Step by Step what to do

Before you enter the room:
1. Write down the vital sighs, DDs, and LIQOR AAA, PAM HUGS FOSS. Be very quick. You have only 20-30 sec to write down the information.
2. Remind yourself again to stay calm…don't forget KISSS (Keep It Short Simple Slow).

Entering and Introduction:
1. Knock on the door 3 times
2. Walk in (watch your posture)
3. Look at the Pt's eyes…Smile with a nice, warm smile, not a huge one showing all your teeth. You don't want to look silly, do you? Smile with your eyes too. Make the patient comfortable by just being in the room.
4. Say: 4.1. Hello, Mr./Mrs. ___
    4.2. I am Dr. Dinovski, physician in charge.
    4.3. Nice to meet you!
5. Shake hands.
6. Say: Can I seat?...Thank you!
7. Say: I'd like to ask you a few questions and do a physical exam. Is that OK with you?
8. Ask: What brings you in today? What brought you to the hospital today?
9. Ask: Could you please describe to me more about your problem? (open ended Q), and continue with some specific Qs.

History taking Qs:
Follow LIQOR AAA for pain Qs and for the rest of the cases use the Diagram. For the specific cases ask the specific Qs.
Don't let the Pt think that you are not confident. Even if you don't remember all the Qs to ask, don't panic, remain calm and ask more open Qs. The SP will tell you everything. In other words if you don't know all the cases the SP knows his/her case. SP presents the same case over and over again.

Physical Exam:
Pay attention to: asking to perform the physical exam (Can I start now the physical exam?), draping techniques (practice them well), let the SP know what are you going to do, be nice and gentle, start with the Most Important System (just in case if you run out of time you will be done with the Most Important System), be quick and don't waste time with complicated maneuvers not related to the case.

Don't think that somebody is watching you or filming you. It this situation, there are only two people in the universe; you and the SP. Make him/her feel comfortable.

Physical exam can be simplified to 3 easy steps for every maneuver you do:
1. Explain what you are going to do.
2. Do the maneuver.
3. Say: "thank you" and continue with the next one.

Closure:
The exam of the SP is not over yet. Keep the same pace as the rest of the exam and finish up everything in the best way you can. Give your physical impression, DD, workups, and let the SP know that you are always there for him/her. Counseling is very important too.

Practice well the Most Common Cases like smoking, drinking, diabetes, HTN, abuse (child, women, and elderly), depression.
Say goodbye and shake hands.

Challenging cases:
Read the cases from FA and UW well. You can't memorize all of them, but at least you will have the idea what to say. Improvise. Be an actor this time. For the introduction, Hx taking, physical, and closure, follow the right pattern and the mnemonics, but for the challenging cases don't memorize all of them, it is too much. Make up something, be yourself, imagine that you are in your office. General rules are:
1. Be nice no matter how angry or upset the patient is.
2. Don't give false reassurance.
3. Always refer the problem to the future moment.
4. Use words like I am here for you, I am here to help you, together, we will, although.

O-LIQR AAA

CC: 1. What brought you in today? 2. Can you please describe to me more about your problem?

Onset, Progression Duration Frequency
MM: O-PDF

Onset: 1. When did it first start? → if CC is chest pain
2. When did you first notice? → if CC is vaginal bleeding or discharge
3. Was the **onset** all the sudden or progressive (gradual)?
Progression: Since the pain started, is it getting worse or better?
Duration: How long have you had your pain/cough/diarrhea? NO
Frequency: 1. Is it constant? **OR** 2. Does it come and go (intermittent)?
YES for intermittent→
2.1. When your pain (headache) starts, how long does it last? **Duration**
2.2. How often do you get headaches/pain (episodes)? **Frequency**
2.3. How do you feel between attacks (episodes)?
You can skip the Q for Duration. It is covered in Onset and Frequency. You

Location

- Can you please show me where exactly the pain is?

Intensity (Severity)

1. How would you grade your pain on a scale of 1 to 10?
2. If the cc is not a pain you can assess its severity by asking questions such as: "How bad is it?" "Does it interfere with your daily activities?" or "Does it interfere with your sleep?"

Quality

Start with an open Q:
1. How do you describe your pain?
If the Pt doesn't open continue with closed Qs like:
2. What does if feel like? I mean, is it sharp, dull, throbbing, cramping or burning?

Radiation

- Does it/the pain/your pain move anywhere?

Aggravating (Exacerbating) and Precipitating factors

1. **Aggravating:** Have you ever found anything that makes your problem/pain worse? **What makes it worse?**
2. **Precipitating:** What were you doing when it first began? What brings it on?
3. For abdominal pain: Is there any relationship to food? Any types of food that make the pain worse?

Alleviating (Relieving) factors

1. Have you ever found anything that makes your problem/pain better? **What makes it better?**
2. Have you treated yourself?
3. Has the treatment helped?

Associated problems

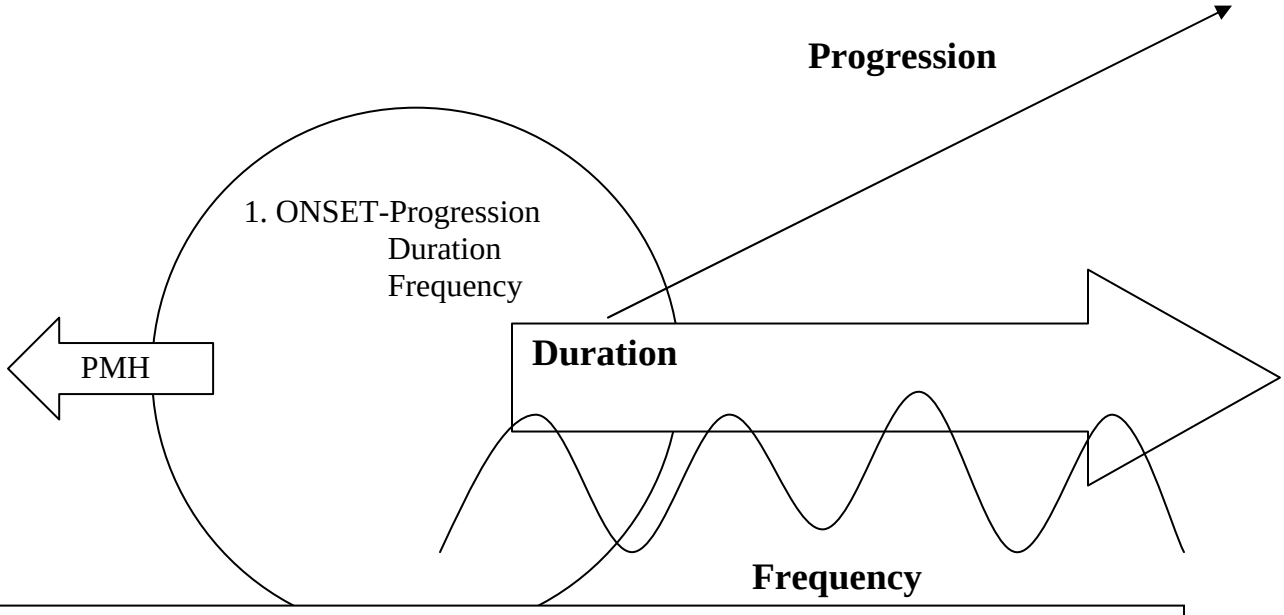
- Start with an open Q: Do you have any other symptoms besides chest pain? If the Pt doesn't open and ask, "Like what?" continue with specific Qs by systems, which can be related to the CC.

