Clinical examination & record-keeping: Part 2: History taking

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In brief

Discusses how information can be gathered from the patient prior to the chairside consultation with the clinician.

Provides guidance on collecting dental, medical and socio-behavioural history from patients.

Contains a useful quick reference list of recommendations for history taking, specifying whether elements are conditional, basic or aspirational.

This article is the second part of a *BDJ* series of Practice papers on the subject of clinical examination and related record keeping. The series is taken from the Faculty of General Dental Practice UK (FGDP[UK]) 2016 Good Practice Guidelines book on this topic, edited by A. M. Hadden. This particular article discusses history taking, where information may be gathered prior to the patient seeing the clinician or, in some cases, this may be carried out chairside by the individual. The information gathered can include a medical history, socio-behavioural history, and patient anxiety levels.

It is important to note that throughout this article (and the *BDJ* series and associated FGDP[UK] book), the specific guidelines will be marked as follows: **A:** Aspirational, **B:** Basic, **C:** Conditional. Further information about this guideline notation system is provided in Part 1 of this series (*BDJ* 2017; **223:** 765–768).

Introduction

In many practices, some information is provided by the patient prior to the chairside consultation with the clinician. It can be helpful to obtain information in advance as not only can this save valuable chairside time, but it can also enable the patient to provide detail when they do not feel under pressure. Usually a form is given to the patient to complete on arrival or sometimes in advance of the first visit, and this article describes information that can be gathered. A summary of the recommendations is provided at the end of this article in Table 1.

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Clincial Examination & Record-Keeping*

Part 1. Dental Records

Part 2. History Taking

Part 3. Electronic Records

*This series represents chapters 2, 3, and 8 from the FGDP(UK) Good Practice Guidelines entitled *Clinical Examination & Record-Keeping*, which is available online at https://www.fgdp.org.uk/guidance-standards. The content herein is reproduced with kind permission of FGDP(UK).

Pre-examination

While the objective of a pre-examination is to ensure adequate detail about the patient, this procedure can also assist in finding out why the patient is attending, and if they have any concerns or are seeking any particular treatment.

It is for the practitioner to decide how much detail should be collected at this stage, and this is something that may vary between different patients and practices. Forms for patient completion can be constructed by the practice accordingly.

The information in the 'pre-exam' comprises:

- Personal information.
- Medical history.
- Socio-behavioural history.

Often this can be included in one form for the patient to complete.

The history and information may also include:

- Previous dental history.
- Reason for the patient attendance.
- Financial detail. Where relevant, this can include information about payment mechanisms such as NHS, private, or capitation scheme.

Personal information

Details to be recorded during a pre-exam should include:

- Name. **B**
- Address. **B**
- Date of birth. **B**
- Parent/Guardian contact – If the patient is a child, then details of the person with 'parental responsibility' need to be recorded. This is usually self-evident when a family attends a practice and the child's record may simply note that parents attend. **C**
- Information of the responsible party – If the patient is in any way dependent on others for example due to disability, limited capacity, or as a vulnerable adult, full information of the responsible party (eg carer, next of kin) should be recorded. **C**
- Phone numbers. These should include home, work, and mobile. The preferred contact number should be clearly indicated. A method of communication should be agreed and noted. **B**
- Email address. **C**
- Emergency contact details. **B**
- Patient's General Medical Practitioner (GMP), and contact details (although this

may be available on the medical history form). **B**
- Relevant specialist practitioners, and contact details. **C**
- NHS identification number (where required, to confirm eligibility for NHS care). **C**
- Occupation. **B**
- Patient's signature (or that of the responsible party) – for verification details of various forms, or on requests for information. **B**

Not all the above information will be available or necessary for every patient and it is for the practitioner to decide the level of information required for patient care and safety.

Medical history

Understanding a patient's medical history and being aware of the patient's medical condition throughout the time of providing care is essential[1] as medical care may influence the dental care provided. There are many conditions which can have a bearing on the dental treatment, and the clinician should be aware of the compromises necessary when treating patients with particular medical conditions or problems. It is not the purpose of this book to describe these in detail. The medical history must be recorded, and updated as necessary. (Example forms are included in Appendices 3a and 3b in the FGDP[UK] Good Practice Guidelines.)

