МІНІСТЕРСТВО ОХОРОНИ ЗДОРОВ'Я УКРАЇНИ
Харківський національний медичний університет

EDUCATIONAL CASE HISTORY ON PEDIATRICS
(4th year – Pediatrics, 5th year – Diseases of blood system in children)

Practical policies for students

НАВЧАЛЬНА ІСТОРІЯ ХВОРОБИ З ПЕДІАТРІЇ
(4-й курс – Педіатрія, 5-й курс – Хвороби системи крові у дітей)

Робочий зошит для студентів

Затверджено
Вченою радою ХНМУ.
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Навчальна історія хвороби з педіатрії (4 курс – Педіатрія, 5 курс – Хвороби системи крові у дітей) : робочий зошит для студентів / упоряд. Н. І. Макєєва, К. К. Ярова, Н. П. Алєксєєва та ін. – Харків : ХНМУ, 2021. – 36 с.

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INTRODUCTION

Writing a medical history is a mandatory part of a student's out-of-class work in the study of clinical disciplines, in particular, "Pediatrics". The purpose of writing a medical history in clinical departments is not only to improve the skills of collecting complaints and anamnesis, to conduct a physical examination of the patient, but also to acquire skills in clinical understanding of the information received (rationale of preliminary and final diagnoses, drawing up an examination plan, making a differential diagnosis, prescribing therapy). In addition, the implementation of this type of work in writing (writing a medical history) according to a scheme that includes the main elements of diagnostic and therapeutic actions of a doctor in his professional activity, contributes to the formation of a concise and reasonable presentation of information using medical terminology.

The scheme of case history includes the basic elements of doctor's diagnostic and curative actions during his professional activities: history taking, examination, diagnosis, differential diagnosis, treatment, prevention of disease, analyses of effectiveness, prognosis, keeping medical documents, etc. The scheme of the case history for 4-year-students – "Pediatrics" (Supplement 1) and 5-year-students – "Diseases of blood system in children" (Supplement 2), offered by the Department of Pediatrics No. 2 of KhNMU, includes 12 sections that must be completed after the initial examination and the results of additional methods of examining the patient by the student. Until the moment the medical history is submitted for verification, the student can get advice from the teacher on issues that cause difficulties (interpretation of data, conducting a differential diagnosis, etc.). Checking the medical history allows you to objectively assess the level of clinical training and theoretical knowledge of the student.

GENERAL RECOMMENDATIONS OF THE DEPARTMENT OF PEDIATRICS № 2 REGARDING WRITING THE CASE HISTORY

Writing a medical history is a difficult and time-consuming process, so do not hesitate this work up to the last night before the deadline.

After physical examination of the patient, "decipher" ("spell out") your notes and, if any questions arise, solve them promptly (help from a friend, teacher, etc.).

Before writing a medical history directly, read the literature on the disease that is diagnosed in the patient.

RECOMMENDATIONS FOR WRITING SOME SECTIONS OF THE CASE HISTORY

Section "ANAMNESIS MORBI". Complaints are presented considering their diagnostic significance for the diagnosis. When writing an anamnesis of a present disease, it is necessary to concisely describe the course of the patient's disease from its onset to the initial examination by the student.

Section "ANAMNESIS VITAE". It is necessary to collect as much as possible an anamnesis of the patient's life during supervision. If the child cannot answer any questions, do not hesitate to check the patient's life history with the teacher.

Do not forget that a well-collected history is key to the success of the final diagnosis.

Section "PHYSICAL EXAMINATION". The OBJECTIVE data should not include your interpretation of the physical findings obtained (e.g., "allergic rash", "lymph nodes are not enlarged", "submandibular lymph nodes the size of a pea", etc.). It is necessary to name the elements of the rash (papular, petechial, etc.), to indicate the dimensions in centimeters or millimeters, to use generally accepted topographic landmarks, etc.

Section "PROVISIONAL DIAGNOSIS (substantiation of the provisional diagnosis)". Based on the data obtained (characteristic complaints, anamnesis of the disease, identified syndromes), the main preliminary DIAGNOSIS is established and substantiated in accordance with the accepted classifications. In the presence of concomitant pathology, it is necessary to indicate it (justification is not required).