1. Headache 2. Nausea/Vomiting 3.Thyroid problems 4. SOB/Wheezing 5. Palpitations/Sweating/Lightheadedness 6. Fever and Chills 7. Diarrhea/Constipation and Abdominal pain 8. Edema 10. Fatigue 11. Urinary frequency/burning

- At this point, you can also ask some specific Qs based on the DD.
- Don't forget to ask for a Fever and Fatigue. It is very common.
- If Infection ask for ill contacts.

The Diagram

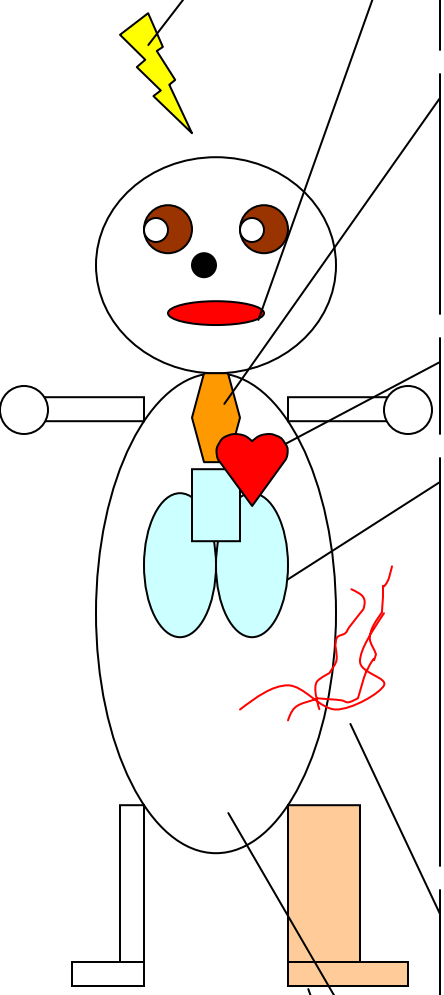
1. What brings you in today? What brought you to the hospital today?
2. Could you please describe to me more about your problem? (open ended Q), and continue with some specific Qs for Onset-PDF, Quality and AAA.



2. Quality: You can always ask again an open ended Q like: Can you tell me more about your___ or Can you describe more about your ___ ?, than ask some specific Qs
HEADACHE: How would (do) you describe your headache? Is it sharp…dull…pulsating…pressure like…throbbing?
DIZZINESS: 1.1. Tell me exactly what you mean by dizziness? How would you describe the feeling of dizziness (open Q)? If the patient doesn't open properly ask: Did you feel the room spinning around you, or did you feel lightheaded as if you were going to pass out (close Q)?
1.2. Is it constant or intermittent?
DISCHARGES: 1. Open ended Q 2. ABC-O

3. Follow AAA:
3.1. Aggravating factors and Precipitating factors/events
3.2. Alleviating factors and Treatment.
3.3. Associated symptoms.

1. When did it start? + Can you describe more about it?
2. Since it started, is it getting worse or better?
3. Is it constant? Or Does it come and go? If intermittent continue with DF and Between.
4. What makes it worse? What brings it on?
5. What makes it better? Specific Qs: Have you treated yourself? Has the Tx helped?
6. Do you have any other symptoms besides ____ ?



HEADACHE: Have you had headaches? How often and how severe are they?
YES→ follow up Qs for headache.

NAUSEA AND VOMITING: 1. Have you felt nauseated? Do you feel nauseated?
2. Have you been vomiting or throwing up? **YES→**
3. How many times (Frequency)? What does the vomitus look like (Description)? Follow ABC-O: What color was it? Was there any blood?
4. Ask the nature of the vomiting. Example: Have you had projectile vomiting?

THYROID: 1. Have you ever had problems adjusting to temperatures?
2. Has your voice changed recently? (Hoarseness in hypothyroidism)
3. Have you noticed any change in your bowel movements? (Constipation in hypo and diarrhea in hyperthyroidism)
4. Have you had any weight change lately? Have you lost or gained any weight lately?

HEART: 1. Palpitations: Do you have Palpitations? Did you feel your heart pounding or racing? 2. Sweating? 3. Lightheadedness? 4. Syncopy?

COUGH: Do you have a cough? **YES→** follow up Qs for cough: OQ-AAA-ABCO
For any case of chronic cough ask for HIV, TB, and ACEi.
CHEST PAIN: Do you have chest pain? **YES→** OLIQR-AAA
TB: 1. Have you been exposed to TB? 2. When did you take your last PPD (Test for TB)? 3. Do you have Night sweats?
SOB: 1. Have you ever had any problems with your breathing? Have you had **wheezing**? (They know what wheezing is)
2. How far do you walk on level ground before you have trouble breathing? Do you have to stop to rest…..to catch your breath?
3. Have you had any attacks of breathlessness in the night? (PND)
4. Do you need to be sitting up in order to get to sleep? (orthopnea)

FEVER: Do you have a fever? Have you had a fever? **YES→**
1. How long have you had a fever? - Duration
2. How high did your fever get? Was it a low-grade or high-grade fever?
3. Is it a continuous or intermittent fever? – Frequency
4. Is it accompanied (Do you have) with chills and/or sweating?
Bear in mind to ask for FEVER and FATIGUE almost all of the cases.

DIARRHEA/CONSTIPATION: Similar to the upper GI symptoms of nausea and vomiting, at this point you can ask some Qs for:
1. Diarrhea and constipation.
2. Abdominal pain.

EDEMA: Have you had swelling in your arms or legs? or Do your ankles swell? **YES→**
1. Where did you first notice it?
2. Ask them about any diurnal variation: Do they swell more in the day or night?
3. Tenderness of Legs (suggestive of DVT that can predispose to Pulmonary Embolism), helps for the DD of chest pain.

Pediatric history

Pregnancy

_ “Was your pregnancy full term (40 weeks or nine months)?”
_ “Did you have routine checkups during your pregnancy? How often?”
_ “Did you have any complications during your pregnancy/during your delivery/ after delivery?”
_ “Was an ultrasound performed during your pregnancy?”
_ “Did you smoke, drink, or use drugs during your pregnancy?”
_ “Was it a vaginal delivery or a C-section?”
_ “Did your child have any medical problems after birth?”
_ “When did your child have his first bowel movement?”

Growth and development

_ “When did your child first smile?”
_ “When did your child first sit up?”
_ “When did your child start crawling?”
_ “When did your child start talking?”
_ “When did your child start walking?”
_ “When did your child learn to dress himself?”
_ “When did your child learn to tie his shoes?”
_ “When did your child start using short sentences?”
_ “When did your child start putting things in his mouth?”

Feeding history

_ “Did you breast-feed your child?”
_ “When did your child start eating solid food?”
_ “How is your child’s appetite?”
_ “Does your child have any allergies?”
_ “Is your child’s formula fortified with iron?”
_ “Are you giving your child pediatric multivitamins?”

Routine care

_ “Are your child’s immunizations up to date?”
_ “When was the date of your child’s last routine checkup?”
_ “Has your child had any serious illnesses?”
_ “Is your child taking any medications?”
_ “Has your child ever been hospitalized?”

