PLAN OF CASE HISTORY
IN CLINIC OF GENERAL SURGERY

Recommendations to a concise and systemic study for IIIrd year students of faculty for international students studying in English medium

1. PATIENT DETAILS

1.1. Initials (surname, name, patronymic name)
1.2. Age
1.3. Gender
1.4. Education: (primary, secondary, specialized secondary, higher)
1.5. Occupation
1.6. Place of employment
1.7. Home address
1.8. Date of hospitalization
1.9. Who directs the patient (has addressed independently, polyclinic, is delivered by ambulance car)
1.10. Diagnosis

2. PATIENT´S COMPLAINTS

Complaints are made on all bodies and systems at date of primary survey of the patient. The patient is asked, "What are your complaints?" A few dull patients do not really understand what do you want to know and may start irrelevant talks. In that case, he should be asked, "What brings you here?"

It is necessary to allocate the basic and minor complaints. The basic complaints are complaints concerning the main disease which has resulted the patient in the hospital. Minor complaints are complaints from accompanying diseases. It is necessary to specify time and a place of occurrence of this or that abnormal symptoms (pain, pathological sensation, feeling etc.). Each complaint is as much as possible detailed on character, location, severity, conditions of occurrence or disappearance, connection with other moments worsening or make it better.

The question should be such that it leaves the patient with free choice of answer. As for example the question should be, "Does the pain ever move?" If the patient says, "Yes", you should ask, "Where does it go?" So the questions should not necessarily be leading, but to help the patient to narrate the different aspects of his symptoms to arrive at a definite diagnosis. Sometimes negative answers are more valuable in arrivivng at a diagnosis and should never be disregarded.

The Respiratory System

Difficulty of nasal breathing, nasal discharge, nasal bleeding.

Chest pain: Do you have the chest pain? Where is it localized? What is its character (acute, dull, piercing, shooting, aching), intensity (slight, moderate, intensive) and duration (permanent, periodical, paroxysmal)? Does the pain radiate to a specific area of the body? Does the position of the body, deep breathing, coughing influence on the pain – provoke it or aggravate it?

Cough: Do you have a cough? How strong is the cough (slight, moderate, intensive)? What is its character (dry, with sputum; permanent, periodical, paroxysmal, duration of paroxysm; shallow, deep)? When does it occur (morning, day, night, the whole day)? How frequent is it? Are there factors that seem to precipitate or aggravate it?

Sputum: How is sputum discharged (easily, hardly, as a small spittle or as full mouth)? What factor influences the sputum discharge (changes of body position, day time)? What is the character of the sputum (serous, viscous, mucous, purulent, mucopurulent, bloody? What is its color and odor?

Dyspnea (shortness of breath): Do you have any difficulty in breathing? What is the character of the dyspnea (inspiratory, expiratory, mixed, permanent, periodical)? When does dyspnea occur (at rest or with exercise)? After how much effort does dyspnea appear (climbing stairs, quick or slow walking, or simple movements)? Carefully determine the timing and setting of dyspnea, associated symptoms, factors that aggravate it or relieve it. Do you have asthma episode or asthma attack? What is it duration? What provokes the asthma attack?

The Cardiovascular System

Cardiac pain: Do you have cardiac pain? Where is the pain localized? What is the character of the pain (pressing, squeezing, weight-like, stabbing, burning, piercing, shooting, aching), intensity (slight, moderate, intensive) and duration

(permanent, periodical, paroxysmal) of the pain? Does the pain irradiate to the some area of the body? What is the cause and time of pain appearance (physical exertion, labile emotions, rest, at night)? Which factors relieve the pain and how quickly?

Palpitations: Do you have palpitations or are you aware of your heartbeat? What is it like? Is it fast or slow? Regular or irregular? How long does it last? When does it occur? If there was an episode of rapid heart action, did it start and stop suddenly or gradually?

Dyspnea (shortness of breath): Do you have dyspnea? When does it appear (at rest, with physical exertion, during brisk walking, while climbing upstairs, while walking in room, getting up from a bed)? Do you have episodes of sudden dyspnea at night?

Edemas: Have you had any swelling anywhere? Where does edemas appear? When does it occur? Is it worse in the evening or in the morning?

Weakness and fatigue: Do you have weakness and fatigue? When do they appear? How long does this condition last? What is its character (permanent, periodical)?

