R. N. MANKEVICH, I. M. LASTAUKA, A. A. ASTAPAU

PLAN FOR EXAMINATION OF THE PATIENT AND WRITING THE TRAINING HISTORY OF THE DISEASE «MEDICAL CHART OF THE STATIONARY PATIENT» ON CHILDREN'S INFECTIOUS DISEASES

Minsk BSMU 2021

Репозиторий БГМУ

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ
БЕЛОРУССКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ
КАФЕДРА ДЕТСКИХ ИНФЕКЦИОННЫХ БОЛЕЗНЕЙ

Р. Н. Манкевич, И. Н. Ластовка, А. А. Астапов

ПЛАН ОБСЛЕДОВАНИЯ ПАЦИЕНТА И НАПИСАНИЯ УЧЕБНОЙ ИСТОРИИ БОЛЕЗНИ «МЕДИЦИНСКАЯ КАРТА СТАЦИОНАРНОГО ПАЦИЕНТА» ПО ДЕТСКИМ ИНФЕКЦИОННЫМ БОЛЕЗНЯМ

PLAN FOR EXAMINATION OF THE PATIENT AND WRITING THE TRAINING HISTORY OF THE DISEASE «MEDICAL CHART OF THE STATIONARY PATIENT» ON CHILDREN'S INFECTIOUS DISEASES

Методические рекомендации

Минск БГМУ 2021

Репозиторий БГМУ

УДК 616.9-053.2(075.8)-054.6
ББК 57.33я73
М23

Рекомендовано Научно-методическим советом университета в качестве методических рекомендаций 18.11.2020 г., протокол № 13

Р е ц е н з е н т ы: д-р мед. наук, проф., зав. каф. инфекционных болезней И. А. Карпов; канд. мед. наук, доц. 1-й каф. детских болезней И. А. Козыро

Манкевич, Р. Н.

М23 План обследования пациента и написания учебной истории болезни «Медицинская карта стационарного пациента» по детским инфекционным болезням = Plan for examination of the patient and writing the training history of the disease «Medical chart of the stationary patient» on children's infectious diseases : методические рекомендации / Р. Н. Манкевич, И. Н. Ластовка, А. А. Астапов. – Минск : БГМУ, 2021. – 16 с.

ISBN 978-985-21-0754-9.

Отражены современные требования к ведению и оформлению медицинской документации в стационарных условиях. В качестве приложения приведены все необходимые нормативы физиологических показателей детей с учетом возраста, позволяющие правильно интерпретировать данные лабораторного обследования пациентов.

Предназначены для студентов 4-го курса медицинского факультета иностранных учащихся, обучающихся на английском языке.

УДК 616.9-053.2(075.8)-054.6
ББК 57.33я73

ISBN 978-985-21-0754-9

© Манкевич Р. Н., Ластовка И. Н., Астапов А. А., 2021
© УО «Белорусский государственный медицинский университет», 2021

Репозиторий БГМУ

INTRODUCTION

The purpose of writing these recommendations was to teach students how to properly maintain medical records, form an algorithm for examining a sick patient in a future doctor and develop clinical thinking.

The medical history is currently referred to as the «Medical records of the in-patient», but for simplicity of name, in the future we will use the traditional medical history (MH). This is a document of great practical, scientific and legal significance, therefore it should be clear, concise and to the point. It contains all the necessary information about the patient, the development of his diseases, the results of clinical, laboratory and instrumental examinations, the effectiveness of the therapy.

Educational MH differs from the working documentation maintained by doctors, it includes a comprehensive examination of the patient and a systematic presentation of all the results obtained (with interpretation), a more detailed objective examination of the patient by organ systems and a description of dispensary observation.

The algorithm for making the final clinical diagnosis includes several successive stages: substantiation of the preliminary diagnosis.

When writing MH the student learns to correctly receive information from the patient and, in accordance with the requirements, draw up medical documentation.

In the «Treatment» section, algorithms for choosing a regimen, diet, drug therapy (etiotropic, pathogenetic, symptomatic), rules for daily entries in diaries and writing a discharge epicrisis are presented.

At the same time the educational history does not include such sections as informed voluntary consent to medical interventions, refusal to medical intervention, recording the results of consultations. emergency notification, statistical cards and much more, which young doctors will get acquainted with while working in a hospital during their internship.