PAM HUGS FOSS for past medical Hx

Transition Q: OK Mr. ___ now I would like to ask few Qs regarding your past medical health. Is that OK with you?

Previous Episode of CC
PECC

1. Have you had **similar** problems before? Yes→ Can you tell me more? + When? Was it diagnosed? Was it treated? For chest pain you can assess the previous episode compare to the recent one. Ask the same Qs: OLIQR-AAA.

Past Medical Problems
PMP

2. Past medical problems**: start with an open Q→** DO YOU HAVE ANY OTHER MEDICAL PROBLEMS?

For any case ask for High blood pressure and Diabetes.

In cases related to specific system the following specific Qs are to be asked:

- CNS: 1. Have you ever had any stroke?
  2. Do you have any Hx of migraine headaches?
  3. Have you ever had seizures?
- CVS: 1. Have you ever had heart problems? ...like Heart attack? Heart failure?
  2. Do you have a high cholesterol levels?
- RS: Have you ever had any lung problems? ...like TB? Astma?
  1. Have you ever had TB?
  2. Do you have any Hx of Asthma?
- GIT: 1. Have you ever had any stomach problems? …like ulcers?
  2. Have you ever had any problems with your gallbladder or liver?
- Renal: 1. Have you ever had any kidney problems? …like Kidney infections? Kidney stones?
  2. Have you ever had any problems with your prostate?
- Thyroid: 1. Have you ever had any problems with your thyroid? **Never forget to ask about thyroid as many cases** (Ex: SP with c/o weight loss/gain, depression, amenorrhea etc) are related to thyroid.
- Cancers: 1. Have you ever been DIAGNOSED with any type of cancer?

Allergic Hx

- Do you have any allergies? →if Pt's complains are not mainly related to allergy like case of menopause, psychiatry case…

- Are you allergic to pets…Pause…drugs?...foods?...cold?...or dust? →if the case is related to allergy (most of the SPs have some allergy Hx though it is not related to the chief complain). Therefore you have to take the allergy Hx and ask some follow up Qs.

Start with open-ended Qs:

Could you please describe more about your allergy?

If the SP doesn't open, ask:

1. How often do you get allergic episodes (frequency)?
2. Are you taking any medication for that?
3. What kind of allergy related reactions did you have?

Medicines

- Do you take any prescription medications? Any over-the-counter medications (Ca2+ or vitamin D)?

Hospitalization

1. Have you ever been **hospitalized**? What for? When? Hospitalization most of the time covers the next Q for past surgical Hx.
2. Have you ever had any **surgery**? What for? When?
3. Have you ever been involved in a serious accident? Did you break any bones? Did you have any serious head injury?

Urinary complains

If the case is not related to urinary system just ask:

- Have you ever had any problems with your urination?

If the case is related to Genitourinary system, take a detailed history.

1. h/o pain/Burning micturition (on urination): Do you have any pain/burning during urination?
2. h/o of change of Color: Have you noticed any change in the color of your urine?
3. h/o incomplete Emptying: Do you feel that you haven't completely emptied your bladder after urination?
4. h/o Frequency/nocturia: How often do you urinate? Do you have to wake up at night to urinate?
5. h/o Incontinence: Have you ever been unable to control the passing of your urine?
6. h/o of Hesitancy: Do you have to wait before you start to urinate?
7. h/o of Hematuria: Have (Did) you noticed any blood in your urine?
8. h/o Pyuria: Have you noticed any pus in your urine? Was there any pus in your urine?
9. h/o Straining: Do you have to strain/push during urination?
10. Changes in the Stream of the urine: How is your flow of urine? Is it continuous? Is there any dribbling after urination?
11. h/o Urgency: Did you ever have to rush to urinate?

GI problems

If the case is not related to GIT just ask:

- Have you ever had any problems with your bowel movements?

If the case is related: 1. Do you have diarrhea? Are you constipated? (Have your bowel movements changed?) **YES→** Ask for Onset + PDF, than Quality and AAA.
Onset: When did is start? Progression: Since it started, is it getting worse or better? Duration: How long have you had diarrhea/constipation? Frequency: How often do you move your bowels? (How many bowel movements do you have per day/week?)
Quality (ABC-O): Open Q for Quality: What does your stool look like…than ask ABC-O, and add a Q for Consistency: What consistency? Is it soft?
5. Have you noticed any **black** or **tarry stools**?
6. Do you feel any **pain** when you have a bowel movement?
7. Did you **travel** recently?

Sleep

1. Do you have any problems with your sleep? **If so, ask for:**
2. Do you have difficulties falling asleep? Or maintaining sleep? …Or early wakeup?
This is mainly required in ALL psychiatric cases.
3. Do you snore? Do you feel refreshed when you wake up? Do you feel sleepy during the day?
4. How many hours do you sleep? Do you take any pills to go to sleep?

Pose a transition Q: OK Mr.___ now I would like to ask few Qs regarding your family's health, is that OK with you? And continue as follows:

Family History

1. Does any one in your family have **similar** problems?
2. Are your parents living?

YES→ How is their health?

NO→ show some empathy: Oh, I am sorry to hear that, could you please tell me the cause of their death?

If necessary ask for the family history of 1.Diabetes 2.High blood pressure 3.Stroke 4.Heart problems

Transitional Q: OK Mrs.___ now I would like to ask few Qs regarding your gynecological health, is that OK with you? Continue as follows:

OB/GYN Hx

If it is not an OB/GYN case, just ask:

1. When was your last menstrual period?
2. Are/Were your cycles regular?

If it is an OB/GYN case enquire about:

Cycle

1. When was your **last** menstrual period?
2. Are your periods/cycles regular? NO→ When did the change in cycle start?
3. Menarche: How old were you when you had your **first** period?
4. How many days does your period last?
5. Have you ever bled (had bleeding) between cycles?
6. How many pads/tampons do you use in a heavy day?
7. Do you have abdominal cramps/pain with your periods?
8. Did you ever notice any bleeding after intercourse?

Vaginal Discharge

1. Have you ever had any vaginal discharge?

YES→ Follow ABC-O and add these Qs: 1. Do you have any vaginal itching?
2. Have you ever had any sores or infections around the vagina?

Pregnancy

Have you ever been pregnant? How many times?

1. Any miscarriages or abortions? YES→ 1.1. How many times did you abort? 1.2. In which week/month/trimester of your pregnancy? 1.3. Do you know the reason for the abortion?

If the Pt has children ask:

2. Have you had any complications during pregnancy?
3. Have you had any complications during delivery?

Abdominal pain

Have you ever had any pain in your belly?

YES→ continue with Qs for pain: LIQOR AAA

PAP smear

1. Have you been getting regular PAP smears?
2. When did you have the last PAP smear?

OTHER Qs: 1. Do you have pain during intercourse?
2. Do you have any problems controlling your bladder?

You can use the mnemonic CV-PAP.