The Gastrointestinal Tract

Abdominal pain: Do you have abdominal pain? What is the pain like (aching, cramping, burning, acute, dull, stab-like, gnawing)? Where is its localization? Does it radiate to any part of the body (to the shoulder, scapula, vertebra, groin)? What is the character (permanent, periodical, colicky), connection with the eating (before, after, during meal) of the pain? What relieves pain (meal, vomiting, warmth, medicines, defecation)? What are the associated symptoms (vomiting, fever, jaundice, diarrhea, constipation)?

Do you have some other unpleasant sensation or discomfort in the abdominal area (sensation of heaviness, discomfort, borborygmus, bloating, tenesmus)? Do you have pain during defecation, burning and itching sensation in the rectum, hemorrhoids?

Heartburn: Do you have heartburn? How frequent is it? What is the intensity of the heartburn? How long does it last? When does it appear (before or after meal, during changes of the body position)? Which factors relieve it?

Appetite: Which type of appetite do you have (good, mild, low, lack of appetite, increased, perverted)? Do you have aversion to some type of food (meet, milk)? Do you have some foul (unpleasant) taste in the mouth (sour, bitter, metallic, sweetish)? Do you feel thirsty, have dry mouth, salivation? Do you have pain, difficulties during chewing?

Dysphagia: Do you have difficulties in swallowing? Ask the patient to show you where dysphagia is felt. When does it start? Is it intermittent or persistent? Is it progressing and if so, how quickly? What kind of food is difficult to swallow (solid or liquid)? What are the associated symptoms?

Regurgitation or Eructation: Do you have regurgitation? What is the taste and consistency of the regurgitated content (air, food, acidic or bile-stained fluid, rotten air)? When does it occur?

Nausea: Do you have nausea? How frequent is it occurs? When does it appear (before or after meal)? How long does it last?

Vomiting: Do you have vomiting? How frequent is it? When does it occur (during fasting, before or after meal, after taking medicines, not depending of meal)? What

are the associating symptoms? Does it relieve general condition of the patient or not? What is the character of vomit (color, presence of blood, bile, mucus, food eaten today or yesterday)? What is the amount of vomit?

Stool: How often do you have stool? What is more often constipation or diarrhea? Diarrhea: How many times per day do you have stool? What provokes diarrhea (excitement, stress, some types of food)? Constipation: How many days is there no stool? What helps you to have stool (enema, laxatives, food)? What is the consistency and form of the feces (shaped, sausage-shaped, porridge-like, watery, pebble-like)? What is the color of the feces (brown, light, colorless, black, tarry)? Are there any admixtures in feces (blood, pus, mucus, indigested food, helminth)?

The Urinary System

Pain: Do you have pain in the waist or in the back? What is the character of pain (dull, acute, cramping). How long does this pain last (prolonged, paroxysmal)? Does pain irradiate anywhere (to the center of the abdomen, to the groin, to sacrum)? Do you have pain or discomfort above the pubic bone? Is it associated with urination? What are the causes which make the pain more severe or reduce pain?

Urination: Do you have any problems with urination (increased or decreased urine amount, frequent urination, frequent urination at night, painful urination)? What is the color of urine (yellow, red, brown, black, clear or cloudy)?

Endocrine system

Do you have increased appetite, thirst, excessive sweating, weakness, weight loss, chilliness?

Neuropsychic System

Headache: Do you have headache? Where is it localized (frontal, occipital, temporal, parietal area)? What is the character, intensity, duration of headache? What is the time of appearance and causes of headache? What relieves pain?

Sleep: Do you have any sleep disturbances (sleeplessness, interrupted sleep, difficult falling asleep, nightmare)?

Obsessions, anxiety.

Disturbances of Sensitivity: Do you have any sensitivity disturbances (pain sensitivity, temperature sensitivity, tactile sensation)?

Movement: Do you have any abnormalities in motor system

(weakening or lack of movements in the extremities)?

3. HISTORY OF PRESENT ILLNESS

This history commences from the beginning of the first symptom and extend to the time of examination. For this, ask the patient, "How long have you been suffering from each of these complaints?" You should ask the patient: when these symptoms appeared for the first time in your life? Did you follow any treatment and what was its effect? Why did he present today? You should to write the date and the time of beginning the present illness in case of urgent surgical diseases. Is there something new today as compared to every other day when this problem has been present already? Is this related to a gradual worsening of the symptom itself? It is necessary detailed to describe the circumstances in case of trauma. These should be recorded in a chronological order.

