

ГОСУДАРСТВЕННОЕ ОБРАЗОВАТЕЛЬНОЕ УЧРЕЖДЕНИЕ
ВЫСШЕГО ПРОФЕССИОНАЛЬНОГО ОБРАЗОВАНИЯ
«КАЗАНСКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ
ФЕДЕРАЛЬНОГО АГЕНСТВА ПО ЗДРАВООХРАНЕНИЮ
И СОЦИАЛЬНОМУ РАЗВИТИЮ»

КАФЕДРА ПРОПЕДЕВТИКИ ВНУТРЕННИХ БОЛЕЗНЕЙ

Схема истории болезни
Учебно-методическое пособие



Scheme of medical case report
Manual

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Учебно-методическое пособие составлено в соответствии с Государственным образовательным стандартом высшего профессионального образования, Государственными требованиями к минимуму содержания и уровню подготовки выпускника вуза по специальности 040100 «Лечебное дело», типовой и рабочей программами по дисциплине «Пропедевтика внутренних болезней» (2003). В учебно-методическом пособии приводится последовательность изложения истории болезни, принятая в клинике внутренних болезней, с использованием соответствующей терминологии, краткой характеристикой подразделов, обоснованием диагноза и патогенезом симптомов. Пособие предназначено для иностранных студентов III курса медицинских вузов.

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STRUCTURE OF EDUCATIONAL MEDICAL CASE REPORT

A medical case report, a medical record, health record, or medical chart in general is a systematic documentation of a single patient's long-term individual medical history and care.

A patient's individual medical record identifies the patient and contains information regarding the patient's entire case history.

Medical case report generally includes the following parts.

I. The patient identification data (ID).

II. Medical history.

The medical history or anamnesis of a patient is information gained by a physician by asking specific questions, either of the patient or of other people who know the person and can give suitable information (in this case, it is sometimes called heteroanamnesis), with the aim of obtaining information useful in formulating a diagnosis and providing medical care to the patient. The medically relevant complaints reported by the patient or others familiar with the patient are referred to as *symptoms*, in contrast with clinical *signs*, which are ascertained by direct examination on the part of medical personnel.

A practitioner typically asks questions to obtain the following information about the patient:

Identification and demographics: name, age, height, weight.

The "chief complaint (CC)" - the major health problem or concern, and its time course (e.g. chest pain for past 4 hours).

History of the present illness (HPI) - details about the complaints, enumerated in the CC. (Also often called 'History of presenting complaint' or HPC.)

Past Medical History (PMH) (including major illnesses, any previous surgery/operations, any current ongoing illness, e.g. diabetes).

Allergies - to medications, food, latex, and other environmental factors

Childhood diseases - this is very important in pediatrics.

Family history (diseases) - especially those relevant to the patient's chief complaint.

Psychosocial history (medicine) (PSH) - including living arrangements, occupation, marital status, number of children, drug use (including tobacco, alcohol, other recreational drug use), recent foreign travel, and exposure to environmental pathogens through recreational activities or pets.

Sexual history, obstetric/gynecological history, and so on, as appropriate.

Medications and habits (MH) regular and acute medications (including those prescribed by doctors, and others obtained over-the-counter or alternative medicine)

Review of systems (ROS) Systematic questioning about different organ systems

History-taking may be comprehensive history taking (a fixed and extensive set of questions are asked, as practiced only by health care students such as medical students, physician assistant students, or nurse practitioner students) or iterative hypothesis testing (questions are limited and adapted to rule in or out likely diagnoses based on information already obtained, as practiced by busy clinicians).

III. Physical examination

Physical examination or clinical examination is the process by which a doctor investigates the body of a patient for signs of disease. It generally follows the taking of the medical history — an account of the symptoms as experienced by the patient. Together with the medical history, the physical examination aids in determining the correct diagnosis and devising the treatment plan. This data then becomes part of the medical record.

General examination. A systematic examination generally starts at the head and finishes at the extremities. General examination includes

- estimation of general patient's status,
- patient's consciousness, position, constitution,
- taking temperature,
- defining of face expression peculiarities characteristic of certain diseases,
- as well as estimation of status of skin, nails, hair, observed mucous membranes, subcutaneous fat, lymph nodes, muscles, bones and joints.

