The Orthopedic History and Physical Exam

By Dr. Fred Sitati

MBChB, Mmed, FCS,Dip SICOT

Orthopedic Surgeon

The History

- Welcome the patient - ensure comfort and privacy
- Know and use the patient's name - introduce and identify yourself
- Set the Agenda for the questioning

The History

- Elicit the Patient's Story
- Ask **open-ended questions**
- Encourage with silence, nonverbal cues, and verbal cues

Components of the History

- Biodata : Name, age, gender, hand dominance (in upper limb conditions)
- Chief complaint
- History of Present Illness
- Past Medical History
- Past Surgical History
- Allergies
- Medications

The Components

- Social History
- Family History
- Review of Systems

Chief Complaint

- This is why the patient is here in the emergency room or the office

- Examples:

Common Examples

- Pain
- Stiffness
- Swelling
- Deformity
- Weakness
- Instability
- Loss of function
- Change in sensibility

History of Present Illness

- This is the detailed reason why the patient is here.
- It is the why, when and where, etcé
- Use the OPQRSTA approach to cover all aspects of information

History of Present Illness

- OPQRSTA
  - Onset
    - When did the chief complaint occur
  - Prior occurrences of this problem
  - Progression
    - Is this problem getting worse or better
    - Is there anything that the patient does that makes it better or worse
  - Quality
    - Is there pain, and if so what type– how would the patient describe it in their words

History of Present Illness

- OPQRSTA (continued)
  - Radiation
    - Do the symptoms radiate to anywhere in the body, and if so, where?
  - Scale
    - On a scale of 1 to 10, how bad are the symptoms
  - Timing
    - When do the symptoms occur?
      - At night, all the time, in the mornings, etcé

History of Present Illness

- OPQRSTA (cont)
  - Associated symptoms
    - Any other info about the chief complaint that has not already been covered
    - Ask if there is anything else that the patient has to tell about the chief complaint

neoplastic and infectious symptoms

Å constant pain, night pain

Åfever, night sweats

Åanorexia, fatigue, weakness, weight loss

Past Medical History

- These are the medical conditions that the patient has chronically and that they see a doctor for.
- Blood Transfusions
- Examples:
  - Hypertension, GERD, Depression, Congestive heart failure, hyperlipidemia, Diabetes, Asthma, Allergies, Thyroid problems, etcé

Past Surgical History

- These are any previous injuries or operations. When?

- Examples:
  - Tonsillectomy, Hysterectomy, Appendectomy, Hernias, Cholecystectomy.

Medications

- Include all meds the patient is onð even over the counter meds and herbals
- Try to include the dosages and frequency.
- Corticosteroids.

Allergies

- Ask about latex, food, drugs and seasonal allergies

Social History

- Things to include:
  - Occupation.
  - Marriage status
  - Tobacco used – how much and for how long
  - Alcohol use
  - Illicit drug use
  - If pertinent, sexually transmitted disease history

Family History

- Ask if the patientôs parents, grandparents, siblings or other family members had any major medical conditions
  - Examples:
    - Heart disease, heart attacks, hypertension, hyperlipidemia, diabetes, sickle cell disease

Review of Systems

- The review of systems is just that, a series of questions grouped by organ system including:
- General/Constitutional
- Skin/Breast
- Eyes/Ears/Nose/Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Neurologic/Psychiatric
- Allergic/Immunologic/Lymphatic/Endocrine

Physical Exam

- General examination and vital signs.
- Musculoskeletal
- Heart
- Lungs
- Abdomen
- HEENT
- Neck
- GU if pertinent to the chief complaint

Physical Exam

Develop a systematic approach for doing the physical exam

MUSCULOSKELETAL EXAMINATION

Requirements:

- Tape measure
- Goniometer
- Patella hammer
- Sharp point and cotton wool

MUSCULOSKELETAL EXAMINATION

- LOOK
- FEEL
- MOVE

LOOK

- SKIN: SCARS, BRUISES,SINUSES,COLOUR CHANGES.
- SWELLING
- MUSCLE WASTING
- DEFORMITY
- POSITION

FEEL

SKIN: warm/cold, dry/moist.

SOFT TISSUES: SWELLING, PULSES

BONES AND JOINTS

TENDERNESS

EFFUSION

MOVE

- ACTIVE MOVEMENT:Pt. Moves without your assistance.
- PASSIVE MOVEMENT: Examiner moves pt.
- NEUROLOGICAL EXAMINATION:MOTOR AND SENSORY FUNCTION

SPECIAL TESTS

- Dependent on problem.

Assessment and Plan

- This is what you think is wrong with the patient, and what you plan to do initially.
- INVESTIGATIONS:
- Diagnostic Imaging
- Laboratory