بسم الله الرحمن الرحيم
HISTORY TAKING AND CLINICAL EXAMINATION
GENERAL SCHEME OF NOTE.TAKING

- The general scheme serves as a basis for the special schemes dealing with particular types of surgical cases.
1- HISTORY

1. **Personal history**: Name ; age ; sex ; race ; nationality ; religion ; occupation; marital state ; residence and postal address ; special habits.

2. **Chief complaint and its duration**

3. **History of present illness** (H.P.I.) : Exact date and mode of onset ; course and chronological sequence of symptoms ; other symptoms referable to the various body systems.
4. **Past history**: Previous similar illness, Acute, chronic and endemic infections; trauma; previous medications or operations.

5. **Family history**: Similar complaints in the family; hereditary and familial diseases and predispositions; health and mode of death of close relatives.
II-GENERAL EXAMINATION

1. **General condition**: Mental state (level of consciousness); type and degree of any distress; posture; facies; build and nutrition; skin, hair and nails; mucous membranes (conjunctivae, lips and tongue).

2. **Vital signs**: Temperature; pulse; blood pressure; respiration.

3. **Systematic examination**: Head and neck; heart chest; abdomen; perineum; trunk; limbs; nervous system; urine.
III. LOCAL EXAMINATION
1. Inspection. 2. Palpation. 3. Percussion.
4. Auscultation. 5. Special tests.

IV. SPECIAL INVESTIGATIONS
1. Endoscopy.
2. Radiography.
3. Laboratory tests.
4. Biopsy.
5. Therapeutic tests.
6. Repeated observation.
7. Operative exploration. 8. Post-mortem examination
V. DIAGNOSIS
1. Provisional diagnosis.
2. Differential diagnosis.
3. Final diagnosis

VI. MANAGEMENT
1. Treatment :
   a) Conservative : General ; local.
   b) Operative : *Pre-operative preparation .
      *operative procedure .
      *post-operative treatment.

2. Progress : General ; local.
3. Results

a) Condition on discharge: cured; improved; status quo; deteriorated.

b) Death: cause of death and result of postmortem examination.

4. Follow-up: General; local.
1. Name:

Apart from its necessity for *identification*, the name may indicate the *religion* and thus save a rather disagreeable inquiry.

Calling the patient by his name helps to create a *friendly relation* with him and thus paves the way for gaining his confidence and *cooperation*. 
2. **Age:**

Certain diseases show a special predilection for special age groups.

- **At birth**: congenital anomalies, e.g. meningocele, hare-lip and cleft palate.
- **Infancy** (0-2 years): intussusception, cystic hygroma and Wilms' tumour of the kidney.
- **Childhood** (2-12 years): osteomyelitis, tuberculosis, rickets and sarcoma.
- **Adolescence** (12-20 years): scoliosis, appendicitis and osteoclastoma.
- **Young adult life** (20-40 years): thyrotoxicosis, peptic ulcer and sarcoma.
• **Middle age** (40-60 years) : chronic cholecystitis and carcinoma.
• **Old age** (over 60 years) : carcinoma, atherosclerosis and oesteoarthritis.

3. **Sex:**
   Apart from diseases of the sex organs, certain diseases tend to affect one sex more often than the other, e.g. tumours of the alimentary tract are much commoner in males than females whereas chronic cholecystitis and movable kidney have a much higher incidence in females.

4. **Race, religion and nationality :**
   The incidence of a disease may be related to race, religion or nationality. *Crohn's disease* and *non-specific ulcerative colitis* are common in Europeans and Americans but very rare in Arab.
5. Occupation:

- Some diseases are closely related to certain occupations, e.g. bilharziasis in Egyptian farmers, ruptured semilunar cartilage in footballers, prepatellar bursitis in housemaids and hydatid disease in shepherds.
- Occupational cancers and precancerous states are well-known problems in industrial countries.

6. Residence and postal address:

- The postal address is naturally important for correspondence but the permanent residence is of more clinical significance because certain diseases tend to have a particular geographical distribution, e.g. endemic goitre in Switzerland, hydatid disease in Australia and carcinoma of the liver in South Africa.
7 Marital state.

- It should be noted if the patient is single, married, divorced or widowed.

- Venereal disease is generally commoner among unmarried than married people.

- In females the menstrual history and the number and dates of pregnancies and miscarriages should be noted.

- Repeated miscarriages and stillbirths are suggestive of syphilitic infection.
8 - Habits:

- The habits of work, sleep, eating and recreation are inquired about smoking, alcohol and dietary indiscretions are particularly important.

- Smoking predisposes to cancer of the lip, tongue and lungs and alcohol to liver cirrhosis and pancreatitis.
9. Chief- complaint (c.c.) and its duration:

- The chief complaint is the most distressing symptom which forces the patient to seek medical advice (presenting symptom).

- Ask the patient: "What do you complain of?" and "How long have you been suffering from it?" Record the complaint in the patient's own words and not in scientific terms, e.g. pain in the loin. lump in the breast, blood in the water, etc.
10. History of present illness (H.P.I.):

- The present illness extends from the first symptom to the present moment and its duration is often longer than that of the chief complaint.

