Anamnesis

'Anamnesis' '(from the Greek' 'Αναμνήσις' ', anamnésis, ie remembrance, recollection) is a summary of information about the patient's previous life essential for the assessment of his current state of health. The essence of the anamnesis is well illustrated by the Czech equivalent of "pre-disease".

The anamnesis can be divided into two large groups according to who the anamnestic data are obtained from.

- *Direct anamnesis* - is taken directly from the patient.
- *Indirect anamnesis* - is taken, for example, from the patient's escort.

The principle when taking a medical history is to record all the information that the patient provides. Important information is not only what diseases and health complications the patient had, but also what diseases or complications the patient did not have.

Small (minimal) medical history (MA)

The minimal history contains a brief summary of the reason for hospitalization, it should not be longer than one sentence. Sometimes the minimal anamnesis is not given separately at all and is fully replaced by the "current disease" section.

CAVE

It is an optional part of the anamnesis and contains only a brief list of problems, which are usually elaborated in other parts of the anamnesis. Evaluation is in the form of a patient has & nbsp; (+) / does not have (-) the problem. The importance of this part is obvious especially at the moment when we are forced to deal with an acute condition in the patient and we do not have enough time to study the complete documentation. CAVE contains:

- the type of allergy and the subsequent "allergic reaction" (there is a big difference between the anaphylactic shock type reaction and, for example, intestinal problems);
- DM (diabetes mellitus) (+/−);
- heart attack (+/-);
- bleeding disorders and anticoagulant therapy (+/−);
- paroxysmal diseases (+/−) (eg epilepsy).

Current disease (NO)

The current illness contains detailed information about the current cause of hospitalization, ie details about admission to the hospital and the onset of difficulties (eg pain, anorexia, fever, ...). Information on the onset of the problem is essential, including the circumstances that led to the problem, the further development of the problem and the steps that the patient took to alleviate the problem (eg self-medication). It is also stated how the patient was transported to the hospital.

Personal history (OA)

Personal history is a chronologically arranged overview of diseases that the patient has suffered from birth to the present. Special attention should also be paid to the so-called "common childhood diseases" (sometimes even referred to only as "bdn"), as they can sometimes contain valuable guidance to explain the current situation. Personal injuries and surgical procedures are also mentioned in the personal history. Conditions that the patient has not been treated with can also be diagnostically valuable.

When collecting the disease, the examiner specifically asks about significant past illnesses and significant difficulties related to disorders of some organ systems. In case of a positive answer, information on the method of therapy is also ascertained, or previous therapies. In particular, the occurrence of the following disorders is monitored:

- cardiovascular and respiratory system: hypertension, ischemic heart disease, past myocardial infarction, past stroke, chest pain], claudication, swelling, shortness of breath, palpitations, cough,
- endocrine system: diabetes mellitus,
- gastrointestinal system: gastroduodenal ulcer disease, gallbladder problems, cholecystolithiasis, biliary colic, jaundice, infectious [[hepatitis]]], diarrhea, constipation, ...
- urogenital system: dysuria, polakisuria, urinary stones, ...
- central nervous system: headache, dizziness, disorders of consciousness, ...
- locomotor and support system: joint and muscle pain.

Family history (RA)

🔎 *For more information see Family history.*

The family history contains basic information about the disease and possibly also about the deaths of the patient's close relatives. The greatest emphasis is placed on diseases in which there is a clear *'familial occurrence'* , which is why blood relatives are especially interesting. Sometimes it can be useful to have information about the illness of blood unrelated people living with a patient in the same household. It is always necessary to capture at least the approximate age at which the person became ill and the possible "age of death". Typically, the occurrence of:

- cardiovascular diseases, especially hypertension, ischemic heart disease, myocardial infarction and stroke,
- diabetes
- and cancer.

Although for many diseases there are empirically set limits for distinguishing between spontaneous disease and disease due to genetic predisposition, a limit of fifty years can be used for rough orientation. The disease that appears before the age of 50 is rather genetically determined, the disease that appears after the age of 50 can be considered rather acquired.

Pharmacological history (FA)

The pharmacological history contains information on what substances the patient is taking. This is mainly information about the drugs used, including the dose and dosing schedule. Information on food supplements, vitamin preparations and phytopharmaceuticals is also important.

Abuse or toxicological history (TA)

The abuse section contains information on the use of addictive substances, especially tobacco products, alcohol, as well as the consumption of black coffee. Not only information about the current state, but also about recent history is important. Due to clearly negative connotations, some patients tend to report data below reality.

Allergic history (AA)

The allergic history contains information about the patient's allergies to drugs, food and other allergens, as well as allergies to transfusion products.

Gynecological history (GA)

🔎 *For more information see Gynecological history.*

For understandable reasons, a gynecological history only makes sense for women. It should include information on the first (menarche) and last (menopause) menstruation, the length and regularity of the cycle and any difficulties during menstruation. A necessary part of the gynecological history is also the determination of the number pregnancy, including their termination. The use of hormonal contraception is also being investigated.

Occupational history (PA)

The medical history contains important information about the patient's current and previous occupations, or information about retirement. Professional history can be a valuable guide in assessing the risk factors for some diseases. Information on the mental and physical demands of employment is generally important. Sometimes a specific profession may be important, eg an innkeeper is usually a heavy passive smoker, a veterinarian is at higher risk anthropozoonotic infections, a glass grinder or miner has a higher risk silicosis.

Social history (SA)

The social history contains information about the patient's social situation, especially about how, where and with whom he lives. In other words, we ask: if he lives in a house with an elevator, or in a barrier-free apartment, if someone takes care of the patient at home and how he manages the care. Social history can play a role, for example, in deciding on the length of hospitalization.

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