradual pleuritic pain + cough, sputum, fever, chills.
    - Musculoskeletal (tenderness, trauma, costochondritis).
    - Oesophagitis (burning retrosternal pain, worsens with eating).
    - Mediastinal or chest wall malignancy (constant, progressive pain).
    - Unstable angina → Sudden heavy retrosternal pain at rest, ~30 min, not relieved by NTG, no sweating/vomiting.
    - Stable angina → Gradual exertional retrosternal heaviness, relieved by rest or NTG.
    - PE → Sudden pleuritic chest pain + SOB ± hemoptysis, ask about DVT signs.
    - Aortic dissection → mid interscapular tear-like pain, Marfan syndrome & uncontrolled HTN
    - Pericarditis → Sharp precordial pleuritic pain, worse with inspiration, relieved by leaning forward.
    - Herpes zoster → Burning dermatomal pain with/preceded by vesicular chest rash.
    - Trauma → Localized reproducible pain; ask about injury, coughing, or rib tenderness

Internal Monologue History-Taking Scenario for chest pain

"Alright, time to get the full hx on this chest pain. Start by introducing myself and making sure u take PP.

I'll quickly get the basics (SOCRATES+1), when did the pain start, where exactly is it, and how does it feel? I need to know if crushing or pressure-like pain raises red flags for ischemia; sharp or pleuritic points more to pulmonary or musculoskeletal causes, radiates anywhere, and if it's constant or comes and goes (duration of episode and time between 2 episodes). I'll find out what makes it better or worse and how bad it is on a scale. Then I'll check if they had this before, important to know if it's something new or recurring. Next, I'll look for any red flags or warning signs: palpitations, shortness of breath, any swelling, or GI symptoms like heartburn that could mimic chest pain. I won't forget to ask about any recent trauma or muscle pain that could explain it, Do analgesics reduce pain, Does food change pain severity?

Systemic symptoms like fever or weight loss might point to other causes (calculate BMI).

I'll move on to the medical history of heart disease, lung problems, surgeries, and meds, especially beta-blockers or nitrates that could affect symptoms.

Family history might reveal inherited risks, any sudden cardiac death, arrhythmias so ask about that too.

I'm mentally organizing red flags vs benign causes, remembering that syncope might be cardiac (arrhythmia, obstruction), neurogenic, or even orthostatic. Chest pain differential is broad: ischemic, pulmonary embolism(sudden, caused by hypotension and hypoxemia), aortic dissection (interscapular pain radiation), pericarditis (flu like symptoms relieved with NSAIDs and may come with connective tissue diseases), musculoskeletal(caused by forceful coughing, CT diseases), GI causes like GERD(relived by Antacids), anxiety, and more."

Finally, the social stuff, smoking (pack years), alcohol, occupational exposures, travel, and transfusions, all might give clues.

Extra Respiratory notes related to Hx taking

Weight Loss

- Common in lung cancer, COPD, ILD, TB, bronchiectasis.
- Due to appetite loss and systemic inflammation.
- Ask extent, duration, appetite.

Sleepiness

- Excessive daytime sleepiness suggests sleep apnea (OSA/OSASH).
- Symptoms: snoring, repeated breathing pauses, non-restorative sleep, daytime drowsiness.
- Risk factors: obesity, large neck >17 inches , male sex, alcohol use.
- Ask about sleep patterns, daytime sleepiness, partner's observations.
- Use Epworth Sleepiness Scale if needed.
- Advise no driving until investigated.

Fever, Rigors, Night Sweats

- Common in respiratory infections, but also malignancy or vasculitis.
- Rigors: intense shaking, usually bacterial sepsis (e.g., pneumonia).
- Night sweats: persistent suggests TB or lymphoma.
- Clarify symptoms carefully (shivers, chills, shaking).

