MEDICAL DOCUMENTS OF CLINICAL DIAGNOSIS

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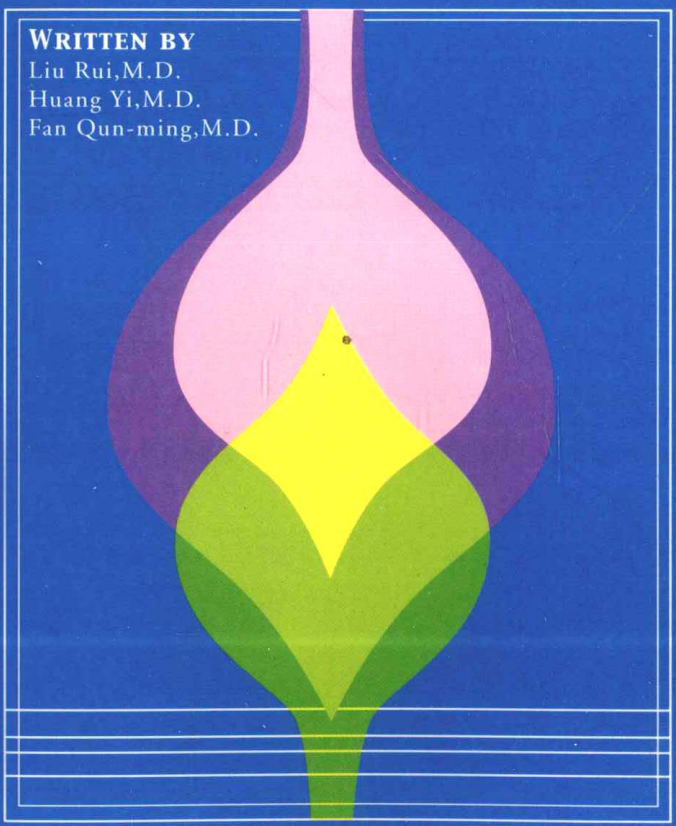

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Preface

In the light of current medical situation in China, we compile this English medical monograph to fulfill the needs of medical students and clinical doctors.

The book aims to concern the correlation between the medical documents and the clinical diagnosis. To learn to write good medical documents is an important and basic skill for both the clinical doctors and medical students, which needs the certain professional knowledge as well as the correct medical history writing and physical examination recording. The book also covers this sort of problems.

The book has *Medical History and Physical Examination* by Paul D. Chan and Peter J. Winkle as its reference, and develops itself into the following chapters: Chapter 1 focuses on how to write medical documents such as course of disease record, operation record, surgery record, transfer record and leave-hospital summary. Chapter 2 illustrates some examples of medical documents to help the beginners' study. Chapter 3 discusses on how to grasp the main diagnostic points during the interrogation and physical examination, and the classification of some symptoms and physical signs according to their etiology, helping the readers to analyze and judge. The last chapter sets out the normal values of the laboratory examination in common use. Just like it is said by Lord Dawson that every doctor is a student until his last day, and he is studying as long as he is living. It is the author's desire

to share with readers the happiness and harvest brought by the book.

Contents

CHAPTER 1 INTRODUCTION OF MEDICAL DOCUMENT

1. History-taking and Physical Examination

How to heal patients is an important problem for every medical student and doctor to learn. During the process, how to make correct diagnosis is the first problem they may face, which requires a mastering of the wide knowledge in the traditional and modern science as well as some basic skills such as medical history taking, physical examination, laboratory tests and image examination. The first contact between the doctor and the patient is extremely important because the patient can obtain confidence through the first impression. The doctor should consider the patient as an individual in need of assistance in stead of a simple clinical case. Even under the emergency situation, he still should let the patients know his concentration on them.

Medical history taking is an inquiring and skillful task which needs proper training. It is unacceptable to do it without the careful inquiry of history, or with the careless physical examination, or draw up a hasty judgement and conclusion according to the first impression. The clinical diagnosis should be established on the ba-

sis of a complete, systematic, and accurate medical history and deduction. The inquirer should at first find out the facts, look for the correlative clues, and make clear which questions the patients are concerning about. Only after all the materials are collected can the doctors discuss the analysis results of the medical history.

