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PATIENT INTERROGATION

BY

JACOB COHEN, O. D.

Philadelphia, Pa. U.S.A.

The practitioner of any healing art is guided in his examinations by the statements of the patient. The value of these statements will often be determined by the type of questions asked. The purpose of this paper is to aid the practitioner in his interrogation of the patient so that the responses received will be of the greatest value. Let us state at the very beginning that we are not attempting to set up a list of questions which would be suitable for all patiens, all practitioners and all situations.

There is good reason for our not being able to recommend a fixed, all-knowing routine for patient interrogations. In view of the innumerable possibilities which may confront the practitioner in his daily contact with patients, any attempt to line up an all-inclusive, fool-proof method of questioning would prove futile. If we but stop to consider the tremendous store of knowledge and experience needed for questioning a patient inteligently and pertinently, we must conclude that devising a complete and through routine of patient questioning is an almost impossible task. Yet, both inside and outside our field of endeavor, the seeming weakness of some practitioners in searching out and recording an adequate and relevant patient history moves the author to attempt to give at least some direction in history taking and recording and to offer some suggestions in the type of thinking which should motivate the questioner.

To those experienced practitioners who may think it presumptuous on the part of the author to undertake this weighty subject, let us assure them that we humbly agree with their point of view. Nevertheless, the author feels that his interest in the subject, his own background and length of experience make him somewhat more qualified to offer the material which follows.

We like to think that primary reason for practicing our profession is to aid those seeking our counsel and help. Ideally, if our patients are to receive the best possible care, every step undertaken should be carried out adequately and every necessary test should be performed in the effort to correct any and all defects presented. This brings us to the beginning of the examination or, more correctly, to the beginning of our patient contact, i.e., meeting the patient.

There is no question but that the manner with which the doctor and patient greet each other and the manner in which they continue to communicate throughout subsequent visits will produce certain definite, mental impressions on one another. The very start of the relationship may spell the success or failure of handling a case. The initial phase of contact should start the conveying of a feeling of confidence. This is important because the confidence established in the mind of the patient in the short interval between the initial greeting and the beginning of interrogation will often determine the kind of responses that will be given to the questions asked.

Perhaps, some clarification is needed for the term, *patient interrogation*, as used here. To the writer, this term embraces meeting the patient, taking his pre-history, and eliciting all subjective ocular symptoms and complaints as well as any pertinent systemic symptoms which may exist in the present or have existed in the past. While taking the pre-history, the doctor will have suprficially psychoanalyzed and evaluated the patient. The patient's ability to comprehend and respond has registered and the doctor's insight into the patient's relative intellectual capacity has been exercised. Any further questioning will now depend upon the doctor's evaluation of the patient's comprehension and answering ability.

The pre-history is followed by the taking of the actual history. History is defined as a recording of the past. Many doctors prefer to record significant past actions and reactions under history and to list significant symptoms under another heading. The author prefers to include, under the heading of history, all significant actions and reactions of the past, subjective symptoms of the present, and aims of prevention for the future. History taking naturally continues during subsequent testing and all salient remarks are recorded.

The aim of our interrogation should be twofold: first, to try to resolve the patient's complaints and symptoms into a "chief complaint", which many times is not so easy to do as it might appear; and second, to proceed there from to apply all our art and all our knowledge to the end of rendering the patient comfortable and satisfied. May we repeat our thesis for emphasis? We interrogate the patient and elicit his significant complaints so that we may evaluate his condition and thus apply all the knowledge and procedures we have available to give him the relief he seeks.

For all history taking, we should formulate a list of stock questions and use these as basis for interrogation. We should make this list as complete as possible and use it in its entirety, omitting only the questions which obviously do not apply to the particular patient. Gradually, as we become more adept in history taking, we may make use of variations, additions, substitutions and deletions to pin-point pertinent symptoms and complaints.