You should make it very clear that the patient was free from any complaint before the period mentioned by the patient. For this, you should ask the patient, "Were you perfectly well before the appearance of the complaint?" This is very important, as very often the patients may not mention some of his previous complaints as he considers them insignificant or unrelated to his present trouble. But, on the contrary, this may give a very important clue to arrive at a diagnosis.

Also, the progress of the disease with evolution of symptoms in the exact order of their occurrence have to be ascertained, and the treatment which the patient might have received.

4. HISTORY OF LIFE OF A PATIENT

The history of life of a patient includes the childhood, youth, working conditions, past history, operations, family anamnesis, harmful habits, allergic anamnesis.

Childhood: Where and in which family the patient was born (workers, employees, agricultures workers). Record any relevant perinatal and developmental history. Ask if the patient was born prematurely. Ask about any complications associated with their birth. Ask if they were told how old they were when they spoke their first word or took their first step. How many children were in the patient's family? Conditions of nutrition, state of health and development.

Youth: When the patient did start to study? How did he or she study? What was the level of education? Ask if the patient attended special educational classes. Ask if he or she has a learning disability and if the patient has any other problem such as a hearing impairment or speech problem. These data are very important in the psychiatric assessment of the patient.

In women, the menstrual history must be recorded perfectly - the beginning menses and their character (regularity, duration, morbidity).Whether any pain is associated with menstruation or not and last date of menstruation. The number of pregnancies and miscarriages are noted with their dates. Whether the deliveres were normal or not, whether the patient had Caesarean section or not and if so, for what reason.

Working conditions: If the patient is employed, ask about the beginning of working activity, place of work and the post. You should to ask about characteristic of working place, presence of professional harms. Regimen and duration of work (day or night work). If the patient is not employed, ask about whether the patient currently is looking for work. Also inquire if a previously held job was lost as a result of the illness. Obtain as much detailed information as possible.

Trying to find out the patient's live events associated with the problem that has made them seek out the medical aid, the doctor has to interview the patient's standard of living. Ask if the patient has a house and the living conditions, nourishment (hot, cold food, regular or no regular nourishment). How the patients do spend free time. Inquire if they have a family and if they have contact with the family members. Ask where the patient will go after discharge from hospital. Also ask who will ensure that the patient remains compliant with medication therapy. These become crucial points when finding placement for patients at discharge and planning long-term follow-up care. Ask patients about physical exercises.

Ask patients their marital status. Record the number, sex and age of the patient's children.

Past history: All the diseases suffered by the patient, previous to the present one, should be noted and recorded in a chronological order. There should be mention of dates of their occurrence and the duration. These diseases may not have any relation with the present disease, but rather to assist you in identifying risk factors for particular illnesses (e.g. HIV, hepatitis). Particular attention is paid to the diseases like diabetes, diphtheria, rheumatic fever, bleeding tendencies, tuberculosis, syphilis, gonorrhea, asthma etc.

Operations: Previous operations or accidents, which patient might have undergone or sustained. The dates and types of operations should be mentioned in a chronological order.

Family anamnesis: This is also important. Many diseases do recur in families. Haemophilia, tuberculosis, diabetes, essential hypertension, peptic ulcer, majority of the cancers particularly the breast cancer and certain other diseases like fissure-in-ano, piles etc. run in families. Not forget to enquire about other members of family, such as about the parents if they are still alive. How are they maintaining their health? Did they suffer from any major ailments? If they are dead, what were the causes of their deaths? You should also enquire about the brothers, sisters and children of the patient.

Harmful habits: Under this heading, the patient's habit of smoking (cigarettes, cigar or pipe and the frequency), drinking of alcohol (quality and quantity), using of narcotics or any drugs, diet (regular or irregular, vegetarian or non-vegetarian, takes spicy food or not etc.) are noted.

Allergic anamnesis: This is very important and should not be missed under any circumstances, while taking history of a patient. The patient should be asked whether he or she is allergic to any medicine or diet. It should be noted with red type on the cover of the history sheet. You should make it a practice and they will definitely find that this valuable practice will save many catastrophes.

5. PHYSICAL EXAMINATION

5.1. General inspection

The state of patient: good, satisfactory, mild, severe, extremely severe, preagonal.

Position of patient: active, passive, forced.

State of consciousness: clear; depressed (stupor, sopor, coma, delirium).

Facial expression: normal; excited; febrile, suffering; Hippocratic face, etc.

Body-build (constitution): normosthenic, hypersthenic, asthenic. Growth. Weight.

