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Federal State Budgetary Educational Institution
higher education
"North Ossetian State Medical Academy"
Ministry of Health of the Russian Federation
(FGBOU VO SOGMA MRussian Health Ministry)

DEPARTMENT OF INTERNAL DISEASES №2

SCHEME FOR WRITING THE HISTORY OF THE DISEASE IN THE THERAPEUTIC CLINIC

METHODOLOGICAL MATERIALS

main professional educational program of higher education - specialty program in the specialty 05/31/01 Medicine,
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Methodological materials are intended for teaching 4th year students (7-8 semesters) of the Faculty of General Medicine.GBOU VO SOGMA MRussian Health Ministry in the discipline "Faculty therapy"

Compiled by:
Head Department of Internal Medicine No. 2, Associate Professor, Ph.D. M.M. Tebloyev
Associate Professor of the Department of Internal Medicine No. 2, Ph.D. Tsabolova Z.T.
Assistant Department of Internal Diseases No. 2, Ph.D. Gioeva I.Z.
Assistant Department of Internal Diseases No. 2, Ph.D. Ktsoeva A.A.
Assistant of the Department of Internal Medicine No. 2, Ph.D. Kusova A.B.

Reviewers:

R.V. Yenaldiyeva, MD, DSc, Professor of the Department of Internal Diseases No. 1 of the Federal State Budgetary Educational Institution of Higher Education, SOGMA
I.N. Totrov - Doctor of Medical Sciences, Associate Professor, Head of the Department of Internal Medicine No. 1 FGBOU VO SOGMA

DISEASE HISTORY WRITING SCHEME

I. PASTE SECTION

Surname, name, patronymic of the patient (oh)

Age

Floor

Nationality

Family status

Education

Profession

Place of work

Job or position being performed

Home address

Directed by

Date of admission to the clinic (for emergency patients: hours and minutes)

Diagnoses:

1) referring hospital
2) on admission
3) clinical:
    a) the underlying disease
    b) concomitant diseases
    c) complications

II. COMPLAINTS

In this section, it is necessary to state all the patient's complaints at the time of his examination. It is recommended to identify complaints in the following sequence:

1. Respiratory system

Cough: time of onset, strength, duration, dry, with phlegm.

Sputum: time of its appearance, quantity, character, color, smell, admixture of blood. Dependence of sputum separation on the patient's position.

Chest pain: intensity, character, irradiation, connection with breathing and coughing.

Shortness of breath: nature, time of onset, duration.

Nose and pulmonary bleeding, frequency of occurrence, duration and amount.

Temperature increase.

2. Circulatory system

Shortness of breath, its nature and time of onset.

Palpitations.

Interruptions.

Pain in the region of the heart and behind the sternum, their nature, duration, irradiation.

Hemoptysis.

Swelling.

3. The digestive system

Oral pain.

Bitterness in the mouth.

Smell from the mouth.

Swallowing (free, difficult, impossible, painful).

Bleeding from the esophagus.

Pain: localization, their nature, dependence on food intake, duration, irradiation, pain relief agents.

Vomiting: time of onset and nature of vomit.

Dyspeptic symptoms: nausea, heartburn, belching.

Appetite (good, bad, perverted, aversion to food).

Thirst (the amount of fluid you drink).

Losing weight.

Flatulence.

Intestinal bleeding.

Stool: diarrhea, constipation, bowel movements.

Liver and gallbladder

Pain in the right hypochondrium (constant or in the form of attacks).

Jaundice.

An increase in the size of the abdomen.

Discolored stools and dark urine.

Spleen

Pain in the left hypochondrium

Pancreas

Pain in the left upper abdomen and their nature.

Dyspeptic disorders.

Losing weight.

Jaundice.

Thirst.

4. System of urinary organs

Swelling.

Headache.

Violation of urination.

Coloration of urine.

Fights in the lumbar region.

Dysuric phenomena.

Dyspeptic disorders.

Visual disturbances.

5. Hematopoietic system

6. Nervous system

Headaches, dizziness, noise in the head.

Mood: even, calm, elated, depressed, anxious.

Weakening, lack of movement in the limbs.

Unstable gait.

7. Endocrine system

Complaints must be carefully detailed. Then, the main complaint (s) are identified, on which the justification of the preliminary diagnosis will be based.

III. HISTORY OF THE PRESENT DISEASE (Anamnesis morbi).

It is found out when and under what circumstances fell ill (a). What does the patient associate with the onset of the disease (mental trauma, physical or mental fatigue, hypothermia, overheating, intoxication, infection, etc.). The onset of the disease (acute or gradual). The first symptoms of the disease. The time of seeking medical care, the nature of this care and its effectiveness.

