Grodno State Medical University

Department of Infectious Diseases with the course of children's infections

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Lecturer:

SCHEME OF HISTORY DISEASE

Name the patient
Age
Address
Job
Date of admission
The clinical diagnosis
primary
comorbidities
complications

Curator
Date

I. Complaints (at admission and at the time of Supervision).
II. A history of the disease (from onset of illness to the patient's supervision).
III. Epidemiological history (given only specific to the patient data, contributing to the differential diagnosis of similar diseases, and necessary for the antiepidemic measures in the outbreak).
IV. A history of life and allergological anamnesis: specify only the data relevant for the final diagnosis, premorbid conditions, comorbidities, bad habits and past illnesses, vaccination, bad working conditions, etc.
V. Results of the objective examination of the patient:
1. More consistently (Systems) described only those marked with patient survey, palpation, percussion, auscultation of changing systems, organs, individual characteristics of the functional state of the patient, who had been involved in the pathological process in this disease.
2. In the presence of comorbidities described all known symptoms of this disease.
3. Description of the objective status of the patient is in the sequence adopted by faculties therapeutic profile, with a detailed description of the temperature curve.
VI. Preliminary diagnosis (without justification).
VII. Plan examination of the patient: includes all the common purpose (see list of treetment) and in addition, only those that speed up the diagnosis, are more informative and specific, contribute to the differential diagnosis. If necessary, can be used by additional laboratory tests, including functional, instrumental, immunological, morphological and other examinations.
VIII. Results of laboratory examinations (given only the data changes which are characteristic for a particular patient and the disease, the interpretation of which is necessary to substantiate a definitive diagnosis).
IX. Differential diagnosis:
A. List all major illnesses, which held a differential diagnosis (infectious and noninfectious etiology).
B. Give 4-5 c with which the most difficult to differentiate the disease in an individual patient, listing the first general and then distinguishing the clinical and laboratory examination.
X. Justification final diagnosis:
On the basis of complaints, personal history of disease, epidemiological history, medical history, physical examination results and data obtained in laboratory and instrumental examination of the patient, the differential diagnosis exhibited a definitive diagnosis. In support of the diagnosis include only specific, informative, specific data set that allowed a definitive diagnosis, diagnose concomitant pathology (not grounded) and the complications of underlying disease.
XI. Treatment and prevention (are the main types of therapy the patient and reflects the effectiveness of it, a summary of the plan control activities at a particular disease).

Note: when writing the history of the disease used monographic literature, bibliographic data, on which the supervisor receives a teacher's supervision on the first day the patient.

Signature (legibly)