Scheme
Academic medical history

I. TITLE SHEET

II. PASSPORT DATA

1. Surname, first name, patronymic of the patient.
2. Age.
3. Address.
4. Occupation.
5. Date of admission to the clinic.
6. Dates of curation. Complaints

III. COMPLAINTS

This section includes the patient's complaints related to the underlying disease for which the patient is admitted to the surgical clinic. Complaints should be characterised in detail and presented in a logical sequence. When talking to the patient, it is necessary to actively identify those complaints that may be present in this disease, but the patient for some reason did not mention them. At the same time, it would be unnecessary to list all the complaints of the patient, since some of them are related to comorbidities. The latter should be listed in the appropriate section of the medical history (respiratory system, circulatory system, etc.).

If complaints have changed during the patient's stay in the clinic (up to the time of the start of treatment), it is necessary to allocate two subsections: "complaints on admission" and "complaints at the time of treatment".

IV. HISTORY OF PRESENT ILLNESS

This section should describe in detail the onset, course and development of the present illness from its first manifestations to the time of the curator's examination of the patient. It should seek to identify those facts that may have played a role in the aetiology and pathogenesis of the disease, as well as to show the dynamics of clinical symptoms, the emergence of complications, the effectiveness of treatment, etc. In addition, it is necessary to actively identify those symptoms that went unnoticed by the patient or he/she was not aware of them.

In addition, it is necessary to actively identify those symptoms that have gone unnoticed by the patient or he himself considers them unimportant.

Thus, this section of the case history should not be a simple record of the patient's account of his or her illness. All information obtained from the patient should be critically appraised and presented in the light of a proper understanding of the mechanism of the disease.

V. PATIENT'S LIFE HISTORY

This section includes brief biographical information in chronological order from the patient's birth to admission to the clinic: place of residence and family of birth, early childhood development, schooling, beginning of independent working life and further work history.

Menstruation, marriage (marriage), pregnancies, childbirth, abortions.

Abuse of alcohol, tobacco, drugs.

Past illnesses.

Working and living conditions:

1) working conditions, occupation characteristics, occupational hazards;
2) housing conditions;
3) Nutrition: qualitative and quantitative characteristics of the diet, its regularity.
   nutrition, its regularity.

Heredity: presence in the family of syphilis, mental diseases, metabolic diseases, haemophilia, tuberculosis, malignant neoplasms, alcoholism, etc.

VI. PRESENT CONDITION OF THE PATIENT

General condition of the patient: satisfactory, moderately severe, severe. Body temperature.
Position of the patient: active, passive, forced.

Body build: constitution, height, weight.
Skin and mucous membranes: colour (normal, pale, jaundiced, "earthy", blue), pigmentation, depigmentation, scars, scabs, haemorrhages, rashes, vascular "stars", elasticity, moisture.
Subcutaneous fat fibre: its development (moderate, weak, excessive), places of greatest fat deposition. Presence of pastosity and edema, their localisation and prevalence.
Lymph nodes: palpation of submandibular, cervical, supra- and subclavian, ulnar, axillary and inguinal lymph nodes. At enlargement - determination of size, consistency, painfulness, mobility, their fusion with each other and with the skin.
Muscles: the degree of their development (moderate, weak, good).
Joints: changes in their configuration, pain and crunch when moving, the volume of active and passive movements.
Bones: deformations, painfulness when feeling. Thickening of the terminal phalanges of fingers and toes in the form of "drumsticks".
Examination and palpation of the thyroid gland, mammary glands.
In case of thyroid and mammary gland diseases - these organs are described in detail in a special section - "LOCAL STATUS".

VII. RESPIRATORY SYSTEM

Complaints

1. Chest pain: intensity, character, irradiation, relationship to breathing.
2. Dyspnoea: nature, time of onset, duration, choking attacks.
3. Cough: time of occurrence, strength, duration, character (dry, with sputum).
4. Sputum: time of its appearance, quantity, colour, odour, blood. Dependence of sputum separation on the position of the patient.
5. Nasal and pulmonary haemorrhages: frequency of appearance, duration.

