Case history scheme. Inquiry of patient: present complaints and their detailing, questioning on organs and systems.

Methodical instructions for students

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Authors: T.V. Ashcheulova
          O.M. Kovalyova
          G.V. Demidenko
          M.O. Vizir
CASE HISTORY

STANDARD MODEL

A. SUBJECTIVE EXAMINATION

1) Passport part
2) Patient’s present complains
3) Questions about general condition (general symptoms)
4) Questions on organs and systems
5) Anamnesis morbi
6) Anamnesis vitae

B. OBJECTIVE EXAMINATION

1) General inspection
2) Examination of respiratory organs
3) Examination of cardiovascular system
4) Examination of digestive system
5) Examination of urinary system

C. BACKGROUND FOR THE PRELIMINARY DIAGNOSIS

D. PATIENT’S ADDITIONAL EXAMINATION PLAN AND ANALYSIS RESULTS

E. BACKGROUND AND STATEMENT OF CLINICAL DIAGNOSIS
**INQUIRY**

Inquiry is used in everyday observation of the patient, and it is very important to have good interview technique. Sometimes information obtained during interview is sufficient to correct preliminary conclusion.

The ability to elicit an accurate history from the patient is crucial. It is the history, which provides the basis for priorities in the clinical examination and subsequent investigation, and management. The style of obtaining a history leads to the therapeutic alliance between doctor and patient – so essential for establishing trust and satisfaction.

It should be remembered that some people are naturally better communicators that others. From the patient’s perspective the most important component of the clinical examination is the explanation. Clinicians who are courteous and patient, appear interested, encourage patients and relatives to ask
questions and to spend time explaining situation in a way, which is understood, are judged to be ‘good doctor’, irrespective of their attributes.

Inquiry includes following aspects: general information (passport part) – name, date of birth, age, address, occupation, etc; patient’s present complains; history of the present disease (anamnesis morbi); and past history (anamnesis vitae).

**Passport part**

1. Last name, first name.
2. Age (date of birth).
3. Address (phone number).
4. Place of job.
5. Occupation.
6. Date of admission.

**Patient’s present complains**

It is important to establish the patient’s presenting complaint or complaints. The patient needs to understand what is being said. Generally speaking, technical terms are best avoided. The public is becoming increasingly informed through the Internet and mass media, but their use of medical jargon does not necessarily mean they understand the terms. Similarly there are terms such as ‘shock’, ‘nervous breakdown’, and ‘gastric flu’, which need to be clarified, if used by the patient.

The presenting complaint, as described by the patient, is the body of the history. The main complaints, those are most pronounced and determine the clinic of the disease, should be first detected. As a rule, the patient firstly describes the main complaints. However, sometimes the patient complains on
unimportant signs, and only additional questioning helps to evaluate the main complaints. Detail description of each complaint should be given according to definite plan: location, intensity, character, course, duration, frequency, radiation, associated symptoms, cause of onset, aggravating factors, and relieving factors.

Answer standard:

Patient complains of retrosternal pain, pressing, of moderate intensity, with radiation to the left part of the body, periodic, arising after physical and emotional exertion, 2-3 times per day, lasted 10-15 min, relieved at rest and after 1-2 tab of nitroglycerine taking, accompanied by dyspnea, palpitation. Patient complain on headache in occipital region, of moderate intensity, periodic, after emotional stress, caused by blood pressure elevation, lasted 20-30 min, relieved by antihypertensive drugs intake, accompanied by dissiness, deranged vision (“nets” before eyes), weakness, fatigue, sweatness.

Questions about general condition (general symptoms)

General weakness, fatigue, body temperature elevation, skin itching andrashing, perspiration, changes of the body mass.

Questions on organs and systems

Inquiry should be started from that system, on which are the main complaints.

1. CENTRAL NERVOUS SYSTEM

   Work ability, mood, memory, attention, sleep (deepness, duration, insomnia), headache, dizziness, vision, hearing.

2. RESPIRATORY SYSTEM

   Sneeze, voice changes, pain in the chest (time and cause of appearance), asphyxia, cough (dry, with sputum, costant, periodic, timing: morning, evening, night), sputum (amount per day, color, odor, character, blood admixtures, timing and posture when amount of expectorated sputum increases).

