CLINICAL METHODS 30HOURS

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Madam Caroline

MODULE UNITS

- General Examination and Vital signs
- Respiratory System Examination
- Cardiovascular System Examination
- Digestive System and Abdominal Examination
- Neuromuscular System Examination
- Genitourinary System Examination

HISTORY-TAKING

- Most important communication skill
- Patient derived from Latin word *patiens*, meaning sufferance
- Overall purpose of medical practice is to relieve suffering
- To do this, a diagnosis has to be made, so as to design a proper management scheme
- A thorough clinician makes use of history taking skills to elucidate information from patient
- Clinical methods is the skills used by clinicians to gather information from patients

HISTORY-TAKING…

- Main steps in making a diagnosis
  - Establish clinical features by history and examination (clinical database)
  - Interpreting the clinical database
- Setting the scene
  - Most encounters with patients occurs in the outpatient department
  - Make an early assessment of patients in the waiting bay
  - Observe
  - The patients demeanor, their hearing, their walking and the accompanying person to patient

HISTORY-TAKING…

- Greet the patient and introduce yourself
  - Observe how the patient responds
  - Does the patient smile, appear anxious, do they maintain eye contact
  - Do they appear frightened or depressed
  - Is posture normal?
- Do they look very sick or have any difficulty in breathing or wheezing
- Confirm the full names, age or date of birth, address
- Ensure a pleasant surrounding for both patient and clinician to be at ease

HISTORY-TAKING…

- Ensure there is adequate privacy for the patient to be confident to open up
- Use open ended questions
- Establish and maintain eye contact
- Read any referral letters if any
- Ask patient what brings them to the hospital

BEGINNING THE HISTORY

- Greet patient
- Get the bio-data
  - Name
  - Age
  - Sex
  - date
  - Residence
  - Religion
  - Marital status
  - Occupation
  - Next of kin

FLOW OF HISTORY TAKING

Chief complaints

- What has brought patient to hospital

History of presenting illness

- Explore the main complaints
- Analyze patient's principal complaints and describe in terms of
  - Location
  - Quality, quantity or severity
  - Timing
  - The setting which they occur
  - Aggravating and relieving factors

FLOW OF HISTORY TAKING…

- Consider course or shape of illness i.e. the progress since it started to the present time
- Has it improved or worsened
- Any current medication including dose and frequency
- Exhaust thoroughly the affected system covering all the relevant findings either positive or negative

Review of the systems

- This is arranged under anatomical systems

FLOW OF HISTORY TAKING…

- Purpose - ensure no symptom or disorder is neglected and to assess effect of illness on other systems
- **General**
  - Weight
  - Sleep
  - Energy
- **Cardio-vascular system**
  - Dyspnoea
  - Pain or tightness
  - Palpitations

FLOW OF HISTORY TAKING…

- **Cardio-vascular system..**
  - Cough
  - Oedema
  - Lassitude
- Respiratory system
  - Cough
  - Sputum
  - Breathing
  - Wheeze
  - Chest pain

FLOW OF HISTORY TAKING…

- Gastro-intestinal system
  - Pain
  - Appetite
  - Vomitting
  - Flatulence
  - Water brash
  - Heart burn
  - Dysphagia
  - Diarrhea
  - Consitpation
  - Jaundice - Liver or gall bladder pain

FLOW OF HISTORY TAKING…

- Genital system
  - Puberty onset
  - Erections
  - Emmisions
  - Testicular pain
  - Libido
  - In(fertility)
- Urinary system
  - Amount of urine
  - Nocturia
  - Color of urine

FLOW OF HISTORY TAKING…

- Urinary system..
  - Continence
  - Stream
  - Blood in urine
  - Dysuria
  - Frequency
  - Volume
  - Undue thirst
- Nervous system
  - Stroke

FLOW OF HISTORY TAKING…

- Nervous system…
  - Epilepsy
  - Headache
  - Mental state
  - Dizziness
  - Loss of balance
  - Tremors
  - ataxia
- Loco-motor system
  - Arthritis
  - Rheumatic fever
  - Painful joints

FLOW OF HISTORY TAKING…

Past medical and surgical history

- Ask about childhood illnesses and adult illnesses
- Surgical illness – include all important operations or injuries from infancy onwards
- Beware of ready made diagnoses
- History of transfusions or drug allergies

Personal and social history

- Get any relevant history about patient as a person

FLOW OF HISTORY TAKING…

- Personal history…
  - Lifestyle e.g. alcohol consumption and cigarette smoking
  - Occupation information
- Family history – information about family e.g.
  - Parents, alive or dead. If dead, state cause
  - Order of birth
  - Siblings – alive or dead, if dead state cause of death
  - Any illness that runs in family e.g. hypertension, diabetes, asthma

FLOW OF HISTORY TAKING...

- Gynecological history
  - LMP
  - Age of onset
  - Regularity of periods
  - Amount of bleeding
  - Duration of the flow
  - Associated problems
  - Last delivery
  - Mode of delivery