In the section "Plan of examination" the student must name all the studies that are necessary to confirm the preliminary diagnosis. You should not include in the plan of examination those studies that are not diagnostically significant.

In the section "Test results", after indicating the actual results, it is imperative to give them an interpretation using medical terminology (for example, "neutrophilic leukocytosis", "proteinuria", "hyperkalemia", etc.). In addition, it is necessary to try to explain the reason for the origin of the identified changes.

In the "Diary" section it is necessary to provide brief information about the patient's condition on the day of the examination. Mandatory data: Complaints. General condition (satisfactory, moderate, severe, etc.). Temperature. Pulse. Breathing rate. Skin. Mucous membranes. Respiratory system. Heart (tones, noises). Stomach. Liver. Spleen. Chair. Urination.

If there are any violations in organs and systems, it is necessary to describe them in detail.

The description of the status depends on the age of the patient. In infants, more attention should be paid to feeding habits, weight, and stool.

The structure of the status changes depending on the nature of the disease. Instructions regarding these aspects can be obtained from the teacher.

The “DIFFERENTIAL DIAGNOSIS” section is usually the most difficult to write a case history. The differential diagnosis is carried out in a narrative form (rewriting tables is not allowed!!!). First, the patient's symptoms are indicated, which are common both for the alleged disease and for others with which the differential diagnosis is made. Then, for each disease under consideration, it is necessary to prove why it is excluded.

Section "DIAGNOSIS AND ITS RATIONALE" means the rationale for the final diagnosis using complaints, anamnesis, objective data, data from additional research methods, dynamics of observation, and the differential diagnosis carried out.

Section "TREATMENT AND ITS RATIONALE (with the obligatory prescription of drugs prescribed for the supervised patient)". Each point of therapy must be substantiated (do not forget diet and regimen!). Therapy (etiotropic, pathogenetic, symptomatic) should be necessary and sufficient. Avoid polypharmacy (simultaneous administration (often unjustified) to a patient of several drugs)!!! Writing prescriptions for prescribed drugs is MANDATORY with the indication of doses calculated for the supervised child, considering body weight or surface area.

The section "EPICRISIS" or "a summary of the previous series", after reading which you can get a complete picture of the patient, the competence of the diagnosis, the dynamics of the child's condition on the background of the prescribed treatment, recommendations for further treatment and observation. The epicrisis should be concise, but sufficient to obtain complete information about the patient, recommendations - specific and detailed.

REFERENCES

1. Bates' Guide to Physical Examination and History Taking 12th edition. Edited by Lynn Bicley. – Lippincott Williams &Wilkins. – 2016. – 1072 p

2. Nelson textbook 20th Edition by Robert M. Kliegman, MD, Richard E. Behrman, MD, Hal B. Jenson, MD and Bonita F. Stanton, MD. Видавництво: SAUNDERS

3. The Harriet Lane Handbook, 21st edition. International edition, 2018. – 1255 p.

Supplement 1

KHARKIV NATIONAL MEDICAL UNIVERSITY

DEPARTMENT OF PEDIATRICS №2

STUDENT'S CASE HISTORY (SCH)

(the 4th year studying)

Student (In Charge):_____

Group _____

Faculty _____

Course (year) _____

Teacher_____

Date of giving the SCH for checking up

_____

Mark _____

Teacher's Signature_____

Date " _____" _____ 20

KHARKIV

I. GENERAL INFORMATION

Name _____
Age, date of birth _____
Address _____
_____
Date and time of admission _____
With what diagnosis _____
_____
Final diagnosis _____
_____
_____

II. COMPLAINTS (at time of admission) _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

III. ANAMNESIS MORBI (* - underline)

Mode of onset and dates of onset of the symptoms. Health immediately before illness. Supposed and possible causes, e.g. injury. Progress of the disease and appearance of fresh symptoms in their order as to onset. State of activity, appetite, bowels, sleep, changes in temperament, before and during the illness. Inquiry as to specific physical signs and symptoms if information is not volunteered, e.g. wasting or loss of weight, with reference to weight-card if available, vomiting, pain, cough, convulsions, enuresis.

