Министерство здравоохранения Республики Беларусь

УЧРЕЖДЕНИЕ ОБРАЗОВАНИЯ
«ГРОДНЕНСКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ»

Кафедра пропедевтики внутренних болезней

М.А. ЛИС
Т.П. ПРОНЬКО

СХЕМА ОБСЛЕДОВАНИЯ БОЛЬНОГО В КЛИНИКЕ ПРОПЕДЕВТИКИ ВНУТРЕННИХ БОЛЕЗНЕЙ

Методические рекомендации
для студентов III курса отделения иностранных студентов
с преподаванием на английском языке

SCHEME OF PHYSICAL EXAMINATION OF A PATIENT IN THE CLINIC OF PROPAEDEUTIC OF INTERNAL DISEASES

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

Гродно 2007

УДК 616.1/.4-07(075.5)
ББК 54.1
Л 63

Рекомендовано Центральным научно-методическим советом УО «ГрГМУ» (протокол №3 от 27 февраля 2007 г.).

Авторы: зав. каф. пропедевтики внутренних болезней,
проф., д.м.н. М.А. Лис,
ассист. каф. пропедевтики внутренних болезней,
к.м.н. Т.П. Пронько

Рецензент: зав. каф. госпитальной терапии, д.м.н., В.М. Пырочкин

Лис М.А.

Л63 Схема обследования больного в клинике пропедевтики внутренних болезней : методические рекомендации для студентов III курса отделения иностранных студентов с преподаванием на английском языке (на англ. яз.) / М.А. Лис, Т.П. Пронько. – Гродно: ГрГМУ, 2007. – 16 с.
ISBN 978-985-496-249-8

Методические рекомендации предназначены обеспечить подготовку студентов III курса отделения иностранных студентов с преподаванием на английском языке по освоению методики клинического обследования больного и оформления учебной истории болезни.

The given recommendations aim to prepare IIIrd year students of foreign faculty who are studying in English medium to master methods of physical examination of patient and presentation of case history.

УДК 616.1/.4-07(075.5)
ББК 54.1

ISBN 978-985-496-249-8

Introduction

This scheme of physical examination of a patient in the clinic of Propaedeutic of Internal Diseases is prepared in order to train foreign students of IIIrd year studying in English medium. It may also be used by senior students as a plan consisting of principles of case report writing and presentation. Our recommendations are based upon the plan for physical examination of the patient published by department of Propaedeutic of internal diseases in the year 1999.

The aim of these recommendations is to help medical students acquire adequate knowledge and practical skills for a systemic and complete examination of patient.

Consecutive examination of patient according to the provided plan helps to achieve a more rapid and complete information set, necessary for making correct diagnosis and plan of treatment. Data received after examination of patient, observation of disease progress, treatment and its effects are recorded in the case study. The case report is an officially legal document. Moreover, it indicateds the level of the doctor's qualification, his attitude to the work, the standard of the hospital.

Doctors or students may additionally elucidate questions, which are not included to the plan of examination of patient, in case further information is required concerning the patient and his illness. On the other hand, students do not require to write irrelevant information about patient that may not be used for diagnostic or treatment purposes.

We also recommend to use Latin terms during formulating the diagnosis and writing prescriptions.

1. IDENTIFYING DATA

1.1. Surname, name, patronymic name_____
1.2. Age _____
1.3. Sex _____
1.4. Education: primary, secondary, higher secondary, tertiary(underline)_____
1.5. Occupation _____
1.6. Appointment _____
1.7. Place of employment _____
1.8. Home address _____
1.9. Date of hospitalization _____
1.10. Who gives direction for hospitalization _____
1.11. Diagnosis: Basic Diagnosis _____
Complications _____
Diagnosis of concomittant diseases_____

2. PATIENT´S COMPLAINTS

This part includes the reason for coming to the clinic. Most often, this is described and recorded as the patient's own words in quotation marks. The patient initiates this process by describing a symptom. It depends on the you as a doctor whether to take that information and use it as a springboard for additional questioning that will help identify the root of the problem. The patient's reason for presenting to the physician is usually referred to as the **Chief Complaints**.

