MINISTRY OF HEALTHCARE OF UKRAINE
KHARKIV NATIONAL MEDICAL UNIVERSITY
Department of Neurology № 2

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STUDENT'S CASE HISTORY (SCH)

_____

(The patient's name)

Main diagnosis:_____
_____
_____
_____
Additional diagnosis:_____
_____
_____

Student – course _____ group _____ faculty _____

_____

(Name)

The mark: _____

Signature of teacher:_____

Kharkiv – 20_____

Student's case history: study guide for English medium medical students/ O. Tovazhyanska, N. Nekrasova, Ye Soloviova et. al. – Kharkiv: KNMU -2015, 26 p.

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Recommended KNMU Academic Council
(protocol № 11 from 19 of November 2015)

The scheme is designed to help students in the writing of educational case histories.

I. GENERAL INFORMATION

Personal details:

1. The patient's name: _____

2. Date of birth: _____

3. Place of employment: _____

4. Education: _____
(higher, secondary, special)

5. Marital status: _____

6. Date of admission to hospital: _____

II. COMPLAINTS (at time of admission)

(Describe the main complaints of the patient. Also describes complaints that are not marked by patients but discovered during the inspection and survey of family.)

III. ANAMNESIS MORBI

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.

IV. ANAMNESIS VITAE (life history)

(Briefly displayed data about presence occupational hazard factors, bad habits and past illnesses, injuries and surgery, working and living conditions (housing, nutrition, rest). Separately recorded: the presence of hereditary diseases and meaningful information about the disease relatives or causes of death. Indicates the presence of allergies (food, plants, medicines,etc.)

_____

_____

_____

_____

_____

V. PHYSICAL EXAMINATION (On examination)

General condition_____, body temperature_____°C.

Patient's posture_____

_____

Level of consciousness _____

Face expression_____

Constitutional type_____.

Skin

Color _____(cyanosis, jaundice, pallor, erythema), texture_____,

eruptions_____,

hydration_____,

edema_____,

Hemorrhagic manifestations_____,

scars _____, dilated vessels _____and direction

of blood flow, hemangiomas_____.

Hair_____

Nails_____

Visible mucous membranes_____

Subcutaneous fat_____

Presence of edema_____

Lymph nodes_____

Muscles_____

Bones_____

Joints_____

RESPIRATORY SYSTEM

Voice sound _____

Rate of respiration _____Type of breathing_____,

Dyspnea_____

Vocal fremitus_____

Comparative percussion_____

_____

_____

_____

Auscultation: breathing_____ râles

_____,

crepitation_____, wheezing_____.

CARDIOVASCULAR SYSTEM

Inspection.

visible pulsations on the neck_____

Apex beat_____,

cardiac humpback_____, murmurs_____, etc.).

_____

Pulse_____

Blood pressure on the left arm_____mm Hg, on the right arm_____mm Hg

Percussion.

Borders of relative cardiac dullness:

right_____

upper_____

left_____

Auscultation:

Heart sounds_____

Heart murmurs_____

Added sounds_____

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 _____.

SPLEEN

Palpable or not. Size_____.

URINARY SYSTEM

Inspection_____

Palpation_____

Percussion_____

Characteristics of urination_____
(urinary frequency, urinary incontinence, incomplete emptying, hesitancy, dysuria, hematuria, volume of urination)

VI. NERVOUS SYSTEM

Cranial nerves:

I (n. olfactorius) - _____

(sense of smell is not altered, hyposmia, anosmia (on the right and left sides), dizosmia, olfactory hallucination)

II (n. opticus) – Visual acuity: S_____ D_____

Fields of vision:_____

(are not affected; hemianopsia (on the right and left sides))

Visual hallucinations:_____

III (n. oculomotorius) IV (n. trochlearis), VI (n. abducens) - _____

(voluntary eye movements are full, restricted (up, down, sideways, to the nose); strabizmus)

