МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ

УЧРЕЖДЕНИЕ ОБРАЗОВАНИЯ
«ГОМЕЛЬСКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ»

Кафедра пропедевтики внутренних болезней

Л. И. Друян, Л. В. Романьков, И. В. Пальцев

СХЕМА УЧЕБНОЙ ИСТОРИИ БОЛЕЗНИ В КЛИНИКЕ ПРОПЕДЕВТИКИ ВНУТРЕННИХ БОЛЕЗНЕЙ

Учебно-методическое пособие
для студентов 3 курса факультета подготовки специалистов
для зарубежных стран, обучающихся по специальности «Лечебное дело»

SCHEME OF EDUCATIONAL MEDICAL HISTORY IN THE CLINIC OF PROPEDEUTICS OF INTERNAL DISEASES

Teaching workbook
for third year students of the
Faculty of General Medicine for Overseas Students,
specialty of «General Medicine»

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Рецензенты:
доцент, заведующая кафедрой внутренних болезней № 1 с курсом гематологии Гомельского государственного медицинского университета
И. И. Мистюкевич;

доцент, заведующий кафедрой поликлинической терапии и общеврачебной практики с курсом дерматовенерологии Гомельского государственного медицинского университета
Э. Н. Платошкин

Друян, Л. И.

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В учебно-методическом пособии представлена схема подготовки и написания учебной истории болезни по пропедевтике внутренних болезней. Данное пособие предназначено для студентов 3 курса факультета подготовки специалистов для зарубежных стран, обучающихся по специальности «Лечебное дело».

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FOREWORD

Writing of a medical history is one of the most important stages of teaching clinical medicine to students, which allow to systematize knowledge of the methods of patient`s clinical examination and apply received with their help data on a patient in order to diagnose, prescribe treatment and take prophylactic measures. The present scheme is aimed to help a medical student examine a patient while making up and keeping of the patient`s medical card.

The suggested scheme of the patients` examination is meant for the third year medical students.

The medical history is the main document made for every patient, who enters a hospital notwithstanding the aim of entering and terms of staying at hospital. The patient`s history contains records of observations over the patient, diagnostic, treatment and preventive measures during the whole period of stay in a medical institution and it must contain all the data received at the patient`s examination.

Work on the educational medical patient`s history according to the planned in advance scheme promotes getting of full information, necessary for the students to diagnose and to make up a plan for the further patient`s examination.

The medical history/report or medical in-patient`s card (its official name) consists of the following parts:

I. Subjective examination or questioning of patient (anamnesis, interrogatio).

II. Objective examination (status praesens obectivus).

III. Diaries of medical history (anamnesis morbi).

IV. Treatment (therapia).

V. Epicrisis (epicrisis).

In turn, the questioning of patient includes:

1. Passport data.
2. Patient`s complaints (molestia).
3. History of present disease (anamnesis morbi).
4. Life patient history (anamnesis vitae).

Objective examination includes:

1. Examination of patient (inspectio).
2. Palpation (palpatio).
3. Percussion (percussio).
4. Auscultation (auscultatio).
5. Laboratory and instrumental methods of examination.

The medical report is an official medical document that does not allow careless attitude to its execution. The medical history should be written clearly and legibly. The presence of abbreviations, corrections, erasures and strikeouts of the text, execution of the diary post factum or date corrections are ruled out. If there is an incorrect or erroneous note, beside it a doctor writes «erroneous note», mentions date and time and signs. It is recommended to use Latin terminology while writing parts of the medical history and pointing the prescribed remedies (medicines).

This scheme of the patient`s examination may be also used by the 4–6 year students as it contains all the parts of a typical medical history.

Order of execution of the cover page
of the educational medical history

MINISTRY OF PUBLIC HEALTH OF THE REPUBLIC OF BELARUS

GOMEL STATE MEDICAL UNIVERSITY
DEPARTMENT OF PROPEDEUTICS OF INTERNAL DISEASES

Head of the Department: academic degree, title, name.
Teacher: post, academic degree, title, name.
Curator: name, year of studies, group No.
Time of supervising: date of the supervising teacher`s observation of a patient is to be mentioned.

EDUCATIONAL MEDICAL HISTORY

Patient: full name.

Clinical diagnosis:
a) basic disease_____
b) complications of the basic disease_____
c) accompanying diseases and their complications_____

Gomel 2010

PLAN
OF PATIENT`S CLINICAL EXAMINATION
AND WRITING OF MEDICAL PATIENT`S HISTORY

I. QUESTIONING OF PATIENT
(interrogatio, anamnesis)

1. PASSPORT DATA (general information about the patient):

1) patient`s name _____
2) age_____
3) sex _____
4) home address _____ _____
5) place of work, profession, post _____
6) date of entering (for emergency patients it is necessary to mention time) _____
7) who sent_____ _____
8) diagnosis of the referred institution _____ _____
9) clinical diagnosis:
basic disease _____
complications of the basic disease _____ _____
accompanying diseases and their complications _____

2. PATIENT`S COMPLAINTS (molestia)

At first, it is necessary to find out all the patient`s main complaints, worrying him/her at the moment of entering a clinic, then list other (additional) complaints.

The medical history consists of the main complaints with their detailed and systematized description as well as additional complaints — systematically (in accordance with systems of organs). The further detail of the additional complaints is not obligatory. It is recommended to write down each of the main complaints in detail and in one sentence.

QUESTIONING OF COMPLAINTS
IN ACCORDANCE WITH SYSTEMS
(anamnesis communis)

RESPIRATORY APPARATUS

Difficulty of nasal breathing: duration, causes; nasal discharge: its characteristics (mucous, purulent, bloody), quantity (small, moderate, profuse), causality (cooling, inhalation of odors, dust, pollen of plants etc.).