Prevention of a problem, by use of risk management, is useful and a method of highlighting relevant information should be adopted. Examples include penicillin allergy, or patients taking anticoagulants.

There are many examples of medical history forms available commercially, and some practices will produce their own (see Appendix 3 in the FGDP[UK] Good Practice Guidelines). Guidance on the completion of the questionnaire should be given when appropriate, eg language difficulties, mental or physical impairment. In order to gain the most accurate information, a clinician should work through the questionnaire in collaboration with the patient.[2,3] It should be established that the patient fully understands each question. Clinicians should satisfy themselves that the information is correct and explore any area of ambiguity or concern, seeking clarification and obtaining details as required. Once complete, the form should be signed and dated by the patient, (unless software does not permit this – see part 3 of this *BDJ* series or chapter 8 in the FGDP[UK] Good Practice Guidelines), and by the clinician.

Although there may be notices in the practice such as in the waiting room, or at reception, asking patients to inform the dentist of any changes to their medical history, particularly medication, it is easy for the patient to forget, unless prompted. It follows that the medical history should be checked, but not necessarily recorded, at each appointment where invasive treatment is to be carried out. Any changes should be noted, dated, and initialled.

At a recall exam the medical history should be confirmed, dated, and initialled by the patient and the dentist. This form can be 'pp' on behalf of the dentist by a suitably trained DCP who would verbally advise the dentist of change, if any, so that the dentist is informed. Any changes should be noted, the form dated and initialled by the patient (unless software does not permit this – see part 3 of this *BDJ* series or chapter 8 in the FGDP[UK] Good Practice Guidelines) and the treating clinician.

Socio-behavioural history

This may be included as part of the medical history form. It can include:
- Tobacco/smoking habit. **B**
- Alcohol consumption. **B**
- Recreational drug use (the patient may not wish to divulge). **A**
- Eating habits. **A**
- Dietary information (where relevant). **C**
- Participation in contact sports. **C**
- Playing of musical instrument involving use of mouth. **C**
- Occupation. **B**

It may be easier for the clinician to discuss these above points directly with the patient at chairside, however having the questions on a form given to the patient will help stimulate the patient's thoughts in these areas.

History information to be recorded

Medical history information to be recorded at pre-exam, recall exam, emergency dental, emergency trauma, and on receiving referral:
- New form completed or updated. **B**
- Dated and signed by patient and clinician. **A**

Previous dental history

This information can be sought with a suitably worded form, or as part of the medical history form, and completed by the patient prior to consultation. Prior to the formal first clinical examination, the dental history should record details of previous dental care (eg orthodontic and/or implant treatment), including analgesia/anaesthetics, any oral allergic reactions not recorded in the medical history, and any other information that the patient volunteers.

Useful information would include:
- The ability and confidence to chew foods comfortably.[4-6] **B**
- Previous restorative procedures involving fixed and removable prostheses. **B**
- Orthodontic treatment. **C**
- Endodontic treatment. **C**
- Implant treatment. **C**
- Previous periodontal conditions and or treatments. **C**
- Previous difficulties. **C**
- Oral surgery procedures. **C**
- Oral hygiene regime (tooth brushing, oral hygiene aids, mouthwash). **B**
- Unease, apprehension, or anxiety and fear of dentistry. **B**
- Good or bad experience with dentistry. **C**
- Aesthetic concerns in respect of their teeth. **C**
- Changes that the patient has noticed within their own oral cavity. **C**
- History of fissure sealants or preventative treatment provided by schools dentist C
- Anything else the patient mentions. **C**

It is a matter of the clinician's personal preference whether to discuss the patient's dental history directly with the patient as part of general history taking or to provide the patient with a form to complete prior to chairside consultation. By using the form completed by the patient, the dentist can make additional notes on the same form for clarification as required.

