SAMPLE CONVERSATION DURING GENERAL ASSESSMENT

How to establish rapport and ask the reason for consulting a physician
DOCTOR: Good day Mr (Patient's last name). What brought you here today? (Patients should be asked their reason for seeking medical help.) It is important to get the expressed health concern or chief complaint in the patient's own words. If the illness is chronic, they should be questioned as to what changes in their condition prompted them to seek help or when they last felt well. Basic Medical History)

How to inform the patient about the assessment
DOCTOR: I will be taking a health history and performing a physical assessment to help meet your health care needs. The assessment will also provide a baseline picture of your health status so that we can notice any changes in your condition.

How to get information about patient's occupation and social activity
DOCTOR: May I know your present occupation? (Current occupations may be different than what a person normally does (for example the produce worker in the market may be a coal miner who is temporarily unable to perform his/her usual occupation).
DOCTOR: What about your usual occupation?
DOCTOR: Any other jobs you may have had? (Provides information about possible health risks and psychosocial information)
DOCTOR: Have you ever joined the military? (Allows the examiner to assess if the patient has been exposed to atypical substances such as Agent Orange or out-of-country microorganisms. Also can provide psychosocial information)

How to know whether the illness was acquired from another country or not
DOCTOR: Have you travelled recently?
DOCTOR: Any other countries you have visited? When was that? (People oftentimes bring home more than just souvenirs from out of country trips. Unexplained skin conditions and gastrointestinal problems may have originated from exposure to unfamiliar microorganisms. Note the location of the travel and the length of time since returning home)

How to get information regarding childhood illness and immunization
DOCTOR: Have you experienced any type of disease during childhood?
DOCTOR: Can you still remember the immunizations you have had? (If appropriate, ask questions about the person's history of varicella, polio, measles, mumps, and rubella. Also ask about the person's DPT status and last immunization for tetanus)

How to get information about medical and surgical history
DOCTOR: Have you ever been hospitalized?
DOCTOR: What was the reason for the hospitalization? Can you still recall the date? (Reasons for hospitalizations, years of occurrence, and outcome of illnesses should be assessed)
DOCTOR: Do you have any past major illness? or What is the sickest you have ever been?
DOCTOR: Have you undergone any surgical procedure?
DOCTOR: What about injuries or fractures? (Past history of serious injuries and fractures should be established. Patients can be asked if they have ever been in a serious automobile or industrial accident)

SAMPLE CONVERSATION DURING GENERAL ASSESSMENT

How to assess whether patient has allergy or not
DOCTOR: Do you have any drug, food or airborne allergy? (The patient should be questioned as to food, drug, and airborne allergies. Reactions to allergens should be established. Assess past and current treatment for allergic reactions)
DOCTOR: Are you currently taking any medications including over the counter drugs and folk medicines.
DOCTOR: Can you please tell me the name, dosage and frequency?

How to ask personal questions pertaining to lifestyle
DOCTOR: Do you smoke?
DOCTOR: How many cigarettes can you smoke in a day?
DOCTOR: Do you drink alcohol?
DOCTOR: Have you ever thought you drank too much? Or Have your family or friends ever complained about the amount you drink?"
DOCTOR: Have you tried using narcotics?
DOCTOR: Do you exercise?
DOCTOR: Are you sexually active?
DOCTOR: Now, let's talk about your family's health status. Are any of your parents presently ill? What about your siblings? What about your spouse and children?
DOCTOR: Any hereditary illness you are aware of on both mother and father side?

General Assessment (Sample notes)

- Height
- Weight
- Build (thin, obese, emaciated, etc.)
- Temperature
- Radial Pulse
- Respirations
- Blood Pressure (sitting, standing, and lying if related to current illness or over age 50)
- Posture
- Speech (descriptive terms include: fast, slurred, thick, articulate, speaks no English, absence of speech)
- Emotion (descriptive terms include slightly nervous, comatose, calm, etc.)
- Stated Aged Versus Apparent Age (documentation would read "appears chronological age" or "stated age 40, looks 50")