5.4 Previous illness relevant to respiratory history

History	Current implications
Eczema, hay fever	Allergic tendency relevant to asthma
Childhood asthma	Many wheezy children do not have asthma as adults, yet many adults with asthma had childhood wheeze
Whooping cough, inhaled foreign body, measles	Recognised causes of bronchiectasis, especially if complicated by pneumonia
Pneumonia, pleurisy	Recurrent episodes may be a manifestation of bronchiectasis. Some pneumonias may cause bronchiectasis
Tuberculosis	Reactivation if not previously treated effectively Post-tuberculous bronchiectasis – sputum, haemoptysis. Aspergilloma in lung cavity may present with haemoptysis
Connective tissue disorders, e.g., rheumatoid arthritis	Many have respiratory manifestations, e.g., pulmonary fibrosis, effusions, bronchiectasis Immunomodulatory treatments for rheumatological diseases may cause pulmonary toxicity or make patients susceptible to respiratory infection
Previous malignancy	Recurrence, metastatic/pleural disease Chemotherapy can cause pulmonary fibrosis (e.g., bleomycin) Radiotherapy-induced pulmonary fibrosis
Cancer, recent travel, surgery or immobility	Pulmonary thromboembolism
Recent surgery, loss of consciousness	Aspiration of foreign body, gastric contents leading to pneumonia, lung abscess
Neuromuscular disorders	Respiratory failure Aspiration

5.5 Respiratory problems caused by drugs

Respiratory condition	Drug
Bronchoconstriction	Beta-blockers (including eye drops) Opioids Nonsteroidal anti-inflammatory drugs
Cough	Angiotensin-converting enzyme inhibitors
Bronchiolitis obliterans	Penicillamine
Diffuse parenchymal lung disease	Cytotoxic agents: bleomycin, methotrexate Anti-inflammatory agents: sulfasalazine, penicillamine, gold salts, aspirin Cardiovascular drugs: amiodarone, hydralazine Antibiotics: nitrofurantoin
Pulmonary thromboembolism	Oestrogens
Pulmonary hypertension	Oestrogens Dexfenfluramine, fenfluramine
Pleural effusion	Amiodarone Nitrofurantoin Phenytoin Methotrexate Pergolide
Respiratory depression	Opioids Benzodiazepines
Tuberculosis	Reactivation by glucocorticoids or disease modifying antirheumatic drugs (DMARDs)/ biological immunomodulators given for rheumatic disease

5.6 Occupational factors in respiratory disease

Respiratory disease	Toxic agent(s)	Affected occupations
Asthma Rhino-conjunctivitis	Isocyanates Flour, grain dust, enzymes Animal dander/urine Wood dust	Spray painters Baking industry Laboratory and veterinary workers Joiners
Chronic obstructive pulmonary disease	Cadmium fumes Coal dust Silica Coke dust	Solderers Underground miners Stone cutting, masonry, tunnelling, quarrying, pottery, metal ore mining, siliceous abrasive users, foundry workers Coke oven workers
Byssinosis	Cotton dust	Flax workers
Pneumoconiosis	Coal (Coal Miners Pneumoconiosis) Silica (Silicosis) Asbestos (Asbestosis) Iron (Siderosis) Tin (Stannosis)	Miners see above Former laggers, asbestos textile manufacture; asbestos insulation work including marine engineering, shipbreaking. Iron ore miners, welders, iron foundry fettlers Tin smelters
Hypersensitivity pneumonitis	Thermophilic bacteria: • Mouldy hay • Mouldy grain • Mushroom compost • Mouldy sugar cane (Bagassosis) Avian serum/excreta Metal working fluids	 Farmers Grain workers Mushroom pickers Sugar workers Bird fanciers Machinists
Pneumonia	*Strep. pneumonia* Q fever (*Cox.burnetii)* Psittacosis (*C. psittaci*) Leptospirosis (*Leptospira*)	Welders Dairy farmers, abattoir workers Poultry workers Sewage workers, animal handlers, vets
Tuberculosis	Silica (silicotuberculosis)	See above
Granulomatous disease	Beryllium (Berylliosis)	Aerospace industry, nuclear industry, oil/gas drilling, dental technicians
Pleural disease	Asbestos: pleural plaques, diffuse pleural thickening, mesothelioma	See above
Lung cancer	Asbestos Silica Coke dust	See above
Connective tissue disease	Silica increases the risk of scleroderma.	See above

Palpitations History Checklist

1. introduction:

- Introduce yourself and take consent.
- Confirm the patient profile.