Nasal bleedings: causes, frequency, duration, intensiveness.

Feeling of tickling, dryness, pain in nose: constant, occasional, duration, causes.
Feeling of dryness, pain or tickling in throat: cause, frequency, duration.

Change of voice: weakening, gruff voice, husky voice, hoarseness, absence of voice (cause, duration).

Cough: periodicity, frequency, duration, time and conditions of appearance; intensiveness: weak, moderate, bad cough; type: barking (whooping), hoarse, loud, husky, with sputum or without (productive or dry), whether cough is accompanied with chest pains, vomiting.

Sputum: whether it coughs up freely or with difficulty, in separate spittles or in full mouse; its approximate amount and its change depending on the patient`s condition and time of day.

Sputum characteristics: serous, mucoid, purulent, bloody (rusty, blood streaked), color, smell (absence, excessive sweet, putrid etc.), consistence (watery, viscous, dense, slaty), foreign substances, aliquation/disintegration in elutriation.

Hemoptysis: its frequency, amount of spitted blood (some spittles or many), their type (blood streaks, watery blood, clots, foamy, «rusty» sputum), color (scarlet, dark).

Chest pains: their localization, type (acute, aching/boring, dull, stabbing etc.), intensiveness (weak, moderate, strong), duration (constant, attack-like, occasional/periodical), irradiation of pains; connection with movements and changes of body positions, cough, how the pains are cut off (restriction of breath depth, definite pose of the patient, intake of medicines etc.).

Breathlessness: intermittent or constant; type: inspiratory, exspiratory, mixed, its intensity; causes of dyspnea; whether it is exertional (exercise) dyspnea (give its magnitude — it appears: when a patient goes upstairs — which floor, physical activity is ordinary or heightened, it appears in a quiescent state, when body position changes, other causes.

Asthmatic fits: time, causes (physical activity, its magnitude and characteristics, cough, inhalation of dust, odor etc.), duration of fit, condition in which a fit is cut short (due to changing of body position, stop of physical activity, intake of medicines).

CARDIOVASCULAR SYSTEM

Heart pains: precise localization, duration (constant, attack-like, intermittent), frequency and duration of attacks; type of pains (acute, dull, stabbing, constricting, cramp-like/spasmodic, burning, aching); intensiveness (weak, moderate, acute, intolerable, changing).

Causes of pains: physical activities (give magnitude of load: pains appear when a patient walks — how many meters, or goes upstairs — which floor), psycho-emotional stress, changing of body position, whether they appear in a quiescent state, without reason.

Time of pain appearance (in daytime, at night), irradiation of pains, conditions when pains stop (stop of physical activity, medicines, other methods).

Intermissions in heart activities: constant, attack-like, frequency, conditions of appearance (changing of body position, physical activity, food intake, psycho-emotional factors), time of appearance (at night, in daytime), conditions of cutting short (rest, breath-holding, medicines, other methods).

Palpitation (heartbeat): constant, intermittent, duration, intensiveness, cause (physical activity, nervousness, food intake etc.), conditions of cutting short (medicines, rest, certain body position etc.).

Breathlessness: constant or intermittent, characteristics, connection with physical activities, body position, other causes; whether it is accompanied with cough, phlegm, phlegm characteristics.

Oedemas: their localization, time of appearance and disappearance (in the morning, in the evening), whether they are over or only decrease, color of skin over oedemas (normal, pale, cyanotic, hyperemia).

DIGESTION SYSTEM

Change of appetite: on the same level, increased, reduced, dysgeusia (aversion to fat, meat or dairy products, hunger for non-traditional food – chalk, clay, uncooked cereals and meat etc.).

Feeling of satiation: whether it comes quickly, slowly, or is absent.

Change of taste: absence of one of gustatory sensations, absence of taste in general, foul taste in mouth (sour, bitter, metallic, sweetish).

Salvation: normal, intensified (drooling/salivary discharge), deficient (dry mouth).

Halitosis. Hiccups: causes, intensiveness.

Mastication: whether a patient chews food good or chewing is painful.

Dysphagia: painful, painless, impossible, constant, intermittent (causes), liquid or solid food; feeling of food retention in gullet (which level).

Eructation: connection with meals, its characteristics; duration, appearance rate (degree of severity according to severity score); features (sour, bitter, foul, gaseous, food eructation).

Heartburn: appearance rate, intensiveness (degree of severity according to severity score), duration, dependence on type and time of meals; factors, easing or eliminating heartburn (intake of water, milk, soda, drugs).

Nausea: appearance rate, duration, dependence on type and time of meals and whether it comes before vomiting.

Vomiting: frequency, time of appearance (on an empty stomach, after meals, immediately or after some time, irrespective of meals, at height of pains in stomach, after intake of medicines). Amount of vomit mass (abundant, small). Characteristics of vomit mass (with food eaten not long ago or the day before), presence of foreign substances (bile, mucus, blood — fresh or like coffee grounds). Taste, smell in mouth after vomiting (sour, bitter, putrid, stinking). Relief after vomiting (yes, no).

Abdomenal aches: localization, type (acute, stinging, cutting, aching, dull), intensiveness (weak, severe, moderate, dagger-like), recurrence (constant, occasional, attack-like), frequency, irradiation (in back, breastbone, shoulder or inguinal region etc.). Connection with meals (early, late, famine, night), connection with amount and quality of food, physical activity, changing of body position, defecation act, nervousness, seasonal prevalence of pains. Factors, easing or eliminating pain (goes away by itself, due to meal, water, vomiting, heat, drugs etc.). Pains are accompanied by: rising of temperature, jaundice, diarrhea, vomiting etc.

