Схема истории болезни
Учебно-методическое пособие

Казань, 2010


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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 intercostal 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 bubby sounds similar to blowing bubbles through a straw into a sundae. They are heard on expiration and inspiration. It is the result of viscus fluid in the airways. Fine crackles or crepitations 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 palpation. An apex beat in the axilla would indicated 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 S1 and S2 - if the splitting is abnormal or louder than usual. Should sound like [lub-dub lub-dub] and the presence of S3 - like [lub de dub] sound, S4 - like [T lub-dub]. If S1 S2 S3 S4 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).

**Examinations** 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, Muis's) 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 aglotes 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

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_______________________________________________________________
2. HPI_______________________________________________________________
   | Symptoms analysis (location, quality, quantity, chronology, setting, aggravating- |
   | alleviating factors, associated manifestations)______________________________ |
   | Secondary complaints__________________________________________________ |
3. PMH
   | A. Other medical problems______________________________________________ |
   | B. Allergies___________________________________________________________ |
   | C. Major childhood illnesses___________________________________________ |
   | D. Injuries, hospitalizations, and operations_____________________________ |
   | E. Immunizations (hemotransfusion)______________________________________ |
4. FH

History of recent admission_________________________________________________
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__________________________________
Facilities (underline the necessary).

D. Occupational life. Nature of the occupation______________________________
______________________________
Marriage status________________________ Family___________________________

E. Sexual history. Pubertal period had gone without (with) complications at____y.
Had sexual contacts from_____y., has (not)___childs (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
______________________________________________________________

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.

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<th>Topographic lines</th>
<th>Right (cm)</th>
<th>Left (cm)</th>
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Defining of diaphragmatic excursion

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Lung auscultation

Cardiovascular system
Inspection of precordium

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

Cardiac impulse Epigastric pulsation

Other pulsations
BP on the left arm__________________mm Hg, on the right arm__________________mm Hg.

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_________________________

Tonsils_________________________
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, auscultouffriction, splashing sound methods the lower stomach border is defined at the level_________________________
Gastric greater curvature_________________________
Pylorus_________________________
Pancreas_________________________
Inspection of the liver area_________________________
Urinary system
Inspection of the kidneys area
Kidneys palpation
Pasternatsky's sign
Ureteral algesic points
Urinary bladder

IV. INVESTIGATIONS DATA

V. CLINICAL DIAGNOSIS
Main

VI. SUBSTANTIATION OF BASIC DIAGNOSIS
Diagnosis is based on

VII. PATHOGENESIS OF SYMPTOMS AND SIGNS
REFERENCES