edicine books, visit our website www.jaypeebrothers.com,for detailed information on medicine books



History Taking and Clinical Examination Pattern at a Glance

Rano Mal Piryani
Suneel Piryani

3rd Edition

JAYPEE

CONTENTS

SECTION 1: GENERAL GUIDELINES

1. Learning Communication Skills 3
2. Learning History Taking Skills 5
3. General Guidelines on How to Perform an Examination 8
4. Recording and Presenting Clinical Notes 11

SECTION 2: MEDICINE

5. History Taking 15
6. General Physical Examination 20
7. Respiratory System 30
8. Cardiovascular System 38
9. Gastrointestinal and Urinary System 46
10. Nervous System 55

SECTION 3: PSYCHIATRY

11. History Taking 79
12. Clinical Examination 83

SECTION 4: DERMATOLOGY

13. History Taking 91
14. Clinical Examination 93

SECTION 5: OPHTHALMOLOGY

15. History Taking 101
16. Clinical Examination 103

SECTION 6: PEDIATRICS

17. History Taking 119
18. General Physical Examination 126
19. Neonate Examination (Initial Assessment) 133
20. Follow-Up: Neonatal History and Examination 138

SECTION 7: GYNECOLOGY AND OBSTETRICS

21. Gynecological History Taking and Clinical Examination 143
22. Obstetrical History Taking and Clinical Examination 151
23. Puerperium History Taking and Clinical Examination 160

SECTION 8: SURGERY

24. History Taking 167
25. Clinical Examination 170
26. Examination of Lump or Swelling 173
27. Examination of Sinus and Fistula 179
28. Examination of an Ulcer 182
29. Examination of the Peripheral Arterial System 186
30. Examination of the Peripheral Venous System (Varicose Vein, Deep Vein Thrombosis, and Thrombophlebitis) 195
31. Examination of the Thyroid Gland 202
32. Examination of the Breast 209
33. Examination of Hernia 216
34. Examination of Scrotal Swelling 223
35. Examination of the Male External Genitalia 227
36. Examination of the Anus, Rectum, and Prostate Gland 232

SECTION 9: ORTHOPEDICS

37. History Taking 239
38. Examination of the Joint: General Principles 242
39. Examination of the Specific Joint 247
    - Spine 247
    - Shoulder Joint 248
    - Elbow Joint 249
    - Wrist and Hand 250
    - Hip Joint 251
    - Knee Joint 253
    - Ankle and Foot 255
40. Examination of the Bone Injuries (Fracture) and Diseases 257

SECTION 2

MEDICINE

This Section Includes Chapters 5 to 10:

5. History Taking
6. General Physical Examination
7. Respiratory System
8. Cardiovascular System
9. Gastrointestinal and Urinary System
10. Nervous System

JAYPEE BROTHERS

CHAPTER 5

History Taking

A. **General information (particulars of the patient)**
Name:_____ Age:_____ Sex:_____
Religion/ethnicity:_____ Occupation:_____
Address:_____ Date of admission: _____
[A___years gentleman/woman, Hindu/Muslim/Buddhist/Christian by religion, _____by profession, resident of _____presented in outpatient department (OPD)/emergency with the following complaints].

B. **Chief/presenting complaints**
- The chief complaint is the patient's brief statement explaining why he/she sought medical consultation. It is the answer to the question, "What is/are the medical problem/s that brought the patient to the health care facility."
- Mention it/these in
  - Patient's own words
  - Chronological order with duration.

C. **History of present illness**
- The history of the present illness refers to the recent changes in health of person that led the person to seek medical consultation at this time
- It describes the information relevant to the chief complaint in detail
- By the end of this, doctor should have a clear idea about the nature of the problem along with exactly how and

JAYPEE BROTHERS

when it started, how the problem has progressed over time, and what impact of present illness has or will be on the patient's general physical health, psychology, social, and working life.

- This is best dealt with in two phases:
  1. In the first phase, put an open-ended question to patient and allow the patient for sometimes to tell what has happened.
  2. In the second phase, one should revisit the entire narrative and ask detail if required. These direct questions may provide an opportunity to clarify queries and add detail to the story.

     Remember, this interaction should feel like a conversation, not an interrogation.
- At the end of the history of presenting illness:
  - One should have established a problem list
  - One should tell summary to the patient, what have been told by the patient
  - Ask the patient if there is anything further that s/he would like to share.
- **For each symptom, determine:**
  - The exact nature of the symptom
  - Severity
  - The onset:
    - The date it began.
    - How it began? (e.g. suddenly, gradually over how
    - long?)
    - If longstanding, why is the patient seeking help now?
  - Periodicity and frequency:
    - Is the symptom constant or intermittent?
    - If intermittent how long does it last each time?
    - What is the exact manner in which it comes and goes?
  - Progression: Is it improving or deteriorating?
  - Aggravating factors: What makes the symptom worse?
  - Relieving factors: What makes the symptom better?
  - Associated symptoms if any.

JAYPEE BROTHERS

D. **Past medical history**
- Ask about relevant past medical history
- Any similar episode/s in past
- Medical problems/conditions—diabetes mellitus (DM), hypertension (HTN), tuberculosis (TB), chronic obstructive pulmonary disease (COPD), myocardial infarction (MI), angina, stroke, epilepsy, etc.
- Hospitalizations—include admissions for medical, surgical, and psychiatric illnesses
- Surgical intervention/operation/procedure and anesthetic problem if any—e.g. fine-needle aspiration cytology (FNAC), pleural aspiration, appendectomy, etc.
- History of blood and blood product transfusion
- History of any injury or accident.

