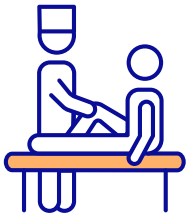
CHAPTER 3



THE FUNDAMENTAL PRINCIPLES OF MEDICAL HISTORY (ANAMNESIS) TAKING AND PHYSICAL EXAMINATION

Hasan BOSTANCI[1]

Anamnesis

Medical history (anamnesis) taking and physical examination always begin with good documentation. Initiating a comprehensive medical history (anamnesis) and conducting a thorough physical examination are foundational aspects of patient care. In situations where a printed form is not available, the following protocol ensures meticulous documentation:

1. **Introduction and Identification**: Begin by inscribing your complete name and surname or employing an official seal on a blank A4 paper. Record the examination date and, if relevant, include the precise time.
2. **Patient Data:** Capture and document essential patient information, date of birth, including full name, surname, age, gender, marital status, residence, birthplace, and occupation. When obtaining these particulars, be mindful of the patient's state; if the patient is unable to communicate adequately, succinctly note the information source to enhance the medical history's credibility.

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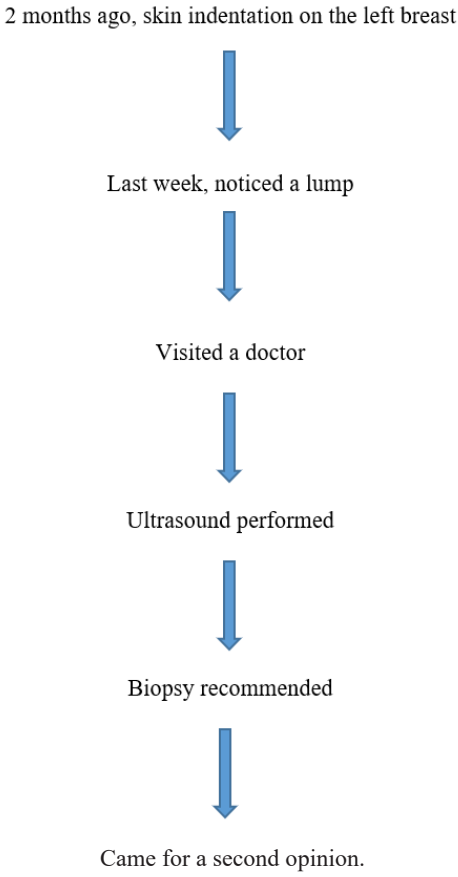

Figure 1.

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