3. CARDIOVASCULAR SYSTEM
Pain in the heart, in the retrosternal region (location, character, intensity, radiation, permanent or periodic, cause of onset, duration, relieving/aggravating factors, accompanied symptom), dyspnea (in physical exertion, at rest), asthma attack (time and cause of appearance), palpitation (constant, periodic, intensity, duration, cause of onset), escaped beats (intermissions) (constant, periodic, intensity, duration, cause of onset), edema (place and time of arising, duration, cause of decreases or disappearing).

4. DIGESTIVE SYSTEM

Appetite, thirst, dysphagia (swallowing and food passage through esophagus disorders), dyspepsia (pyrosis, regurgitation, nausea, vomiting), pain in the abdomen (location, character, radiation, relation to the food intake, relieving factors), stools (rate, consistency, color, blood or mucus admixtures).

5. URINARY SYSTEM

Urination (rate, tenderness, night to day diuresis ratio, urine color), pain in the lumbar region.

8. LOCOMOTOR SYSTEM

Pain in the joints, bones, muscles, joints movements disorders.

Answer standard:
- Questions about general condition (general symptoms)
  Body temperature elevation, skin itching and rashing, perspiration, changes of the body mass are absent.
- Questions on organs and systems
  CARDIOVASCULAR SYSTEM
  Asthma attack, escaped beats, edema are absent.
  CENTRAL NERVOUS SYSTEM
  Work ability mood, memory, attention are decreased, complain on insomnia, hearing is without changes.
  RESPIRATORY SYSTEM
  Sneeeze, voice changes, pain in the chest, asphyxia, and cough are not disturbed.

DIGESTIVE SYSTEM
Appetite is preserved, thirst, dysphagia, dyspepsia (pyrosis, regurgitation, nausea, vomiting), pain in the abdomen are not disturbed; stools is 1 time per day, of usual color without blood and mucus admixtures.

**URINARY SYSTEM**

Complain on pain in the left lumbar region, of moderate intensity, radiated in left inquinal region, increased during physical exertion, relieved after Urolesan intake, accompanied by general weakness, increased urination rate. Urination 4-6 times per day, free, painless, 24 hours diuresis is to 2 liters with predominance of daily portion, urine is of light yellow color, transparent, without blood and mucus admixtures.

**LOCOMOTOR SYSTEM**

Pain in the joints, bones, muscles, joints movements disorders are not disturbed.

**KNOWLEDGE CONTROL**

1. **To which section of the case history is the complaint of dyspnea entered:**
   A. Present complaints
   B. Details of the complaints
   C. Questioning about the organs and systems
   D. Anamnesis morbi
   E. Anamnesis vitae

2. **Inheritance linked to the gender is characteristic:**
   A. Ulcer disease
   B. Hypertension disease
   C. Diabetes mellitus
   D. Hemophilia
   E. Bronchial asthma

3. **Previous diseases are described in the following section:**
   A. Anamnesis vitae
   B. Passport part
   C. Questioning about organs and the systems
   D. Present complaints
   E. Anamnesis morbi

4. **Which section of the case history is called medical biography:**
   A. Present complaints
   B. Passport part
   C. Anamnesis vitae
   D. Anamnesis morbi
   E. Asking about the organs and systems
5. A 28-year-old patient complains of a pronounced productive cough, weakness, perspiration, fatigue, loss of appetite. His main complaint is:
A. Weakness
B. Fatigue
C. Loss of appetite
D. Perspiration
E. Productive cough

6. To which section is the complaint of weight loss entered?
A. Asking about general condition
B. Present complaints
C. Anamnesis vitae
D. Anamnesis morbi
E. Asking about organs and systems

7. A detailed description of the complaints is entered to the following section:
A. Asking about organs and systems
B. Present complaints
C. Anamnesis morbi
D. Anamnesis vitae
E. Passport part

8. Asking about the systems is started from:
A. The system the patient complains on
B. Nervous system
C. Cardiovascular system
D. Genitourinary system
E. Respiratory system

9. In which section of the case history are unhealthy habits described?
A. Present complaints
B. Anamnesis morbi
C. Anamnesis vitae
D. Asking about organs and systems
E. Asking about general condition

10. History taking is:
A. Subjective method
B. Objective method
C. Additional method
D. Laboratory method
E. Instrumental method
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Authors: T.V. Ashcheulova
        O.M. Kovalyova
G.V. Demydenko
M.O. Vizir

Chief Editor Ashcheulova T.V.

Редактор____________
Корректор____________
Компьютерная верстка_____________

g. Харьков, пр. Науки, 4, ХНМУ, 61022
Редакционно-издательский отдел