Data obtained by the clinician during general examination have a great diagnostic importance giving a possibility on one hand, to disclose characteristic (although often non-specific) signs of disease, on the other hand, to give a preliminary estimation of pathologic process extent and functional disturbances degree.

Respiratory system.

Examination includes 4 parts: observation, auscultation, palpation, percussion

Observation involves observing the respiratory rate which should be in a ratio of 1:2 inspiration:expiration. It is best to count the respiratory rate under pretext of some other exam, so that patient does not sub consciously increase his baseline respiratory rate. Also observe for retractions seen in asthmatics. Retractions can be supra-sternal, where the accessory muscles of respirations of the neck are contracting to aid inspiration. Retractions can also be intercostal, there is visible contraction of the inter costal muscles (between the ribs) to aid in respiration. This is a sign of respiratory distress. Observe for barrel-chest (increased AP diameter) seen in COPD. Observe for shifted trachea or one sided chest expansion, which can hint pneumothorax.

For palpation, place both palms or medial aspects of hands on the anterior and posterior lung fields. Ask the patient to count 1-10. The point of this part is to feel for vibrations (tactile fremitus) and compare between the right/left lung field. If the pt has a consolidation (maybe caused by pneumonia), the vibration will be louder at that part of the lung. This is because sound travels faster through denser material than air.

On comparative percussion, you are testing mainly for pleural effusion or pneumothorax. The sound will be more tympanic if there is a pneumothorax because air will stretch the pleural membranes like a drum. If there is fluid between the pleural membranes, the percussion will be dampened and sound muffled.

If there is pneumonia, palpation may reveal increased vibration and dullness on percussion. If there is pleural effusion, palpation should reveal decreased vibration and there will be 'stony dullness' on percussion.

Lung auscultation is listening to the lungs bilaterally at the anterior chest and posterior chest. First of all, identify the main breath sound. Then specify an

adventitious breath sounds. Wheezing is described as a musical sound on expiration or inspiration. It is the result of narrowed airways. Coarse crackles are bubbly sounds similar to blowing bubbles through a straw into a sundae. They are heard on expiration and inspiration. It is the result of viscous fluid in the airways. Fine crackles or crepitation are only heard during inspiration. It is the result of alveoli popping open from increased air pressure.

Cardiovascular system.

The precordial exam, also cardiac exam, is performed as part of a physical examination. The exam includes several parts: inspection, palpation, percussion and auscultation.

General Inspection: - inspect the patient status whether he or she is comfortable at rest or obviously short of breath.

- inspect the neck for increased jugular venous pressure (JVP) or abnormal waves

Then inspect the precordium for: visible pulsations, apical impulse (apex beat), masses, scars, lesions, signs of trauma and previous surgery (e.g. median sternotomy), permanent Pace Maker, praecordial bulge.

Palpation: the valve areas are palpated for abnormal pulsations (known as thrills) and precordial movements (known as heaves). Heaves are best felt with the heel of the hand at the sternal border. The apex beat is typically palpable in the left fifth intercostal space and 1 cm medial to the mid-clavicular line. It is not palpable in some patients due to obesity or emphysema. To accurately determine the location of an apex beat which can be felt across a large area, feel for the most lateral and inferior position of pulsation. An apex beat in the axilla would indicate cardiomegaly or mediastinal shift.

Percussion of the heart allows to define relative and superficial cardiac dullness borders and to make idea about the heart configuration and its diameter.

Auscultation of the heart: one should comment on S_1 and S_2 - if the splitting is abnormal or louder than usual. Should sound like [lub-dub lub-dub] and the presence of S_3 - like [lub de dub] sound, S_4 - like [T lub-dub]. If S_4 S_1 S_2 S_3 were all present it would sound like [T-lub-de-dub], also known as a quadruple gallop rhythm; diastolic murmurs (e.g. aortic insufficiency, mitral stenosis), systolic murmurs (e.g. aortic stenosis, mitral regurgitation), pericardial rub (suggestive of pericarditis).