As the interrogation progresses, the direction the examination will take becomes formulated in our mind. Here, the old adage, "Experience is the best teacher", was never truer. Let us take a look at the suggested outline below and examine it carefully. The symptoms and complaints listed are everyday disturbances which bring patients into our offices seeking relief. Often, on the one hand, a single symptom may be indicative of a variety of conditions; while, on the other hand, a combination of symptoms (syndrome) may indicate only a single defect.

OUTLINE

During interrogation the following preliminary data are obtained from the patient:

Pre-History:

Name:	Date:
Address:	Telephone Number:
Date of Birth:	Occupation:
Sex:	Avocation:
Source of Referral:	Name of Family Doctor:

The taking of preliminary data is followed by an interrogation which requires the best answers the patient is able to supply. The doctor must be patient and must search out the correct answers by persistent questioning and careful, attentive listening.

Oculary History:

1. The first questions here may be, "What is troubling you? Why are you having your eyes examined?" These might be termed the leading questions.

2. These questions are followed by: "Did you ever have your eyes examined before?" Obviously, there is no outstandinng clue to show that the patient has had previous eye care. If the patient has had his eyes examined before, we might expect him to be somewhat familiar with the examination routine and to display

a lesser degree of anxiety when he describes his symptoms than would someone who has never had an eye examination.

3. If the patient is wearing a correction, we may ask him. "How long have you been wearing your glasses?" If the patient is not wearing glasses but gives a history of having had his eyes examined previously, the practitioner should find out as accurately as possible whether treatment was instituted at the time, the nature of any treatment, and whether or not glasses were prescribed.

4. If the patient is wearing glasses, a determination of his visual acuity both with and without the glasses in place may tell the complete story of the type of correction he is wearing. Often, the obvious, physical aspects of the lenses will be sufficient to give the desired information.

5. Ordinary physical symptoms, such as smartling, burning, itching, aching and the sensation of pain, all seem to have different meanings to differen people. It is helpful to have the patient disclose the area of disturbance. For example, *itching* may result from an allergic dermatitis, or it may be related to a low grade blepharitis or to a conjunctivitis, or to both of the conditions. *Smarting* and *burning* present acute sensations, the former usually being less severe than the latter. *Smarting* may arise from the presence of smoke and fumes in the atmosphere, while a *burning* sensation arises when some foreing matter is accidently flown or rubbed onto the conjunctiva. The complaint of *aching* might lead us to think of an accommodative spasm, an acute conjunctivitis, or possibly of *glaucoma simplex*. The existence of pain should alert us at once. *Pain* denotes a sharp discomfort and leads us to look for such causes as an imbedded foreign body, a *keratitis*, an *iritis*, an *acute glaucoma, dacryoadenitis* or *cystitis*.

6. The complaint of *photophobia* is an all-present type of symptom. It may accompany any one or more of the preceding symptoms and be combined with other complaints, of which fatigue is a common membre.

7. Excessive *tearing* is a common complaint. It has various indications. When it is present, the direction of our thinking, as in the case of many of the symptoms above, must depend on a consideration of the presence of associated and accompanying complaints.

8. There are many types of *headaches*. The complaint of *headaches* may or may not indicate a need for a refractive correction or an associated treatment. It is important to ascertain the usual time of onset of the headaches, their frequency, the type of work done by the patient and the lighting conditions associated with his work and other activities. Any of these data may offer important clues. Parietal headaches and morning headaches are rarely the results of ocular distress,

although all other types of headaches may be caused by stresses and disturbances accompanying visual effort.

9. The doctor should find out about any past injuries. We should ask, "Did you ever have any injury or accident to your eyes?" If the answer is in the affirmative, we must then ask, "How, when, where?".

10. After we are satisfied that we have a clear understanding of the patient's reasons for seeking our services, we may then state concisely and simply to the patient his chief complaint. The reaction to our statement will tell us what the patient really desires.