Educational MH is issued during the period of curation of the patient in the department, in accordance with the MH scheme. It should be written in an official business style without the use of colloquial words and phraseological units. When formalizing, only generally accepted abbreviations are allowed. The title page, passport part and epicrisis must be written in handwritten text, the rest of the MH sections must be printed.

Репозиторій ВДМУ

THE MODEL PLAN OF EXAMINATION OF THE PATIENT
AND WRITING OF THE MEDICAL HISTORY OF THE STATIONARY
PATIENT ON CHILDREN'S INFECTIOUS DISEASES

Department of Pediatric
infectious diseases BSMU
head of department
____

MEDICAL RECORD OF THE STATIONARY PATIENT № _____

First name, last name of the patient ___________________________________
Clinical diagnosis ____
____

Curator ____________________________
First name, last name of the student
Course, group, faculty_________________
Term of the cure:
Start (date) __________________________
Termination of the cure (date) _________
Teacher ____________________________
First name, last name of the teacher

Minsk, 20___

Репозиторий БГМУ

PASSPORT PART

First name, last name of the patient ____________________________________

Age ______________ (birthdate) _____________________________________

Address ____

The name of children's collective which is visited by the child______________

Date of the last visit of children’s collective ____________________________

Date of receipt ___________________ Day of illness ____________________

Date of discharge from the hospital ____________________________________

Illness outcome: recovery, improvement, without change, deterioration, death (to emphasize)

Who directed the patient? (name of medical institution) ___________________

The diagnosis of the directed establishment ______________________________

The diagnosis at receipt ____

The clinical diagnosis:

Basic, date of establishment ____

Complications of illness ____

Concomitant diseases ____

Number of bed-days ____

COMPLAINTS OF THE PATIENT

To find out complaints from the patient, his parents or relatives on the date of visit.

DISEASE ANAMNESIS (ANAMNESIS MORBI)

Information for this section is compiled from the following documents: the direction available in the clinical MH, an extract from another medical institution, if the patient is transferred, the records of the doctor of the admission department, as well as information received by the student-curator from the patient (his representative).

The history of the disease should reflect the **dynamics** of the disease. The emergence, course and development of this disease from its first manifestations to the present moment is described in detail in chronological sequence. The data on the dynamics of the initial symptoms, the nature and time

Репозиторий БГМУ

of the onset of new symptoms, the previous treatment and its effectiveness, the previously conducted diagnostic measures and their results are presented. The writing of the medical history ends with a description of the last deterioration of the patient's condition or other reasons that led to this hospitalization.

It should be borne in mind that by the beginning of curation he had already been in the department for a certain time, therefore, in chronological order (briefly), indicate the dynamic effectiveness of the therapy carried out by the beginning of curation.

EPIDEMIOLOGICAL ANAMNESIS

1. What factors the patient (parents) connects a disease: contact with similar patients, accommodation in epidemic unsuccessful district, the endemic center, trips abroad and to what countries for the last 1 month.
2. Disease incidence in child care facility which is visited by the patient.
3. The use of dirty vegetables, fruit, substandard products and canned food, use of water from an unknown source, existence of ektoparazit, stings animals, injections, surgeries, bruises, etc.
4. Immunological status:

– vaccination (what, when, how many time, intervals, reactions to an inoculation);

– introduction of medical serums (what, when, way of introduction and their shipping).

PATIENT ANAMNESIS (ANAMNESIS VITAE)

A. Information on parents and relatives:

1. State of health of parents and close relatives, existence of chronic hereditary diseases, chronic virus infection carrier state or bacteria carrying.
2. From what pregnancy the child was born; as the real pregnancy and childbirth proceeded; than the previous ended.

B. Information on the child:

1. Childbirth was in time or not?
2. I cried at once or not (a look and duration of asphyxia).
3. The body weight and growth at the birth.
4. Nature of feeding (natural, artificial, mixed), terms and time of introduction of feedings up.
5. For what day of life the umbilical rest? How the umbilical wound began to live disappeared?
6. Whether there was a jaundice, its intensity and duration?
7. For what day of life it is discharged from maternity hospital?