In chronological order, the dynamics of the disease is clarified, starting with the first symptoms. All diagnostic and therapeutic measures from the onset of the disease to the present examination of the patient are clarified. What diagnoses were made. What treatment was carried out and its effectiveness. It is important to follow the sequence of strengthening, weakening and changing the nature of the disease. If possible, get acquainted with the results of paraclinical studies, outpatient card, etc.

Work ability during the illness. The time of the onset of the last exacerbation, in what way it was expressed. Smooth or urgent hospitalization.

IV. LIFE STORY OF THE PATIENT (Anamnesis vitae).

1. Brief biographical information:

Place of Birth. The age of the parents and what kind of child was born. The nature of the feeding. Development and health status in childhood. The beginning of his studies, what educational institutions he graduated from, how he studied. When I started working, the nature and conditions of work, occupational hazards, changes in the profession. Working conditions, use of days off and vacations, etc. physical education and sports.

2. Household history:

Material security. Living conditions from childhood. Eating conditions, adherence to the diet, whether eating at home or in canteens.

3. Family and sex history:

The time of the onset of puberty. In women - the time of the onset of menstruation, their regularity, duration, soreness, etc. Time of marriage. The number and course of pregnancies, the number of abortions, normal births, obstetric pathology. Women's diseases. The number and health of children, if they died, is the cause of death. Menopause in women and men, the age of its onset, course, duration and treatment.

4. Past diseases:

The transferred diseases, operations, injuries are listed. At the same time, their severity and duration, complications, and therapeutic measures are indicated.

Reactions to medication, food intake, etc.

5. Epidemiological anamnesis:

Contact with tuberculosis and infectious patients. Vaccinations and reaction to them.

6. Heredity:

The state of health or cause of death (with indication of age) of close relatives of the patient: father, mother, brothers, sisters, children, etc. At the same time, attention is drawn to tumor, neuropsychic, endocrine, metabolic and allergic diseases.

7. Bad habits:

Smoking, alcohol consumption, drugs. At what age does he smoke, the number of cigarettes, cigarettes, cigars, etc. smoked. Does he smoke at night, on an empty stomach? Drinking alcohol, at what age, how often and in what quantity. Drug use: what, at what age and how often. Failure to comply with the general regime in the sense of alternating work and rest, diet and ignoring physical culture are also considered as bad habits.

V. PRESENT OBJECTIVE STATE OF THE PATIENT (Status praesens objectivus).

Assessment of the general condition of the patient: satisfactory, moderate, severe, very severe, agonizing. Body temperature.

Consciousness: clear, unclear, stupor, stupor, coma.

Examination of the face, hair (hair loss, shine, fragility, degree of development, the presence of hirsutism in women).

The position of the patient: active, passive, forced (which one).

Facial expression: calm, indifferent, excited, masked, suffering.

Physique (habitus), constitution (normosthenic, asthenic, hypersthenic), height, weight, gait.

Skin and visible mucous membranes: color (pale, icteric, pink, earthy, cyanotic), pigmentation, depigmentation (vitiligo, leicoderma), scratching, hemorrhages, scars, rashes, xanthomas, elasticity, moisture. Subcutaneous fat, its development: moderate, weak, excessive, places of local disappearance or the greatest deposition of fat, general obesity. The presence of pastiness and edema; characteristics of edema; their localization and prevalence.

Lymph nodes: localization of palpable lymph nodes (occipital, parotid, submandibular, cervical, supra- and subclavian, axillary, ulnar, inguinal, femoral, popliteal), their size, shape, surface (smooth, bumpy), consistency (hard, soft, elastic). Whether the lymph nodes are soldered to the skin, surrounding tissue or

to each other, their mobility. Soreness on palpation, the condition of the skin above them.

Muscles: the degree of their development - moderate, weak, good.

Bones: curvature and thickening of bones, soreness when palpating and tapping (especially sternum, ribs, tubular bones, spine), thickening of the terminal phalanges of the fingers and toes ("drumsticks"). Condition of nails: shape ("watch glasses", etc.), color, longitudinal striation, brittleness, destruction of nails.

Joints: the configuration of the joints, their swelling, hyperemia of the skin above them, changes in local temperature, soreness when feeling. Noises during movements in the joints (crunching, clicking). The range of motion in the joints (active, passive) and the presence or absence of pain during movement. Restricted mobility. The presence of fluid in the articular cavities. The spine, its shape, mobility in different parts. Curvature of the spine: lordosis, kyphosis, scoliosis.