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IV. ANAMNESIS VITAE

A. Previous Health

Antenatal.

Health of the mother during the pregnancy (medical supervision, diet, etc.). Rubella or other infections, medication, and stage of pregnancy at which it occurred. Vomiting. Toxemia. Antepartum hemorrhage. (Supplement from antenatal records in indicated cases, e.g. Wassermann reaction, Rhesus constitution). Employment during pregnancy.

_____
_____
_____
_____
_____
_____
_____

Postnatal.

Gestational age _____ Birth weight _____. *****Whether infant was born at home or in hospital (in the latter case, supplement from hospital record if indicated, including resuscitation, oxygen administration) _____
_____

Neonatal. Apgar score _____. *****Whether skin color, cry and respiration were normal; jaundice; feeding difficulties, rashes; twitching, flaccidity. Any other abnormalities noted _____. Transfusion or other treatment (confirm from hospital record) _____.

Later life.

Exact details of feeding in early months; whether breast-fed _____, and if so, for how long _____; type of formula feeding used _____; whether vitamin additives were given _____, and if so, the preparation's amount and duration _____. Weaning transition to solid feeding: age and ease with which carried out _____. Appetite in infancy and subsequently
_____
_____

History of convulsions, skin rashes, diarrhea, infectious or other illnesses.

_____
_____
_____
_____
_____

Inquire specifically measles, rubella, pertussis, mumps, and chicken pox.

_____
_____
_____
_____

Immunization and tests

_____
_____
_____
_____

Operations: _____

Recent contact with infectious diseases, especially tuberculosis:

_____
_____
_____
_____

B. Development
– Ages of head balance _____, sitting _____ and unsupported walking _____, talking (words _____ and sentences _____), reading _____.
– Ages at which gained control of bowel _____ and bladder _____ (a) during day, (b) at night. Any special difficulties in toilet training _____
– Whether child can eat _____ and dress himself _____, and if so, how early he began to do so _____.
– School progress, e.g. average age of class and place in class; school report if indicated _____
Special aptitudes.
– Social adjustment with other children at home, at school _____
_____

C. Family history.
Parents' age and whether any consanguinity exists. (In familial conditions, including genealogical tree, showing affected members, any consanguinity marriages, etc.). Health of close relatives (especially hereditary and congenital disorders, nervous and mental diseases).
Mother _____
_____
_____
_____
Father _____
_____
_____
_____
_____
_____
The children in their order, with details of age and health, and including death, stillbirth, and abortions.

D. Social history
Whether the mother is employed part-time or full-time, and if so, what care provided for children. Size of house, situation, sanitation, ventilation, lighting, access to playground or open air. Details of family income if relevant.
_____
_____
_____
_____
_____

E. Habits
– Eating: appetite _____, food dislikes _____, feeding habits of child's parents _____.
– Sleeping: hours _____, * disturbances, snoring, restlessness, dreaming, and nightmares.
– Exercise and play _____.

K. Disturbances (*)
Excessive bed wetting, masturbation, thumb sucking, nail biting, breath-holding, temper tantrums, tics, nervousness, undue thirst, other. Similar disturbances among members of the family. School problems (learning, perception).

V. PHYSICAL EXAMINATION (On examination)

Temperature (t°) _____
pulse rate (Ps) _____
respiratory rate (RR) _____
blood pressure (BP) _____
weight _____
height _____
(The results of investigations must be compared with age standards).

GENERAL CONDITION

_____
Degree of prostration: degree of cooperation _____
state of comfort _____
nutrition _____
and consciousness _____
abnormalities _____
gait _____
posture _____
and coordination _____
estimate of intelligence _____:
reaction to parents, physician, and examination: nature of cry and its degree; facial expression _____

SKIN

Color _____ (cyanosis, jaundice, pallor, erythema),
texture _____
eruptions _____,
hydration _____,
edema _____,
hemorrhagic manifestations _____,
scars _____,
dilated vessels _____,
hemangiomas _____,
nevi _____,
Mongolian (blue-black, coffee-like) spots _____,
pigmentation _____,
turgor _____,
elasticity _____,
and subcutaneous nodules _____.
Striae and wrinkling _____.
Sensitivity _____,
hair distribution _____.