репозиторий БГМУ

9. Neuropsychic development: lag, advancing, compliance to age.

10. The diseases postponed earlier (what, when).

11. Allergy anamnesis: allergic reactions and diseases, including reactions to foodstuff and medicines.

OBJECTIVE EXAMINATION (STATUS PRESENS) ON DAY OF VISIT

GENERAL VIEW OF THE PATIENT

Date ________ day of illness __________ day of treatment __________.

General view of the patient. *General state:* satisfactory, average weight, heavy, very heavy, moribund. *Position of the patient:* active, passive, adynamic, compelled (on one side, a meningealny pose, etc.). Consciousness: clear, somnolentia, sopor, stupor, coma. Look: calm, excited, feverish, masklike, suffering. Temperature ______. Weight ______. Growth ______. Assessment of physical development ______.

SURVEY BY ORGAN SYSTEMS

It is carried out in the following sequence: examination, palpation, percussion, auscultation. Absent manifestations in the patient should not be described, other than those that are relevant to support the diagnosis.

Skin. *Colour:* pink, red, pallid, icteric, cyanotic, marmorate, sallow complexion etc. *Turgor:* normal, lower, very lower. *Humidity:* normal, high, lower (dry).

Rash: localization and type (roseola, macula, haemorrhage, vesicle, papula etc.) Having combed existence on skin, decubituses, giperkeratoz, hematomas, gemangiy, hypostases, expansion of veins; their localization, staging of emergence. Itch.

Mucosa. Coloring of the visible mucous. Damp, dry. Existence of raids, thrush, hemorrhages, enanthema, erosion, ulcers and other pathological changes.

Subcutaneous fat. Extent of development of a subcutaneous fat (thickness of fatty folds). At insufficient development of a hypodermic and fatty layer to define hypotrophy degree, and at superfluous — surplus % (for establishment of a paratrophic or degree of obesity). Turgor of tissue. Hypostasis: the general, local (persons, cervical cellulose, extremities).

Lymph nodes. Size it’s (mm), form, consistence, mobility, sickliness and primary localization of pathologically changed lymph nodes, cohesion among themselves and with the subject fabrics, change of color over them, fluctuation existence. Existence of a generalized limfadenopatiya.

Репозиторій ВДНМУ

Salivary glands. To define degree of increase and existence of morbidity in the field of parotid and submaxillary salivary glands, change of skin color over them, their consistence, fluctuation existence. The availability of a symptom of Murson.

Muscular system. General development of muscles: good, moderate, weak. A muscle tone, morbidity at a palpation or the movements. The availability of an atrophy, hypertrophy or consolidations.

Osteoarticular system. The availability of pains in bones and joints, their character and force. Deformations, cracks, thickenings, swelling, fluctuation, crunch, contractures, anchylosis. Hillocks and softening of bones of a skull, condition of big and small fontanels, their edges. The movement volume in joints.

Respiratory organs.

Dyspnea. It's character and expressiveness. Frequency of the respiration in a minute.

Cough: emergence time (day, night) and it's character (dry, damp, "barking"), frequency (constant or paroxysmal), attack duration (painful, painless), existence of reprises.

Phlegm: mucous, purulent, mucopurulent, blood impurity.

Pain in a breast: localization of pain and it's character (sharp, stupid). Communication of pain and intensity of the movement, physical tension, depth of breath or cough.

Nose: breath free, complicated. Separated from a nose: quantity and character (serous, purulent, bloody).

Voice: loud, pure, hoarse, silent, hoarse voice, hoarseness, aphonia, twang.

Chest: normal, emphysematous chest, rickets breast, keeled chest, funnel chest ect. Deformation of a thorax, existence of rachitic beads. Uniformity of expansion of both half of a thorax at breath. Condition of intercostal intervals (participation of auxiliary muscles in the act of breath, retraction of pliable places of a thorax).

Definition of voice trembling. Comparative percussion of lungs, the characteristic of a percussion sound (pulmonary, muffled, existence of obtusion, dullness, a timpanit or box sound).

Topographical percussion of lungs. Topographical percussion of lungs. Border of lungs on middle clavicular and on middle axillary scapular lines from both parties.

Comparative auskultation of lungs. Type of breath: puerilny, vesicular, rigid, weakened, the extended exhalation, amphoric breath sounds, lack of respiratory noise.