Skin and mucous membranes: color (normal, red, pale, cyanosis, jaundice, sallow, tanned), pigmentation, rash, extravasations, peeling, scars, moisture, plasticity of the skin (turgor).

Hair: growth, falling out, grey-haired.

Nails: form (normal, clubbing), surface (smooth, streaked), color.

Subcutaneous fat: degree of development, places of the largest fat deposit (abdomen, thigh).

Lymphatic nodes: palpation of submaxillary, mental, cervical, retroaural, supraclavicular, subclavicular, ulnar, inguinal, femoral, popliteal lymph nodes. The enlarged lymph nodes should be carefully palpated to know their size, consistency, painful, mobility, fixity to surrounding structures.

Edemas: localization (face, eyelids, limbs, waist, anasarca), intensity (large, moderate, small), consistency (soft, strong).

Thyroid gland: size, degree of increase, consistency (soft, strong, tuberous), palpatory tenderness.

Eye symptoms: exophthalmos, shine.

Muscles: degree of development, tone (normal, decreased, increased), pain.

Bones: deformation, pain during palpation, finger clubbing.

Vertebra: spinal curvature (lordosis, kyphosis, scoliosis, gibbus), mobility at (flexure, extension, lateral movements), morbidity of separate vertebras at palpation, loading on an axis.

Joints: (configuration, deformation) swelling, hyperemia of the skin around joints, local temperature, painful movements, range of motions about a joint, the amplitude of active and passive movements.

Measurement of the circumference and length of a limb is to be performed both on the affected and intact sides, the results obtained being compared.

5.2. Respiratory system

Characteristics of breathing: free, heavy, nasal, oral.

Inspection of the chest: The form of the chest: normal (normosthenic, hypersthenic, asthenic), pathological (paralytic chest, barrel chest, pigeon chest, thoracic kyphoscoliosis, etc.).

The symmetry of the both half of thorax and their movement in the breathing. Condition of intercostal intervals at breath (outpouching, retraction). Type of breathing mainly (thoracal, abdominal, mixed). The rate of breathing (min^{-1}) and the depth (deep, ordinary, superficial). Rhythm of breathing.

Characteristics of dyspnea (inspiratory, expiratory, mixed). Measurement of chest circumference: during normal breathing, in maximal inspiration and in maximal expiration (in cm) phases.

Palpation of the chest: detection of painful points and places (skin, muscles, bones, intercostals nerves). Estimation of resistance of thorax and vocal tremor.

Percussion of the lungs: a) comparative percussion: character of the percussion sound over the symmetric places of the chest along all topographic lines; b) topographic percussion of the lungs: the inferior borders of the lungs are estimated along all standard vertical lines, mobility of the inferior borders of the lungs along midclavicular and midaxillary lines. The apex of each lung is estimated anteriorly and posteriorly.

Auscultation of lungs: characteristics of breath sounds: vesicular (normal, increased, decreased), rough, bronchial, amphoric, absence of sounds. You need to indicate place of auscultation of every type of breath sounds.

Adventitious sounds: crackles: dry (wheezes, high pitched, low pitched), rhonchi (small bubble, medium bubble, large bubble) and their resonation. Crepitation. Pleural friction rub. Investigation of bronchophony on symmetrical areas over each lung.

5.3. Cardiovascular System.

Inspection of the heart and large vessels regions: outpouching heart region (cardiac hump). Apical impulse: location, diameter. Neck vessels pulse: jugular pulse, carotid shudder. Peripheral arteries hyperpulsation.

Palpation of the heart and vessels region: Central precordial impulse, location, amplitude and force. Upper chest localized impulse, the epigastric pulsation if they are present or not. Definition of thrilling of a thorax in the heart region (cat's purring), its localisation and character. Zones of hyperalgesias their localisation. Definition of retrosternal aorta pulsation.

Pulse palpation: is the pulse equal over the both radial arteries, its tension and fullness, rate, rhythm. Property of arterial wall (soft, elastic, hard). Evaluation of pulse at temporal artery, arteries of lower extremities (femoral, popliteal, posterior tibial, dorsalis pedis).

Venous pulse (negative, positive). Inspection of veins of lower extremities (varix dilatation).

Percussion: Detection of the right, left and superior borders of relative heart dullness. The width of vascular fascicle in cm (over the 2d rib interspace). Configuration of heart. Detection of the right, left and superior borders of absolute heart dullness.