RESPIRATORY SYSTEM

Inspection

Nose: difficulty breathing, the nature and amount of discharge from the nose (mucus, pus, blood). Pain in the paranasal cavities. Participation of the wings of the nose in breathing. Pain when speaking and swallowing. Larynx. The nature of the voice: hoarseness, aphonia. Eruptions of fever (herpes).

The nature of breathing (nose, mouth), free breathing, difficulty. The shape of the chest (normal or pathologically altered), its symmetry, deformation, circumference. Breathing type, symmetry of breathing movements, depth and rhythm of breathing. The number of breaths in one minute. Respiratory chest excursion.

Venous collaterals of the chest wall.

Palpation

Determination of chest resistance.

Identifying painful areas. Definition of voice tremor.

Percussion

Comparative percussion - the nature of the percussion sound in symmetrical areas of the chest: pulmonary, tympanic, dull, dull, boxed.

Topographic percussion: determination of the upper border of the lungs - the height of the tops of the lungs in front above the collarbones (in centimeters); behind - in relation to the spinous process of the seventh cervical vertebra; determination of the lower border of the lungs along all vertical lines of the chest (on the left, the study is carried out starting from the anterior axillary line). Determination of the mobility of the lower edge of the lungs on both sides of the chest.

Auscultation

The nature of breathing in symmetrical areas of both lungs: vesicular, weakened, increased, lack of breathing. Breathing is hard, bronchial, amphoric.

Wheezing: dry (whistling, buzzing), wet (fine-, medium-, large-bubble, voiced, non-voiced).

Crepitus. Pleural friction murmur. Pleuro-pericardial murmurs. Bronchophonia in symmetrical areas of the chest.

CIRCULATORY SYSTEM

Inspection

Neck examination: visible enlargement of the thyroid gland. Condition of veins and arteries, pathological pulsation ("dance" carotid, positive venous pulse, etc.).

Inspection of the heart area (identification of the heart hump and pathological pulsation in the heart area), apical impulse and its properties, cardiac impulse, its location.

Palpation

Palpation of the apical and cardiac impulse; their characteristics (localization, strength, prevalence, etc.). Determination of systolic and diastolic tremors (chest vibration - "cat's purr").

Percussion

Determination of the relative dullness of the heart: right, left and upper boundaries. The dimensions of the diameter of the relative dullness of the heart in centimeters.

Heart configuration.

Determination of the absolute dullness of the heart: right, left and upper boundaries.

Dimensions of the diameter of the vascular bundle.

Auscultation

Heart sounds: loud, muffled, muffled.

Detailed characteristics of heart sounds: a) change in tones; 1) weakening of I and II tones; 2) strengthening of I and II tones; b) changes in the I tone (weakening, strengthening); c) change in the II tone (weakening, strengthening); d) splitting and bifurcation of the II tone; e) the rhythm of the gallop; f) quail rhythm.

Heart rhythm disorders: tachycardia, bradycardia, extrasystole, atrial fibrillation.

Noises and their characteristics: relation to the phases of cardiac activity (systolic, diastolic, etc.), character (blowing, sawing, musical, etc.), strength (sharp, weak), duration (long, short), increasing decreasing. The place of the best listening to murmurs (apex of the heart, aorta, pulmonary artery, base of the xiphoid process, Botkin-Erb point). Noise conductivity. Changes in noises depending on the position of the patient. Pericardial rubbing noise. In the presence of insufficiency of the aortic valves, listening on the femoral artery of a double Traube tone and a double Vinogradov-Durozier murmur.

Research of blood vessels. Pulse properties

The state of the vascular wall of the peripheral arteries: elasticity, visible pulsation.

Properties of the pulse of the radial arteries: asynchrony (pulsus differens), frequency (pulsus frequens rarus), rhythm (pulsus regularis, irregularis), tension (pulsus durus, mollis), filling (pulsus magnus, parvus), the nature of the pulse wave (pulsus celer, tardus), pulse deficit.

Pulse study on aa. temporalis, dorsalis pedis, poplitea, femoralis.

Study of the veins of the lower extremities. Phlebeurysm.

Determination of arterial and venous blood pressure.

Detection of capillary pulse in case of aortic valve insufficiency.

Digestive system

Inspection

Examination of the oral cavity. Tongue: color, moisture, nature and severity of the papillary layer, the presence of plaque, glossitis, cracks, ulcers, dental prints.

Lips: color, moisture, eruptions (herpes), ulceration of the corners of the mouth, cracks, deformities ("cleft lip").