Rales: dry rales (whistling, buzzing), bubbling rales (large bubbling rales, medium moist rales, small bubbling rales), a crepitation. Existence of noise of friction of a pleura.

репозиторий БГМУ

Cardiovascular system. The top push of heart (poured or not) is defined visually or in time of palpation (in what intercostal space).

Percussion: heart borders (right, left in the 5th or 4th intercostal space, in the 3rd intercostal space and a vascular bunch).

Auscultation: tones of heart (clear, the deafs clapping), bifurcation and splitting of tones. Accents, gallop rhythm (precordial, ventricular). Noise in heart and their relation to phases of cardiac activity (systolic, diastolic). Heart rate in a minute.

Pulse: frequency in a minute, tension degree (weak, satisfactory), a rhythm (correct, arrhythmic). Respiratory arrhythmia, other violations of a rhythm. Size of arterial pressure (systolic and diastolic).

Digestive organs.

Appetite: normal, low, absent. Thirst.

Oral cavity: coloring mucous, existence of an enantema, oral moniliasis, hyperaemia, Belsky–Filatov–Koplik spots, ulcers. Number of teeth, existence of caries in them.

Tongue: dry, wet, it is laid over by a raid and its color, “crimson”, “chalky”, “geographic”, “laked”, existence of prints of teeth.

Pharynx: hyperaemia (diffuse or limited), palatine tonsils are normal or hypertrophy and increase degree of them, existence of films on almonds (fibrinozny, necrotic, continuous, extends out of limits of palatoglossal archs), color of a film (white, yellow, grayish-white, gray, dirty color), existence of purulent follicles, abscesses, ulcers. Existence vesicles on palatoglossal archs. Back wall of a throat: hyperaemia, cyanosis, films, increase in follicles.

Uvula: hyperemic, edematic, it’s mobility, ulcers, vesicles.

Smell from a mouth: fetid, sweetish, putrefactive, acetone, etc.

Existence of regurgitation, nausea, vomiting (single, recurrent, repeated).

Abdomen: configuration, existence of a meteorizm, retraction of a stomach, participation in the act of breath, visible peristalsis and anti-peristalsis, existence of a venous network, divergence of muscles of a abdomen, existence of hernias (inguinal, umbilical, femoral, white line of a abdomen), infiltrate, invaginat, pains, symptoms of irritation of a peritoneum: painful zone of Shoffar, painful points of Dezharden, Mayo–Robson, Shchetkin–Blyumberg, Voskresensky, etc. The tension of muscles of a abdomen at a palpation: general or localized.

At newborns: condition of an omphalos (hyperaemia, weeping, purulence, existence of the separated.

Liver: pains in the right hypochondrium (constant, colicky pain) their force, irradiation. Percussion delimitation of a liver (top, lower), the liver sizes across Kurlov. Liver palpation: the keen edge rounded a consistence (elastic, dense, firm), a surface (smooth, hilly), morbidity at a palpation and it’s localization.

Palpation of a place of a projection of a gall bladder. Vesical symptoms (Murphy, Kerr, Myussi, Ortner, etc.).

Репозиторий БГМУ

Spleen: presence of pain in the left upper quadrant (blunt, sharp). Percussion: the definition of the transverse dimension and the length of the spleen. Palpation: sensitivity, density, roughness. Existence of pains in the left hypochondrium (blunt, sharp). Percussion: determination of diameter and longitudinal axis. Palpation: sensitivity, density, tuberosity.

Stool (stateful, liquid, soft, abundant, washy, scant), rate, colour, smell, presence of pathologic impurity and helminthes.

Urogenital system.

Pains in lumbar area and their characteristic. A swelling in kidneys. Palpation of kidneys, their mobility. Symptom of tapotement. Bladder (palpation, percussion). Pains at an urination. The urine volume, color, rate of an urination and allocation from the urethral channel (pus, blood).

Thyroid gland: size, consistence, symptom of Grefe, Mebius.

Vision: nystagmus, strabismus, ptosis, anisocoria, visual acuity, presence “nebula”, “net”, “flys” in front of eyes, diplopia, keratitis, conjunctivitis, exophthalmus, width of fissures of eyes, glitter of eyes, small tremor fingers. The color of sclera.