LYMPH NODES

Location _____,
size _____,
sensitivity _____,
mobility _____,
consistency _____.
(One should routinely attempt to palpate the suboccipital, preauricular, anterior cervical, posterior cervical, submaxillary, sublingual, axillary, epitrochlear and inguinal lymph nodes).

HEAD
Size _____, shape _____, circumference _____, asymmetry _____, cephalohematoma _____, fossae _____, craniotabes _____, fontanel (size _____, tension _____, abnormally late or early closed _____, suture _____, dilated veins _____, scalp _____, hair-texture _____, distribution _____, parasites _____, etc.).

FACE
Symmetry _____, paralysis _____, the distance between a nose and mouth _____, depth of the nasolabial folds _____, the bridge of the nose _____, a size of the mandible _____, swellings _____, hypertelorism _____, Chvostek's sign _____, tenderness over the sinuses _____.

EYES
Photophobia _____, visual acuity _____, muscular control nystagmus _____, Mongolian slant _____, Brushfield spots _____, epicanthic folds _____, lacrimation _____, discharge _____, the lids _____, exophthalmos or enophthalmos, the conjunctivas _____; papillary size _____, shape _____, and reaction to light and accommodation _____; medial (corneal opacities cataracts), fundus, visual fields (in older children) _____.

NOSE
Exterior _____, shape _____, mucosa _____, patency, discharge _____, bleeding _____, pressure over the sinuses, flaring of the nostrils, the septum.

THROAT
The tonsils (size _____, inflammation _____, exudates _____, crypts _____, inflammation of the anterior pillars _____), mucosa _____, hypertrophic lymphoid tissue _____, postnasal drip _____, epiglottis, *voice (hoarseness, stridor, grunting, type of cry, speech).(* – underline)

***EARS**
The pinnas (position _____, size _____), canals _____, tympanic membranes (landmarks, mobility, perforation, inflammation, discharge), mastoid tenderness and swelling _____, hearing _____.

***NECK**
Position (torticollis, opisthotonos, inability to support the head, mobility), swelling the thyroid (size _____, contour _____, tenderness _____).

THORAX
Shape _____ and symmetry _____, the veins, retractions and pulsations, Harrison's groove _____, flaring of the ribs _____, pigeon chest, funnel shape, size and position of the nipples _____, breasts _____.
Intercostal and substernal retraction _____, asymmetry _____, the scapulas _____, clavicles _____.

EXTREMITIES

A. General (*): deformity, hemiatrophy, bowlegs, knock-knees; paralysis, edema, coldness, posture, gait, stance, asymmetry.

B. Joints (*): swelling, redness, pain, limitation of motion, tenderness, rheumatic nodules, carrying angle of the elbows, tibia torsion.

C. Hands and feet (*): extra digits, clubbing, simian lines, curvature of the little finger, deformity of the nails, splinter hemorrhages, flat during the first two years), abnormalities of the feet, the width of the thumbs and big toes, syndactyly, length of various segments, dimpling of the dorsa, temperature.

D. Peripheral vessels (*): presence, absence, or diminution of arterial pulses.

SPINE AND BACK

Posture _____, curvatures _____, rigidity _____, a webbed neck _____, spina bifida _____, pilonidal dimple or cyst _____, tufts of hair, mobility, Mongolian spots _____, and (*) tenderness over the spine, pelvis, and kidneys _____.

RESPIRATORY SYSTEM

Voice sound _____

Rate of respiration _____ Type of breathing _____,

Dyspnea _____

Vocal fremitus _____

Comparative percussion _____

Auscultation: breathing _____

râles _____,

crepitation _____,

wheezing _____.

CARDIOVASCULAR SYSTEM

Inspection and palpation of the heart area

Apex beat _____,

cardiac humpback _____, murmurs _____, etc.).