Oral mucosa: color, pigmentation, aphthae, ulcers, cracks, deformities ("cleft palate"), etc.

Dental condition: dental formula, presence of carious teeth and gangrenous roots, sagging, dentures, etc.

Gums: discoloration, looseness, ulceration, necrosis, hemorrhages, soreness.

The state of the soft and hard palate: coloration, plaque, hemorrhages, etc.

Pharynx: color, hyperemia, hypertrophy or atrophy of the tonsils, plaque and necrosis.

Examination of the abdomen. The shape of the abdomen, participation in the act of breathing, asymmetry, the presence of venous collaterals, visible peristalsis of the stomach and intestines.

Measurement of the abdominal circumference at the level of the navel.

Palpation

Superficial, approximate palpation; determination of soreness and tension of the abdominal muscles (muscle protection), identification of hernias and divergence of the rectus abdominis muscles.

Methodical deep sliding palpation according to Obraztsov-Strazhesko. Palpation order: sigmoid colon, blind, the final segment of the ileum, appendix, transverse colon, stomach, liver, spleen, pancreas, kidneys. Characteristics of various parts of

the large intestine: location, soreness, mobility, smoothness, density, elasticity, thickness, rumbling.

Determination of the lower border of the stomach (greater curvature) by palpation, percussion, auscultatory percussion and the method of detecting splash noise.

Percussion

The nature of the percussion sound: tympanic, dull-tympanic, dull.

Determination of free fluid in the abdominal cavity by percussion and fluctuation methods.

Auscultation

Listening to intestinal motility.

Liver

Examination of the liver area

The presence of diffuse or limited bulging; ripple.

Percussion

Determination of the boundaries of the liver according to M.G. Kurlov: the upper border along the right midclavicular line; lower - along the right midclavicular and median lines. The border of the liver along the left costal arch.

Palpation

Liver edge: smooth, bumpy, granular.

Measurement of the liver according to M.G. Kurlov: along the midclavicular line, midline and left costal arch.

Auscultation

Listening to the rubbing noise of the peritoneum.

Gall bladder

Examination of the gallbladder area. Palpation of the superficial and deep areas of the gallbladder; when it increases, the determination of the size, consistency, soreness. Determination of painful areas and points.

Spleen

Examining the spleen area

The presence of diffuse or limited bulging.

Percussion

Measurement of the diameter and longitudinal dimension of the spleen.

Palpation

Characteristic of the edge of the spleen: thin, round, soft, dense, painful, painless. Surface: smooth, bumpy.

Auscultation

Listening to the rubbing noise of the peritoneum.

Pancreas

Examination of the pancreas area

Palpation is superficial and deep; identification of soreness, enlargement and thickening of the pancreas.

URINARY SYSTEM

Examination of the kidney area

Swelling, redness.

Palpation of the kidneys

Descent, enlargement, displacement, soreness of the kidneys.

Percussion

Revealing Pasternatsky's symptom by the tingling method.

Bladder

Examination, palpation of the suprapubic region. Percussion of the bladder.

NERVOUS SYSTEM AND SENSE ORGANS

Consciousness, intelligence, speech, attention, ingenuity, thinking. Emotional sphere. Memory. Sleep. Sensitivity. Soreness along the nerve trunks on palpation. Features of gait, paralysis, ptosis. Reflexes: tendon, skin, mucous membranes (conjunctival, corneal, posterior pharyngeal wall). Pupil reaction to light. Pathological reflexes. Meningeal symptoms (stiff neck, Kernig's symptom, etc.). Vasomotor disorders, dermographism.

ENDOCRINE SYSTEM

Compliance with general development for age. Height and ratio of individual body parts. Skin condition (dry, thinning or roughness, stretch marks and their localization). Pigmentation of the skin and mucous membranes. Condition of hair, scalp. The shape and color of the face. The development of subcutaneous adipose tissue (the severity of obesity and the predominant localization of the subcutaneous fat layer).

Examination and palpation of the thyroid gland, its size and consistency, soreness, mobility. Tremor of hands, eyelids, tongue. Symptoms of Graefe, Moebius, Shtelvag, etc. Breast glands in women - the degree of development, the presence of scars, visible and palpable tumors, mastopathy, fistulas. Palpation of the lower abdomen in women (uterus and its appendages). External genital organs in men: testicular underdevelopment, anorchism, cryptorchidism. Anomalies and deformities of the penis.

Vi. PRELIMINARY DIAGNOSIS AND ITS JUSTIFICATION

The preliminary diagnosis is based on complaints, anamnesis data and an objective examination of the patient.