2/A. Chief complaint (+its duration) + History of Present Illness: (PALP^{2}IT + COPD)

- Precipitants: what triggers or brings on the symptom? Stress?
- Length/timing
- Previous cardiac history + Previous history of sudden death.
- Improving/reliving factors: What helps improve or relieve the symptom (e.g., rest, medications)?
- Type/Nature of sensation: regular, irregular
- Onset: When did it start? Sudden or gradual?
- Duration: How long does each episode last?
- Pattern: Continuous or intermittent? how frequent per day/week?Time of day it usually occurs?
- Character: How does it feel? Rapid, forceful? Can the patient tap it out to mimic the rhythm?
- Associated Symptoms:
    - Chest pain, syncope, dizziness, orthopnea (how many pillows do you use and since when?), PND (did you ever wake up grasping for air at night?)
    - SOB (New York classification for HF), asthma, lower limb edema
    - Fatigue, pallor → anemia
    - Polyuria: pheochromocytoma
    - Joint pain
    - Weight loss, sweating, heat intolerance → hyperthyroidism
    - Fever, cough, night sweats, hemoptysis → TB/cancer

4.6 New York Heart Association classification of heart failure symptom severity

Class	Description
I	No limitations. Ordinary physical activity does not cause undue fatigue, dyspnoea or palpitation (asymptomatic left ventricular dysfunction)
II	Slight limitation of physical activity. Such patients are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnoea or angina pectoris (symptomatically 'mild' heart failure)
III	Marked limitation of physical activity. Less than ordinary physical activity will lead to symptoms (symptomatically 'moderate' heart failure)
IV	Symptoms of congestive heart failure are present, even at rest. With any physical activity, increased discomfort is experienced (symptomatically 'severe' heart failure)

2/B. Systemic Symptoms (Red Flags)

- Fever, night sweats
- Appetite changes
- Weight loss (how much & duration), BMI
- Review of systems (brief unless relevant)

3. Past History

- Similar previous episodes? Previous history of family sudden death?

- Previous hx oh heart diseases or cardiac surgery?

- MI (which may cause arrhythmias too)
- Wolf Parkinson white syndrome?
- Aortic stenosis
- Hypertrophic cardiomyopathy

- Chronic conditions:
    - Hypertension
    - Ischemic heart disease (IHD)
    - Heart failure (HF)
    - Congenital or rheumatic heart disease
    - Hyperthyroidism
    - Anemia

- Recent viral illness (URTI)?
- Past surgeries:
    - Valve replacement, Major surgeries with blood loss
    - Recent childbirth (postpartum thyroiditis

. Drug History

- Chronic meds: antihypertensive, thyroid meds
- Specific meds:
    - β2-agonists (e.g., salbutamol)
    - Levothyroxine
    - Digoxin
    - Diuretics
    - Stimulants (e.g., ADHD meds)
    - OTC drugs and energy drinks

. Family History

- Sudden cardiac death
- Arrhythmias
- Thyroid or hematologic diseases

. Social History

- Smoking (pack years)
- Alcohol
- Caffeine or energy drink intake
- Recent stress or lifestyle changes
- Occupation and physical activity (e.g., stairs at work/home)
- Recent travel?
- Blood transfusion history?
- Gynecological History (if female):
    - Last menstrual period (LMP)? , menorrhagia, pregnancy?, postpartum status?

Internal Monologue Palpitations History

"Alright, stay calm and focused. Let's begin with a warm intro, make the patient comfortable and get their profile straight. They're here for palpitations, so my job is to find the rhythm behind the rhythm.

Let's break it down, I need to go PALP2IT + COPD.

First: when did this all start? Sudden or gradual? Are the episodes short bursts or lingering flutters? I'll ask about duration, pattern, and whether they're worse at night, after coffee, or during stress. Can they tap out the rhythm? Regular or chaotic? That tells me a lot.

Now the triggers: stress, anxiety, heavy meals, caffeine, alcohol, even cold meds could be culprits. I won't forget exertion or lying flat, could hint at heart failure.

Time for the associated symptoms: I need to listen carefully here. Chest pain? Syncope or dizziness? Shortness of breath or orthopnea? Maybe this is ischemic or structural. Any lower limb edema or signs of fluid overload? If they mention fatigue or pallor, I'm thinking anemia. Weight loss and heat intolerance? Let me rule out hyperthyroidism. Fever or hemoptysis? TB or malignancy should be in my back pocket. Make sure u review the system in brief.

Next, past medical history. Have they had previous episodes? Any heart disease, congenital issues, hyperthyroidism, or recent infections? Recent surgery or childbirth may also be relevant, such as postpartum thyroiditis.