Inspection

Breathing: through nose, mouth, free, difficult.
Voice: hoarseness, aphonia.
Chest: shape, symmetry, deformation, participation in breathing,
circumference. Respiratory excursion of the chest.
Dilation of the superficial venous collaterals of the chest wall.
Breathing: type, depth, rhythm. Number of breaths per 1 minute.

Palpation

Identification of painful areas. Determination of chest resistance. Determination of vocal tremor.

Percussion

1. Topographic percussion: a) determination of the upper border of the lungs: height of the apexes above the clavicles (in centimetres); from behind - in relation to the spinous process of the VIIth cervical vertebra. Percussion of Krenig's fields and their measurement; b) determination of the lower border of the lungs along the lines: median clavicular, anterior axillary, posterior axillary, scapular, periapsovertebral. On the left side, the study is carried out starting from the anterior axillary line. The mobility of the lower edge of the lungs is determined along the median and posterior axillary lines on both sides of the chest.
2. Comparative percussion. Character of percussion sound: normal pulmonary, tympanic, blunt, boxy.

Auscultation

Respiratory pattern: vesicular, bronchial, amphoric, etc.
Rales: dry, moist (small, medium, large bubbles).
Crepitation. Noise of friction of the pleura.
Study of bronchophony in symmetrical areas of the chest.

Functional tests

Breath-holding test: Stange and Saabraze

VIII. CARDIOVASCULAR SYSTEM

Complaints

1. Dyspnoea, its nature, time of onset.
2. Heart palpitations, sensation of interruptions.
3. Pain in the area of the heart and behind the sternum, its nature, duration, irradiation.

Inspection

Examination of the neck: identification of the condition of arteries and veins, their abnormal pulsation.

Examination of the heart area: identification of cardiac "hump" and abnormal pulsation in the heart area; apical tremor and its properties, cardiac tremor, its location and character.

Palpation

Palpation of apical and cardiac tremor, their characterisation. Determination of systolic and diastolic tremor.

Percussion

Determination of the right, left and upper limits of relative cardiac bluntness in centimetres.

Determination of the right and left borders of the absolute cardiac bluntness. Configuration of the heart. Vascular bundle cross-sectional dimensions.

Auscultation

Heart tones: loud, muffled, deaf.
Detailed characterisation of heart tones:
1) at the apex of the heart;
2) on the aorta;
3) on the pulmonary artery;
4) on the tricuspid valve;
5) on Botkin's point.
Rhythm disturbance: tachycardia, bradycardia, extrasystole, atrial fibrillation, etc.

Noises and their characterisation. The best place to listen to noises and their conductivity. Change in the character and strength of the noise depending on the position of the patient and physical activity. Noise of pericardial friction.

A study of the blood vessels. Properties of the pulse.

Condition of the vascular wall of peripheral arteries: elasticity, tortuosity, visible pulsation.

Properties of the pulse of radial arteries: synchronisation, frequency, rhythm, tension, filling. Deficiency of the pulse.

Study of the pulse on the carotid, femoral, hamstring arteries, arteries of the feet. Arterial pressure.

Study of veins of the lower extremities.

In patients with vascular diseases of the extremities - a detailed description of the affected limb is placed in a special section - "LOCAL STATUS".

IX. DIGESTIVE SYSTEM

Complaints

1. A feeling of bitterness in the mouth, breath odour.
2. Appetite (bad, perverse, aversion to food).
3. Swallowing (difficult, painful).
4. Abdominal pain: localisation, character, irradiation, dependence on food intake, duration, connection with the act of breathing, physical activity, means contributing to their relief.
5. Bloating of the abdomen.
6. Dyspeptic phenomena: nausea, heartburn, belching. Vomiting, the time of its appearance, the nature of vomit masses (bile, fresh blood, liquid of the colour of "coffee grounds", the presence in the vomit masses of remnants of food eaten the day before).
7. Stool: diarrhoea, constipation, stool and gas.
8. Nature of faeces: "tarry faeces, with an admixture of blood and mucus, discharge of blood not mixed with faeces, shape of faeces ("ribbon-shaped", "sheep" faeces).

Oral examination

Tongue: colour, moisture, presence of plaque, glossitis, cracks, ulcers.