Vessels examination includes blood pressure, pulse rate and rhythm, jugular venous pressure (JVP) and pulse defining, palpation of peripheral arteries.

Gastrointestinal tract.

The exam includes several parts: inspection, auscultation, percussion and palpation.

On inspection the patient should be examined for masses, scars, sinuses, lesions, signs of trauma, bulging flanks - best done from the foot of the bed, jaundice/scleral icterus, abdominal distension, caput medusae - dilated blood vessels radiating from the umbilicus (may be present in liver failure). Especially pay attention on stigmata of liver disease: fetor hepaticus, asterixis (flapping tremor); on hands: clubbing, Dupuytren's contracture, palmar erythema; and estrogen related: spider nevi, testicular atrophy, gynecomastia; associated with portal hypertension: hematochezia (blood in

stool), hematemesis - gastric bleed, esophageal varices, caput medusae (rare) - venous distension, ascites.

Auscultation is sometimes done before percussion and palpation, unlike in other examinations. It may be performed first because vigorously touching the abdomen may disturb the intestines, perhaps artificially altering their activity and thus the bowel sounds. To conclude that bowel sounds are absent one has to listen for 5 minutes. Growling sounds may be heard with obstruction. Absence of sounds may be caused by peritonitis.

Palpation in all 9 regions - light (superficial) then deep.

In light palpation, note any palpable mass, hernial orifices if positive cough impulses, assessing muscle tone- there are 3 reactions that indicate pathology: guarding (muscles contract as pressure is applied), rigidity (rigid abdominal wall indicates peritoneal inflammation) and rebound (release of pressure causes pain) – positive Shchetkin-Blumberg's sign. The light palpation also includes examination for ascites: bulging flanks, fluid wave test (fluctuation sign), shifting dullness test.

In deep palpation, detail examination of the mass, found in light palpation, bowel, liver and gallbladder and spleen. Special maneuvers include complementary (Cair's, Murphy's, Ortner's, Lepene's, Mussis') signs of cholecystitis.

Urinary system examination includes inspection of the kidneys area, kidneys deep palpation, percussion of the lumbar region (Pasternatsky's sign), palpation of the ureteral algesic points, and palpation and percussion of the urinary bladder.

IV. INVESTIGATIONS DATA

After the main organ systems have been investigated by inspection, palpation, percussion and auscultation, specific tests may follow.

The results of testing, such as blood tests (e.g., complete blood count), radiology examinations (e.g., X-rays), pathology (e.g., biopsy results), or specialized testing (e.g., pulmonary function testing, ECG) are included. Often, as in the case of X-rays, a written report of the findings is included in lieu of the actual film.

V. CLINICAL DIAGNOSIS

The assessment is a written summation of what are the most likely causes of the patient's current set of symptoms. The diagnosis documents the expected course of disease, its severity, complications and accompanied diseases according to comprehensive classification of illnesses.

VI. SUBSTANTIATION OF BASIC DIAGNOSIS

List the typical (pathognomonic or specific) symptoms and signs, changes in the laboratory and instrumental diagnostic methods data which prove your diagnosis.

VII. PATHOGENESIS OF SYMPTOMS AND SIGNS

Describe pathogenesis of symptoms and signs found in the course of patient's examination. Try to find "cause-consequence" relationships within found signs, grouping them in the syndromes typical of established disease.

FORM of MEDICAL CASE REPORT

THEME _____

Student name _____

Group № _____ Date _____

I. PATIENT'S ID.

1. Name _____

2. Age (date of birth) _____

3. Occupation _____

4. Home address _____

5. Date of admission _____

II. MEDICAL HISTORY

1. CC _____

Symptoms analysis (location, quality, quantity, chronology, setting, aggravating-alleviating factors, associated manifestations) _____

Secondary complaints _____

2. HPI _____

History of recent admission _____

3. PMH

A. Other medical problems _____

B.

