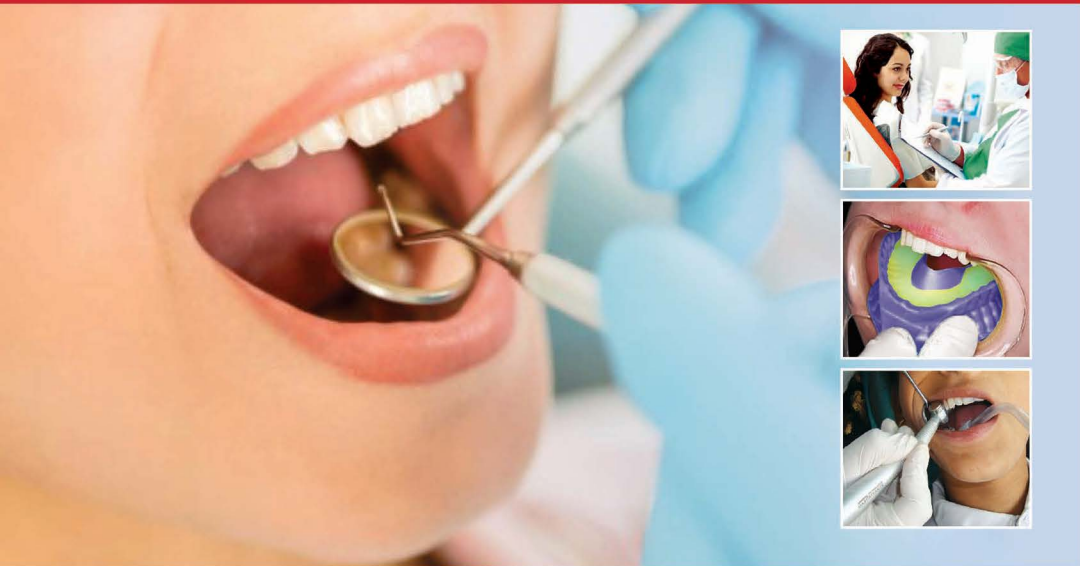




# A Practical Manual of Public Health Dentistry

SECOND EDITION



CM Marya



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## Chapter 2

# Methods of Recording a Case History

Establishing a good rapport with the patient is important for recording a complete history with valid information. A sincere smile and being a good listener will help reassure the patient that it is appropriate and safe to divulge personal information.

There is usually a traditional approach in the design of a case history. The preliminary part of the case history is usually based on questionnaires.

It is a classical form of maintaining record which ranges from clinical pictures to detailed and extended features that help in formulating diagnosis and treatment plan of a patient before treatment.

### ■ STEPS IN CASE HISTORY TAKING

1. Gather all the information from chief complaint, medical history, dental history and diagnostic tests.
2. Interpret all the assembled hints to reach the provisional diagnosis.
3. Make a differential diagnosis of all possible complications.
4. Select a closest possible final diagnosis.
5. Then based on all clues plan treatment.

### ■ GUIDELINES FOR TAKING CASE HISTORY

History taking should be conducted with the patient sitting comfortably. In order to produce an all-round history it is, however, customary to resort to directed questioning. Always introduce yourself to the patient and any accompanying person, and explain what your role is in helping them.

Remember that patients are (usually) neither medically nor dentally trained, so use easily understood language. Questions are a key part of history taking and the manner in which they are asked can lead to a quick diagnosis. Leading questions should be avoided as they impose a preconceived idea upon the patient.

For example, 'is the pain worse when you drink hot drinks?' Rather you should ask "when do you feel the pain is worst".

However, with the more reluctant patient it may be necessary to ask leading questions to elicit relevant information. For Infants under 5 years, parents should be interviewed.

The questions should be clear and should touch various aspects of the disease. Symptoms described by the patient should be recorded in his own words.

As one gets completely familiar with the techniques of the history taking and physical examination, one should remember the important differences between subjective data and objective data.

<i>Subjective data</i>	<i>Objective data</i>
Characteristics/features/symptoms told by the patients	Characteristics/features/symptoms assessment on examination by physician, investigator or dentist
The history of symptoms from chief complaint through review of systems	All physical examination findings
Subjective findings: General: Night sweats, falling hair, nutrition Head: Headache Throat: Soreness, hoarseness, difficulty in swallowing	Objective findings: Vital signs: Weight, height, blood pressure Skin: Color, texture

### Sequence of Case Recording and Evaluation

- General information
- Chief complaint
- History of present illness
- Previous dental history
- Medical history
- Family history

- Personal history
- General physical examination
- Extraoral examination
- Intraoral examination
- Provisional diagnosis
- Investigations
- Final diagnosis
- Treatment plan.

## A Practical Manual of Public Health Dentistry

### *Salient Features*

- A detailed step- by- step approach to the history taking, clinical diagnosis, treatment planning and prevention of dental diseases
- Student friendly
- As per updated syllabus
- New chapters on Pit and Fissure Sealants (with procedural steps), Topical Fluorides, Sterilization have been added
- Frequently asked important Viva Voce questions with explanations have been added
- Well- explained procedures with supported diagrams
- Both theory and clinical aspects of medical/dental history and indices are presented in a well-structured manner with figures, diagrams and photographs
- Exclusively available book in the market for public health dentistry.

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