Transition Q: 1. OK Mr.___ Now, I need to ask you a few personal questions. 2. Please don't feel embarrassed. 3. Everything you say will be kept confidential…try to be as honest as possible. 4. Is that OK with you? Continue as follows:

Sexual Hx

Are you sexually active?
YES→ 1.Who is your sexual partner?
2. Do you have any other sexual partner? Over the last year?
3. Do you relate sexually to men, women or both?
4. Are you satisfied with your sexual life?
NO→ 1. Do you have any problems with your sexual life? The Qs are mostly for men.
2. Type (psychological or organic): Do you have morning erections?
3. Libido: Any loss of interest in sex?
4. Duration: Since when do you have this problem?
5. Orgasm: Are you able to reach an orgasm?
6. Do you have any feelings of depression because of this problem?
Qs ONLY for sexually active, obviously:
Do you use any means of contraception?
YES→ What type of contraception do you use? Do you use it regularly?
NO + Pts with multiple sexual partners, Pts with homosexual Hx continue with following Qs (most of the time they have this Hx and so never miss it)→
1. Have you ever had a Sexually Transmitted Disease?
2. Have you ever been tested/treated for Sexually Transmitted Diseases?
3. Have you ever been tested for HIV?

Transitional Q: OK Mr.___ now I would like to know about your social habits and personal life style, is that OK with you?

Social Hx

- **S**-moking
- **O**-ccupation
- **D**-rugs (Illicit)
- **A**-alcohol + CAGE questionnaire

Smoking
- Do you smoke?

YES→ 1. How many packs do you smoke per day? How much do you smoke?
2. How long have you been smoking?
3. Have you ever thought about quitting (attempted to quite)?
NO→ Have you ever smoke in the past? **Most of the SPs have smoking Hx.**

Occupation and exposure
1. Do you work? What type of work do you do?
2. Is it a stressful job? **If mental**-depression, **if physical**-carpal tunnel syndrome.
3. Are you exposed to any health hazards in your work or personal life?
4. Do your job involve sun exposure? **(for a case of rush)**
5. Are you exposed to a loud noise at work? **(for a case of hearing loss)**

Drugs
- Have you ever tried any recreational/illicit type of drugs?

YES→
1. What kind of drugs?
2. How long have you been taking them?
3. Have you ever injected drugs?
4. If the drug used is related to the CC: When was the last time you used drugs?

Social Hx continues

Alcohol

- Do you drink alcohol?

YES→ 1. What **type** of beverages do you take?
2. How much do you drink per day?
3. How long have you been drinking?
CAGE of suspected alcohol abuse cases (upper GI bleeding, RUQ pain, epigastric pain):
C---Have you ever tried to CUT DOWN on alcohol drinking?
A---Have you ever been ANNOYED by other people for your drinking?
G---Have you ever had GUILTY feelings about your alcohol drinking?
E---Do you drink alcohol EARLY in the morning (eye opener)?

If you have time, continue with some more social Hx Qs. The mnemonic is DA WEST. Think that people from the western world are always on Diet with no success, because they have a lot of Appetite. The result is that they are over-Weight. So, they try to Exercise (again no success), and when they have Stress, they usually Travel.

Diet
1. Can you please tell me about your diet? Any change in your eating habits?
2. What does your diet mainly consist of? What do you usually eat?
3. Are you on a special diet?
4. Did you eat anything unusual lately?
For peri/postmenopausal women ask: 5.Do you take Ca2+ supplements?

Appetite
1. How is your appetite?

Weight
1. Have you lost or gained any weight lately?
YES→ How many pounds did you gain/lose? In what period of time (Over what period of time did it happen?) Was the weight gain/lose intentional?

Exercise
1. Do you exercise regularly?

Stress
1. Do you have stresses from your family?

Travel
1. Have you traveled outside the US in the recent years?
2. When?
3. Where?

HISTORY Qs starting from the head and no including the Qs for Pain and PMH

Headache

The first Q is: Do you get headaches? If the Pt obviously has headache, don't ask.
YES→ use LIQOR AAA first:
L-Can you please show me where exactly the pain is?
I-How would you grade your pain on a scale 1 to 10?
Q-Quality: How would (do) you describe your headache? Sharp? Than ask for the opposite of sharp Dull?, and than for the 3P: Pulsating, Pounding (aka splitting aka throbbing, in case of migraine, which starts on one side), and Pressure-like.
O- Onset----When did it first start?
Progression: Does you headache progress (change) during the day? I mean does it get worse or it gets better? **Tension headache** gets worse as the day progresses.
Duration: When your headache stars, how long does it last?
Frequency: How often do you get headaches?
R-Does the pain move anywhere? Does your pain goes anywhere else? Like to your jaw, or back of the neck?

A-Is there anything that makes the pain worse? What makes it worse?
Precipitating factor: What causes the headache to start?
A-Is there anything that makes the pain better. What makes it better?
A-Associated symptoms: Have you ever had this pain before?
YES→ 1. **Migraine**: *Do you get to know that you are going to have headache (aura)?* I mean do you feel any blurriness or seeing flashes BEFORE you get the headache? Or you can ask: Do you notice any change in your vision before/during/after the headache?
2. **Cluster**: unilateral, periorbital pain associated by ipsilateral nasal congestion, rhinorrhea, lacrimation, redness of the eye, and Horner's syndrome. Episodic daily pain in clusters. Often awakes the patient at night: *Do your headaches wake you up at night?* More common in men.
3. *Do you notice any numbness or weakness before/during/after the headache?*
4. *Do you feel nauseated? Do you vomit?*
5. **Meningitis**: Do you notice any fever or stiff neck with your headache?

A-Additional Qs for headache: 1. Tell me what happens before/during/after your headache? (this Q was covered).
2. Timing: Do your have headaches at certain times of the day? **Depression:** early in the morning.
3. *Have you noticed any relationship with menses?*

Cough

Start with: Do you have a cough? Or if the patient main symptom is cough doesn't make sense to ask this question, just proceed to the next question.

You can use part of the LIQOR AAA mnemonic: O(PDF)Q AAA

1. **O**nset: When did it start? **P**rogression: 1. Since the cough started, is it getting worse or better? 2. Does your cough change during the day? (for Chronic cough). 3. Do you cough at night?

Duration: How long have you had cough?

Frequency: How often do you cough?

2. **Q**uality: Open Q: Can you tell me more about your cough? Can you describe your cough? Closed Q: Does anything come up when you cough (productive), or is it dry? Do you bring up sputum?

YES for Productive cough → use the mnemonic: ABC-O:

A-Amount: Can you estimate the amount of it? Teaspoon? Tablespoon? Cupful?

B-Blood (you can ask for amount too): Is there any blood in it?

C-Color: What color is it? Consistency and Content: What does you sputum look like?

O-Odor: Does it smell? Is it foul smelling? Does it have any bad odor?

3. **A**ggravating: Does anything make it worse?

and **P**recipitating factors: What brings it on?

4. **A**lleviating Factors: Does anything make it better?

5. **A**ssociated problems: 1. Do you have chest pain? SOB?

2. Have you been exposed to TB? Night seats? Fever?

3. When did you take your last PPD test?

You can use the same protocol for:

Vaginal discharge: with additional questions of Itching, Sores and Douching

Vomiting: with additional questions of Nausea. Don't ask for Odor (it smells bad).

Sputum: preceded by a question like: Is cough Productive or Dry?

Diarrhea: with additional questions of Tenesmus, Urgency and Fecal incontinence; in addition to blood ask for Mucus and Melena also; ask Travel Hx and Contact with people with diarrhea. **What does you stool look like? Is it soft? What consistency?**

Constipation: with additional questions of Tenesmus and Fecal incontinence and Pain on defecation: **Do you feel any pain when you have a bowel movement?**

Blood in stool: ask the Pt to describe more (blood before, during, or after defecation)+ the same additional Qs for Diarrhea/Constipation.