When a new patient attends with a dental phobia it can be useful to assess the patient's condition quantitatively. This could, in turn, significantly modify the clinical management of the patient. Whilst there are many ways of measuring anxiety, the Modified Dental Anxiety Scale[7] (see appendix 11 in the FGDP[UK] Good Practice Guidelines) is a five-question, self-completion questionnaire that asks patients to rank their anxiety on a five-point scale ranging from 'not anxious' to 'extremely anxious'. It has proven to be a highly reliable and valid method of indicating

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a patient's anxiety status. Alternatively, a more subjective questionnaire, which includes more social aspects can be used (see appendix 10 in the FGDP[UK] Good Practice Guidelines).[8]

Reason for patient attendance

This question can be included in the form given to the patient prior to consultation. However, many clinicians may prefer to ask the question directly at chairside. It is important to discuss this with the patient during the consultation to ensure an accurate understanding of the patient's needs and expectations. **B**

General patient management

Some clinicians will prefer to discuss much of the above at chairside, and this can help relax the nervous patient prior to examination. The most important point is that personal details and medical histories should be recorded. This is an essential part of information to be retained at each type of exam discussed in this book.

Other information that can be included:

- An agreed method of contacting the patient, to avoid any ethical or confidentiality issues. **A**
- Availability to attend appointments. **A**
- Whether a carer is required to be present. **C**
- Best time for an appointment. **A**
- Patient's mobility, eg coping with stairs. **C**
- Travel considerations. **A**

Patient attitude to dental health

It is helpful to understand a patient's attitude to dental care, and to see if the patient has any particular aims of treatment. (A questionnaire, such as the one provided in appendix 10 in the FGDP[UK] Good Practice Guidelines may be helpful).

Table 1 History taking – summary of recommendations

Personal information	
Name	B
Address	B
Date of birth	B
Phone numbers	B
Contact method	A
Child – parental contact	C
Patient dependent on someone	C
Email	C
Emergency contact	B
General Medical Practitioner	B
Relevant Specialist Practitioner	C
NHS identification number	C
Occupation	B
Signature for verification	B
Details checked/updated	B
Medical History	
New form completed or updated	B
Dated and signed by patient and clinician	A
Socio-behavioural history	
Smoking	B
Alcohol consumption	B
Eating habits	A
Dietary information	C
Contact sports	C
Musical instruments	C
Recreational drug use	A
Previous dental history	
Chewing unrestricted	B
Restorative procedures	B
Orthodontic care	C
Endodontic care	C
Oral surgery procedures	C
Oral hygiene routine	B
Anxiety	B
Good/bad past experiences	C
Aesthetic concerns	C
Changes noticed by patient	C
Factors affecting appointment	
Timing	A
Mobility	C
Carer to be present	C
Travel considerations	A
Reason(s) for attendance	B
Payment method	B

A – Aspirational, B – Basic, C – Conditional

1. General Dental Council, Standards, Guidance, Standard 4.1.1, 2013. Available online at https://www.gdc-uk.org/api/files/NEW%20Standards%20for%20the%20Dental%20Team.pdf (accessed November 2017).
2. Scully C, Boyle P. Reliability of a self-administered questionnaire for screening for medical problems in dentistry. *Community Dent Oral Epidemiol* 1983; **11:** 105–108.
3. de Jong K J, Abraham-Inpijn L, Vinckier F, Declerck D. The validity of a medical risk-related history for dental patients in Belgium. *Int Dent J* 1997; **47:** 16–20.
4. Nikias M K, Sollecito W A, Fink R. An empirical approach to developing multidimensional oral status profiles. *J Public Health Dent* 1978; **38:** 148.
5. Burke F J, Wilson N H. Measuring oral health: an historical view and details of a contemporary oral health index (OHX). *Int Dent J* 1995; **45:** 358–370.
6. Locker D. The burden of oral disorders in a population of older adults. *Community Dent Health* 1992; **9:** 109–124.
7. Humphris G M, Morrison T, Lindsay S J. The Modified Dental Anxiety Scale: Validation and United Kingdom Norms. *Community Dent Health* 1995; **12:** 143–150.
8. Green R M, Humphris G M, Lindsay S E, Mellor A C, Millar K, Sidebotham B. Minor psychiatric morbidity, pain and fear in patients in general dental practice. *Community Dent Oral Epidemiol* 1997; **25:** 187–188.