Ideally, you would like to hear the patient describe the problem in their own words. Open ended questions are a good way to get more details; such as: "What brings your here? How can I help you? What seems to be the problem?" These types of questions elicit responses that provide the basis of the interview. Push the patients to be as descriptive as possible. As the interview progresses, more specific or close-ended questions can be asked in order to obtain specific information needed to complete the interview. Successful interviewing requires avoiding medical terminology. Thus, we make use of a descriptive and common language that is familiar to the patients. These types of questions help patients to understand what information is needed from them.

There are several broad questions which are applicable to any complaint. These include:

1. Location. Where is it?
2. Radiation. Does it radiate?
3. Quality or Severity. What is it like?
4. Quantity or Character. How bad is it?
5. Duration. When does it start? How long does it last?
6. Frequency. How often does it come?
7. Aggravating Factors. What are the factors that make it worse?
8. Relieving Factors. What are factors that make it better?
9. Associated Symptoms.

While it is simple to focus on a single dominant complaint, patients occasionally describe more then one issue at a time. At this point, explore deeper by giving addition questions, which can help you to identify the pathology. This part comprises of the **Additional Complaints**. To clarify the unsorted bunch of complaints described by patients, it is necessary to review the body systems extensively. Generally, this step consists of a list of questions grouped according to organ system, designed to identify disease within that area. These questions often bring out information that support a certain diagnosis or helps you grade the severity of the pathology.

We hv provided an example of systems' review for different illnesses below.

The Respiratory System

Difficulty of nasal breathing, nasal discharge, nasal bleeding.

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 (rusty-red, blood streaked, pure blood and its amount)? What is its color and odor? How much sputum is produced in 24 hours (a teaspoon, tablespoon, half cup, cupful)?

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?

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 on the sides/ flanks or in the back? What is the character of pain (dull, acute, aching, cramping, excruciating). 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 is the patient's story of the presenting problem and any additional details that leads the patient to visit the doctor. This includes information about beginning and progress of disease till the time of presentation. You should ask the following questions: When you felt such pain for example or when this symptom appeared for the first time in ur life? Did you have any cases of hospitalization, if so, When and Where was it? Did you follow any treatment and what was its effect? After how much time do you usually have exacerbation or recurrence of the disease? What does the patient think the problem is and/or what is he worried it might be? Why did he present today? This is particularly relevant when a patient chooses to mention symptoms/complaints that appear to be long standing. Is there something new/different 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? Has the patient developed a new perception of its relative importance (e.g. a friend told them they should get it checked out)? Do they have a specific agenda for the patient-provider encounter?

4. THE REST OF THE HISTORY

The rest of the history includes past medical history, surgical history, medications and allergies, family history of illness, social history, perinatal and developmental history, bad habits.

The remainder of the history is obtained after completing the History of present illness. As such, the previously discussed techniques to facilitate obtain information are still applied.

Past Medical History: Start by asking the patient if they have had any medical problems. If you receive little/no response, the following questions can help uncover important past events: Have they ever received medical care? If so, what problems/issues were addressed? Was the medical care continuous (i.e. provided on a regular basis by a single person) or episodic? Have they ever undergone any procedures, X-Rays, CAT scans, MRIs or other special methods of investigation? Were they ever hospitalised? If so, for which purpose? It's quite amazing how many patients forget what would seem to be important medical events. You will all encounter such patients who report little past history during your interview yet reveals a complex series of illnesses to your questioning! These patients are generally not purposefully concealing information. They simply need to be prompted by the right questions!

Past Surgical History: Were they ever operated on, even as a child? At which age? Were there any complications? If they don't know the name of the operation, try to at least determine why it was performed. Encourage them to be as specific as possible.