Meteorism: flatulence, bursting and heavy stomach, feeling of pouring, rumbling.

Defecation act: free, dyschesia, false urges, tenesmus, prolapsus of rectum and hemorrhoids, itching in the region of anus.

Type of stool: regular, irregular, frequency, characteristics (in accordance with Bristol Stool scale). Color (brown, dark brown, light, white clay like, black, tar-like). Foreign substances: blood, pus, mucus, undigested food particles, helminths. Odor: normal, sour, putrid, stinking.

Diarrhea: defecation rate, time of day, connection with food type, excitement.

Constipation: defecation rate, apply of enemas, laxatives (specify).

Alternation of diarrhea and constipation, feeling of incomplete bowel emptying, involuntary defecation.

Passage of gases (flatus): free, difficult, profuse, moderate, bad-smelling.

URINATION SYSTEM

Pains: localization in the region of loin, flanks (unilateral, bilateral), above pubis. Type (acute, dull, aching, stabbing, burning, attack-like, continuous, intermittent). Causes: physical activity, changing of body position, walking, abrupt movements etc. Irradiation. Frequency. Accompanying complications (fever, dysuric disorders) and things that alleviate (hot-water bottle, hot bath, medicines etc.).

Disorder of urination: rate per day, number of night urinations, painful and (or) difficult urination, amount of urine per day (anuria, oliguria), intermittence and weakening of urine sheet, false vesical tenesmus, involuntary urination, urinary incontinence.

Changing of color of urine: colorless, dark, beer-like, color of meat slops, turbid with flakes, dashed with scarlet blood.

Urine odor: normal, fruit, poignant, fecal etc.

ENDOCRINE SYSTEM

The versatile influence of endocrine system practically on all the functions of organism calls forth diverse complaints of the patients who suffer from the diseases of endocrine system. One should specify the following complaints:

general weakness, decreased working capacity, hyperhidrosis or skin dryness, hyperpigmentation, sensation of fever and chill, change of appetite, thirst, weight loss or weight gain, insomnia or sleepiness, irritability, emotional excitement or apathy, memory impairment, sexual weakness, disorders of menstruation, sterility, decreased libido etc.

LOCOMOTIVE SYSTEM

Pains in joints, spine, bones and muscles: localization, type (acute, dull, aching, shifting), frequency, duration, time of appearance or enchancement during a day, seasonal prevalence, intensiveness (moderate, severe), intermittence (intermittent, continuous, attack-like), irradiation. Whether pains are accompanied with oedema, reddening, limitation of movements. Conditions of appearance (movements, physical work, weather changes, cooling, certain body position etc.).

Cutting short or relieving pains: rest, certain body position, heat, cold, medicines (specify).

Joint stiffness: morning, starting, duration, conditions of appearance, relief or cutting short.

Limitations of joint movements: localization, type of limitation (flexion, extension, derivation, adduction, rotation etc.), degree of intensiveness (small, moderate, high, complete absence of movements).

Crepitation (crackling) in joints: localization.

Decline of muscular strength, **muscle atrophy**: localization, degree of evidence (small, moderate, high).

BLOOD SYSTEM AND HEMOPOIETIC ORGANS

Signs of anemic syndrome: general weakness, rapid fatigability, sleepiness, headaches, dizziness, fainting fits, heartbeats, heart pains, dyspnea, pains and burning in tongue, feeling of heaviness in stomach and stomachaches, stool disorders, change and perversion of appetite.

Signs of tumorous hyperplastic syndrome (leukemia): fever, pains in bones, joints, lymphadenopathy, tumor-like mass in different parts of body, pains and enlargement of abdomen in right (liver) and (spleen) hypochondrium.

Signs of hemorrhagic syndrome — bleeding sickness: onset of spontaneous hemorrhages or hemorrhages appeared on skin or mucous membrane after small external actions: localization, characteristics, size; painfulness of bleedings: localization, evidence (small, moderate, profuse), duration of bleedings.

NERVOUS SYSTEM AND SENSE ORGANS

Sleep disorders: insomnia, interrupted sleep, impairment of falling asleep, sleepiness, disorder of sleep.

Headaches: localization, evidence, rate, time of appearance, causes.

Giddiness: frequency (continuous, intermittent, with loss of consciousness and coordination of movements or without), duration, conditions of appearance (changing of body position, physical work, at rest etc.).

Noise in head: continuous, intermittent, time and conditions of appearance.

Derangement of memory: evident, moderate, considerable.

Visual impairment: reduced (considerably, to a little degree), «flashing of flies before eyes», blackout etc.

Hearing impairment: reduced, deafness, unilateral, bilateral.

Olfaction impairment: reduced, absent, keen.

Skin sensitivity impairment: reduced sensitivity, localization, type (painful, temperature, tactile), presence of paresthesias, skin itching (localization, characteristics).

If it is impossible to contact a patient (disorder or absence of consciousness, poor condition), the necessary information is collected from relatives or accompanying persons.

3. HISTORY OF PRESENT DISEASE (anamnesis morbi)

In this part one gives characteristics of the underlying disease from the moment of its beginning to the moment of entering the clinic.

When, where, and under which circumstances the disease developed.

To what the patient himself/herself attributes the disease (overwork, exposure to cold, infection, intoxication, psychic trauma etc.).

The onset of the disease (acute or gradual). The first symptoms, their further dynamics, new symptoms, complications, frequency and cause of acute conditions of the disease, duration of remissions.