_____

Percussion: border of the heart dullness (relative).

Border	In child	Normally
Right		
Upper		
Left		

Auscultation:

Heart rate _____ BP _____

Heart sounds _____

Rhythm _____

Murmurs (location, position in cycle, intensity, pitch, effects of change of position, transmission, effect of physical exercises) _____

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ABDOMEN
Size and contour _____, visible peristalsis _____,
respiratory movement _____,
the veins (distention, direction of flow) _____,
umbilicus _____, hernia _____, musculature _____,
tenderness and rigidity _____,
palpable organs or masses (size _____, shape _____, position _____, mobility _____),
fluid wave _____,
reflexes _____
_____,
bowel sounds _____.

LIVER
Size (palpation _____, percussion _____).
Tenderness _____.
Surface _____.
Inferior margin _____.

SPLEEN
Palpable or not _____.
Size _____,
surface _____,
tenderness _____.

UROGENITAL SYSTEM
Urination _____.
Frequency _____, painfulness _____,
retention of urine _____.
Pasternatsky's sign _____.
Genitalia _____.
Abnormal development.

RECTUM AND ANUS
Irritation _____, fissures _____, prolapse e_____, anal atresia (in newborns).

STOOL _____

NERVOUS SYSTEM
General behavior _____, level of consciousness _____,
intelligence _____, emotional status _____,
memory orientation _____; illusion _____;
ability to understand and to communicate _____,
speech _____, ability to write _____,
performance of skilled motor acts _____.
Vegetative reactions. Dermography _____.
Reflexes: Babinski's _____,
Brudzinski's _____; meningeal _____.
Organs of sense. Sense of smell _____, sight _____,
taste _____, touch _____,
hearing _____.

VI. PROVISIONAL DIAGNOSIS (TO GROUND)
(Diagnosis based on the facts of the Case History and Physical Examination).

VII. PLAN OF CLINICAL AND LABORATORY EXAMINATIONS (INVESTIGATIONS)

VIII. TEST RESULTS (Data and interpretation)

Blood analysis

Date			
Hb			
RBC			
CI			
Reticulocytes			
Ht			
Platelets			
WBC			
Stab neutrophils			
Segmented neutrophils			
Eosinophils			
Basophiles			
Lymphocytes			
Monocytes			
ESR			

Conclusion:

Urine analysis

Volume			
Colour			
pH			
Specific gravity			
Protein			
Glucose			
WBC			
RBC			
Casts - hyaline - granular - RBC' - WBC' - other			
Epithelium			
Mucous			
Bacteria			

Conclusion:_____

Other investigations:

IX. CURSUS MORBI (DIARY)

Date	Results of physical examination of the patient	Prescriptions
t° – Ps – RR – BP –		Diet Regimen Drugs

X. DIFFERENTIAL DIAGNOSIS (2–4 diseases)

XI. FINAL DIAGNOSIS (TO GROUND)

XII. TREATMENT AND ITS GROUND (FOR THE DISEASE IN GENERAL AND FOR THE PRESENT ONE IN PARTICULAR)

Regimen

Diet

Drugs with prescriptions

XIII. LITERATURE DATA ON THE PRESENT DISEASE (etiology, pathogenesis, clinical manifestations, classification, treatment, and prevention in general and concerning the present patient).

XIV. SUMMARY (*Lat. Epicrisis*)

Supplement 2

KHARKIV NATIONAL MEDICAL UNIVERSITY

DEPARTMENT OF PEDIATRICS №2

STUDENT'S CASE HISTORY (SCH)

(the 5th year studying)

Student (In Charge): _____

Group _____

Faculty _____

Course (year) _____

Teacher _____

Date of giving the SCH for checking up

_____

Mark _____

Teacher's Signature_____

Date "_____" _____ 20 _____

KHARKIV

I. GENERAL INFORMATION

Name _____
Age, date of birth _____
Address _____
_____
Date and time of admission _____
By what medical establishment was directed to hospital _____
_____
With what diagnosis _____
_____
Final diagnosis _____
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II. COMPLAINTS (at time of admission) _____
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III. ANAMNESIS MORBI (* – underline)

Mode of onset and dates of onset of the symptoms. Health immediately before illness. Supposed and possible causes, e.g. injury. Progress of the disease and appearance of fresh symptoms in their order as to onset. State of activity, appetite, bowels, sleep, changes in temperament, before and during the illness. Inquiry as to specific physical signs and symptoms if information is not volunteered, e.g. wasting or loss of weight, with reference to weight-card if available, vomiting, pain, cough, convulsions, enuresis.