Sometimes the family history is of the great importance, for instance, the colic polyposis is such a case. Furthermore, the doctors should carefully study the family histories of other diseases such as diabetes, Peatz-Jegher's syndrome(PJS), chronic pancreatitis and tumor.

The medical history can reveal some hidden problems of one's health. Some patients think they have never been ill, while others may say they are always ill. A correct judgement can not be drawn when ignoring the detailed study of the past history. The experienced doctors will not miss any important information through the systematic review.

The personal history such as marital status, history of vaccination, drinking and smoking history, drug allergy history, working condition, and female menstrual history, can provide the correlative background information of a patient. For a patient with hypogastralgia, some doctors come to the diagnosis of ectopic pregnancy, while some experienced doctors can easily exclude the diagnosis according to her medical history, age, and menstrual history.

Physical examination should be made normatively and carefully. Even for an emergency case, the systematic examination

should be emphasized.

1.1 History-taking

A complete history consists of the items as follows:

1.1.1 Identifying data and chief compliants: patient's name, age, sex, marital status, nationality, occupation, address, chief compliant (reason given by patients for seeking medical care and the duration of the symptom), admission date, name of informant (patients, relatives), and recording date.

1.1.2 History of present illness: describing the course of the patient's illness, including when it began, character of the symptoms, where the symptoms began, aggravating or alleviating factors, pertinent positives and negatives; describing past illnesses, surgeries, and past diagnostic testing.

1.1.3 Past medical history: Past diseases, surgeries, hospitalizations and medical problems. History of measles, meningitis, typhoid, hepatitis, diabetes, hypertension, peptic ulcer disease, asthma, myocardial infarction, and cancer. History of vaccine injection. History of blood transfusion. Allergy to drugs. In children including birth history, prenatal history, immunization, and type of feedings.

1.1.4 Personal medical history: social background (such as employment situation, marital and living status), habit of alcohol or smoking (including time and amount), and menstruation, last menstrual period (frequency, duration),

age of menarche in female.

1.1.5 Family history: medical problems in family, including problems similar to patient's disorder, such as asthma, coronary artery disease, heart failure, cancer, tuberculosis.

1.1.6 Review of systems:

General: weight gain or loss, loss of appetite, fever, chills, fatigue, night sweats.

Skin: rashes, discolorations.

Head: headaches, dizziness, masses, seizures.

Eyes: visual changes, visual field deficits.

Ears: tinnitus, vertigo, hearing loss.

Nose: nosebleeds, discharge, sinus diseases.

Mouth and throat: dental disease, hoarseness, and throat pain.

Respiratory: cough, shortness of breath, sputum (color).

Cardiovascular: chest pain, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, claudication, edema, and valvular disease.

Gastrointestinal: dysphagia, abdominal pain, nausea, vomiting, hematemesis, diarrhea, constipation, melena (black tarry stools), hematochezia (bright red blood per rectum).

Genitourinary: dysuria, frequency, urgency, hematuria, discharge.

Gynecological: abortions, menopause, dysmenorrhea, con-

traception, vaginal bleeding, breast masses.

Endocrine: polyuria, polydipsia, skin or hair changes, heat intolerance.

Musculoskeletal: joint pain or swelling, arthritis, myalgias.

Skin and lymphatics: easy bruising, lymphadenopathy, lymphadema.

Neuropsychiatric: weakness, seizures, memory changes, and depression, anxiety.

1.2 Physical Examination

1.2.1 General appearance: mental status and affect, growth, note whether the patient looks "ill", well, or malnourished.

1.2.2 Vital signs: temperature, heart rate, respirations, bloodpressure.

1.2.3 Skin: rashes, scars, moles, and capillary refill.

1.2.4 Lymph nodes: cervical, supraclavicular, axillary, inguinal nodes (size, tenderness).

1.2.5 Head: bruising, masses, facial sensation.

1.2.6 Eyes: pupils equal round and react to light and accommodation, extra ocular movements intact, and visual field. Funduscopy (papilledema, arteriovenous nicking, hemorrhages, exudates), scleral icterus, ptosis. Close eyes tightly. Corneal reflex.