Now onto meds, could this be a side effect? I'll ask about β-agonists, levothyroxine, diuretics, stimulants, energy drinks. Don't miss the subtle ones.

I won't forget family history, sudden cardiac death or inherited arrhythmias are red flags.

Time for a reality check: their social life. Smoking? Alcohol? Stress levels? Do they climb stairs or sit at a desk all day? Any recent travel or blood transfusions?

If it's a female, always ask about LMP, pregnancy, and postpartum status. Hormonal shifts can mess with the heart too.

Syncope / Presyncope / Dizziness History-Taking Checklist

 1. Introduction

- Greet the patient, introduce yourself.
- Take permission for the history.

 2/a. Chief complaint + History of Present Illness ("Do Not Fall Down, Always watch real signs!)

- Duration of the complaint (when did it start?)
- Number of episodes
- Frequency (per day/week/month)
- Duration of each episode
- Was it witnessed? Who saw it and what did they observe?
- Recovery: How did the patient recover? (Time to full consciousness and mental clarity)
- Sudden or gradual in onset?
- Previous Episodes: Any similar events in the past?

- Associated Symptoms:

    - Special senses: Visual disturbances, Photophobia, Phonophobia
    - CVS: Chest pain, Palpitations
    - GI: Nausea, GI discomfort, vomiting
    - Headache?
    - Sleeplessness?
    - Lightheadedness
    - Tinnitus
    - Other: Fever, Sweating, Pallor

2/B. Systemic Symptoms (Red Flags)

- Fever, night sweats, Pallor
- Appetite changes
- Weight loss (how much & duration), BMI
- Review of systems (brief unless relevant)

Before the Episode: same as associated symptoms
Ask if the episode was preceded by:

- CVS: Chest pain, Palpitations
- GI: Nausea, GI discomfort, vomiting
- Lightheadedness
- Headache
- Tinnitus

During the Episode

- Any loss of consciousness (LOC)? And its duration !!!
- Any abnormal movements (e.g. jerking limbs)?
- Eye rolling?
- Frothy secretions?
- Tongue biting?
- Fecal or urinary incontinence?

After the Episode

- Recovery time: seconds, minutes, or longer?
- Post-event fatigue or confusion?

2/b. Clarify Symptom Nature

- If presyncope or dizziness (Sensations without the experience of losing consciousness) , ask the patient to describe exactly what they felt: spinning (vertigo), floating, blackout, or imbalance?
- Cause Clue in History Hint:

Ask	If yes, think...
"Did you feel the room spinning?"	Vestibular (Ear)
"Were you sitting or lying when it happened?"	Cardiac cause (dangerous)
"Was there a warning (nausea, sweating, vision dimming)?"	Vasovagal (Benign)
"Did you bite your tongue or lose control of urine?"	Seizure (Neurologic)
"Was there head trauma or new headache?"	Brain cause or bleed
"Did it happen on standing up quickly?"	Orthostatic hypotension

Injuries: Any fall or trauma from the episode? Any fractures, bruises, or head trauma?

Triggers

- Postural change (postural hypotension)
- Prolonged standing
- Heat, dehydration
- Stress, sleep deprivation
- Fasting or long time since last meal (hypoglycemia)
- Stimulants (caffeine, energy drinks)

3.past history: Medical History

- Epilepsy !!!11
- Stroke or TIA
- Hypertension
- Diabetes
- Cardiovascular diseases (arrhythmias, valvular disease, etc.)

. Surgical History: Recent or major surgeries?

. Medication History

- Drugs for chronic conditions (e.g., antihypertensive)
- Specific meds:
    - Nitrates
    - Beta-blockers
    - Digoxin
    - Amiodarone
    - ACE inhibitors
    - Diuretics

. Family History

- Sudden cardiac death
- Epilepsy
- Structural heart disease or cardiomyopathy
- Arrhythmias

. Social History

- Occupation (e.g., climbing stairs, machinery)
- Driving status
- Smoking and pack years
- Alcohol use
- Physical activity level
- Any recent travel?
- Blood transfusion history
- Sick contacts at home or work?

. Diet

- Timing of meals
- Any recent fasting?
- High caffeine intake?