Medications: Do they take any prescribed medicines? If so, what is the dose and frequency? Do they know why they are being treated? Medication

non-compliance/confusion is a major clinical issue, particularly when regimens are complex, patients are older, cognitively impaired or simply disinterested. It is important to ascertain if they are actually taking the medication as prescribed. This can provide critical information as frequently what appears to be a failure to respond to a particular therapy, is actually due to non-compliance to a prescribed regimen. Identifying these situations requires some tactics, as you would like to encourage honesty without sounding accusatory. It helps to clearly explain that without this information your ability to assess treatment efficacy and make therapeutic adjustments becomes difficult/potentially dangerous. If patients are in fact, missing doses or not taking medications altogether, ask them why this is happening. Perhaps there is an important side effect that they are experiencing, a reasonable fear that can be addressed, or a more acceptable substitute regimen which might be implemented. Don't forget to ask about over the counter or "non-traditional" medications. How much are they taking and what are they treating? Has it been effective? Are these medicines being prescribed by a practitioner? Self administered?

Allergies/Reactions: Have they experienced any adverse reactions to medications? The exact nature of the reaction should be clearly identified as it can have important clinical implications. Anaphylaxis for example, is a life threatening reaction and an absolute contraindication to re-exposure to the drug. A rash, however, does not raise the same level of concern, particularly if the agent in question is clearly the treatment of choice.

Social history: Obtain a complete social history of the patient. Ask patients their marital status. Also, inquire about employment status. If the patient is employed, inquire about the frequency of absences from work. If the patient is not employed, inquire 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.

Recording an accurate educational history is imperative. Inquire about the level of education. Ask if he or she attended special educational classes. Ask if the patient has a learning disability and if the patient has any other problem such as a hearing impairment or speech problem. These issues are very important in the psychiatric assessment, and patient’s care could be jeopardized if they are not addressed. A patient's communication problems, for example, could be due to a language disorder rather than a thought disorder and the initiation of psychiatric medications could further affect communication, not to mention legal concerns for the physician prescribing the drugs. All of these things must always be kept in mind while completing the social history.

Record the number, sex and age of the patient's children. Ask if any of the children have any medical or psychiatric problems. List the patient's bad habits, including past and current use of tobacco, alcohol and narcotics or any drugs. This is important because many patients can become dependent on prescribed

medications. Try to determine whether the patient has a history of drug abuse.

Include any military history, including length of service and rank.

Another important issue in obtaining a very thorough patient history is the patient's standard of living. This becomes a vital part of the discharge plans. Ask if the patient has a house. 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. Therefore, careful recording of housing and support is very important.

Inquire about the existence (and number) of siblings, their names and phone numbers and any church affiliations, just in case the information is needed later.

Also in the history section, record any legal problems the patient may have had in the past. This should include jail time, probation, arrests (eg, for driving while intoxicated or driving under the influence of drugs), and any other relevant information that can provide insight into the patient's problems with the law.

Patient history also should include hobbies, social activities, and friends. If the patient has any history of abuse, mental or physical, it should be recorded here. Any other relevant information that may be useful in treating the patient or helpful in aiding in aftercare should be recorded in the patient history.

Perinatal and developmental history: 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.

Family History: In particular, you are searching for heritable illnesses among first or second degree relatives. Most common, at least in America, are coronary artery disease, diabetes and certain malignancies. Patients should be as specific as possible. "Heart disease," for example, includes valvular disorders, coronary artery disease and congenital abnormalities, of which only coronary disease has genetic implications. Find out the age of onset of the illnesses, as this has prognostic importance for the patient. For example, a father who had an MI at age 70 is not a marker of genetic predisposition while one who had a similar event at age 40 certainly would be. Also ask about any unusual illnesses among relatives, perhaps revealing evidence for rare genetic conditions.

Smoking History: Have they ever smoked cigarettes? If so, how many packs per day and for how many years? If they quit, when did this occur? The packs per day multiplied by the number of years gives the pack-years, a widely accepted method for smoking quantification. Pipe, cigar and chewing tobacco use should also be noted. **Alcohol:** Do they drink alcohol? If so, how much per day and what type of drink? Encourage them to be as specific as possible. One

drink may mean a beer or a 12 oz glass of whiskey, each with different implications. If they don't drink on a daily basis, how much do they consume over a week or month? **Other Drug Use:** Any drug use, past or present, should be noted. Get in the habit of asking all your patients these questions as it can be surprisingly difficult to accurately determine who is at risk of a certain pathology strictly on the basis of appearance. Remind them that these questions are not meant to judge but rather to assist you in identifying risk factors for particular illnesses (e.g. HIV, hepatitis). In some cases, however, a patient will clearly indicate that they do not wish to discuss these issues. Respect their right to privacy and move on. Perhaps they will be more forthcoming at a later date.