In all chronic cough patients don't forget to ask about HIV status and tuberculosis. They will not tell you until you ask about his HIV status*. You should also ask about drug intake especially about the use of ACE inhibitors*

Ask also for preceding symptoms/events like URI.

Tenesmus: Do you feel that you need to defecate but nothing comes out?

Urgency: Do you feel that there is no time to reach the bathroom when you want to defecate?

Daily Activities (for dementia patients)

Start with: Tell me about your day yesterday?

Can you please describe me about your typical day, like your routine activities of daily living?

DEATH for Katz activities of daily living

D-Dressing: 1. Do you need any help getting dressed?

2. What do you need help with when you are getting dressed?

E-Eating: 1. Do you need any help feeding yourself?

2. What do you need help with when you eat?

A-Ambulating: 1. Do you need any help transferring from your bed to the chair?

2. Do you need any help going to the toilet?

T-Toileting: 1. Have you ever had accidents with your urine or bowel movements?

2. Do you ever not make it to the toilet on time?

H-Hygiene: 1. Do you need any help bathing?

SHAFT for Instrumental Activities of Daily Living

S-Shopping:

H-Housekeeping: cleaning, doing laundry, telephone, taking medications

A-Accounting:

F-Food preparation:

T-Transportation:

Dizziness

1. Quality: 1.1. Tell me exactly what you mean by dizziness? How would you describe the feeling of dizziness (open Q)? If the patient doesn't open properly ask: Did you feel the room spinning around you, or did you feel lightheaded as if you were going to pass out (close Q)?

    1.2. Is it constant or intermittent?

2. Onset: When did it start?
   Duration: How long does it last?
   Frequency: How often did you get dizziness?

+ Timing: Have you noticed any particular time of the day when dizziness comes?

3. A-Positions that can elicit (provoke) the dizziness: lying down, sitting, standing up
   What causes this dizziness to happen?
   A-Positions that can relieve the dizziness

4. Questions about Hearing:

Ask the patient how is his hearing. Use the mnemonic: He can't **Hear**-ing loss, because of the **Tin**-nitus, **Ful**l-ness and Pressure **Disc**-harge.

Hearing loss: Did you notice any change in your hearing?
Tinnitus: Do your ears ring?
Fullness and Pressure
Discharge

5. Did you loose Consciousness? YES→ Did you fall when you lost consciousness? How long did it last? Did you black out? is a similar question (Lose consciousness, faint; also, experience a temporary loss of memory).
6. GI: Do you feel Nauseated? Do you vomit?
   Do you have Diarrhea? YES→ABC+O
   Do you have abdominal pain?
7. Have you had any Falls? (the Patient feels dizzy, it is normal if he falls)
8. Do you have Headaches? Have you had any Head trauma? (because of number 7)
9. Have you had any URI recently? (for labyrinthitis and vestibular neuronitis)
9. Fever: Do you have Fever? Fatigue: Do you feel weak?

For a case of fainting=passing out=syncope=loss of consciousness, continue for #5 with the next Qs:

1. Loss of consciousness before/during/after the fall: 1.1. When did you loose consciousness? Before/During/or After the fall?

    1.2. Do you know for how long you lost consciousness?
    1.3. Did you sense something unusual before losing consciousness like sounds, lights, smell?
    1.4. Did you feel lightheaded before the fall?
    1.5. Were you confused after you regain consciousness?

2. Palpitations before the fall: Did you have any palpitations (heart racing) before the fall.
3. Did you have shaking during the time you passed out? YES→1.1 Duration: How long?

    1.2. Did you bit your tongue?
    1.3. Did you loose bladder control?

1.4. Did you feel any weakness/numbness after the fall?
1.5. Did you have any speech difficulties?

4. Have you had any similar episodes of lightheadedness, passing out and falls before?
5. Have you noticed any gait abnormalities?

Fat loss (weight loss): Have you had any weight change lately?
Cold intolerance: Have you ever had problems adjusting to temperatures?
Skin/Hair: Have you notice any skin changes? Is your skin dry? Does your hair falls out more than usual?
Constipation: Are you constipated?
Voice: Has your voice changed recently (hoarseness)?

Depression: Do you feel depressed?
Sleep: Do you have any sleeping problems? Falling asleep? Staying asleep? Early waking? Snoring?

FACE SLIPS

General Qs: 1. Tell me about yourself and your future goals?
2. Do you have any idea what might be causing this?
3. What do you thing makes you feel this way?
4. Can you tell me more about it?

F-Feelings of Guilt and Blame: Do you feel guilty about anything?
Anger and Aggression: 1. Do you feel angry?
2.Do you feel like you want to hurt other people? Have you ever done so?
3. Do you have any thoughts of harming yourself/others?
Worthlessness:
Hopelessness: Do you feel hopeless?
Loneliness: Do you feel lonely?

A-Appetite: Has your **appetite** changed lately?
Has your **weight** changed recently?
Is there any kind of special **diet** that you are following?

C-Concentration levels: 1. Do you have any **memory** problems?
2. Do you have difficulty **concentrating**?

E-Energy: 1. How is your energy level?
2. Can you still perform your daily functions and activities?
Events (RECENT, ASSOCIATED): 1. Have you had any recent **emotional or financial problems**?
2. Have you had any recent **traumatic event in your family**?

S-Sleep disturbances: 1.Do you have any problems falling asleep/staying asleep/waking up?
2. Do you **snore**? (for sleep apnea in Pt with fatigue)

L-Libido: How is your **sexual desire**?
Loneliness: Do you feel lonely?

I-Interests and Hobbies: 1. What interests/hobbies do you have? Do you enjoy them?
2. Do you take interest or pleasure in your daily activities?
3. Have you lost any interest in your social activities and relationships?

P-Psychomotor symptoms (psychosis): 1. Do you ever see or hear things that others can't see or hear?
2. Do you feel as if other people try to harm or control you?

Performance (JOB): 1. Can you still perform your daily functions and activities?
2. Do you have any problems in your job? How is your performance on your job?
Pleasure levels: 1. Do you take interest or pleasure in your daily activities? It is similar to Interests and hobbies

S-Suicidal Qs for Thoughts: Have you ever had any thoughts of hurting yourself or ending your life?

Plans: 1. Do you have a plan to end your life? Would you mind telling me about it?

Attempts: Have you ever tried to end your life?

Associated symptoms: fever/chills, chest pain, cough, SOB, cold intolerance, skin/hair changes

Family Hx:
1. Has anyone in your family ever experienced depression?
2. Has anyone in your family ever been diagnosed with a mental illness?
3. Whom do you live with?
4. How do they react to your bahaviour?

Support: Family and Friends: Do you have any friends or family members you can talk to?

Others: 1. Would you like to meet with a counselor to help you with your problem?
2. Would you like to join a support group?

Thyroid problems: 1. Have you ever had problems adjusting to temperatures?
2. Are you loosing any hair?
3. Has your voice change?
4. Have you noticed any change with your bowel movements?

For all Fatigue cases consider Depression, Hypothyrodism, and Anemia in the DD.