Hearing: hearing acuity in the left and right ear (normal, low). Secretion from a ear, palpatory tenderness on the tragus and mastoides.

Nervous system.

Consciousness (clear, disturbance of consciousness, stupor, sopor, unconscious, coma), delirium, hallucinations. Compliance of age and mental development.

Conduct: active, passive, disturbing.

Cephalalgia: cyclic, constant, it’s localization, following of nausea, vomiting.

Giddiness: buzzing in the head, buzzing in the ears, syncopes, readiness for convulsions, convulsions.

Gait: normal, shaky, ataxic gait, paralytic. Romberg’s symptom. Tremor of the palpebra with eyes closed.

Pupils: size, reaction on the light.

Reflexes: tendinous, peritoneal, conjunctive, pharyngeal. Availability of pathological reflexes. Dermographism.

Sensitivity of skin: lower, higher (tactile, painful, thermic).

Meningeal symptoms (rigid muscles of neck, Kernig’s symptom, Brudsinsky symptom upper, lower ect.). At the childrens up to one year: bulging of fontanel, tension and pulsation of fontanel, symptom of Lessage.

РЕПОЗИТОРИЙ БГМУ

PRIMARY DIAGNOSIS

It is proposed on the basis of the patient's examination data (complaints, medical history, epidemiological history, objective examination results), concomitant disease, complications of the disease.

Given the complaints (indicate which ones), anamnesis morbi (if there is data), epidemiological anamnesis (if there is data), the results of objective research (list).

Primary diagnosis:____

Concomitant diseases____

The preliminary diagnosis makes it possible to formulate a further examination plan and prescribe a treatment plan.

THE PLAN OF EXAMINATION AND TREATMENT OF THE PATIENT

In the educational MH the examination and treatment plan is drawn up for the supervised patient, based on the preliminary diagnosis in order to clarify the clinical diagnosis, taking into account the algorithm for examining the patient with this pathology and conducting the differential diagnosis.

A. The main and additional methods of examinations (which you consider necessary to appoint).

B. 1) regimen; 2) ration; 3) medicine (which you consider necessary to appoint):

– etiotropic therapy;
– pathogenetic therapy;
– symptomatic remedys.

Signature of the student _____________

LABORATORY EXAMINATIONS AND CONCLUSION OF CONSULTATION (WITH OBLIGATORY INTERPRETATION OF ALL PATHOLOGICAL CHANGES)

The results of all laboratory, tool, radiological researches in dynamics and also given consultations of experts and consultations with the indication of date correspond.

репозиторий БГМУ

CLINICAL DIAGNOSIS (PRINCIPAL DIAGNOSIS)

It is carried out specifically in relation to the disease in the supervised patient with a detailed analysis of complaints, anamnestic and epidemiological data, clinical symptoms and syndromes, and also taking into account the data obtained from additional examination (list the deviations from the norm identified during instrumental and laboratory examination, confirming the diagnosis).

The structure of the diagnosis includes:

– clinical diagnosis (principal diagnosis) ___________________________ including an indication of the form, severity and nature of the course (acute, subacute, chronic, recurrent) disease

– complications____

– concomitant diseases ____

DIARYS (not less than 3 days)

The diary has to reflect dynamics of a course of disease (improvement, deterioration, without changes) with the daily description of a condition of the patient during the period of the curation.

Date	The detailed description of a condition of the patient on the date of a curation	Prescriptions in a hospital (at the time of a curation)
t °C		

Signature of the student __________________

THE TEMPERATURE LIST

It is drawn up on a standard form or on a hand-drawn one for the entire period of the patient's stay in the hospital.

EPICRISIS

The discharge epicrisis is a summary of the entire MH and includes passport data, main complaints, brief anamnestic data (if necessary), as well as information about past other diseases. the performed surgical interventions and manipulations; a detailed description of laboratory and instrumental examinations (without interpretation), research results, lists the medicinal products that the patient received after hospitalization specialists.

репозиторий БГМУ

Recommendations (if necessary) are giving for outpatient treatment, dispensary observation: observation by narrow specialists, diet regimen, drug therapy (international, non-trade, name of drugs indicating doses, time of administration and duration of use) or other methods of treatment.