Obstetric (where appropriate): Have they ever been pregnant? If so, how many times? What was the outcome of each pregnancy (e.g. full term delivery; spontaneous abortion; therapeutic abortion).

Sexual Activity: This is an uncomfortable line of questioning for many practitioners. However, it can provide important information and should be pursued. As with questions about substance abuse, your ability to determine on sight who is sexually active (and in what type of activity) is rather limited. By asking all of your patients these questions, the process will become less awkward. Do they participate in intercourse? With persons of the same or opposite sex? Are they involved in a stable relationship? Do they use condoms or other means of birth control? Married? Health of spouse? Divorced? Past sexually transmitted diseases? Do they have children? If so, are they healthy? Do they live together?

5. PHYSICAL EXAMINATION

5.1. General inspection

*The state of patient***:** satisfactory, mild, severe and extremely severe, agonal.

*Position of patient***:** active, passive, forced, bed-ridden but active.

*State of consciousness***:** clear; depressed (stupor, sopor, coma); excited (delirium and hallucinations).

*Facial expression***:** normal; excited; suffering; specific (face mitralis, facies Corvisart, face of Basedow's disease, mixedematous face, acromegalic face, face nephritis, face tuberculous).

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

*Inspection of skin and visible mucous membranes***.** During skin inspection you should pay attention to the color of the skin, presence of eruptions, scars, scratches. Color **(**pink, pale, red, cyanosis, jaundice). Moisture of the skin (moderate, excessive, dry, peeling). Elasticity (normal, reduced).

*Hair***:** 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). Lipomas. Skinfold thickness on the umbilicus level.

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

*Lymphatic nodes***:** localization, consistency, size, painful or not, adhesion to skin.

*Muscles***:** tone (normal, decreased, increased), development, pain, atrophy.

*Bones***:** deformation, pain during palpation, finger clubbing. Vertebra: spinal curvature (lordosis, kyphosis, scoliosis, gibbus).

Joints: configuration, swelling, hyperemia of the skin around joints, painful movements, range of motions about a joint.

5.2. Respiratory system

5.2.1. Inspection of the chest

Static inspection includes assessment of supraclavicular and infraclavicular fossae, position of the clavicles, direction of ribs, breadth of the ribs interspaces, description of the costal (epigastric) angle and sternal (Louis) angle, description of the scapulas. It is necessary to assess the symmetry of the chest and its sizes (anterposterior and lateral /transversal).

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

Dynamic inspection includes observation of rate, rhythm, depth and effort of breathing.

Depth of breathing (deep, shallow, moderate depth).

Rhythm of breathing: normal, pathological (Biot´s breathing, Cheyne-Stokes breathing, obsructive breathing).

Chest circumference: during normal breathing, in maximal inspiration and in maximal expiration (in cm) phases.

5.2.2. Palpation of the chest

Painful places, elasticity, tactile fremitus (normal, increased, decreased, absent (indicate localization of changes)).

5.2.3. Percussion of the lungs

*Comparative percussion***:** character of the percussion sound over the symmetric places of the chest along all topographic lines (resonant, tympanic, dull, hyperresonance).

*Topographic percussion of the lungs***:** The inferior border of the lungs s estimated from the right side along vertical lines: parasternal line, midclavicular line, anterior, midaxillary and posterior axillary lines, scapular line and paravertebral line. The inferior border of the left lung is estimated along the following vertical lines: anterior, midaxillary and posterior axillary lines, scapular line and paravertebral line.

The apex of each lung is estimated anteriorly and posteriorly.

Diaphragmic excursion is estimated along midclavicular line, midaxillary

line, scapular line.

5.2.4. Auscultation of lungs

Breath sounds: vesicular breath sounds (normal, increased, decreased), rough breathing, bronchial breath sounds, absence of sounds. You need to indicate place of auscultation of every type of breath sounds.