What is Qs

1. What is an ECG? Electrical recording of heart beat
2. What is a U/S? A non-invasive imaging technique using sound waves to look inside the body
3. What is a colonoscopy? Visualize your bowel using a scope passed through your bottom.
4. MRI? Taking internal pictures of the body using magnets
   CT-scan? Serial X-ray of the…
5. ERCP? It is a procedure in which a tube is inserted through mouth to see bile ducts, gall bladder, and pancreas
6. Sputum? Phlegm/Secretions from your wind pipe
7. HbA1C? HbA1C test is a way to see what your blood sugar has been for the last 2 to 4 months
8. Abscess? Cavity with pus
9. Abdomen? Stomach, Belly, Tummy
10. Abduction? Push out…Adduction? Push in
11. Abuse? Do your parents (boyfriend/girlfriend,roommate,husband/wife)treat you badly?
12. Acidosis? Condition when blood contains more acid than normal
13. Alzheimers disease? age related memory loss
14. Amenorrhea? absence of menstrual periods
15. Angina? Chest Pain due to Reduced Blood Supply to the Heart
16. Anus? Rear end
17. Anxiety? A feeling of nervousness
18. Appendicits? an inflamation of a tiny structure of your intestine that we call appendix
19. Arrhythmia? Irregular heart beat
20. Astma? repeated episodes of difficult breathing due to some allergens and irritable airways
21. Babinski? I will be tickling your feet lightly
22. BPH? increse in size of a gland outside a pipe like structure(urethra) and compressing the flow of urine through it
23. Bronchitis? Inflammation of the air ways
24. Bipolar? Ups and Downs in your mood
25. Cervix? Neck of womb
26. Claudication? Limping
27. Clavicle? Collar bone
28. Colitis? Infection if the large intestines
29. Conjunctivitis? Inflammation of the outer layer of your eye
30. Connective tissues? Tissues between bone and muscle
31. Constipation? Passing hard stools or unable to pass any stools
32. Convulsions? Sudden, jerky movements out of your control
33. Cushing? Raised levels of steroids in the body
34. Cyanosis? Blue nails on your fingers and toes
35. Deep palpation? I need to press a little bit more deep on your belly
36. Dementia? Forgetfulness

37. DM? A disease that causes high sugar levels on your blood
38. Diaphoresis? Excessive sweating
39. Diarrhea? Loose motions
40. Diplopia? Double vision
41. Disc herniation? The disc supporting the backbone is out of place
42. Disease? Medical condition
43. Diuretic? Water pill
44. Diverticulosis? Out pouching of the bowel wall
45. Dizziness? Light headedness, feeling like you are going to faint
46. Drape=sheet? May I lift the sheet
47. Dyschezia? Pain while passing stools
48. Dysfunctional uterine bleeding? Heavy or irregular menstrual bleeding that is not caused by any evident underlying physical abnormality
49. Dysphagia? Difficulty while swallowing/blockage of food pipe resulting in difficulty in eating or drinking
50. Dyspnea? Difficulty breathing
51. Dysuria? Burning urination
52. Ectopic pregnancy? Pregnancy occurring outside the womb lining
53. Edema? Swelling/Fluid retention
54. Endoscopy? It is a tube with camera in it to see the gut/bowel/stomach
55. EEG? Recording of the electrical activity of the brain
56. Enuresis? Bed-wetting
57. Emesis? Vomiting/Throwing up
58. Epilepsy? Seizures (sudden burst of excess electrical activity in the brain)/ A Brain Disorder characterized with occurance of Fits (older term)
59. Epistaxis? Nose bleed
60. Esophageal varices? Swelling of internal veins of the food-pipe that can result in rupture and bleed
61. Esophagus? Food pipe
62. Euphoria? Feeling happy without a reason
63. Exophthalm? Eyes poping out
64. Expectoration? Spitting out phlegm
65. Faeces? Poop/Stool
66. Family Hx? Any condition running in your family
67. Fibroids? Common benign tumors of the uterus that can cause pain and bleeding during periods
68. Flatulence? Passing gas
69. Flex=Bend
70. Gout? Inflammation of joints because of uric acid crystals
71. h/o of delusions? Do you have certain beliefs which majority of your colleagues feel as unreasonable?
72. Premature ejaculation? Do you get premature discharge during sexual intercourse?
73. Habitual abortions? Repeated abortions
74. Haematemesis? Vomitus (Vomiting) containing blood
75. Hallucinations? Do people ever tell you that they think you're hearing or seeing things that others dont?

76. Heart murmur? a sound between the two normal sounds of the heart that sounds like someone blowing, and can be caused by different heart pathologies or may be a normal finding in some cases
77. Hematochezia? Red, fresh blood in stool
78. Hematuria? Blood in urine
79. Hemoptisis? Coughing up blood
80. Hemorrhoides? Swollen veins in the back passage
81. Hesitancy on urination? do you feel like going to rest room but urine will not come out?
82. Hypertension? Hign Blood Pressure
83. Hypervventialtion? Fast breathing
84. Hypoxia? Lack of oxygen causing difficulty breathing
85. Icterus=jaundice? yellowish discolouration of eye and skin
86. IBS? Abnormal bowel movements
87. Immunocompromised? having an immune system that has been impaired by disease or treatment
88. Incontinence of urine? Have you ever licked urine without your knowledge?
    Incontinence of stool? Have you ever lost control of stool?
89. Inf. Mononucleosis? Swollen glands disease/u might have infection of glands in your neck
90. Inhale=breath in
91. Insomnia? Problems with your sleep
92. Inspect=look at
93. Intrathecal? a route to deliver some medication directly into your brain
94. Ischemia? lack of Oxygen to the heart/brain because of narrowing of the vessel supplying the blood
95. Ischemic bowel disease? Decreased blood supply to a portion of bowel
96. Libido? Sexual desire/drive
97. Lymph nodes (glands)? Let us look for any swellings over your neck
98. Melena? Black tarry stool
99. Menopause? When a women stop having periods naturally
100. Micturition? Passing urine/urinate
101. Impotence? Loss of erection
102. MS: patchy inflammation of the brain tissue
103. Mucosa: inner lining of the intestines and some other organs
104. Nausea: feel like you wanna puke
105. Orthostatic hypotension: drop in BP significantly with change in posture
106. Osteoarthritis: Inflammation of joints due to wear and tear and aging
107. Palpate: press on
108. Palpitations: racing heart beet
109. Parkinson's dis: abnormal limb movements at rest
110. Percussion: tapping
111. Placenta: connection between you and the baby
112. Polyuria: excessive urination
113. Post traumatic stress disorder: A depressive condition subsequent to trauma of any sort

114. Post-nasal drip: Do you feel something sticky dripping at the back of your throat ?
115. Projectile vomiting: forceful vomiting
116. Proptosis: Eyes seeming to pop out\
117. Prostate: a gland around the neck of the bladder
118. Ptosis: droopy eyes
119. Pulmonary embolism: CLOT IN BLOOD VESSEL SUPPLYING LUNGS WHICH CAN LEAD TO SOB
120. Pus: a thick yellowish fluid consisting of bugs, tissue and white blood cells
121. Pyrosis: heartburn, waterbrush (spontaneous flooding of the mouth with a clear, slightly salty fluid, which may be of sufficient quantity to require expectoration)
122. RA: inflammation of the joints
123. Radiate: move
124. Rectal examination: examination of the back passage
125. Rectum: back passage
126. Regurgitaion: To bring out the food that was recently eaten
127. Rotate: turn
128. Schizophrenia: abnormal thoughts
129. Steatorrhea: greasy stool
130. Stool: poop
131. Stroke: due to lack of a blood supply to part of your brain
132. Suicide: ending your life
133. Superficial palpation: I need to press lightly on your belly
134. Swelling: lumps or bumps
135. Syncope: Faint
136. Tachycardia: abnormally rapid heart rate
137. TB: it is a contagious disease of the lungs that spreads by sneezig and coughing,can cause fever, chronic cough, bloody sputum, night sweats and weight loss
138. Thrombosis: blood clot
139. TIA: A Mini-Stroke or a momentary loss of brain function due to temporary blockage of blood to the brain
140. Tingling: pins and needles sensation
141. Tinnitus: ringing in the ears
142. Trachea: wind pipe
143. Tremor: shaking
144. Trigeminal neuralgia: pain due to inflammation of a nerve
145. Tumor: mass
146. Umbillicus: belly button
147. Urine: pee
148. Vagina: front passage
149. Vaginal discharge: Have you ever had discharge from down under?
150. Vertigo: feeling of spinning
151. Wheeze: whistle like sound when you breath

