History and Physical Examination in short:

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It is said that over 80% of diagnoses are made on history alone, a further 5-10% on examination and the remainder on investigation.[1] Whether this adage is true or not may be open to debate but it is clear that history and examination skills remain at the very core of clinical practice. This record will aim to provide you with some helpful tips; your patients will teach you the rest.

history and examination general scheme:

A) HISTORY

1. General Information:

Name:
Age/Gender:
Address:
Source of history: Patient/Relative/Carer

2. Chief complaints:

Complaint X Duration
Chronological order
Maximum 4-5 major symptoms
Should include all major symptoms (important for making hypothesis)
Duration should be specific rather than time interval (e.g. 10 days instead of 1-2 weeks)
Chief complaints can be included in retrospect

Example:
Lower abdominal pain X 2 days
Nausea and vomiting X 1 day

3. History of Presenting Illness:

“OPQRST” for each symptoms

Onset (acute, insidious, chronic)
Provocative/Palliative and Progression
Quality and/or Quantity
Region and Radiation
Severity
Timing and Temporal relationships
Others:
Duration and Frequency
Any diurnal variation
Associated symptoms
Last meal and Tetanus status
Negative history:

Red-flag symptoms
Ruling out differentials
Probable etiology
Severity and complications
Treatment received for the complaint

Review of systems: may or may not be related to chief complaint – include only positive finding
Add for females

Menstrual and Obstetric History:
- LMP
- Duration of flow/Cycle Length
- Clots passage, Average number of pads soaked, Dysmenorrhea
- GxPxAxLx – mode, indication and time
- Contraceptives

Add for pediatric patients

- Birth history

Any antenatal/natal/postnatal complications
At birth – gestational age, mode of delivery, weight
- Development history: Gross motor/Fine motor/Language/Social

Development of this __ months old child matches the chronological age in all 4 spheres of development. OR if delayed
Development of this __ months old child in the __ area corresponds to a chronological age of between __ to __ months.

Nutritional history

24 hour dietary recall

Immunization history

Are immunizations up to date? If not – why?

4. Past history:
HTN, DM, TB or any prolonged illness (duration; treated/untreated)

Surgeries with indication and time

Hospitalizations with indication and time

5. Personal history:

Smoking

Alcohol

Drug abuse

Eliciting smoking and alcohol history

6. Family history:

History of 2-3 generations for similar disease or related disease, hypertension or diabetes mellitus.

7. Drug and Allergy history:

Prescribed drugs and other medications

Compliance

Allergies and reaction

Neonatal history taking

Physical Examination

General examination:

G/C – Note relevant findings and abnormalities in –
Mnemonic: ABCDEF

Appearance

Built

Consciousness

Decubitus

Environment

Facies

Vitals –

Temp:

PR:

RR:

BP:

SpO2:

Pallor, Icterus, Lymphadenopathy, Clubbing, Cyanosis, Edema, Dehydration:

Mention positive findings

Characterize positive finding if applicable

Grade positive finding if applicable

GCS and pupils – if applicable

Local examination: Of hypothetically involved system (present in detail)

P/A:

- Any abnormalities on inspection incl. hernia orifices and external genitalia
- Tenderness/Guarding/Rigidity
- Organomegaly
- Costovertebral angle tenderness
• Percussion – if ascites (shifting dullness/fluid thrill)
• Bowel sounds or other added sounds
• P/R and P/V findings (if applicable)

Chest:

• Any abnormalities in RR, Shape, Movement or use of accessory muscles
• Any abnormalities in tracheal position, chest expansion, vocal fremitus or tenderness
• Hyper-resonant/Resonant/Woody dullness/Stony dullness – location
• Vesicular/Bronchial/Broncho-vesicular – location if abnormal
• Wheeze/Crackles/Other added sounds – location
• Vocal resonance

CVS:

• Any abnormalities in shape or visible pulsation
• Apex beat – location and any abnormality
• Left parasternal heave/thrills
• S1 S2 – any abnormality
• Murmur
• Location (A, P, T or M)
• Systolic/Diastolic
• Grading
• JVP and HJ reflex (if relevant clinically)

CNS:

• Higher mental functions: note only abnormalities
• Cranial nerves: note only abnormalities
• Motor system: note any abnormality; grade power of relevant muscles
• Reflexes: note any abnormality; compare and grade relevant DTR
• Sensory: light touch, superficial pain, temperature, vibration, joint position sense, stereognosis/graphesthesia
• Cerebellar signs: mention if any sign present
• Signs of meningeal irritation: mention if any sign present

Skin lesions:

• Morphology:
  • Primary: Macule/Papule/Plaque/Nodule/Abscess/Wheal/Petechia/Purpura/Telangiectasia/Cyst/Milia/Burrow
  • Secondary: Scale/Erosion/Ulcer/Fissure/Excoriation/Scar
  • Shape and configuration
  • Distribution
  • Single or Multiple
  • Color
  • Edge

Joints and Spine:

• Look: SEAD (Swelling/Erythema/Atrophy/Deformity)
• Feel: Skin to bones and joints – note temperature, tenderness, swellings
• Move: Active and Passive ROM
• Measure: Motor, Sensory and Circulation status
• Special tests: e.g. SLRT, Scaphoid test, Talar tilt test, Tests for knee ligaments, etc.

Ear:
• External ear
• EAC
• TM
• Hearing test

Nose:

• External nose
• Nasal mucosa and discharge

Throat:

• Oral cavity
• Tonsils
• Posterior pharyngeal wall

Eye:

• Visual acuity
• Orbit and adnexal structures
• Ocular movements
• Pupil – Size, shape, symmetry, reflex
• Conjunctiva
• Cornea
• Digital tonometry

System examination: Other than that mentioned in local examination (mention only abnormal findings)

If normal – mention as following:
• Chest: B/L NVBS, no added sounds
• CVS: S1S2 M0
• P/A: soft, non-tender, BS+
• CNS: grossly intact

Characterize lymph node, lump and organomegaly:
• Site/Size/Shape/Surface/Sounds (bruits)
• Tenderness/Transillumination/Temperature
• Fluctuation
• Mobility/Margin and Edge/Multiple or single
• Color/Consistency

Arrange findings in order of inspection, palpation, percussion and auscultation.

Provisional Diagnosis

Differential Diagnoses

1.
2.
3.

Management and Advice (Including investigations)

1.
2.
3.
4.
5.