*Adventitious sounds***:** crackles, wheezes (high pitched, low pitched), rhonchi (small bubble, medium bubble, large bubble), pleural rubs. How cough does influence to this sounds?

*Bronchophony***.** Ask the patient to say "*чашка чая*", or we may ask patients to say "*thirty three*" several times. Auscultate several symmetrical areas over each lung.

5.3. Cardiovascular System.

5.3.1. Inspection and palpation.

*Inspection of the neck***:** We assess the neck veins, their pulsations.

*Apical impulse***:** We determine the location, diameter, amplitude and force of apical impulse. We also asses central precordial impulse, upper chest localized impulse, the epigastric pulsation if they are present or not. Chest palpation should include a search for thrills.

Pulse palpation: Usually we measure the pulse over the radial artery. The pulse has some qualities which reflect the state of the cardiovascular system, such as rate, its rhythm, character, amplitude**,** fullness and the shape of the pulse wave. Pulsation of temporal artery, popliteal artery, posterior tibial artery and dorsalis pedis artery are also determined.

5.3.2. Percussion of the heart

Detection of the borders of *relative heart dullness***:** the right border along the 4^{th} rib interspace and the 3^{d} rib interspace; the left border along the $5^{th,}$ 4^{th} and 3^{d} interspace; the superior heart border.

Detection of the borders of *absolute heart dullness***:** the right border along the 4^{th} intercostal space, the left border - 5^{th} interspace, the superior border.

The width of *vascular fascicle* is measured over the 2^{d} rib interspace.

5.3.3. Heart auscultation

*Characteristics of the heart sounds***:** (normal, diminished, accentuated). You need to indicate: changes of both or one heart sounds loudness and place of these changes during auscultation; appearance of the third and forth heart sounds, place of auscultation; split of the heart sounds, opening snap, clicks (localization); gallop rhythm (atrial gallop, early diastolic gallop, summation gallop) as well as changes of the rhythm (tachycardia, bradycardia, arrhythmia, extrasystole).

Murmurs: systolic murmur, diastolic murmur (early diastolic murmur, middiastolic murmur, late diastolic (presystolic)). Character of murmurs (rumbling, blowing, machinery, scratchy, harsh, or musical). Grade of the

murmur (from 1 till 6). Location and radiation of the murmurs. Changes in loudness of the murmurs after physical exercises, during inspiration and expiration, change of intensity of murmurs with positional maneuvers.

Extracardial murmurs (pericardial friction rub).

Measurement of *blood pressure* over both upper extremities.

5.4. The Gastrointestinal Tract

5.4.1. Examination of the mouth

The lips: color **(**brownish-red, red, pale, cyanotic), dryness, fissures. *The teeth***:** number and condition. *The gums***:** color, bleeding, lines at the margin of the gum. *The tongue***:** moist or dry, color, presence of filiform papillae or atrophy of the papillae, furring, ulcers.

5.4.2. Inspection of the abdomen

Form: (normal configuration, enlargement, distension). ***Scars:*** location and type helps identify previous surgery. *Striaes***:** color, localization. *Umbilicus***:** (eversion, inversion). *Distended collateral veins. Hernias***:** (umbilical, incisional, linea alba hernia). *Abdominal circumference* on the umbilical level in cm. *Pulsation*: epigastric. *Visible peristalsis*: (exaggerated, prominent, absent).

5.4.3. Percussion and auscultation of the abdomen.

*Abdominal Auscultation***:** Are bowel sounds present? If present, are they frequent or scarse(i.e. quantity)? What is the nature of the sounds (i.e. quality)?

*Percussion***: (**Tympanic, dull sounds), location.

5.4.4. Palpation of the abdomen

*Superficial palpation***:** tenderness of some areas, resistance of the anterior abdomen wall (localized or generalized). Swelling of the abdominal wall. Detection of hernias**,** of widening of inguinal and femoral rings.

Deep palpation: Define the characteristics (size, shape, location, contours and mobility) of the different parts of intestine upon palpation. Palpation is done in an orderly manner: starting from the sigmoid colon, caecum, colon transversum, colon ascending, colon descending, curvature of stomach and the pylorus.