How to play safe with Challenging Qs

Use this model:
…it may be ___ , or possibly ___
…but we are not sure at this point.
I need to run some tests in order to find out exactly what the problem is/establish the final diagnosis.

- Always refer the Pt to a future point.
- Always use words like:

→ possibly; may be
→ not sure yet; don't know yet
→ Your safety is my primary concern, and I am here for help and support when you need it.
→ together we can decide
→ your symptoms are of considerable concern

Sometimes you can add:
1. Life threatening case (Hearth attack, Appendicitis): We have to make sure that your condition is not life threatening.

PHYSICAL EXAM

HEENT:

Head and Neck:

1. Inspection:
    1.1. Look for scars, lumps, rashes (skin), hair loss, etc.
    2.1. Assymetry, deformities, edema (swelling)
    3.1. Jaw location
    4.1. Orbital ridges
    5.1. Cervical spine
    6.1. JVD, pulsations, masses, edema
    7.1. Yes: conjugate gaze, ptosis
    8.1. Septum location for deviation

2. Palpation: Mr/Mrs.___ I am just going to be palpating different parts of your face and neck, all right?
Palpate first superficially with the pads of your fingers, than deeply. Go superiorly to inferiorly.
If you have any pain with this just let me know.
    1.1.Glabella
    2.1.Orbital ridges
    3.1.Jaw: Can you open your mouth? .....Asses for clicks.
    4.1.Sinuses (4 points) and the bridge of the nose… You can ask for pain again.
    5.1.LAD: -posterior auricular (behind the ear)
        -posterior occipital (at the back of the head)
        -superficial LAD
        -deep LAD (medially to the sternocleidomastoid muscle)
        -submandibular
        -submental (more anteriorly)
    6.1.Thyroid: from behind moving medially
    7.1.Tracheal cartilage: palpating with the tomb and the rest of the fingers
    8.1.Trachea (asses the midline position): palpate with 3 fingers

Mouth and Throat (oral pharynx):

1. Inspection: Always wear GLOVES and use wooden palate.
Say: I am gonna have you opened up your mouth.
    1.1.Cracks, angular chelosis
    2.1.Dentition
    3.1.Tongue→inspect it, than bring the light in and say: If you can stick your tongue out→depress the tongue with a tongue depressor and ask the Pt to say AAA→look at the back of the throat for tonsillar enlargement, redness, or discharge

*in children this is a god examination for trash (white film) on the tongue and bucal mucosa

EYES: Say: Now, I need to examine your eyes.

1. Inspection
    1.1. Symmetry, size
    1.2. Say: I'm just gonna put my hands up here (put your heads on the lower eyelids and pull them down gently)…and Say: Can you look up for me? This is to assess conjunctiva and sclera.
    Note: discoloration, redness, discharge, or lesions. Note any deformity/lesions of the iris and cornea. *on the real exam you are not gonna see any of those findings.

2. Examination by confrontation:
Say: If you can just close your R eye, and look at my L ear. Right here (point your left ear). Pt looks with his L eye at your L ear.
What I am gonna do is, I am gonna move my finger and if you see it moving say YES. Anytime when you change the position of your finger ask the Pt: Can you see this finger moving…and over here.
Examine the R eye. Say: if can just close your L eye, hold your L hand over it. Check the visual fields using the same finger on your R hand. Check all 4 quadrants.

3. Pupillary response to light and convergence.
3.1 Pupillary response to light: I am gonna ask you to look at my finger and I am gonna shine a light in your eye.
-dim the room
check 1. direct 2. consensual reflex→ shine the light 2 times in each eye
-check the other eye, standing on the same side and using the same hand
-turn the light back on
3.2. Convergence: Say: keep your eyes on my finger…than start moving the finger towards Pt's nose.

4. Extraocular muscles (testing also III, IV, and VI):
Say: If you can keep your head still and look at my finger. I am gonna be moving my finger back and forward. Watch Pt's eyes and be sure that they follow the finger and correspond with the move. Follow the H and X directions. Notice: any discrepancies, hesitations, and deficits.

5. Swellen's chart: Pt is always asked to test both eyes, and than cover one and than the other one.
Say: If you could read the smallest line on this chart?
……
and with one hand if you can cover your R eye and read with your L eye the smallest line
……
Now, release that one, and cover your L eye with your L hand.

Don't bother about it on the CS ... merely mention that as an Investigation on the Patient Note (PN). But yeah guys - do the Finger counting test instead.

This is how : Ask the SP to look striaght ahead and then hold your fingers in front of the SP at approximately 3 feet from his/her eyes. Request the SP to count them for you. Now, in real life situations, if the patient cannot count them - it means you gotta perform the next level of testing - that is moving finger test for motion detection. But on the Step 2 CS , since the SPs have normal vision, you wouldn't need to go that far.

On the patient note, mention "visual acuity done by Finger Counting at 3 Feet". And of course mention Snellen's chart testing for visual acuity on the Patient Note, [repeating that in case your eyes missed that on the first line ;-)]

Q. On what cases would you bother testing visual Acuity ?

A. Cases with Visual Problems, cases where visual complications can occur, like DM, HT AND in cases where you will be checking out Cranial nerves !

6. Ophtalmoscope:
-turn off the lights
-Say: If you could look at the picture/clock on the wall…I am gonna put a light in your eye, you just keep your eyes on the wall. R-R-R.
-switch sides. L-L-L.

EAR:
1. Inspection: Say: First I am gonna look at the exterior aspect of your ear. Notice: redness, swelling.
2. Palpation: when palpating Ask: If it is painful let me know.
3. Internal examination: Say: I am gonna examine your ear.
Pull the ear out and upwards. Slowly enter.
4. Whispering: OK Mr/Mrs. ___ I am going to whisper in each ear, you repeat the words as I said them. Doctor. Hospital.
5. Weber: I am gonna put this tuning fork on your head. Tell me: Does it sound different in your R and L ear or Does it sound the same.
If there is a localization of the tone to one side or another you will note this down.
6. Rinne's test: Touch with the tuning fork patien's mastoid. Ask: do you hear that tone? SP: Yes. You: As soon as you don't hear it let me know. SP: Now. Put the tuning fork in front of the Pt's ear and ask: Do you hear it in your ear?
The Pt should be able to hear the tuning fork in both places.