_____

Ophthalmic slits:_____

Photoreaction: _____

V (n. trigeminus) - Sensitivity on the face:_____

(saved, reduced (indicate the area of decreased sensation))

_____

The strength of masticatory muscles:_____

The corneal reflex:_____

Mandibular reflex:_____

VII (n. facialis) – Mimic muscles:_____

_____

_____

Taste in 2/3 anterior part of the tongue:_____

(saved or affected)

The function of the lacrimal gland:_____

VIII (n.vestibulocohlearis) Hearing:_____

(normal, decreased, loss (on the right and left sides)

_____

Vestibular syndrom:_____

(absence, dizziness, nausea, vomiting; nystagmus (horizontal, vertical, rotator, ataxia)

_____

_____

IX (n.glossopharingeus), X (n. vagus) - Swallow:_____

Phonation:_____ Articulation:_____

Bulbar syndrome:_____

Pseudobulbar palsy:_____

_____

Taste in 1/3 posterior part of the tongue:_____
(saved or affected; on the right and left sides)

Dry in the mouth:_____

XI (n. accessorius) -_____

_____

_____

XII (n. hypoglossus) -_____
(the tongue in the midline, deviation of the tongue right, left; hypotrophy of tongue muscles, fibrillation (there is or no))

<u>The motor system:</u>

Volume of active movements of the limbs:_____

_____

Muscle strength - in the upper limbs: proximal S ____, D _____,

distal S ____ , D _____,

in the lower limbs: proximal S ____, D _____,

distal S ____, D _____,

Muscle tone:_____

_____

_____

Tendon reflexes – biceps tendon C_{5-6} S D _____

triceps tendon C_{7-8} S D _____

carpal C_{5-8} S D _____

genual L_{2-4} S D _____

achilles L_5-S_2 S D _____
(> < =) (average vitality, reduced, absent, increasing)

Clonus: _____

Superficial reflexes - abdominal, upper Th_{7-8} S D _____

middle Th_{9-10} S D _____

lower Th_{11-12} S D _____

cremaster L_{1-2} S D _____

plantar L_1- S_1 S D _____
(> < =) (not changed, reduced, absent)

Pathological reflexes_____

_____

Protective reflexes:_____

Fascicular twitching,fibrillation:_____

Tremor:_____

Hyperkinesia:_____

Coordination system:

The presence of vestibular disorders:

- systemic dizziness |__| - spontaneous nystagmus |__|
- unsystematic dizziness |__| - noise in the head |__|
- mixed dizziness |__| - noise in the ears |__|

Romberg test _____

Babinsky test _____

Gait _____

coordination tests: finger-nose S D _____

heel-knee S D _____

diadochocinesia S D _____

dysmetria S D _____

Signs of cerebellar lesions: scanning speech _____

nystagmus _____

handwriting _____

diffuse muscular hypotonia _____

Sensation: Superficial:

pain_____

temperature_____

tactile_____

(saved, reduced, increased (specify in what area of skin)

Deep: musculoarticular _____

vibration _____

pressure _____

weight _____

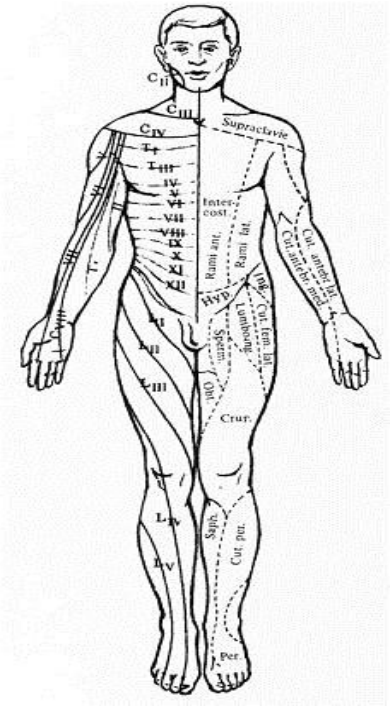
kinesthetic _____

Complex: discriminatory _____

localization_____

two dimensional-spatial _____

stereognosis _____



If the patient has disorders of sensation indicate their type

- mononeuropathy –_____

- polyneuropathy -_____

- radicular - _____

- dissociated -_____

- condactive - _____

- central - _____

Meningeal syndrome:

Higher cortical functions:

The autonomic nervous system

Summary of neurological status

(the patient's symptoms must connect to multiple or single syndrome**)**

The patient has the syndrome:_____,

This is evidenced:_____

_____

_____

_____

_____

_____

The patient has the syndrome:_____,

This is evidenced:_____

_____

_____

_____

_____

_____

The patient has the syndrome:_____,

This is evidenced:_____

_____

_____

_____

_____

_____

Topical diagnosis

(Considering identified syndromes should indicate the level and location of lesions of the nervous system. Topical diagnosis data is written only for neurological status data excluding CT / MRI of the brain.)

VII. PROVISIONAL DIAGNOSIS (TO GROUND)

(Diagnosis based on the facts of the Case History and Physical Examination).

VIII. PLAN OF CLINICAL AND LABORATORY EXAMINATIONS (INVESTIGATIONS)

Since preliminary diagnosis is established, the plan of additional investigations should be worked out. It consists of analytic methods known to be useful for accurate definition of disease peculiarities and differential diagnosis.

The examination of each patient should begin with a obligatory program that includes:

1. General blood test.

2. Urinalysis.

3. Analysis of blood sugar.

4. Wassermann Reaction.

5. Chest X-ray.

Special methods should be appointed on the basis of preliminary diagnosis by direct examination of whether the system or by process of elimination (diagnostic search). Thus students need their own show the full range of knowledge on the subject.

IX. DIFFERENTIAL DIAGNOSIS

(Differential diagnosis is the determination of which one of several diseases may be producing the symptoms. In this part of case history you should list diseases selected for differential diagnosis and then describe similarities and differences between them)

X.FINAL CLINICAL DIAGNOSIS (Diagnosis clinika)

(For substantiation of final diagnosis you should list the typical (pathognomonic or specific) symptoms and signs, changes in the laboratory and instrumental diagnostic methods data. The diagnosis documents the expected course of disease, its severity, complications and accompanied diseases according to comprehensive classification of illnesses)

Considering: patient complaints _____

_____

_____

_____

anamnesis data _____

_____

_____

_____

neurological status data (specified only syndromic)_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Investigations data_____

_____

_____

it is possible make a diagnosis:

Principle disease:

Complications:

Concomitant diseases:

XI. TREATMENT

(First part of treatment description includes information about all available options for current disease (life style modification, diet, medications, and possible surgical interventions). Appropriate information can be obtained from recommended textbooks and lecture notes. Second part of treatment description includes drug prescriptions for given patients. Usually it is one; two or more drugs (use brand names only and avoid multiple prescriptions for safety reasons) which can be administered for patients with current disease)

Rp:_____ Rp:_____ Rp:_____

_____ _____ _____

D.t.d._____ D.t.d._____ D.t.d._____

_____ _____ _____

_____ _____ _____

Rp:_____ Rp:_____ Rp:_____

_____ _____ _____

D.t.d._____ D.t.d._____ D.t.d._____

_____ _____ _____

_____ _____ _____

XII. JOURNAL OF FOLLOW-UP

Date	Clinical status	Treatment

XIII. PROGNOSIS

For life_____

For health_____

For workability_____

Recommendations for follow-up and rehabilitation

(Phased recommendations for prevention and rehabilitation measures should follow the patient after discharge from hospital)

XIV. EPICRISIS

(Epicrisis is an analytical summing up of a medical case history. In this part you should briefly describe all significant data which may characterize current clinical case (identification data, final clinical diagnosis, chief complaints, anamnesis, some physical findings, selected results of laboratory tests, treatment, prognosis and recommendations for follow up).

XV. REFERENCES