Supplementary File 1: Example of a Doctoring checklist that integrates content and process

Doctoring: Master History Checklist

- Use alcohol-based cleanser / wash hands (“foam in”).
- Introduce yourself to the patient.
- Determine how the patient prefers to be addressed.
- Explain your role in health care team.
- Negotiate an agenda for the encounter including the medical history and/or the physical exam.
- Ask the patient’s age.
- Determine the patient’s primary care physician, if applicable.

Chief Concern and History of Present Illness (HPI)
- Identify the patient’s chief concern in his or her own words.
- Allow the patient to complete the chief concern and opening statement without interruption.
- Onset of symptom (when did the symptom(s) begin?)
- Provocation / aggravating factors (what activities/actions make it worse?)
- Palliation / alleviating factors (what activities/actions make it better?)
- Quality of symptom or pain (what is it like? e.g., dry / productive cough, OR throbbing, stabbing, crushing, tightness for pain).
- Location (region) of symptom or pain (where does the symptom/pain occur on the body?)
- Radiation of symptom or pain (does the symptom move? – e.g., to the back, shoulder).
- Severity of symptom or pain (mild, moderate, severe; pain is measured on a scale of 0-10).
- Associated symptoms (other symptoms occurring with the presenting complaint).
- Temporal profile / frequency of symptom or pain (how often does the symptom occur?)
- Previous similar episodes (and how it was treated).
- Ask about patient’s concerns/fears about illness.
- Determine beliefs and/or expectations about illness and treatment.
- Allow patient to relate his/her story, interrupting when appropriate.
- Use open-to-closed ended questions to gather information/explore problems.
- Uses segment summary after HPI and gives the patient opportunity to correct or add information.

Past Medical History
- Transition statement.
- Active medical problems.
- Hospitalizations (including year and reason).
- Previous surgeries (including year and complications).
- Prescription medications (and doses).
- Over-the-counter medications (and doses).
- Herbal or other treatments.
- Allergies to medications.
- Description of the allergic reaction (not applicable if patient has no allergies).
Family History
- Transition statement.
- Illnesses that run in the family.
- Parents, ages, and illnesses (and/or cause of death at what age).
- Siblings, ages, and illnesses (and/or cause of death at what age).
- Children, ages, and illnesses (and/or cause of death at what age).

Social History
- Transition statement.
- Use gender-neutral inclusive language.
- Living arrangements.
- Family and relationships.
- Safety / interpersonal violence screening (if applicable)
- Sources of social support.
- Current work status and occupation, exposure to health hazards.
- Significant stressors and financial hardships that might affect health.
- Depression screening (if applicable and not done in HPI or review of systems (ROS)).
- Effect of current illness on work and family responsibilities.
- Tobacco use (how much and how long in pack-years).
- Alcohol use (quantity and frequency).
- Drug use (including type, frequency, duration and method of use).
- Cultural and religious needs related to medical care (if applicable).
- Nutrition, physical activity, sleep, or sexual history (if applicable).

Review of Systems
- Transition statement.
- **General / constitutional:** fever, chills, change in appetite, change in weight (intentional or unintentional), fatigue, night sweats
- **Head, ears, nose, throat:** head injuries, hearing loss, ringing in ears (tinnitus), use of hearing aid, nose bleeds (epistaxis), nasal discharge (rhinorrhea), loss of smell, bleeding gums, painful swallowing (odynophagia), difficulty swallowing (dysphagia), sore throat, hoarseness, sores in mouth or nose, tooth pain.
- **Eyes:** change in vision, double vision, use of glasses and/or contact lenses, blindness, ocular trauma, eye redness or discharge, eye dryness.
- **Cardiovascular:** chest pain, racing heart (palpitations), dyspnoea on exertion, waking up short of breath (nocturnal dyspnoea), # pillows for sleeping (orthopnoea), swelling in feet (oedema).
- **Pulmonary:** shortness of breath with rest/activity, cough, mucus (specify colour, +/- blood), wheezing.
- **GI:** nausea, vomiting, heartburn, abdominal pain, bloating, change in bowel habits, diarrhoea, constipation, rectal bleeding, black tarry stool (melena), yellow pigment in skin (jaundice), increase in abdominal girth.
- **GU:** urinary frequency, urgency, dysuria, haematuria, decreased libido (women: irregular menses, dysmenorrhea, dyspareunia, vaginal discharge, menopausal symptoms; men: penile discharge, erectile dysfunction, swelling or pain in the testes.)
Musculoskeletal (includes neck/back): muscle aches, joint pain, stiffness, swelling, limited movement, trauma / injury.

Integumentary (skin)/ breast: rashes, lesions, changes in moles, hair loss; breast pain, soreness, lumps, discharge

Neurologic: headache, numbness, weakness, tingling, dizziness (vertigo vs lightheadedness), passing out / fainting or nearly fainting (syncope or near-syncope), difficulty with balance/walking, memory problems, seizures.

Psychiatric: poor concentration, depression, anxiety, insomnia, suicidal or homicidal ideation.

Endocrine: polyuria (excessive urination), polydipsia (excessive thirst), polyphagia (excessive hunger)

Hematologic/lymphatic: easy bruising, easy bleeding, recent travel, swollen glands.

Allergic/immunologic: allergies to foods, animals, insect bites, medications, environmental allergies.

General Approach/Flow of Medical Interview

Use transition statements.
Convey empathy using words and non-verbals that communicate care and concern.

Closure

Summarize information gathered during the encounter.

Ask patient about questions or concerns.
State appreciation to patient.
Shake hands (if appropriate).
Use alcohol-based cleanser / wash hands (“foam out”).