When the patient first appealed for medical aid.

What diagnostic examinations were carried out, their results, if the patient is aware of them.

How she/he was diagnosed.

Applied treatment (in-patient or out-patient), medicaments, other methods, their effectiveness. List in chronological order the previous hospitalizations, specify causes, results of treatment.

When and in connection with what the last acute attack of the disease appeared, what treatment was provided.

Whether the patient is a follow-up, if preventive measures are taken, regularity of examinations.

The reason of this observation to hospital: to specify the character of pathology, small efficiency of out-patient treatment, aftereffects, development of emergency condition with necessity of urgent hospitalization (specify what condition), planned preventive treatment or examination etc.

It is advisable to analyse the out-patient`s card, case records of the previous hospitalizations (if any).

4. PATIENT`S LIFE HISTORY
(anamnesis vitae)

It is a patient`s medical biography, which includes all the main information about his/her life and activities from the moment of his/her birth to the admission to hospital.

1. Childhood and youth years. Place of birth, age of parents at birth, whether was born in time, which child in succession, when began walking, speaking, how was growing up, developed. Life conditions in childhood, meals characteristics, general condition of health and physical development (equally with peers, was behind or outstripped them in development). Studies at school (how old was when went to school, how studied, how many classes finished), further studies.

2. Occupational and life anamnesis. Beginning and further professional activity in a chronological order. Characteristics of the work done at present. Working conditions, labor mode, presence of occupational hazards during the whole period of work.

Living conditions, sanitary characteristic of dwelling. Meals: type of food, its adequancy and diversity, frequency and regularity of meals. Which products are bad for the patient, how it is revealed. Mode and peculiarities of spending free time. Personal hygiene of body. Doing exercises, sports.

3. Family and sexual anamnesis: marital status (when got married), family members, health condition of the members of the family. For women: information about menstruation (beginning of first periods, their duration, regularity, intensiveness, painfulness, date of last menstruation), number of pregnancies and deliveries, their course, abortions and their complications, miscarriage. The onset of menopause, its course. Health condition of wife, husband. For men: time of sexual maturity (growth of moustaches, beard), how many pregnancies the wife had and their outcomes.

4. Hereditary anamnesis. Male and female genealogy of the patient. Are the nearest relations dead or alive? If alive, specify their level of health. If dead — age and cause of death. Whether the parents and nearest relations suffered from inherited or similar diseases as the patient has.

5. Patient`s diseases. They are described in chronological order as well as wounds, injuries, contusions, operations — at what age the patient had each disease. At what age did each disease declare itself? They ask also whether the patient had tuberculosis, venereal diseases, viral hepatitis, oncologic diseases.

6. Bad habits. Smoking (duration, what kind of cigarettes, number of smoked cigarettes per day), abuse of alcohol (duration, what spirits, amount, periodicity), drugs, soporifics and sedatives, hard tea, coffee.

7. Allergic and medicinal anamnesis. The patient`s main manifestations of allergy (skin eruption, lacrimation, itch, respiratory affection etc.), their connection with environmental factors, definite place (at home, at work and other),

job hazards, season, food type, pollen, plant blossom, contact with animals, chemical substances. What medicines the patient has taken during life, pathological reactions to medicines, vaccines, serum. Transfusions of blood and blood substitutes, aftereffects. Presence of allergic diseases in relatives.

8. Expert employment anamnesis. It includes the main information that has to do with expertise of working capacity.

Temporary disability: number of days spent on disability leave during the previous 12 months (because of 1 or several diseases, continuously or interrupted).

Permanent disability: presence of disability group, its causes and duration.

II. OBJECTIVE EXAMINATION (status praesens obectivus)

GENERAL INSPECTION

Status of patient: satisfactory, moderate, severe, very severe.

Position of patient: active, passive, compelled.

Consciousness: clear, depressed (stupor, sopor), loss of consciousness (coma), excited (delirium, hallucinations).

Constitutional type: asthenic, normosthenic, hypersthenic, height, body weight, body weight index, body posture (upright, round-shoulded/stoop), gait (normal, shuffling, slow, paretic etc.).

Skin and visible mucous membranes. Color: pale, with tints (pink, earth, ash grey, icteritous etc.); red, cyanotic (cyanosis) – specify type of cyanosis (diffuse, acrocyanosis, localized (specify localization); icteritous, bronze, brownish, grey, presence of marmoreal picture, focal pigmentation and depigmentation (localization).

Humidity: normal (moderate), high, dry skin, skin desquamation.

Elasticity (turgor): normal, reduced, high.

Rash: type (roseola, erythema, petechias, ecchymoses, blisters, papulae, vesicles etc.), extent of spreading and localization; presence of xanthomas, vascular spiders (telangiectasias), indurations, bedsores, scratches, cicatrix. In case of absence of any rash or scars, skin is stated as clean.

Hair: growth (great, small), falling out, canities etc. Hair distribution (men pattern, women pattern).

Nails: form (normal, spoon-shaped, watch glass-like), covering smooth, striated (type of striate — transverse, longitudinal), transparence of nail plates, color of nail bed, presence of nails fragility.

Subcutaneous fat: degree of development (small, excessive, moderate), distribution (even, uneven), places of largest accumulation of fat, type of obesity (if any), skinfold thickness (cm) at the level of navel at edges of rectus muscles of abdomen, at the level of the angles of shoulder-blade, on shoulder above triceps.

Presence of sponginess, oedemas: localization characteristics of oedemas (face, limbs etc.), type of consistence (soft, dense), evidence (sponginess, small, large, anasarca), color (pale, cyanotic) and temperature of skin over oedemas (warm, cold).