Auscultation: heart sounds: normal, dull, accentuated. Characteristics of the heart sounds: I sound intensive, diminished, split, bifurcate (localization), II sound diminished, with metallic resonance, split, bifurcate (localization).

Changes of the rhythm: tachycardia, bradycardia, arrhythmia, extrasystole.

Murmurs: systolic and diastolic. Grade of the murmur. Location and radiation of the murmurs. Changes in loudness of the murmurs with positional maneuvers (standing, lying supine, lateral decubitus) and after physical exercises. Extracardial murmurs (pericardial friction rub).

Auscultation of large vessels: murmurs (localization). Measurement of blood pressure over both upper extremities.

5.4. The Gastrointestinal Tract

Examination of the oral cavity: tunica mucosa of mouth (colour, pigmentation, aphtae, hemorrhages, ulcerations). Fetor ex ore (putrefactive, bad eggs, ammonia, acetone).

The lips: color (brownish-red, red, pale, cyanotic), dryness, fissures.

The teeth, their condition, presence of carious teeth.

The tongue: dry, moist, clean, furring, varnished, fissures, ulcerations, enlargement. The tonsils: size, colour (hyperemia), presens of purulent discharge.

The pharynx: color of mucous membrane, presence of granulosity.

Inspection of the abdomen is made in position standing and laying. Form: (normal configuration, enlargement, inverted, frog-like, pendulous). Presence of outpouchings, their localization.

The umbilicus: (eversion, inversion). Presence of dilated subcutaneous veins on abdominal wall.

The scars, location and type. Visible peristalsis of stomach and intestine. Abdominal circumference on the umbilical level in cm.

Palpation of the abdomen

Superficial palpation is used to estimate resistance of the anterior abdomen wall (localized or generalized) and tenderness of some areas. Detection of hernias (inguinal, femoral, umbilical, white line) and diastasis recti abdominis.

Deep palpation: Palpation of the sigmoid colon, caecum, colon transversum, colon descending, colon ascending and terminal part of ileum. determination of lower border of stomach. Define the characteristics (shape, size), surface (smooth, tuberous), consistency (soft, elastic, firm), mobility, tenderness, borborygmus.

Definition of symptoms of irritation of peritoneum: Voskresensky, Razdolsky, Stchetkin-Blumberg.

Percussion of the abdomen: definition presence of liquid in the abdominal cavity.

Auscultation: presence of bowel sounds.

Examination of the liver and gallbladder: Palpation of the liver: Detection of the inferior border of the liver along the vertical lines (midsternal, parasternal, midclavicular, anterior axillary line) and the distance from the left costal arch in cm. Characteristics of the lower liver margin: shape (sharp, curved), consistency (soft, firm), tenderness. The surface (smooth, tuberous).

Percussion of the liver: detection of the superior border of the liver along the vertical lines (parasternal, midclavicular, anterior axillary line).

Percussion of the spleen: Detection of the spleen borders (length along X rib and diameter).

The pancreas: palpation (enlargement, induration, tenderness).

5.5. The Urinary System

Inspection of the lumbar region (swelling, hyperemia,), suprapubic region, external genitals.

Palpation of the kidneys bimanually standing, lying supine, lateral decubitus. If the kidneys are palpable you should indicate size, form, surface (smooth, tuberous), tenderness, mobility rate. Pasternatsky's symptom (positive, negative). Palpation of the urinary bladder if it is palpable in suprapubic region. Palpation along the ureter. Palpation of external genitals. Palpation of prostate gland per rectum in male.

Percussion of the kidneys and urinary bladder.

5.6. Nervous System

The consciouness (clear, mental confusion, unconsciousness).

The mood (good, depressed, instable, irritability, emotional outburst).

The sleep (normal, interrupted, sleeplessness, sleepiness). Dreams.

The ability of patient to orient in time, place and description of his personality.

Patient compliance.

Visual, hearing, osmetic impairment. Mobility of eyes. Function of mimic and masseteric musculature. Function of tongue.

6. Status Localis

Status localis – objective description of lesion focus (part of body, system, or organ, which is affected with the disease or where the pathological process is localized).

All objective data are brought in the section of case history, concerning by the amazed areas of a body. For example, if it is a question of disease any organ of an abdominal cavity, all inner organs of the abdomen are described. All foot and function of all its joints is described at a wound on a foot. The description of the local status begins with survey, ande then palpation, percussion, auscultation, measurements are discribed.