Systemic History:

This part of the examination may begin with, "How is your general health?" This is a routine question. Any additional questions and answers will depend on the patient's well-being and on any objective symptoms which may be disclosed during the examination. Such symptoms may apply to ear, nose or throat conditions; to vascular, endocrine, liver, pancreatic, nephritic or intercranial upsets; and to hereditary or congenital defects.

Addenda to History:

Any significant variations from the normal of either an ocular or systemic nature noted during the course of the examination should be followed up by the practitioner. This will require additional questioning and the recording of more data.

Subjective symptoms may have different interpretations at different age levels. As far as possible, the significance of specific symptoms must be evaluated in terms of possible ocular causative factors which have brought the patient to seek our services. The probability of our deductions will be determined as the examination progresses.

As we are all aware, there are an infinite number of questions which may be directed to the patient during an examination. The analysis of one patient's symptoms may be accomplished with facility during the initial questioning period, while the diagnosis of another patient's complaints may be obtained only after a prolonged period of diligent searching. The knowledge and experience of the practitioner will guide him in deciding whether a given questioning period should be of long or short duration. The basis for the amount of interrogation, of course, will depend on the variety of symptoms, apparent seriousness of the complaints and the ability of the practitioner to understand their meanings and evaluate

their possible causes. Usually, there exists one main complaint for which the patient is seeking a remedy. Other disturbances may be either secondary symptoms or complaints which are insignificant compared with the symptom of chief concern. Usually, the greater the severity of the primary complaint, the less will be the need of immediate attention for secondary difficulties. We must be careful not to confuse associated symptoms of the primary complaint with secondary symptoms which may arise from other difficulties of minor importance. Naturally, the greater the doctor's experience, the more pointed and direct will be his questioning. When the complaints do not add up to a clear-cut picture, or the picture seems to present a focus outside the scope of our practice, then a consultation is indicated.

Let us follow the outline just presented and see what type of questions we would employ.

Pre-History:

The patient's geographical location and his living standards may present special problems. We must, therefore, try to be aware of any possible disturbing conditions existing in the area where the patient lives. The age of the patient is important as this should alert us to conditions which may be caused by the factor of time. We should also always keep in mind the occupational hazards to which the patient may be exposed.

The history should begin with the definite complaint of the patient. It should include onset, frequency, duration, etc. However, if the complaint is vague, it is recommended that the questioning start with the ocular history outline suggested here.

A knowledge of symptoms is, of course, mandatory for an understanding of the reasons which motivate the patient to seek attention. The comprehension of cause and effect is helpful in enabling the doctor to correlate the information he obtains. The more definite and informative the responses of the patient, the more readily can the doctor arrive at a tentative diagnosis.

It is not uncommon for a patient's complaints to be of such a nature that the impressions presented will cause practitioners of different specialties to arrive at different decisions. It, therefore, behooves us to utilize the knowledge of differential diagnosis sufficiently to decide on the underlying condition and to decide on whether the patient belong withain our scope of practice, wheter a consultation is desirable, or whether the patient is in need of the services of more than one type of practitioner. It is not neccessary to state here how rewarding it is to be

able to make a proper differential deduction or to be able to channel the patient for special and proper care when that is his need.

Case histories as usually encountered may be grouped into the following categories. It will be observed that each category becomes progressively more challenging.

1. *Simple Defects:* A patietn with a mild degree of myopia will present poor distance vision and good near vision without his correction. The presbyope requires help at the near point. The hyperope shows various degrees of visual acuity, according to age and other factors.

2. *Mildly Involved Defects:* Patients in this clasification may show astigmatic errors, mild muscle defects and combinations of several problems. Their symptoms may be vertigo, headaches, neurasthenia, hysteria, etc.

3. *Defects with complications:* These patients present problems involving stereopsis, diplopia, gross muscle imbalances, antimetropia, aniseikonia, aphakia, etc.

4. *Hereditary and Congenital Defects:* The problems presented by these patients include cataracts, retinitis pigmentosa, colobomas, etc.