Lymph nodes: whether they are identified visually or not, whether they palpated or not, if yes, whether it is possible to define localization (submaxillary, cervical, occipital, subclavicular, supraclavicular, axillary, ulnar, inguinal, popliteal), size, consistence, mobility, painfulness, quantity, cohesion between lymph nodes and skin, presence of fistulas, changes of skin over lymph nodes.

Muscles: level of development, tone (normal, high, low), strength (sufficient, reduced), painfulness in palpation (localization), indurations or atrophy (localization, characteristics), presence of convulsions (localization, tonic, clonic).

Bones: proportionality of ratio of corresponding parts of skeleton, deformations (specify localization, type), presence of thickening of phalanxes of toes and fingers (drumstick fingers), painfulness in palpation, tapotement of flat bones, spinal curvatures (lordosis, kyphosis, scoliosis, kyphoscoliosis).

Joints: changes of sizes, change of configuration, painfulness in palpation, hyperemia and high temperature of skin in joint region, swelling, articular crunch, fluctuation, extent of passive and active movements (full, limited, specify type of limitation, its localization).

Facial expression: normal, calm, depressed, excited, suffering etc. Specific expression «mitral», «nephritic», Basedow`s face, «myxedematous» facies, Hippocrate`s face, Corvisart`s face etc., specify which one. Coloring of face skin, rash on lips.

Swollen eyelids, xanthelasma. Size of palpebral fissures (same, different), exophthalmos, enophthalmos, ptosis, coloring of scleras, pupils (miotic, mydriatic, irregular).

Nose: form, deformations, skin color, presence of respiratory excursions of wings of.

Mouth: form (normal, changed), symmetry of the corners of mouth, state of lips.

Examination of head: form, size (micro-, macrocephaly), position (normal, fixed, bent, thrown back etc.), presence of involuntary movements, muscular convulsions.

Examination of neck: form, size (long, short, thick, thin), changes of skin (pigmentation, scars), presence of enlarged lymph nodes (specify the exact localization).

RESPIRATORY SYSTEM

1.Examinations of chest (thoracic cage): static (to examine morphological features) and dynamic (to specify participation of chest in respiratory act).

Static examination: form of chest — normal (normosthenic, asthenic, hypersthenic), pathologic (emphysematous, paralytic, rickets chest, boatshaped, funnel-shaped, kyphoscoliotic); symmetry, deformation; evidence of supraclavi-

cular and subclavicular cavities; position of collarbones and shoulder-blades; state of intercostal space (dilated, narrowed, bulge, fall back); track of ribs (flat, horizontal, close to vertical); ratio of anteroposterior and back sizes.

Dynamic examination: type of breathing (abdominal, thoracic, mixed); number of breaths per minute, depth of breathing (shallow/hypopnoe, medium-depth, deep); participation of ancillary muscles in breathing; rhythm of breathing (right, arrhythmic: Cheyne-Stokes respiration, Biot`s respiration, Grokko`s respiration, gasping breathing; Kussmaul`s respiration, stridorous breathing); symmetry of breathing – symmetry of participation of chest halves in breathing, respiratory excursion of chest (cm).

2. Palpation of chest (thoracic cage): detection of painfulness of skin, muscles, bone structures, intercostal space, localization, vocal fremitus (normal, is not detected, weakened, intensified, localization of changes, symmetry), resistance and elastance of chest, feeling of pleural friction rub, localization.

3. Percussion of lungs.

Comparative: sound – clear pulmonary sound, box sound, tympanic, dulled, dull, metallic, «cracked pot» resonance; indicate localization.

Topographic: height of standing of lung apexes at front and from the rear, from left and right sides, width of Kroenig's area from left and right, detection of lower borders of lungs on all topographical lines, active excursions of lower borders of lungs along medium-clavicular, medium axillary, scapular lines, percussion of Traube`s space.

4. Auscultation of lungs.

Vesicular breathing: (normal, weakened, intensified, hard, intermittent, indicate localization, ratio of inhalation and exhalation phases.

Bronchial respiration: localization, type (bronchovesicular, amphoric, with metallic sound).

Rales: fine (smallbubbling), medium (mediumbubbling), coarse (largebubbling), sonorous or not sonorous (sibilant), changing of type of rales after coughing out, during forced breathing; localization.

Rhonchi: sibilant (high, treble), sonorous (bass, low); are sounded mostly in inhalation or exhalation.

Crepitation: sonorous, nonsonorous, localization.

Pleural friction rub: soft, rough, localization.

Bronchophony: is detected or is missing on symmetrical parts.

CARDIOVASCULAR SYSTEM

1. Examination of heart and large vessels.

Examination of heart: detection of deformation of chest (cardiac hump), pulsation in heart view and heart vessels — apex beat (positive, negative, local-

ization, square), heart beat, epigastric pulsation, pulsation of aorta, pulmonary artery, aneurism of left ventricle (specify localization, evidence).

Examination of arteries and veins: enhanced pulsation of carotid arteries («carotid dance»), de Musset`s symptom, epigastric pulsation (lying, standing, at height of deep inspiration), detection of swelling of neck veins and their characteristics, presence of vein pulse (positive, negative), if there are any sinuous arteries and increased pulsation of temporal and other arteries, presence of vein dilatation of chest, abdominal wall, arms, legs, tortuosity и tuberosity of these veins.