The absence (or presence, indicate for what disease, indication of contact) of **quarantine in the department during the child's stay in the hospital must be indicated**.

First name, last name of the patient ________________________________
Age ____
Date of receipt ________________, day of illness ___________________
The diagnosis of the directed establishment ________________________
The clinical diagnosis (principal diagnosis)__________________________
Complications ____
Concomitant diseases____
The examination (to specify date and results of the conducted laboratory, radiological researches in dynamics, the conclusions and date of tool methods of inspection and survey of narrow experts) _______________________________
Treatment is carried out (to list all preparations with the indication of daily allowance and/or course doses) ____
The efficiency of the treatment ___________________________________
The outcome of the disease ______________________________________
Recommendations to the patient at an extract it is detailed: mode, food etc. ____
Recommendations to the local pediatrician or other expert in need of further treatment at home____
The number of bad-days is spent __________________________________

DISPENSARY OBSERVATION

What expert has to make regular medical check-up for had this infection, nature of supervision and inspection.

The period of dispensary observation.

The rules of the admission in children’s collective after an extract from a hospital.

Signature of the student ____________________

Репозиторий БГМУ

LITERATURE

1. *Практические* навыки педиатра : практическое пособие / М. В. Чичко [и др.] ; сост. и ред. М. В. Чичко. Минск : Книжный дом, 2018. 848 с.

2. *Детские* инфекционные болезни. Лечебная практика : учеб. пособие / В. М. Цыркунов [и др.] ; под общ. ред. В. М. Цыркунова, В. С. Васильева, А. А. Астапова. Минск : АСАР, 2013. 512 с.

3. *Алгоритм* оформления учебной истории болезни в педиатрическом стационаре : метод. рекомендации / сост. Л. С. Намазова-Баранова [и др.]. 2-е изд., перераб. и доп. Москва : Педиатръ, 2018. 48 с.

Репозиторий БГМУ

CONTENTS

Introduction....3
Passport part....5
Complaints of the patient....5
Disease anamnesis (Anamnesis morbi)....5
Epidemiological anamnesis....6
Patient anamnesis (Anamnesis vitae)....6
Objective examination (Status presens) on day of visit....7
General view of the patient....7
Survey by organ systems....7
Primary diagnosis....11
The plan of examination and treatment of the patient....11
Laboratory examinations and conclusion of consultation (with obligatory interpretation of all pathological changes)....11
Clinical diagnosis (principal diagnosis)....12
Diarys (not less than 3 days)....12
The temperature list....12
Epicrisis....12
Dispensary observation....13
Literature....14

Репозиторий БГМУ

Учебное издание

Манкевич Римма Николаевна
Ластовка Инна Николаевна
Астапов Анатолий Архипович

ПЛАН ОБСЛЕДОВАНИЯ ПАЦИЕНТА И НАПИСАНИЯ УЧЕБНОЙ ИСТОРИИ БОЛЕЗНИ «МЕДИЦИНСКАЯ КАРТА СТАЦИОНАРНОГО ПАЦИЕНТА» ПО ДЕТСКИМ ИНФЕКЦИОННЫМ БОЛЕЗНЯМ

PLAN FOR EXAMINATION OF THE PATIENT AND WRITING THE TRAINING HISTORY OF THE DISEASE «MEDICAL CHART OF THE STATIONARY PATIENT» ON CHILDREN'S INFECTIOUS DISEASES

Методические рекомендации

На английском языке

Ответственная за выпуск О. Н. Романова
Переводчик И. Н. Ластовка
Компьютерная вёрстка Н. М. Федорцовой

Подписано в печать 02.03.21. Формат 60×84/16. Бумага писчая «Xerox office».
Ризография. Гарнитура «Times».
Усл. печ. л. 0,93. Уч.-изд. л. 0,62. Тираж 45 экз. Заказ 80.

Издатель и полиграфическое исполнение: учреждение образования
«Белорусский государственный медицинский университет».
Свидетельство о государственной регистрации издателя, изготовителя,
распространителя печатных изданий № 1/187 от 18.02.2014.
Ул. Ленинградская, 6, 220006, Минск.

Репозиторий БГМУ

Репозиторий БГМУ

ISBN 978-985-21-0754-9