E. **History of treatment and allergy**
- Treatment includes both pharmacological and nonpharmacological
- Ask about prescribed drugs and any other medications patient is taking.
  - Note the name of each drug, dose, drug regimen, and duration of treatment along with any significant side effects
    Allergies—include environmental, ingestible, and drug/medicine related
- Ask details about nonpharmacological treatment.

F. **Family history**
- Any family member has/had similar problem/s
- History of TB, HTN, DM, asthma, hemophilia, thalassemia, schizophrenia
- If a family member is deceased, the age of the person at the time of death and the cause of death should be recorded
- Any in-hereditary and contagious disease/s
- Draw family tree.

G. **Social and personal history**
- Occupation (present and previous occupations)—patient may have occupational diseases like pneumoconiosis in coal miners, malignant mesothelioma in workers exposed to asbestos.

JAYPEE BROTHERS

- Travel—recent travel to infection prevalent areas
- Exposure to any infectious disease patient—TB
- Alcohol consumption—The cut-annoyed-guilty-eye (CAGE) questionnaire
  - A positive response to any of the four questions may indicate someone at risk of alcohol abuse. A positive answer to two or more questions makes the presence of alcohol dependence likely.
  - The CAGE questionnaire
    - C—have you ever felt that you should **C**ut down your drinking?
    - A—have you ever got **A**ngry when someone suggested that you should cut down?
    - G—do you ever feel **G**uilty about your drinking?
    - E—do you ever need an **E**ye-opener in the morning to feel better or steady your nerves or get rid of a hangover?
- Tobacco—smoking [type (cigarettes/cigar/pipe), quantity per day, and duration]
- Any other substance abuse/misuse—e.g. cannabis use
- Socioeconomic status—lower, middle, or upper class
- Marital status
- Sexual history—ask if relevant to the history, menstrual history (in female), sexual partners, use of contraception.

H. **Review of systems**

- In the last, one should perform a brief screening of the other bodily systems called as systemic review
- This often proves to be more important than you expect, finding symptoms that the patient might had forgotten about or identifying secondary, unrelated, problems that can be addressed
- The questions asked will depend on the discussion that has gone before. If you have discussed chest pain in the history of presenting complaint, there is no need to ask about it again.

JAYPEE BROTHERS

- Ask the patient if they have any of the following symptoms:
  - General symptoms—weight change (loss or gain), change in appetite (loss or gain), fever, lethargy, malaise
  - Respiratory symptoms—cough, sputum, hemoptysis, shortness of breath, wheeze, chest pain
  - Cardiovascular symptoms—shortness of breath on exertion, paroxysmal nocturnal dyspnea, chest pain, palpitations, ankle swelling, orthopnea, claudication
  - Gastrointestinal symptoms—indigestion, abdominal pain, nausea, vomiting, a change in bowel habit, constipation, diarrhea, PR blood-loss, dysphagia
  - Genitourinary symptoms—urinary frequency, polyuria, dysuria, hematuria, nocturia, menstrual problems, impotence
  - Neurological symptoms—headaches, dizziness, tingling, weakness, tremor, fits, faints, funny turns, blackouts
  - Locomotor symptoms—aches, pains, stiffness, swelling
  - Skin symptoms—lumps, ulcers, rashes, itching.

JAYPEE BROTHERS

for detailed information on medicine books, visit our website www.jaypeebrothers.com, for detailed

History Taking and Clinical Examination Pattern at a Glance

Salient Features

- The content has been thoroughly updated
- Consists concise and quick-reference format of history taking and clinical examination for students
- Summarizes stepwise account of the history taking and physical examination techniques used in internal medicine, psychiatry, dermatology, ophthalmology, pediatrics, obstetrics and gynecology, general surgery, orthopedics, ENT and dentistry
- Gives essential and critical information needed to obtain a clinically meaningful history from the patient and conduct physical examination in clinical settings
- Compact, lightweight and pocket-sized book can be carried around workplace easily
- Workbook-like exercises with relevant vignettes for practice are included in this edition
- Chapter on Examination of Elderly is added in this edition.

Rano Mal Piryani MBBS MCPS DTCD MD Fellowship in Medical Education is a Professor of Internal and Chest Medicine and Medical Education and Chief Coordinator in Health Professions Training Committee, Universal College of Medical Sciences, Siddharthanagar, Nepal. He has a vast clinical, teaching, education, academic, research, public health and management experiences. He is a resource person for training in medical education and bioethics.

He has published more than 150 research papers and articles in national, regional and international journals and periodicals. He is a peer reviewer of more than 15 medical journals and member of editorial board of some journals. He is a supervisor for Fellow of College of Physicians and Surgeons, Pakistan (FCPS) and MD in Internal Medicine.

Suneel Piryani MBBS MPH MPhil is Research Specialist and Public Health Physician, Department of Community Health Sciences, The Aga Khan University, Karachi, Sindh, Pakistan. He has clinical, teaching, education, academic, research, public health and management experiences. He has published more than 30 research papers in national, regional and international journals and periodicals. He is a facilitator for medical education training.

Available at all medical bookstores or buy online at www.jaypeebrothers.com



JAYPEE BROTHERS
Medical Publishers (P) Ltd.
www.jaypeebrothers.com

Join us on facebook.com/JaypeeMedicalPublishers

Shelving Recommendation
MEDICINE

ISBN 978-93-88958-52-3