2. Palpation of heart and large vessels.

Palpation of heart: presence of painful zones, localization; apex beat (palpated or not), if yes, its square (diffuse, normal, limited), heights (high, low, moderate), strength (non-intensified, intensified, weakened), resistance (resistant, non-resistant, medium-density); heart beat (palpated or not); phenomenon of «cat`s purring» (localization, systolic, diastolic, systolodiastolic); pulsation of aorta, pulmonary artery, epigastric pulsation, retrosternal pulsation of aorta.

Palpation of arteries: properties of wall (soft, hard, elastic); characteristics of pulse of radial artery — is pulse the same or different on symmetrical arteries, rhythm (rhythmic, unrhythmical, specify type of arrythmia), tension (satisfactory, hard, soft), filling (satisfactory, full, empty, same, different, even), amount (normal, large, small, thread-like), speed or shape (normal, fast or jumping, slow); pulse deficiency, amount of deficiency; presence of pulse in carotid femoral arteries, arteries of dorsum of foot with symmetrical comparison of its features.

3. Percussion of heart and vascular fascicle: detection of right, left and top borders of relative and absolute dullness, lateral dimension of relative and absolute dullness (cm), width of vascular bunch in the second intercostal space (cm), configuration of relative dullness (normal, mitral, aortic, trapezoid).

4. Auscultation of heart.

Cardiac rhythm: right, wrong (type of arrhythmia).

Characteristics of tones: clear, damped, dull, intensified (I and II tone in different auscultation points), splitting and divarication of tones (localization), presence of III and IV tones, tones of opening snap of mitral valve, systolic clicks, pericardium tone, «gallop» rhythm, rhythm of «quail», pendulum/tic-tac rhythm, embryocardia.

Cardiac murmurs: relation to phases of heart activity (systolic, diastolic proto-, mid-, presystolic), intensity (quiet, loud), timbre (blowing, scrabing, sawing, whistling), duration (short, long-lasting), other acoustic characteristics (soft, harsh, high, low, descending, ascending), place of best auscultation and zone of murmur conduction, change of noise depending on respiratory phase, patient`s position (vertical, horizontal, on left, right side), after physical activities.

Extracardial murmurs: pericardial friction rub, pleuropericardial murmur (localization, characteristics).

5. Auscultation of arteries and veins.

Presence or absence of Traube`s tone, Durozier`s double murmur, «whirligig» murmur in jugular veins.

6. Blood pressure in both arms: systolic, diastolic (mm Hg), is measured in sitting, lying and standing positions.

SYSTEM OF ORGANS OF GASTROINTESTINAL TRACT

1. Examination of oral cavity: breath (normal, putrid, sour, fecal, alcohol, acetone, ammonia etc.); mucous membrane of oral cavity (color-pale, hyperemia, icteric, humidity, pigmentation, Filatov`s spots, ulcers, thrush, hemorrhages); gums (hyperemia, looseness, hemorrhage, swelling, grey border etc.); teeth (their presence, absence — specify which; carious, staggering, artificial); tongue (symmetry or declination of tongue aside when sticking out, size of tongue – presence of prints on the edges of teeth, dry, humid, furred – moderately, a lot, color of raid, how easy it is removed, evidence of lingual papillas, painted, pink, «geographical tongue», ulcers, cracks, sores, scars); palatine arches, palate (color-normal, hyperemic, swelling or oedema, furs); tonsils (size —normal, hypertrophied, hyperemia, oedema, looseness, presence of purulent plugs, fur); back wall of throat (color of mucous membrane —reddening, blanching, oedema, presence of granulosity, ulcers, scars, fur etc.).

2. Abdomen is examined in standing or lying positions: size, form — normal, swollen (evenly or unevenly), drawn-in, «rog`s belly» pendulous abdomen; state of navel (drawn-in, protruding); abdominal circumference navel-high (cm) mass of subcutaneous tissue; presence of dilated subcutaneous veins on abdominal wall, localization, direction of blood stream; scars (localization, size), ruptures (localization), visible gastric and intestinal peristalsis; pulsations — localization, evidence, parts of pathological skin pigmentation, localization.

3. Palpation of abdomen.

Surface: painfulness (limited with indication of localization, spreading), painful points, Blumberg`s sign. Rise of muscular tonus of front abdominal wall (resistance, muscular tension or muscular defense) – spreading, local with indication of localization. Oedema of abdominal wall, separation of rectus muscle of abdomen, rupture. Detection of ascites with the method of fluctuation.

Profound palpation is done in the appointed succession: sigmoid colon, blind gut, final segment of ileum, appendix of blind gut, ascending, descending, transverse colons, hepatic and splenic bends of large intestine, stomach (detection of greater curvature, pylorus). One detects the following characteristics of each of the above mentioned organs: localization, painfulness, diameter (size), surface type (smooth, tuberous), consistence, presence of rumbling, splash, mobility (displaceability). Presence of neoplasms in abdominal cavity: localization, size, consistence, surface type, painfulness, mobility.

4. Percussion of abdomen: type of tympanic sound over stomach and intestines, localization of dull sound in accumulation of liquid, stool, tumor; percussion detection of free or encysted liquid in abdominal cavity, upper level of liquid in vertical position; Mendel sign.

5. Auscultation of abdomen: intestinal murmurs (normal, weakened, intensified, absent), peritoneal murmur in view of liver (perihepatitis), spleen (perisplenitis).

HEPATO-BILIARY SYSTEM, PANCREAS, SPLEEN

1. Examination of liver and gall bladder.

Examination of liver: skin pigmentation, bulging, limitation of respiratory excursions of front abdominal wall in right hypochondrium.