Dental condition: staggering, carious changes, dentures, etc.

Gums: colour, looseness, ulceration, necrosis.

Condition of soft and hard palate: colouring, plaque, etc. Palatine tonsils.

Abdominal examination

Abdominal shape, size, respiratory involvement, asymmetry, development of venous collaterals, visible gastric and intestinal peristalsis.

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

Determination of localised pain in the abdomen using the "coughing jerk" symptom.

Palpation

Superficial tentative palpation: determination of painfulness, abdominal muscle tension (diffuse and limited), detection of hernias and divergence of rectus abdominis (if the patient's main disease is anterior wall hernia, it is described in a special section - "LOCAL STATUS").

Deep palpation: characteristics of different parts of the large intestine (location, painfulness, mobility, consistency, etc.); if there is a tumour-like mass in the abdominal cavity, a detailed description of it is required (localisation, size, surface character, consistency, painfulness, displacement, etc.).

In acute surgical diseases of abdominal cavity organs, deep palpation starts from the area of the abdomen where pain is less pronounced. The area of localisation of the greatest painfulness is investigated in the last turn, the presence and degree of expression of the Shchetkin-Blumberg symptom, its localisation and prevalence are determined. Symptom of Rovsing, Sitkovsky, Obraztsov, Voskresensky (in acute appendicitis), Meyo-Robson and Voskresensky (in acute pancreatitis) and others are investigated.

Auscultation

The character of peristalsis is determined (amplified, sluggish, ringing, resonating).

Percussion

Percussion reveals the presence of free gas in the abdominal cavity (disappearance of hepatic bluntness), the zone of high tympanitis (Wahl's symptom), the presence of free fluid.

Sucussion

Definition of "splashing noise" (in the stomach, intestines).

Liver and gallbladder

Examination: presence of limited and diffuse bulging, pulsation,

Percussion: definition of borders according to Kurlov - upper border - on the right median clavicular line, median line and on the left rib arch.

Palpation: edge of the liver (shape, consistency), surface (smooth, lumpy, granular). Measurement of the liver according to Kurlov: along the median clavicular line, median line, along the left rib arch.

Palpation of the gallbladder area: in case of its enlargement, determination of size, consistency, painfulness.

Investigation of Ortner's symptom and phrenicus-symptom.

Spleen

Examination: presence of diffuse or limited bulging.

Percussion: measurement of transverse and longitudinal dimensions.

Palpation: spleen margin (thin, rounded), surface (smooth, bumpy).

X. URINARY SYSTEM

Complaints

1. Dysuria (frequent, painful urination, involuntary urination, urinary retention, etc.).
2. Pain in the lumbar region.
3. Changes in the colour of the urine.

Examination of the kidney area

Swelling, redness.

Palpation

Renal prolapse, enlargement, painfulness. Pasternacki's symptom.

XI. NEUROPSYCHIC SPHERE

Complaints

1. Headaches, dizziness, noise in the head.
2. Disturbances in the motor and sensory sphere.

Neurological examination

Consciousness (clear, confused).

Mood (calm, depressed, anxious, euphoric, etc.).

Response of pupils to light. Symptoms of lesions of cranial nerves

Paralysis, paresis.

The nature of dermographism.

Mental disorders (delirium, hallucination).

The state of vision and hearing.

XII. LOCAL STATUS

Local status is described in the following nosological forms studied in the course of faculty surgery: external abdominal hernia, thyroid and mammary gland diseases; acute and chronic vascular diseases of the extremities, haemorrhoids.

It is necessary to consistently and in detail describe the data of examination, auscultation, percussion and palpation, as well as the results of special tests used in the diagnosis of this disease (the symptom of "coughing jerk" in hernia, marching test and Troyanov-Trendelenburg test in varicose veins of the lower extremities, symptoms of "plantar ischaemia" and "white spot" in obliterating arterial diseases, eye symptoms in thyrotoxic goiter, etc.).

XIII. VAGINAL AND RECTAL EXAMINATION

They are carried out obligatory in patients with diseases of abdominal cavity organs, external abdominal hernias, and rectal diseases.