Vii. PATIENT EXAMINATION PLAN

This section sequentially describes those studies that are necessary for the differential diagnosis. For example, if a stomach disease is suspected, fluoroscopy, gastrofibroscopy, fractional study of gastric juice, feces for occult blood, etc. are prescribed. In no case should all research be carried out for each patient, because many of them are burdensome for the patient, do not contribute to the rapid and correct recognition of the disease, but this is evidence of the incompetence of the doctor.

VIII. RESULTS OF THE CONDUCTED STUDY

1. Blood tests: morphological, biochemical, bacteriological.
2. Urine tests.
3. Sputum research.
4. Studies of gastric secretion.
5. Examination of stool.
6. Protocols of electrocardiographic, radiological, ultrasound and other special research methods.

The results of the study should be taken into account in the process of differential diagnosis.

IX. DIFFERENTIAL DIAGNOSIS

The essence of differential diagnosis lies in the fact that after a detailed study of the patient, the most striking symptoms of the disease stand out, i.e. the leading syndrome of the disease is determined. Then diseases that have a similar syndrome are listed. Subsequently, a differentiation is made between these diseases. Describing the characteristic symptoms for each of these diseases, and using the method of exclusion due to the discrepancy between individual symptoms, the student rejects one disease after another in the supervised patient and, thus, comes to a logical conclusion about the diagnosis.

X. FINAL DIAGNOSIS

The final diagnosis is divided into three sections:

1. ***Underlying disease***... It is understood as a disease that more threatens the health and life of the patient, i.e. has the most unfavorable prognosis.
2. ***Accompanying illnesses***... This column includes all diseases that do not have a common etiology and pathogenesis with the underlying disease.
3. ***Complications***... In this section of the diagnosis, pathological processes are recorded that have developed as a result of the underlying and concomitant diseases.

XI. TREATMENT

The student substantiates the individual scheme of complex treatment of the supervised patient (regimen, diet, medication, physiotherapy). Complete prescriptions are given.

XII. DIARY

The diary should reflect the dynamics of the course of the disease. Every day, in a short form, the patient's condition should be noted, all changes that have occurred over the past day, and all appointments made to the patient, including physiotherapy procedures, physiotherapy exercises, as well as various manipulations: banks, enemas, etc. In a special column or in the column appointments mark the prescribed diet, hygienic bath, change of linen, etc.

It is also necessary to note the preparation of the patient for the production of various studies (X-ray, gastric juice, etc.).

Data on temperature (measured at least 2 times a day), pulse, respiration, bowel action, sleep should be noted daily.

Weighing of patients, hygienic bath (if there are no contraindications), change of linen is done once a week. Repeated studies of urine and blood, blood pressure measurements are performed as needed, but at least once every ten days. Other repeated laboratory, instrumental and other studies are done depending on the type of disease and the course of the disease. All new studies, analyzes, consultations of other specialists are also noted in the diary (or glued to the medical history).

XIII. Epicrisis

Epicrisis is the most critical part of the medical history.

An epicrisis is a doctor's conclusion about the disease, the course of the disease, the results of treatment, about the patient's condition at the time of discharge, his ability to work, prognosis, about the patient's further regimen and his treatment.

The detailed diagnosis includes not only the name of the established diseases (including complications and concomitant diseases), but also painful conditions (for example, the stage and forms of hypertension, the stage of heart failure, the presence of jaundice). Then they give a brief description of the disease, indicating the main symptoms of the disease, with the results of laboratory, X-ray and other studies, which substantiate the diagnosis made at the beginning. Briefly describe the treatment and changes in the patient's condition (dynamics of the disease) that occurred during his stay in a medical institution. Based on these data, conclusions are drawn about the prognosis: the further course of the disease (if the patient has not recovered) and about the ability to work.

At the end of the epicrisis, they indicate what advice was given to the patient by the doctor when he was discharged, what kind of treatment he should follow, what kind of treatment to continue (including sanatorium, resort), what work can be done (employment of the patient), whether he should be under the supervision of a local doctor in the future ...

In addition, the so-called milestone epicrises are written in the diary once every 10 days or once every 2 weeks, which summarize the patient's condition over the past

period of his stay in a medical institution. Here, the dynamics of the disease for a given period of time should mainly be reflected: all the changes that have occurred in the patient's condition under the influence of the treatment and regimen, as well as all research and consultations carried out during this period are noted.

Curator's signature _____

End date of supervision _____

List of used literature _____

Assessment _____

Assistant's signature _____