- First, ascertain when the illness really started by asking: "When were you last quite well? and this being answered: "Did you ever have this symptom before? Then allow the patient to tell his own story without interruption and record his symptoms in a chronological order of their appearance.
The history should reveal the mode of onset, the progress of the illness with evolution of symptoms and the nature and effect of, any treatment so far received by the patient.

It is often necessary to put such questions as will bring about relevant information in the history. In doing so, avoid leading questions which may suggest their own answers, e.g. "Have you had any pain in the back?" is better put thus: "Have you had any pain, and if so where?"

As the patient concludes his own story, the functional state of the various body systems should be reviewed by appropriate questions.
All questions should be as simple and clear as possible and should be put in a kindly and sympathetic manner so as to gain the full confidence and cooperation of the patient.

11. Past history (P.H.):

*All previous illnesses* should be inquired about as they may have a causal relationship with the present one. They should be recorded in chronological sequence with the dates of their occurrence and their durations. Inquire about any previous

*similar attacks*, acute and chronic infections, endemic disease.
• **injuries, medications and surgical operations.** When it is necessary to ask about *venereal disease*, it is advisable to use indirect questions, such as a history of urethral discharge or scalding pain during micturition in case of *gonorrhoea*; or a history of genital sore.

• prolonged sore throat, eruptions or repeated miscarriages and stillbirths in case of *syphilis*.

• *IDS*
12. Family history (F.H.):

- Tuberculosis, syphilis, hemophilia, a choluric jaundice, cancer and peptic ulcer are examples of diseases that may affect several members of the same family.

- A clear distinction should be made between the three terms, congenital, familial and hereditary. *Congenital* simply means present at birth; *familial* indicates affection of more than one member of the family, whereas *hereditary* means that the disease is transmitted from parents to offspring according to *Mendelian laws.*
GENERAL EXAMINATION

Every patient should be subjected to a *brief general examination* even though his complaint may suggest an entirely local condition. There are several reasons for this fundamental rule, viz:

1. A local condition may be the first sign of some general disease.
2. Conversely, a local lesion may produce distant or general manifestations such as toxemia, pyaemic abscesses and malignant metastases.
3. Some other and unrelated lesion may be discovered, possibly not yet giving rise to symptoms.

The routine general examination is conducted in 3 parts.
A. **General condition:**

The patient is first observed as a whole, noting:

1. **The mental state**: whether alert, confused, semicomatose or comatose.

2. **The type and degree of any distress.**

3. **The posture**: gait if walking, stance if standing, attitude if sitting or decubitus if lying down.

4. **The facies or facial expression**: This may indicate a pathognomonic condition such as *Graves' disease*, a *cromegaly, leprosy* or *tabes dorsalis* or may merely suggest a constitutional disturbance such as *toxemia* or *dehydration*.

5. **Build and nutrition**: The **build** is determined by the **degree of skeletal development** which may show gross deviations, such as *dwarfism* and *gigantism*, or minor variations from the normal (sthenic) type, such as the **hyposthenic** and **hypersthenic** types.

The state of **nutrition**, on the other hand, depends on the body content of **soft tissues and fluids**. **Variations from the normal include obesity, wasting, cachexia, dehydration and oedema.**
6. **Skin and nails**: Note the *colour* of the skin and the presence of rashes, pigmentations or other abnormalities. Examine the nails and hairs.

7. **Mucous membranes**: *The conjunctiva, lips and tongue* are examined for evidence of *jaundice, cyanosis, anaemia, dehydration* or *vitamin deficiency*.

**B. Vital Signs**

- *The temperature, pulse, blood pressure and respirations are recorded as a routine.*
C. Systematic examination:
The simplest way is to review the whole body from above downwards as follows:

1. **Head and neck**: scalp; eyes and pupils; cranial nerves; mouth; gums and teeth; tonsils and throat; thyroid and cervical lymph nodes.

2. **Chest and heart**: lungs; breasts and axilla.

3. **Abdomen and perineum**: hernial orifices, liver, spleen, kidneys, bowels, external genitals, pelvic organs (rectal or vaginal examination).

4. **Trunk and limbs**: spine, bones, joints, muscles, major blood vessels and main lymph glands.

5. **Nervous system**: motor power, sensations and reflexes.

6. **Urine**: aspect, sp. gr., pH, albumin and sugar
LOCAL EXAMINATION

Examination of the affected region should be conducted systematically by inspection, palpation, percussion and auscultation in this order. The findings should be recorded clearly and accurately. *Illustrative diagrams* should be included whenever possible.

1. **Inspection** should be carried out as the first step after complete exposure of the whole affected area. *Never* use the *fingers* before your eyes and always compare with the corresponding normal side.

2. **Palpation** the feeling of the various parts with the hand and fingers. It is *never* complete without examination of the *lymph nodes* draining the affected area.

3. **Percussion** consists in tapping the region with the fingers and listening to the sound produced. A resonant note indicates the presence of gas (lungs and bowel) and a dull note the presence of solid tissue or fluid collections.

4. **Auscultation** is the hearing of normal or abnormal sounds by means of the stethoscope.
• DIAGNOSIS

• INVESTIGATIONS

• MANAGEMENT
  - 1-Treatment
  - 2-Progress
  - 3-result
  - 4-Follow-up
Thank you

بالتوفيق

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