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IV. ANAMNESIS VITAE

A. Previous Health

Antenatal.

Health of the mother during the pregnancy (medical supervision, diet, etc.). Rubella or other infections, medication, and stage of pregnancy at which it occurred. Vomiting. Toxemia. Antepartum hemorrhage. (Supplement from antenatal records in indicated cases, e.g. Wassermann reaction, Rhesus constitution). Employment during pregnancy.

_____
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Postnatal.

Gestational age _____ Birth weight _____.
Duration of labor and method of delivery _____.
*Whether infant was born at home or in hospital (in the latter case, supplement from hospital record if indicated, including resuscitation, oxygen administration) _____.
Neonatal. Apgar score _____. Whether skin color, cry and respiration were normal; *jaundice; feeding difficulties, rashes; twitching, flaccidity. Any other abnormalities noted _____.
Transfusion or other treatment (confirm from hospital record) _____
_____.

Later life.

Exact details of feeding in early months; whether breast-fed _____,
and if so, for how long _____; type of formula feeding used _____;
whether vitamin additives were given _____,
and if so, the preparation's amount and duration _____.
Weaning transition to solid feeding: age and ease with which carried out _____.
Appetite in infancy and subsequently _____.
History of convulsions, skin rashes, diarrhea, infectious or other illnesses. _____
_____
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Inquire specifically measles, rubella, pertussis, mumps, and chicken pox.

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Immunization and tests _____
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Operations: _____
Recent contact with infectious diseases, especially tuberculosis:

_____
_____
_____
_____

B. Development
– Ages of head balance _____, sitting _____and unsupported walking _____, talking (words _____ and sentences _____), reading _____.
– Ages at which gained control of bowel _____ and bladder _____ (a) during day, (b) at night. Any special difficulties in toilet training _____.
– Whether child can eat _____and dress himself _____, and if so, how early he began to do so _____.
– School progress, e.g. average age of class and place in class; school report if indicated _____.
Special aptitudes.
– Social adjustment with other children at home, at school _____.

C. Family history.
Parents' age and whether any consanguinity exists. (In familial conditions, including genealogical tree, showing affected members, any consanguinity marriages, etc.). Health of close relatives (especially hereditary and congential disorders, nervous and mental diseases).
Mother _____
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Father _____
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The children in their order, with details of age and health, and including death, stillbirth, and abortions.

D. Social history
Whether the mother is employed part-time or full-time, and if so, what care provided for children. Size of house, situation, sanitation, ventilation, lighting, access to playground or open air. Details of family income if relevant.
_____
_____
_____
_____
_____

E. Habits
-Eating: appetite _____, food dislikes _____, feeding habits of child's parents _____.
– Sleeping: hours _____, disturbances, snoring, restlessness, dreaming, and nightmares (*).
– Exercise and play _____.

K. Disturbances (*)
Excessive bed wetting, masturbation, thumb sucking, nail biting, breath-holding, temper tantrums, tics, nervousness, undue thirst, other. Similar disturbances among members of the family. School problems (learning, perception).

V. PHYSICAL EXAMINATION (On examination)

Temperature (t°) _____
pulse rate (Ps)_____
respiratory rate (RR) _____
blood pressure (BP)_____
weight_____
height_____
head circumference _____
(The results of investigations must be compared with age standards).

GENERAL CONDITION

_____
Degree of prostration: degree of cooperation _____; state of comfort _____, nutrition _____, and consciousness _____; abnormalities; gait _____, posture _____, and coordination _____; estimate of intelligence _____: reaction to parents, physician, and examination: nature of cry and its degree; facial expression_____.