5.4.5. Stool and its characteristics

5.4.6 Examination of the liver and gallbladder

*Percussion of the liver***.** Detection of the superior border of the liver along the vertical lines (parasternal, midclavicular, anterior axillary line). Detection of the inferior border of the liver along the vertical lines (midsternal, parasternal, midclavicular, anterior axillary line). Size of the liver on right midclavicular, midsternal lines and on the left costal arch in cm.

*Palpation of the liver***:** localization, shape, consistency, tenderness of the lower liver margin.

5.4.7. Examination of the spleen

Percussion of the spleen: Detection of the spleen borders (length along X

rib and diameter).

*Palpation of the spleen***:** localization, shape, consistency, tenderness over the splenic area.

5.5. The Urinary System

Inspection of the lumbar region (color of the skin, swelling, hyperemia, pain during palpation). Palpation of the kidneys. First percussion (painful or not). Percussion and palpation of the urinary bladder. Characteristics of urination (frequency, color of the urine, painful or not).

5.6. The Endocrine System

Inspection and palpation. Cachexia, obesity, gigantism, nanism, pigmentation of the skin, acromegaly. Exophthalmos, myxoedematous face, enlargement of the tongue. Inspection of the neck and palpation of the thyroid gland. Tremor of the fingers, tongue. Graefe´s sign, Kocher´s sign, Mobius´ sign, Stellwag´s sign.

5.7. Nervous System

The mood (good, depressed). The ability of patient to orient in time, place and description of his personality. Dermographism (red, white, steady, unsteady). Paresis, paralysis.

6. DATA OF LABORATORY AND INSTRUMENTAL INVESTIGATIONS

Blood test, urine analysis, sputum analysis, ECG, X-rays examination and other tests.

7. DIAGNOSIS AND ITS SUBSTANTIATION

You need to formulate main diagnosis and make the substantiation of diagnosis. The diagnosis is usually based on the patient´s complains (list complaints which confirm the diagnosis), anamnesis of the present illness, anamnesis of life (list fact, which may influence on the diseases), physical examination (list changes, which confirm diagnosis) and data of laboratory and instrumental investigations (list data, which confirm diagnosis).

8. DIARY

It is short description of complaints, data of objective investigation of the patient at the given moment of examination. Usually dairy is written by doctor everyday, if it is necessary - 2 or 3 time per day. It is important for the student to write 2 dairies in his case report. Student’s report should reflect the changes of the patient´s state of the health during treatment.

Title-page should be draw up according to the example:

GRODNO STATE MEDICAL UNIVERSITY
Department of propaedeutics of internal diseases
The chief of the department: prof. M.A. Lis
The lecturer: MD, Phd T.P. Pronko

CASE REPORT
Of the patient Surname, Name, Patronymic name
Student: of 3 year, group, faculty
Name, Surname
Date of examination of the patient

Учебное издание

Лис Михаил Александрович
Пронько Татьяна Павловна

СХЕМА ОБСЛЕДОВАНИЯ БОЛЬНОГО В КЛИНИКЕ ПРОПЕДЕВТИКИ ВНУТРЕННИХ БОЛЕЗНЕЙ

Методические рекомендации
для студентов III курса отделения иностранных студентов
с преподаванием на английском языке
(на английском языке)

SCHEME OF PHYSICAL EXAMINATION OF A PATIENT IN CLINIC OF PROPAEDEUTIC OF INTERNAL DISEASES

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

Ответственный за выпуск И.Г. Жук

Компьютерная верстка: И.И. Прецкайло

Сдано в набор 19.04.2007. Подписано в печать 25.04.2007.
Формат 60x84/16. Бумага офсетная.
Гарнитура Таймс. Печать RISO.
Усл. печ. л. 0,93. Уч.-изд. л. 0,89. Тираж 60 экз. Заказ 32 п.

Учреждение образования
«Гродненский государственный медицинский университет».
ЛИ № 02330/0133347 от 29.06.2004. Ул. Горького, 80, 230009, Гродно.

Отпечатано на ризографе в издательском отделе
учреждения образования
«Гродненский государственный медицинский университет».
Ул. Горького, 80, 230009, Гродно.