1.2.7 Ears: acuity, tympanic membranes (dull, shiny, intact,

injected, bulging). Hears watch tic, Weber test (lateralization of sound when tuning fork is placed on top of head), Rinne test (air conduction lasts longer than bone conduction when tuning fork is placed on mastoid process).

1.2.8 Nose: smell, nasal septum.

1.2.9 Mouth and throat: mucus membrane color and moisture, oral lesions, dentition, pharynx, tonsils. Palate moves in midline when patient says "ah" speech. Stick out tongue in midline.

1.2.10 Neck: jugular venous distension at a 45 degree incline, thyromegaly, lymphadenopathy, masses, bruits, abdominojugular reflux.

1.2.11 Chest: equal expansion, tactile fremitus.

1.2.12 Heart: point of maximal impulse, thrills (palpable turbulence), regular rate and rhythm, first and second heart sounds (S1, S2), gallops (S3, S4), murmurs (grade 1-6), pulse.

1.2.13 Lung: percussion, auscultation, rhonchi, crackles, rubs, breath sounds, egophony, and whispered pectoriloquy.

1.2.14 Breast: dimpling, tenderness, lumps, nipple discharge, axillary masses.

1.2.15 Abdomen: contour (flat, scaphoid, obese, distended), scars, bowel sounds, bruits, tenderness, masses, liver span by percussion, hepatomegaly, splenomegaly, muscle guarding, rebound tenderness, percussion note (tym-

panic), costovertebral angle tenderness, suprapubic tenderness.

1.2.16 Spine and extremities: anomaly, tenderness, joint swelling, range of motion, edema, cyanosis, clubbing.

1.2.17 Genitourinary and rectal examination: inguinal masses, scrotum, testicles, varicoceles. Anal sphincter tone, anal fissures, hemorrhoid and anal fistula. Test for occult blood, prostate (nodule, tenderness, size).

1.2.18 Neurological: reflex (plantar, knee, ankle, biceps, triceps). Pathological signs (Babinski's, Oppenheim's, Gordon's, Chaddock's, Hoffmann's). Clonus (patellar, ankle)

1.2.19 Laboratory data: complete blood cell count, coagulation profile, metabolic panel, enzymatic activities and chemistries, selected serum hormones, tumor markers, immunology, urinalysis, X-rays, ECG, *etc*.

2. Daily Progress Note

Once the initial admission write-up is completed, a brief daily progress note should be written every day in serious cases or once two to three days in common cases. These notes summarize what progress has been made in the case since the previous note. The central problems of the progress note address the following questions: a. What are the patient's current symptoms and complaints ? Are there any changes ? b. Is there any change in the physical examination ? c. Are there any new lab data ? Why is it

necessary to take the special examination ? What are the results ? d. Is there any change in the formulation of the case or in the relationship of the patient's various medical problems ? e. What are the current diagnostic and therapeutic plans for the patient ?

3. Procedure Note

A procedure note should be recorded when a procedure is performed. Document that deals with the indications, risks and alternatives to the procedure was explained to the patient and relative of patient. Make sure that the patient was given the opportunity to ask questions and his or her relatives consented to the procedure. Procedure note consists of several items: date and time, indication, anesthesia, description of procedure (briefly describe the procedure, including sterile preparation, anesthesia method, patient position, devices used, anatomic location of procedure, and estimated blood loss), disposition (describe how the patient tolerated the procedure), specimens (describe any specimens obtained and send them to labs test which were ordered).

4. Operation Note

If the patient is operated on, an operation note should be written in 24 hours. It is recorded as follows:

- Date and time: exact time of procedures.
- Preoperative diagnosis: the main diagnosis and secondary diagnosis should be listed in order.