SKIN

Color _____ (cyanosis, jaundice, pallor, erythema), texture _____, rashes, localization and their character: hemorrhage, ecchymosis, petechial, maculopapular elements, etc. _____
_____,
hydration _____, edema _____, hemorrhagic manifestations _____, scars _____, dilated vessels _____and direction of blood flow, hemangiomas _____, nevi_____, Mongolian (blue-black, coffee-like) spots _____, pigmentation _____, turgor _____, elasticity _____, hair distribution_____, character, and desquamation.

LYMPH NODES

Location _____, size _____, sensitivity _____, mobility _____, consistency_____.
(One should routinely attempt to palpate the suboccipital, preauricular, anterior cervical, posterior cervical, submaxillary, sublingual, axillary, epitrochlear and inguinal lymph nodes).

BONE SYSTEM (visible deformation of bones, spine, limb shortening, the shape of the skull)

_____
_____

JOINTS (shape, tenderness, her character, swelling, hyperthermia), movement in the joints

_____
_____

LUNGS

Voice sound _____
Rate of respiration _____ Type of breathing _____,
Dyspnea _____
Vocal fremitus _____
Comparative percussion _____
Auscultation: breathing _____
râles _____,
crepitation _____, wheezing _____.

CARDIOVASCULAR SYSTEM

Inspection and palpation of the heart area

Apex beat _____,
cardiac humpback _____, murmurs _____, etc.).
_____

Auscultation:

Heart sounds _____

Rhythm _____.

Murmurs (location, position in cycle, intensity, pitch, effects of change of position, transmission, effect of physical exercises) _____
_____
_____
_____.

ABDOMEN

Size and contour _____, visible peristalsis _____, respiratory movement _____, the veins (distention, direction of flow) _____, umbilicus _____, hernia _____, musculature _____, tenderness and rigidity _____, palpable organs or masses (size, shape, position, mobility), fluid wave, reflexes, bowel sounds.

LIVER

Size (palpation _____, percussion). Tenderness _____.
Surface _____. Inferior margin _____.

SPLEEN

Palpable or not. Size _____, surface _____, tenderness _____.

UROGENITAL SYSTEM

Urination _____. Frequency _____, painfulness _____, retention of urine _____.
Pasternatsky's sign _____.
Genitalia _____. Abnormal development.

STOOL_____

NERVOUS SYSTEM

General behavior _____, level of consciousness_____, intelligence _____, emotional status _____, memory orientation _____; illusion _____; ability to understand and to communicate _____, speech _____, ability to write _____, performance of skilled motor acts _____.
Vegetative reactions. Dermography _____.
Reflexes: Babinski's _____, Brudzinski's _____; meningeal _____.
Organs of sense. Sense of smell _____, sight _____, taste _____, touch _____, hearing _____.

VI. PROVISIONAL DIAGNOSIS (TO GROUND)
(Diagnosis based on the facts of the Case History and Physical Examination).

VII. PLAN OF CLINICAL AND LABORATORY EXAMINATIONS (INVESTIGATIONS)

VIII. TEST RESULTS (Data and interpretation)

IX. DIFFERENTIAL DIAGNOSIS (2–4 diseases)

X. FINAL DIAGNOSIS (TO GROUND)

XI. TREATMENT AND ITS GROUND (FOR THE DISEASE IN GENERAL AND FOR THE PRESENT ONE IN PARTICULAR)

Regimen

Diet

Drugs with prescriptions

XII. SUMMARY (*Lat. Epicrisis*)

Навчальне видання

Макєєва Наталія Іванівна
Ярова Катерина Костянтинівна
Алєксєєва Наталія Павлівна
Піддубна Ірина Миколаївна
Афанасьєва Оксана Олександрівна

НАВЧАЛЬНА ІСТОРІЯ ХВОРОБИ З ПЕДІАТРІЇ (4 курс – Педіатрія, 5 курс – Хвороби системи крові у дітей)

Робочий зошит для студентів

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Комп'ютерна верстка О. Ю. Лавриненко

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