Internal Monologue Syncope/ Presyncope / Dizziness History-Taking Checklist

"Alright, let's start by making the patient comfortable and getting straight to the core complaint, was this a true blackout, or did they just feel dizzy? Definitions matter. If it's presyncope or vertigo, I need to clarify exactly what they mean spinning, floating, or just about to faint?

Next, I'll time the episodes, when did it start, how often, and how long do they last? A pattern might point me to vasovagal, arrhythmic, or even situational syncope. Did they completely lose consciousness, and how long until they were fully back to baseline? That helps me differentiate between syncope and seizures.

Speaking of seizures, need to ask about eye-rolling, tongue-biting, incontinence, and confusion afterward. If there were jerky movements, it could be convulsive syncope or true epilepsy.

Now any triggers? Standing up quickly? Heat? Missing meals? Stress or lack of sleep? That would support a reflex cause. Palpitations before fainting? I'd better consider arrhythmia. Headache, vomiting, or photophobia? I won't miss signs of raised ICP or meningitis.

Time to scan for red flags, sudden cardiac death in the family, a personal history of cardiac disease or stroke, and dangerous medications like β-blockers or digoxin. I also won't forget caffeine, energy drinks, or stimulant.

I'll round it off with social details occupation, driving (important for safety), stairs at home, and any recent illnesses, travel, or transfusions.

My aim here? Is this cardiogenic, neurogenic, reflex, or something systemic? Stay structured.

Lower Limb / Periorbital Edema History-Taking Checklist

1. Introduction

• Greet the patient, introduce yourself.
• Take permission for history-taking.

2. Chief Complaint + History of Present Illness

"Sudden or gradual swelling? Is it one leg or both?"

Ask about: Deep Swelling Points To Assessment

- Duration: When did the swelling start?
- Site: Is it in one limb or both? → "Have you noticed your pants or shoes getting tight on one side only?"
- Progression: Has it been getting worse, better, or staying the same?
- Time of day: Worse in the morning or evening?
- Associated factors:
- Local symptoms

¬ Redness, warmth, pain? (Think DVT, cellulitis)
¬ Any trauma?!!
¬ insect bites?!!
¬ Rash, pigmentation?
¬ Limited movement?
¬ Itching (especially around the eyes)?

- Systemic symptoms

¬ Shortness of breath, orthopnea, cough, wheezing, cyanosis? (Heart or lung causes)
¬ Constipation, cold intolerance, fatigue? Hypothyroidism
¬ Chronic diarrhea, jaundice?
¬ Lip/tongue swelling? (Angioedema)
¬ Fever?
¬ Weight gain? "Do you know your usual weight? Any recent changes?"

. Past History

• Known cardiac, renal, liver disease, or hypothyroidism?
• Surgical history?

. Drug History

• On any chronic meds? Ask specifically about:

- NSAIDs
- Steroids
- Calcium channel blockers (amlodipine, nifedipine)
- New drug recently started?

. Family History

• Any renal, liver, thyroid, or heart disease?

. Social & Environmental History

• Occupation/home (e.g., long-standing at work, stairs)
• Smoking / alcohol
• Recent travel?
• Diet: salty food or new food ingestion?
• If the patient is a woman of reproductive age, ask about the possibility of pregnancy.

Internal Monologue Edema History-Taking

"Alright, I need to first figure out if this is localized or generalized edema. If it's just in one leg, I'm thinking DVT, trauma, or cellulitis. If both legs or around the eyes? That's likely systemic, maybe heart, kidney, or liver-related.

I'll ask about onset, duration, and progression, did it come on suddenly or has it been creeping in? Redness and warmth point me to infection or inflammation, while frothy urine or facial puffiness? That screams nephrotic syndrome. And if the patient mentions orthopnea or breathlessness, I'm heading toward heart failure.

Drug history is key here, NSAIDs, steroids, or amlodipine can all cause edema.
And I won't skip weight changes, that might reveal fluid retention.

If the patient says the swelling worsens throughout the day, it might just be dependent edema from standing too long. But I still need to rule out serious causes.

Finally, I'll consider their diet, activity level, recent illnesses, and even pregnancy in women. Step by step, I'll narrow it down to whether this is cardiac, renal, hepatic, allergic, inflammatory, or simply positional."

Differentiate between stable and unstable angina history checklist:

1. Introduction

- Greet the patient and introduce yourself.
- Take consent to proceed with history-taking.

