PATIENT HISTORY

&

PHYSICAL EXAMINATION
Making a diagnosis

1. **Anamnesis** = history taking
2. **Physical examination** – inspection, palpation, percussion, auscultation, vital signs, weight, height
3. **Working diagnosis** - preliminary dg., diff. dg. considerations
4. **Further diagnostic examinations** – lab, endoscopy, X-ray, EKG etc.
5. **Final diagnosis**
6. **Therapy**
Making a diagnosis

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Patient history

• Generally
  – Summary of all data regarding the patient’s health from birth to present.
  – Direct vs. indirect

• Rules:
  1. Create an atmosphere of confidence and trust
     a) Privacy
     b) Comfortable environment
     c) Eliminate haste/stress
  2. Ask open questions
  3. Let the patient choose his/her own words
Patient history

1. **Personal data**
   - name, address, date of birth, referring physician, next of kin

2. **Chief complaint**

3. **Social status**
   - occupation, family, daily function, ...

4. **Medical history**
   a) Family illnesses – parents, siblings, children
   b) Prior illnesses – in chronologic order. Duration, treatment, complications
   c) Present illnesses – onset, symptoms, course of symptoms, present status

5. **Review of systems**
   - Skin, head, eyes, ears, nose, mouth, throat, respiratory tract, cardiovascular + lymphatics, GIT, urinary tract, genitalia, locomotor, nervous, psychological state, endocrine, allergies
   - Natural functions: voiding, defecation, eating habits/weight changes, sleep

6. **Stimulantia**
   - Tobacco, alcohol, drug abuse etc.

7. **Medication**
   - All drugs, strength, doses, duration
Physical examination

• **Basic methods**
  
  A. **Inspection**
     - Pigmentation, asymmetry, oedemas, scars
     - Lesions, erythemas, hematomas etc
  
  B. **Palpation**
     - Skin, muscle tonus, temperature, moisture
     - Superficial vs. deep
     - Pain, masses
  
  C. **Percussion**
     - Indirect percussion – “finger on finger”
     - Superficial vs. deep
     - Quality of sound: resonance, hyperresonance, tympanity, flatness, dullness
     - Borders
  
  D. **Auscultation**
     - Indirect – stethoscope with membrane and bell
     - Heart, lungs, intestines, vessels
  
  E. **Smell**
     - Hygiene, ketoacidosis, alcohol, bad breath, foetor hepaticus
Physical examination

• General examination (general impression)
  – Mental state, voice, speech, nutrition, posture, walk

• Skin
  – Pigmentations, rashes, moisture, elasticity
  – Scars, hematomas, hemorrhages, erythemas

• Head
  – Direct percussion of skull
  – CN V exit points – tenderness?
  – CN VII – make grimaces
  – CN XII – protrude tongue
  – Eyes: conjunctiva, pupils round and equal (CN III) – anisocoria?, symmetric accommodation reflex and reaction to light, movements, eyelids
  – Mouth: teeth (prostheses), moist and clean mucosa and tongue, central cyanosis

• Neck
  – Stiffness
  – Venous congestion
  – Palpable gl. thyreoidea
  – Carotid stenosis
  – Lymph nodes
Physical examination

• Thora
  – Normal shape and movements, breathing
  – Breasts
    • description in women >40 years
    • Tenderness, masses, skin changes
    • symmetry of areolae, discharge
  – Axilla
    • Lymph nodes
  – Heart
    • Normal heart sounds, clean tones, no murmurs, respiratory arrhythmia
  – Lungs
    • Breathing sounds (stridor?) and frequency, resonant percussion, borders
    • Auscultation sounds - alveolar vs. tubal breathing, wet or dry sounds, friction murmur

• Spine
  – Pain, stiffness, asymmetry – lordoses/kyphoses/scolioses
  – Ex. Schober’s distance test, Stibor’s distance test
Physical examination

• Abdomen
  – Symmetry: any signs of enlargements or masses? Hernia?
  – Dilated veins – caput medusae
  – Palpation: texture, tenderness/pain?, palpable spleen or liver? – borders, palpable masses or possible tumors?
    • Appendicitis: Rowsing’s sign – palpation of LEFT hypogastrium
      • Plenie’s symptom – percussion tenderness of right hypogastrium
  – Percussion: borders of liver/spleen, tympanites?, ascites?
  – Direct percussion of flanks – kidney tenderness?
  – Auscultation: intestinal sounds
  – Urinary bladder
Physical examination

• **Ext. genitalia**
  – tumors, rash, discharge, pain
  – Testes

• **Rectal exploration**
  – normal tonus of sphincter, tumors
  – Prostata: size (walnut), shape, consistency
  – Brown faeces on glove
Physical examination

• Upper extremities
  – Radial pulse
  – Raynaud’s phenomenon (SLE)
  – Finger clubbing

• Lower extremities
  – Pulse of a. dorsalis pedis and a. tibialis posterior
  – Ischemia – diabetic microangiopathy
  – Edema, varicose veins
  – Lymphedema - elephantiasis
Physical examination

• BASIC NEUROLOGICAL EXAMINATION

A. Cranial nerves
   • N. olfactorius: rarely examined, smell
   • N. opticus: normal visual fields, read letters on table, ophtalmoscopy
   • N. oculomotorius: round pupils, reaction to light and accommodation
   • N. trochlearis: no ptosis, paresis, deviation, nystagmus
   • N. abducens: no pareses, double vision, movements (follow the finger), normal saccadic movements
   • N. trigeminus: normal sensibility for pain and touch in all three branches
   • N. facialis: Asymmetry of face, normal force of muscles of forehead, eyes, nose, mouth. Sentral vs. peripheral paresis
   • N. vestibulocochlearis: Normal hearing, conduction through air better than through bone
   • N. glossopharyngeus & vagus: normal voice, swallowing, elevation of uvula and soft palate
   • N. accessorius: turn head and lift shoulders symmetrically against resistance
   • N. hypoglossus: no deviations upon protrusion of tongue, normal speech
Physical examination

B. Mobility
   • Bradykinesia, dyskinesia, akinesia, tremors
   • Rigidity, spasticity, hypotonicity

C. Force
   • Muscle force over joints: shoulders, elbows, fist, hip, knee, ankle
   • Tempo and fine motor skills

D. Coordination

E. Reflexes
   • Each side
   • Biceps, triceps, radial
   • Patellar, achilles, plantar

F. Sensibility
   • Normal sensibility for pain, touch and temperature

G. Balance and walking
   • Normal walk, stand on heels and toes, rise up from crouching position