Volgograd State Medical University

**Hospital Therapy Department**

***Internal Diseases***

# Sample case history

**(for fifth year students of general medicine department within the English-speaking medium)**

**General information about the patient**

(Last name, first name, age, nationality, profession, marital status, place of work, address).

**Patient’s complaints on admission to the hospital**

Patient’s complaints on admission to the hospital; clinical manifestations. Asking the patient questions about various organ systems.

**Medical history**

General information about the onset of disease (time, duration), association with any aetiological factors (occupational, social factors, etc.), development of disease, treatment (before admission to the hospital).

**Life history**

а) Time and place of birth. Patient’s living conditions in childhood, adolescence. Labour activity.

b) Family history: state of health or causes of death of the father, mother, sisters, brothers, etc.

c) Sexual and family life: Periods: FMP (first menstrual period), its character, LMP (last menstrual period); number of pregnancies, deliveries, miscarriages and their causes. Children, state of their health, diseases they suffered or causes of their death.

d) Social history: Living conditions, relationships in the family. Place of work, occupational hazards. Drug or alcohol abuse. Smoking habits.

e) Past medical history: Diseases which the patient suffered throughout the life: Which diseases has the patient suffered in his life and at what age? Surgical history: Has the patient ever had any surgeries or blood transfusions?

f) Allergies: Has the patient ever suffered any allergic reactions? If yes, which allergic reactions? Clinical manifestations. Aetiology of allergic reactions.

**Patient’s general condition**

1) Patient’s general condition.

Anthropometric indicators: body height, body weight, circumference of the chest, patient’s general condition, correspondence of the patient’s appearance and body height to his biological age. Nutritional status. Body temperature. State of the skin, mucous membranes, subcutaneus fat, muscles, bones, joints, lymph nodes.

2) Physical examination.

**Review of systems**

**RS** (respiratory system): Examination, palpation, comparative percussion of the chest. Determining posterior borders of the lungs and their mobility. Revealing any respiratory murmurs, dry râles. Determining their localization.

**CVS** (cardiovascular system): Examination, palpation of the heart area. Determining the place, character, power, and area of the apical thrust (beat). Percussion and auscultation of the heart. Determining the size of the heart. Examination, palpation of the vessels of the arms and legs. Feeling the pulse. Determining its filling, difference on the right and left arm, deficit, rhythm. Taking blood pressure.

**GIS** (gastrointestinal system): Determining the condition of the patient’s teeth, tongue, oral mucosa and tonsils. Examination of the abdomen in the vertical and horizontal position of the patient. Determining the shape of the abdomen, the extent of asymmetry, protrusion, distension (swelling), peristalsis.

*Abdomen*. Superficial and profound palpation of the abdomen. Determining the extent of muscle tension. Revealing painful sites, indurations and nodes. Examination of the the surface and determining the size of the abdominal muscles. Revealing any peritoneal symptoms.

*Liver.* Percussion of the liver. Determining the upper and lower borders and the size of the liver (cm). Palpation of the margin and the surface of the liver. Determining the type of the surface, its density, tenderness, nodes. Palpation of the gall-bladder.

*Spleen*. Percussion of the spleen. Determining the borders and the size of the spleen. Palpation of the margin and the surface of the spleen. Determining the type of the surface, its density, tenderness.

**GUS** (genito-urinary system):

*Kidneys.* Lumber region examination results: asymmetry, any protrusions. Palpation of the kidneys. Determining their density, mobility, nodes, tenderness. Percussion of the lumber region and revealing any tenderness, edemas.

**ES** (endocrine system): Examination of the thyroid gland. Determining its size, density, tenderness. Palpation of the thyroid gland. Revealing the manifestations of hypothyroidism or hyperthyroidism.

*Sexual glands:* Examination of the sexual organs and secondary sexual characteristics.

*Pancreas:* Palpation of the pancreas. Determining its density, tenderness. Revealing any signs of diabetes mellitus.

**Laboratory studies**

Blood, urine, etc. analyses.

**Instrumental examination**

Electrocardiography, X-ray studies, echocardiography, etc.

**DIAGNOSIS**

**Substantiation of the diagnosis**

**Treatment**

The doctor should administer an adequate regimen, diet, medicines, other treatment. Prescriptions are usually recorded in the treatment sheet.

**Diary**

Patient’s complaints, changes after the treatment, patient’s general condition as well as his well-being, body temperature, pulse, respiration, and blood pressure changes should be recorded in the diary for 5 days.

### Epicrisis

Analysis of the course of the disease and follow-up of the patient should be recorded in epicrisis. The patient’s medical history, laboratory and instrumental test results, peculiarities of the course and treatment of the disease should also be recorded (without coming into details). The patient’s condition by the end of the treatment should also be considered.

### Prognosis and recommendations

Prognosis concerning *life, recovery,* and *work capability.* Occupational and social recommendations should be given. If out-patient treatment is required, it is necessary to give recommendations for different types of treatment, including pharmacologic treatment, physiotherapy, dietotherapy, sanatorium-and-spa treatment, etc.