Percussion of liver: upper border of absolute dullness of liver (on right parasternal, medium-clavicular, anterior axillary lines), lower border (on right parasternal, medium-clavicular, anterior axillary lines, anterior median and left parasternal lines); height of absolute flattering of liver (cm), sizes by Kurlov (on medium-clavicular, anterior median lines, left costal margin).

Palpation of lower border of liver: localization below right costal margin (cm); type of border (not detected, sharp, rounded, smooth or rough), consistence (soft, compacted, solid, gristly), sensitivity (painful, painless), characteristics of projected surface (smooth, hilly); balloting palpation in the presence of ascite (symptom of «floating piece of ice»).

Palpation of gall bladder: palpable or not palpable; if palpable, whether localization if defined, painfulness, consistence (soft, dense), type of surface (smooth, hilly), mobility; presence of the following symptoms: Grekov-Ortner`s, Le Pen-Vasilenko`s, Murphy`s sign, Kehr`s, Mussy-Georgievsky`s, Courvoisier`s.

2. Examination of pancreas.

Inspection: presence of «colored» signs of pancreatitis — Halsted`s, Gray-Turner`s, Kulen-Johnson`s symptoms, skin pigmentation and atrophy of subcutaneous fat in zone of pancreas (Groth`s sign), local bulgings in epigastrium and left hypochondrium.

Palpation. Surface palpation: painfulness in Shoffar`s, Gubergrits-Skulsky`s zones, in Desjardins`s, Gubergrits`s points, resistance of anterior abdominal wall in zone of pancreas. Deep methodological sliding palpation: palpable or not palpable, if palpable, detect localization, painfulness, diameter, consistence (soft, compacted), type of surface (even, hilly, presence of nodes and tumourous mass).

3. Examination of spleen: inspection — presence of bulging in left hypochondrium; percussion — detection of borders of left upper, lower, anterior and posterior (specify localization), longitudinal axis and diameter (in cm); palpation — palpable or not palpable; if palpable, one defines localization of lower border

(degree of increase), shape, type of surface (even, smooth, hilly), consistency (soft, dense, cartilage-like), mobility, painfulness.

URINATION SYSTEM

Inspection and palpation of lumbar region: swelling, hyperemia, painfulness of skin, subcutaneous fat and muscles (specify localization), painfulness in region of posterior (costo-lumbar, costovertebral) and anterior (subcostal, upper and medium) ureteral points.

1. Palpation of kidneys is performed in vertical and horizontal positions: palpable or not palpable; if palpable, one estimates localization, what is palpated — lower pole, the whole kidney, its size, consistence, type of surface, displaceability, painfulness.

2. Percussion: Pasternatsky`s symptom — negative, positive (on left, on right).

3. Auscultation of renal vessels: presence of systolic vascular murmur, localization (from the rear, at front, on left, on right).

4. Percussion and palpation of bladder: projects over symphysis pubis (cm), palpable or not palpable; if palpable, one defines localization, painfulness, type of surface (smooth, hilly), consistence (soft, dense).

ENDOCRINE SYSTEM

If a patient has a disease of endocrine system, changes of appearance (habitus) get a great diagnostic importance. These changes are revealed during the general examination and are written down in the part «General inspection». In the examination of the patient with endocrine diseases one should pay attention to the following characteristic features.

Diseases of hypophysis: growth (dwarfism, gigantism), body weight (hypophysial cachexia), proportionality of skeleton (increase of size of hands, feet, nose, chin, eyebrow arches — in acromegalia).

Diseases of adrenal glands: changes in body weight (cachexia — in adrenal insufficiency, obesity with preferential accumulation of fat on face and body — hyperadrenocorticism, dark brown (bronze) color of skin and mucous membranes of mouth — in adrenal insufficiency, dark red streaks (striaes) on hips and stomach — in hyperadrenocorticism.

In diabetes: emaciation or obesity, pustular rash, scratches on skin, hypertrichosis on back, around shoulder blades and navel, xanthoma, xanthelasma.

Diseases of thyroid gland: weight loss, thin, hot and very wet skin, pretibial myxedema, acropathy — in hyperthyroidism, obesity, dry, pale, peeling skin, compact sedentary oedemas of the whole body including face, brittle, dull, dry hair with a tendency to excessive loss, dull, brittle nails — in hypothyroidism. Change of face: pale, inexpressive, with narrow eye slits, indifferent look

and sluggish mimicry (myxedematous face), exophthalmos, widely opened bright eyes (an expression of surprise or fear) — Basedow`s face, eye symptoms of thyrotoxicosis - Dalrymple`s, Mobius`s, Stellwag`s, Kocher`s, Graefe`s and other.

Inspection and palpation of thyroid gland: degree of growth, its type (diffuse, nodular, mixed), consistence (soft, dense), surface (smooth, nodular), mobility in swallowing. In case of enlarged thyroid glands one measures neck circumference through spinous process of VII cervical vertebrae from behind and the most projected part of thyroid gland at the front.

Auscultation of thyroid gland: presence of vascular murmur over thyroid gland.

BLOOD AND HEMOPOIETIC SYSTEM

The physical inspection of blood system and hematosis system includes first of all the general examination of a patient, which allows to reveal a number of diagnostically important features. These features are written down in the part «General inspection». One should pay attention to skin state (pale, pale-green, waxen tint, golden-yellow — in anemias, hyperemia — in arrhythmia, dryness, peeling — in sideropenia), to the presence of haemorrhagic rash (petechia, ecchymosis, bruising, telangiectasias — in haemorrhagic diathesis) and leukemids, to state of appendages of skin (changes of hair, nails). State of lymph nodes is estimated by means of palpation and visual inspection. Painfulness of flat bones is revealed by means of percussion.