Vaginal examination

Shape and size of the cervix, pain when it is displaced. Palpation of the vaults (bulging, painfulness). Palpation of appendages and uterine body (bimanual examination). Discharge from the genital tract.

Rectal examination

Sphincter tone (normal, increased, sphincter paresis).

Prostate gland (size, surface, painfulness).

Palpation of the walls of the rectum (tumour-like formations, overhang and painfulness of the anterior wall).

Examination of stool traces on the glove (fresh blood, mucus, "tarry" stool, discoloured stool).

XIV. PRELIMINARY DIAGNOSIS

A preliminary diagnosis is formulated, which can be made on the basis of complaints, anamnesis, the above-described objective examination data. After that, the plan of examination of the patient is determined (necessary laboratory and instrumental tests that will allow to make a final full clinical diagnosis).

XV. RESULTS OF LABORATORY AND SPECIAL RESEARCH METHODS

This section includes data from blood, urine, gastric juice, faeces, duodenal probing, cholography, X-ray examination of the gastrointestinal tract, etc. The date when the examination was performed should be indicated. The date on which a particular test was performed should be indicated.

XVI. DIFFERENTIAL DIAGNOSIS

The differential diagnosis should be based on the main clinical manifestations of the disease observed in the patient under observation, followed by a list of nosological forms that have a similar clinical picture. Then, as a result of consistent comparison and comparison of clinical symptoms, those differential-diagnostic signs are identified that allow to exclude each of the above-mentioned diseases in the supervised patient.

Simple enumeration of differential diagnostic features described in the literature should be avoided. The differential diagnosis should be based only on the clinical picture of the disease that is present in the supervised patient.

XVII. JUSTIFICATION OF DIAGNOSIS

To substantiate the diagnosis, complaints, anamnesis data, objective examination, as well as the results of laboratory and special diagnostic methods should be consistently used. This section should not consist of a simple listing of symptoms characteristic of the disease, but should reflect the course of clinical thinking over the patient. If any of the symptoms found in the patient do not fit into the classical picture of the disease, it should not be silenced; rather, an attempt should be made to explain its origin. Not only the diagnosis of the disease, but also the stage of the process and the complications present should be consistently and clearly justified.

In conclusion, a full clinical diagnosis is formulated, followed by a list of concomitant diseases (without special justification), the ICD code of the main and concomitant diseases, which are also placed on the title page of the case history

XVIII. AETIOLOGY AND PATHOGENESIS

In this section, the main theoretical positions regarding the aetiology and pathogenesis of this disease and its complications are carried out.

The focus should be on modern theories. Finally, using data from the case history, the facts that may have caused the disease in the patient under review should be emphasised.

XIX. TREATMENT

This section should highlight the current principles of treatment of this disease. It is necessary to clearly distinguish conservative and surgical methods of treatment, as well as specifically list the indications and contraindications for each of them.

Describing the surgical method of treatment, it is necessary to dwell on preoperative preparation, surgical techniques (radical and palliative), management of the postoperative period, immediate and distant complications.

In conclusion, based on the above data, it is necessary to determine the therapeutic tactics in relation to the supervised patient and describe the complex of therapeutic measures, which is indicated in this particular case.

XX. PATIENT DIARY

During the period of treatment until the patient's medical history is handed over to the teacher, the supervisor should daily record data about the patient, reflecting in the diary the dynamics of the course of the disease, the effectiveness of treatment, etc.

The records should be made according to the scheme below:

Pulse..... Temperature: Morning..... Evening.....	Observation diary of the patient:	Assignments: 1.Mode 2.Table 3.Therapeutic appointment 4. Analyses

If the patient underwent an operation during the period of observation, the text of the latter, taken from the clinical history, is entered after the diary for the corresponding date.

XXI. EPICRISE.

Epicrisis is a summary of the medical history, which should reflect: complaints, anamnesis, data of objective and special methods of research, final diagnosis, treatment, its effectiveness, the patient's condition at the end of the treatment.

In conclusion, the prognosis of the main disease, the prognosis of life and working capacity of the patient is determined

XXII. LITERATURE

List the titles of monographs, manuals, journal articles used by the curator in writing the case history, with the author's surname and year of publication.