Allergies _____

C. Major childhood illnesses _____

D. Injuries, hospitalizations, and operations _____

E. Immunizations (hemotransfusion) _____

4. FH

5 PSH

A. Infancy, childhood, adolescence. Date of birth _____, in time (before term), from _____ pregnancy. Age of parents in the time of child birth: father's _____ y., mother's _____ y. Breast-fed or not (underline the necessary). Began walking at _____ y., speaking at _____ y., gone to school at _____ y., had _____ marks. In intellectual and physical growth and development didn't (did) delay from coevals (underline the necessary).

B. Lifestyle.

Typical day for the patient _____

Recreation the patient engages in _____

Sports _____

Religious beliefs patient holds _____

Patient's school experience _____

After graduating school _____

Patient's military experience _____

Clothes and footwear: (non) hygienic, (not) correspond to the season (underline the necessary).

Feeding: (not) full, (not) regular (underline the necessary), prefers _____

Apartment: _____ rooms, separate (communal), (un)comfortable, with all (partial) facilities (underline the necessary).

C. Homelife. Emotional atmosphere at home _____

Marriage status _____ Family _____

D. Occupational life. Nature of the occupation _____

Toxic exposures _____

E. Sexual history. Pubertal period had gone without (with) complications at _____ y.

Had sexual contacts from _____ y, has (not) _____ child(s) (underline the necessary).

Menstrual function. Menarche from _____ y, cycle length _____ d, (ir)regular, duration of bleeding _____ d, amount of bleeding _____.

Menopause from _____ y. Amount of pregnancies: deliveries _____, abortions _____, misbirths _____.

6. MH

Medications (name, dosage, and regimen of each drug the patient is using) _____

Habits. Tobacco smoking _____

Alcohol consumption _____

Illicit drugs using _____

4

III. PHYSICAL EXAMINATION FINDINGS

General condition _____, t _____ °C.

Patient's position _____, level of consciousness _____

Face expression _____

Constitutional type _____, Height _____ cm, weight _____ kg,

BMI _____ kg/m². WC.....cm. HC.....cm. WC/HC.....cm.

Gait and bearing abnormalities _____

Skin:

Color: physiologic, pale, cyanosis, hyperemia, icterus, other changes _____ (underline the necessary)

Moisture _____ elasticity _____ state of the hair _____

presence of exanthema, hemorrhages, vascular changes, scars _____

Nails _____

Subcutaneous fat: degree of its development _____

Distribution (places of biggest fat deposition) _____

Thickness of cutaneous fold below the scapula _____ cm, presence of edema _____ (point the level of edema)

Thyroid gland _____

Lymph nodes (size, shape, consistency, motility tenderness, adhesions with each other and surrounding tissues) _____

Muscles: general development _____
 Tenderness on palpation _____
 Muscular tone _____
 Muscle strength _____
 Bones. On examination of skull, chest, spine, extremities tenderness and deformations are (not) revealed (underline the necessary) _____

Joints _____

Respiratory system

Nasal breathing is (not) laboured. Nasal form _____
 Chest shape _____ constitutional type _____
 Deformities _____, symmetry _____, respiratory pattern _____
 Respiration is (ir)regular, respiration rate _____ per min.
 Chest respiratory motions of both sides of the chest: (un)even, (a)symmetric, there is (no) a lag in motion on _____ side of the thorax.
 Additional respiratory muscles _____ (don't) participate in respiration.
 Tenderness on palpation _____, elasticity _____
 Tactile fremitus _____

On comparative percussion _____

Topographic percussion data:
 Height of apices pulmones standing: from the front: on the right – _____ cm above clavicle, on the left – _____ cm above clavicles;
 from the rear: on the level of _____ vertebra.
 Krenig's areas width: on the right – _____ cm, on the left – _____ cm.