5. *Acquired Defects:* Patients in this category may display trauma, organic distrubances and secondary ocular involvements related to systemic disturbances.

We are all familiar with cases of simple refraction in which relatived the same error is found in a number of different individuals, each one of whom requires a different approach because each one presents a different set of symptoms. The psychological understanding of the behavior of these patients and the application of our comprehension and knowledge to them may spell the difference between treated patient and *satisfactorily* treated patients. In contra-distinction to these cases, there are some which present semingly more involved errors but require far less pampering and attention. For example, a high astigmatic error may be easier to correct satisfactorily than a low one. Congenital and hereditary defects may require relatively severe courses of treatment and are many times amenable only to the use of subnormal vision aids. Acquired defects usually speak for themselves and are readily identified.

The vastness of the field with which we are concerned makes itself apparent in many ways. For example, when a patient complains of dizziness, for which there are listed at least fifteen causes, we must make an astute deduction to determine whether or not the vertigo may be allayed or subdued by any treatment within our field. The cause may be a single defect or it may be a combination of factors. This type of approach in our thinking must be applied to many symp-

toms encountered in our practice, such as headaches, neurasthenia and hysteria. For enlightment on the causes underlying these complaints, we must draw upon our knowledge of abnormal psychology, pathology, physiological optics, and refraction in its fullest sense. We must be ready to recognize the existence of many systemic diseases which present both subjective and objective ocular symptoms and be able to decide on the type of referral needed. In the case of those defects which are rather severe and show an advanced or irreversible change in ocular function, we must present a report, preferably written, to a (near) member of the family or to the patient's physician.

There are patients who volunteer full, unrelated, historical episodes. Often, this type of individual is very anxious about his eyes and is trying to be most helpful. He may hope to uncover for us the clue which will give him best vision. On occasion, a lonely person may use this approach to prolong his visit. A sympathic ear on our part will help both these types of persons. Of course, we record only relevant data. When time is lacking, we may assume a more dominant attitude and begin asking questions of a more pointed nature. However, it must be admitted that a tolerant and sympathic attitude may be very beneficial to the patient in obtaining the feeling of security which he seeks.

All too rare is the patient who submits himself periodically for ocular investigation as a means of finding out his ocular status. This approach should be encouraged, as a wide-spread habit of periodic eye examinations would benefit the public enormously. This type of patient offer a real challange to the practitioner, since he presents no obvious symptoms.

We must understand and appreciate the psychosomatic aspects of our patients if we are to care for them properly. When we observe a variety of complaints reported by different patients, all with more or less the same defect, and when we find one patient with the same defect as the others and no complaints at all, we are led to wonder. The reason seems obvious. The reaction of the individual to his physical shortcomings depends on his personality. The psychoneurotic, the individual with an anxiety complex, and the neurasthenic, all present symptoms of their discomforts in varying degrees, depending on their emotional states; while phlegmatic and depressed individuals withstand the same difficulties with little or no complaint. To all these considerations must be added an awareness of the working conditions of the patient and the conditions under which he uses his eyes. We must remember that a combination of factors may precipitate symptoms and complaints. We can see that psychosomatic factors play a large part in our practices. It behooves us to try to understand our patients better so that we may prescribe for them with a fuller comprehension.

The author cannot agree with the school of thought which teaches that most symptoms or complaints are present not because of the existence of physical defects, but in addition to them. We believe that the defect precipitates discomforts which are magnified when the ocular apparatus can no longer endure the demands made upon it and than these discomforts are made more noticeable by other contributing factors, such as poor lighting effects and a weakness of emotional stability.

Summary: The true art of prescribing involves the application of the multiple findings of an adequate examination to the salient complaints and symptoms of the patient. To this must be added a thorough evaluation of the findings from a satisfactory history with the personality of the patient included in the final analysis.

Conclusion:

When we can evaluate the probable direction of the examination and prescription from an interrogatory session with the patient, we may conclude that an adequate, informative and enlightened history has been recorded.

Penna. State College of Optometry