One carries also visual, percussion and palpation examinations of spleen. The results of these studies are written down in the part «Hepatobiliary system, pancreas, spleen».

NERVOUS SYSTEM AND SENSE ORGANS

1. General nervous psychic status: mood (good, low, depressed, rapid shifts of mood), orientation in surroundings, time, space (right, wrong), patient`s sociability, intellect, memory, speech.

2. Locomotory sphere: presence of paralysis, paresis, ptosis, face asymmetry (specify localization).

3. Reflex sphere: eye balls (the same, not the same), their reaction to light.

4. Vegetative sphere: dermographism (red, white), unstable, swelling, spreading, hyperhidrosis.

5. Receptor sphere: vision, hearing, sense of smell.

III. PROVISIONAL DIAGNOSIS

The provisional diagnosis is made on basis of the questioning and physical methods of treatment. The diagnosis can be nosological (name of disease) or syndromic (name of syndrome, which signs have been revealed in a patient), can

include elements of anatomical (e.g. localization), etiological (indication of etiology of disease), pathophysiological and functional (degree of severity, degree of organ dysfunction) diagnoses.

The provisional diagnosis is formulated without any substantiation.

IV. PLAN OF LABORATORY AND INSTRUMANTAL EXAMINATIONS OF PATIENT

In this part of the medical history there is a list of main laboratory and instrumental inspections, the fulfillment of which is necessary to make or to confirm the clinical diagnosis of the patient. One should remember that meanwhile each therapeutic patient passes blood test, urine analysis, feces analysis on helminth eggs, examination of the level of fasting glycemia, serologic examination on syphilis, ECG.

Other laboratory and instrumental inspections of patients are performed in presence of indications, in accordance with the protocols of the patient`s examination and thus must be concretized. The concretization is needed in case of biochemical and serological blood analyses (specify the necessary indicator), roentgenological, ultrasound, endoscopic, radioactive tracer analyses (specify organ, type of examination).

V. RESULTS OF LABORATORY AND INSTRUMANTAL EXAMINATIONS

The results of the laboratory and instrumental examinations of the patient are written down in the educational medical history from the medical history of the supervised patient. Meanwhile, only those data obtained during the additional examination which are necessary to diagnose and estimate the patient`s condition are recorded into the educational medical history.

A conclusion is made on basis of the results of each of the methods: norma or pathology, in latter case, what is it.

The data of the additional examination methods are noted down into the educational medical history in the following order:

1. Body temperature and its dynamics (in form of temperature list).
2. Laboratory: general clinical, biochemical, serological and other inspections.
3. Roentgenological and ultrasound examination.
4. Other instrumental examinations: electrocardiogram, rheovasography, respiratory function, etc.
5. Endoscopic inspections.
6. Other inspections.

VI. CLINICAL DIAGNOSIS AND ITS SUBSTANTIATION

To substantiate a diagnosis, one chooses the leading features of the disease, received while studying the complaints, anamnesis and data of the objective methods of the patient`s examination. A thorough pathogenetic analysis of the revealed signs is to be made, as well as their combined assessment with an account of the peculiarities of the clinical picture and course of the disease. The data, obtained with help of the additional laboratory instrumental methods of examination are also analysed. On basis of the received results one makes a conclusion decision about the existing pathology and diagnoses.

While making a diagnosis one takes into consideration modern classifications (ICD of WHO-10). The clinical diagnosis includes: main disease, complications after the underlying disease, concomitant diseases, and their complications.

The diagnosis of the underlying disease must include the name of the disease, its etiology, characteristics and localization of pathological process, degree of severity, stage (period) and its course.

A complication after the underlying disease is a disease of other etiology and has other characteristic features than the underlying disease, but is pathogenetically associated with it.

Concomitant diseases are revealed simultaneously with the underlying disease but do not have a pathogenetic relation with it. The principle of diagnosing the concomitant disease is the same as that of the underlying disease.

VII. DIARIES OF PATIENT`S CARE

The diary is kept daily. One records in the diary dynamics of the patient`s state over the past day, changes of objective data, additionally prescribed inspections, analyses the effect of the ongoing therapy, necessity of making corresponding corrections to the type of the patient`s treatment and care.

VIII. EPICRISIS

This is the final part of the medical patient`s history, which creatively generalizes and critically gives coverage of all the available information about the patient.

The epicrisis reflects the following information:

1. Terms of staying at hospital.
2. Final detailed clinical diagnosis.
3. Results of the patient`s examination in the form of underlying the clinical syndromes and most important diagnostic data about the additional methods of inspection.
4. Data on the patient`s treatment, including regime, diet, remedial gymnastics, physiotherapy, medicines. Moreover, for such drugs as antibiotics, corticosteroid hormone, course doses are to be indicated.

5. Course of the disease and its peculiar features in this very patient, dynamics of the main symptoms.

6. Outcome of the disease: complete recovery, incomplete recovery, considerable improvement, slight improvement, condition without changes, worsening.

7. Recommendations at discharge regarding regime, employment, diet, reasonability of continuation of the particular medicamentous therapy, treatment at a health resort.

In case of a fatal outcome the epicrisis is drawn up in the same sequence but with a more detailed description of differential diagnostic difficulties, ways of their solution, course of the disease, complications and circumstances, affecting the adverse outcome of the disease.

IX. BIBLIOGRAPHY

It contains a list of literary references, used by students to prepare and write the educational medical history. The literary references are written in an alphabetical order in compliance with the rules of bibliographical registration of the list of references.

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Друян Леонид Ибрагимович
Романьков Леонид Васильевич
Пальцев Игорь Владимирович

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