2/a. Chief Complaint + History of Present Illness "Don't S^2top Pumping, T^2hat's A^2ngina!"

- Duration of pain? How long does it last? (Few mins vs persistent >20 mins?)
- Site & Spread: Where is the pain? Central chest, radiating to jaw, left arm, back?
- Precipitating Factors: Exertion? Cold air? Emotion? At rest? large meal?
- Type & Timing: Sharp, dull, squeezing? Sudden or gradual onset? Worse at rest or on effort?
- Alleviating/Aggravating: Does rest or GTN relieve it? Does it persist despite rest?
  After asking these question make sure you use ccs scale

Additional differential questions:

- First time? Has this happened before?
- Frequency: How often does it occur?
- Associated symptoms:
  - Dyspnea
  - Nausea/vomiting
  - Diaphoresis (sweating)
  - Palpitations
  - Syncope
  - Fatigue

4.2 Canadian Cardiovascular Society: functional classification of stable angina

Grade	Description
1	Ordinary physical activity, such as walking and climbing stairs, does not cause angina. Angina with strenuous, rapid or prolonged exertion at work or during recreation
2	Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or climbing stairs after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening
3	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing less than one flight in normal conditions
4	Inability to carry on any physical activity without discomfort; angina may be present at rest

4.3 Nature of chest pain and likelihood of obstructive coronary heart disease

Type	Characteristics	Likelihood of obstructive coronary heart disease
Typical angina	Meets all three of the following characteristics: • retrosternal chest discomfort of characteristic quality and duration; • provoked by exertion or emotional stress; • relieved by rest and/or nitrates within minutes.	++++
Atypical angina	Meets two of these characteristics.	++
Non-anginal chest pain	Meets only one or none of the characteristics.	–

2/b. Clarify Angina Type Based on Clues

Feature	Stable Angina	Unstable Angina
onset	Pattern unchanged for ≥6 weeks	New onset (<6 weeks) or <2 weeks post-MI
Trigger	Exertion, emotion	Can occur at rest or minimal effort
Relief	Relieved by rest/GTN	Not relieved by rest or GTN
Duration	Short (<10 mins)	Prolonged (>20 mins)
Pattern	Predictable (same pattern)	Increasing frequency, severity, or duration
First Episode	No (known condition)	May be the first warning sign

. Past Medical & surgical History

- Hypertension
- Diabetes
- Hyperlipidemia
- Peripheral arterial disease
- Previous MI or stents
- Previous episodes of angina?
- Autoimmune or inflammatory conditions
- History of procedures: Coronary catheterization, stent, bronchoscopy
- Surgical history: CABG, valve replacement, major surgeries (e.g., C-section, hip/knee replacement)

. Drug History

- Nitrates (GTN) relived or not? , β-blockers, statins, aspirin
- Recent non-compliance with medications?
- Cocaine or stimulant use?

. Family History

- Sudden cardiac death
- Ischemic heart disease at a young age

. Social History

- Smoking history (pack years)
- Alcohol use
- Exercise tolerance now vs before
- Occupation (physical stress, mental stress)
- Diet (high cholesterol?)
- Stress levels

Internal Monologue Angina Differentiation History-Taking

"Okay, this is chest pain, but is it angina? First, I need to pin down the character, is it squeezing, tight, retrosternal, radiating? Duration matters too: true angina should be brief, not lingering over 20 minutes unless it's unstable. Let's ask about precipitating factors. Does it only come with exertion? That's more stable. But if it wakes them up at night or occurs at rest, that's a red flag for unstable angina or even a myocardial infarction.If it is stable angina, use the ccs scale

Then I'll move to relieving factors; if GTN or rest helps consistently, it supports stable angina. But if pain persists despite these, or worsens over time, I'm dealing with unstable disease.

I'll probe the associated symptoms: sweating, shortness of breath, or nausea with chest pain are classic ischemic signs. Time to explore risk factors: diabetes, hypertension, lipid profile, smoking, especially if they have a known CAD or previous stents.

Lastly, I must think of the pattern. Stable angina is like a repeat performance. Same triggers, same relief. Unstable angina is like a chaotic debut, unpredictable, dangerous, and escalating. My goal? Decide if this chest pain is a stable pattern or if they're crashing into the danger zone of unstable angina."