Lower lung borders:

Topographic lines	Right	Left
Parasternal		
Midclavicular		
Anterior axillary		
Midaxillary		
Posterior axillary		
Scapular		
Paravertebral		

Defining of diaphragmatic excursion

Topographic lines	Right (cm)			Left (cm)		
	inhal.	exhat.	total	inhal.	exhat.	total
Midclavicular						
Midaxillary						
Scapular						

Lung auscultation _____

Bronchophony _____

Cardiovascular system

Inspection of precordium _____

Apical impulse (location, area, height, strength, resistance) _____

Cardiac impulse _____ Epigastric pulsation _____
 Other pulsations _____

Thrills _____

Heart percussion
 Cardiac relative dullness borders: right _____

 left _____

 upper _____

The heart diameter: ____ + ____ = ____ cm
 Heart configuration _____
 Cardiac superficial dullness borders: right _____

 left _____

 upper _____

Superficial dullness diameter: _____ cm.
 Vascular bundle width _____ cm
 Heart auscultation
 Heart sounds _____

Murmurs _____

Heart rate – _____ per 1 min., (ir)regular _____

Vessels examination
 Arterial pulse _____ per 1 min, (ir)regular, filling _____,
 strain _____, contour _____, (un)equal on both arms.
 Arteries palpation and auscultation _____

BP on the left arm _____ mm Hg, on the right arm _____ mm Hg..
 Venous pulse: negative, positive. Central venous pressure _____ cm.

Gastrointestinal tract.

Fetor oris _____
 Visible mucous of oral cavity _____

Tonsills _____

Gums _____
 Carious tooth _____
 Tongue _____

Abdomen shape: flat, rounded, protruded [(un)even], scaphoid (underline the necessary)
 Respiratory motions of abdominal wall _____

Auscultation data _____

Percussion data _____
 Superficial palpation data _____

Shchetkin-Blumberg's sign _____

Sigmoid colon _____

Cecum _____

Transverse colon _____

Ascending and descending colon _____

Using percussion, auscultopercussio, auscultoaffrication, splashing sound methods the lower stomach border is defined at the level _____
 Gastric greater curvature _____
 Pylorus _____
 Pancreas _____
 Inspection of the liver area _____

Signs of ascites _____

Liver span after Kurlov _____

Liver palpation _____

Gallbladder _____

Complementary signs _____

Inspection of the spleen area _____

Spleen percussion _____

Spleen palpation _____

Urinary system

Inspection of the kidneys area _____

Kidneys palpation _____

Pasternatsky's sign _____

Ureteral algesic points _____

Urinary bladder _____

IV. INVESTIGATIONS DATA

V. CLINICAL DIAGNOSIS

Main _____

Accompanied _____

VI. SUBSTANTIATION OF BASIC DIAGNOSIS

Diagnosis is based on _____

VII. PATHOGENESIS OF SYMPTOMS AND SIGNS

REFERENCES

1. A Guide to physical examination. Third Edition./B. Bates, R. A. Hoekelman.- J.B. Lippincott Company, Philadelphia, 1995, 539p.
2. Introduction to clinical medicine./J.L.Willms, J.Lewis. – Williams and Wilkins, Baltimore, 1991, 260p.
3. Manual of Introductory Clinical Medicine./R.M.Maclis, M.E.Mendelson, G.H.Mudge.- Little. Brown and Company, Medical division, Waltham, 1997, 251p.
4. Схема истории болезни./В.Н.Ослопов, А.Р.Садыкова, А.Р.Шамкина. – М.; МЕДпресс, 2001, 32с.
5. Пропедевтика внутренних болезней Учебно-методическое пособие. Часть I. Introduction to Internal Diseases. Manual Part I. /В.Н.ослопов, А.Р.Садыкова, И.В.Карамышева. Казань, 2005, 65 с.
6. Пропедевтика внутренних болезней Учебно-методическое пособие. Часть II. Introduction to Internal Diseases. Manual Part II. /В.Н.ослопов, А.Р.Садыкова, И.В.Карамышева. Казань, 2005, 86 с.
7. Пропедевтика внутренних болезней Учебно-методическое пособие. Часть III. Introduction to Internal Diseases. Manual Part III. /В.Н.ослопов, А.Р.Садыкова, Л.А.Ануфриева. Казань, 2005, 77с.
8. Пропедевтика внутренних болезней Учебно-методическое пособие. Часть IV. Introduction to Internal Diseases. Manual Part IV. /В.Н.ослопов, А.Р.Садыкова, Л.А.Ануфриева. Казань, 2005, 103 с.