LUNG:

Anterior wall chest exam: the Pt is lying in bed

1. Inspection: Say: Do you mind if I inspect your chest?

Note: rib deformities, sternum (pectus excavatum, pectus carinatum)

2. Palpation: Say: I am going to palpate your ant. Chest and have you take deep breaths for me.

2.1.Put your hands on the chest wall and look for the symmetry of motion of respirations.

2.2. Tenderness

2.3. Tactile fremitus (TVF). Say: I am just gonna put the heal of my hand (show it to the SP) on your chest, and I am gonna have you repeat the words 99. Put your hand in the intercostals space and say: Go ahead! Check 6 spots (if you don't have time check only 4 spots).

3. Percussion: Say: I am gonna be just tapping on your chest wall. Listen to the note of percussion and compare both sides.

4. Auscultation: Say: I am gonna listen to your lungs. Can you turn your head to the other side and take a bid breath for me?

Posterior wall chest exam: The Pt is sitting at the bedside.

1. Inspection. Say: Can I examine the posterior aspect of your chest? Note: ribs, scapula (sholder balde) symmetry

2. Palpation: same as for the anterior aspect of the chest

3. Percussion. Never percuss over the scapula.

4. Auscultation: the same. 4 or 6 times?

HEART: Say: Mr/Mrs. ___ Can I examine your heart?

Sitting:

1. Inspection:

1.2. Visible pulsations in the chest area and visible carotid pulse

1.2. Look for JVD (best when the patient is lying down in bed with his had at 30 degress, so you can do it when the Pt is sitting, but it doesn't hurt if you just look for JVD quickly)

1.3. Carotid bruits (use the Bell of the stethoscope), this is actually part of the auscultation part of the physical exam, but you can do it at this point because you are expecting the neck are. Finish with it and continue with the chest ares.

1.4. Check for dependant/pedal edema. Say: I am going to examine your legs to check for fluid retention. Is that OK with you?

2. Palpation: Say: I am going to palpate your heart, OK?

2.1 Feel for any pulsations, PMI, retrosternal heave, and thrills. Use the pads of your fingers, than the heel of your hand. Asssess the thrill with the heel of your hand on the left sternal border where the R ventricle is, assessing for any kind of heave, than move to the L side of the chest over the area of the L ventricle.

2.2. Palpate the carotid artery, lightly with your fingers

2.3. Check the pulse (regular or irregular). Say: I need to check your pulses in your arms and legs now. OK?

3. Auscultation: Say: I am gonna listen to your lungs now, OK? SAY: CAN YOU HOLD YOUR BREATH, PLEASE?

3.1. Listen to P-A-T-M. If murmur, listen for radiations of the murmur up (listen to the neck on both sides + assessing for bruits) and down (axilla). Say: can you lift your arm up a little bit?

3.2. Listen to the base of the heart with the Pt leaning forward (not necessarily). You better do it after you examine the heart in a lying down position, and ask the Pt to sit up again.

Lying in bed:

1. Inspection: already have been performed + JVD/JVP (the best to assess is with the Pt's head at 30 degrees).

2. Palpation: the same

3. Auscultation: Say: I need to listen to your heart.

3.1. Listen P-A-T-M and for any murmurs.

3.2. Say: if you could please lie to your L side. Use the Bell (for lower sounds) and listen to the mitral area for mitral valve stenosis (only if the case is related)

Ask the Pt to sit up again. Say: Can you sit, please?

Sitting again:

ONLY AUSCULTATION: Listen again to P-A-T-M and ask the patient to lean forward to listen to base of the heart (not necessarily if you don't have enough time)

MMSE

First things first - When to do an MMSE? In cases of non-focal-deficit CNS Cases like:
1. Memory Loss / dementia
2. Confusion / Delirium
3. Schizophrenia / Delusions

Would you do it for every CNS Case? Not really - use priority + time judgment. If patient has a symptoms suggestive of Focal Neurological Lesion/s - Its more important to do a complete CNS exam + gait and then think about MMSE.

I would like to ask you a few question to test your orientation, OK?
1. Can you hear me? If you hear me, can you smile for me? (Consciousness)
2. **Place:** Do you know where are you now?
   Person: Can you tell me your full name?
   Time: What is the date today?
3. What would you do if you found a self-addressed enveloped on the street? (Judgment)

Now I would like to ask you some questions to check your memory.
1. Mr/Mrs ___ I am going to say three words. I want you to say them after me. I will ask you to repeat the same words again after a few minutes. Do you understand? Say, "pen, car, and chair". Ask again at the end of the mental status. (Immediate memory)
2. Do you remember what you had for lunch yesterday? (Recent memory)
3. When did you get married? What happened in September 11th? (Distant memory)
4. Now, Can you repeat for me these three words I mentioned before? (Short-Term memory)

Test for Abstraction:
You: "Can you please spell the word, "WORLD" backwards for me?

Three object command/Three step command:
1. Are you left-handed or right-handed?
2. I will give you a piece of paper. I want you to take the paper in your right hand, fold the paper in half, and put it on the floor.

Closure:
1. Follow-up
2. Need to obtain Hx directly from other family members
3. Need to evaluate home safety and supervision
4. Community resources that help the patient at home
5. Offered support throughout her illness

When to use:

Ophthalmoscope:
1. DB
2. HTN
3. CVA→check the CNs
4. Increase intracranial pressure

When to do DTRs:
1.

HEENT
Routine CBC with diff, ESR
HEAD IMAGING: X-ray, CT, MRI of head
Eye- Snellen's chart, Visual acuity
Ear- Complete audiometry and tympanometry, Culture/Sensitivity for any discharge

CNS
Routine CBC with diff, ESR
IMAGING: X-ray, CT, MRI
Lumbar puncture
Carotid Doppler study
EEG
Electromyography and Nerve conduction studies.
Echocardiogram for suspected embolic phenomena.

Respiratory
Routine CBC with diff, ESR
IMAGING: Chest X-ray, CT, MRI of chest???
sPutum studies (culture/sensitivity, gram stain, AFB)
Pulmonary function tests (PFT) and sPirometry
PPD
ABG and Pulse oximetry

CVS
Routine CBC with diff, ESR???(if infection)
IMAGING: Chest X-ray, Echocardiogram, CT, MRI (???for ct and mri)
EKG
Cardiac enzymes (CPK-MB, Troponin, LDH)
Lipid profile
Thyroid screen
Serum electrolytes

Abdominal

Always start with: rectal examination/ fecal occult blood (P.ulcer, Gastritis, G. cancer).

BLOOD: Routine CBC with diff, ESR (non specific but can see leukocytosis in infection or appendicitis)
IMAGING: 1. Abdominal X-ray
2. ULTRASOUND
2.1. Ultrasound of Abdomen: acute cholecystitis (show stones, thickened gallbladder wall, and sonographic Murphys's sign)appendicitis
2.2. U/S-Pelvis: ovarian pathology, intrauterine pregnancy
3. CT abdomen/pelvis: appendeceal inflammation, abscess, or signs of other GI or GYN pathology)

UPPER GI SERIES: (esophagus, stomach, and small intestine):
1. Endoscopy+Biopsy: P.ulcer, Gastritis, G.cancer

2. Barium swallow: cancers, ulcers, problems that cause narrowing of the esophagus)
3. ERCP (Endoscopic retrograde cholangiopancreatography): liver, gallbladder, bile ducts, and pancreas disease

LOWER GI SERIES: Enema, Colonoscopy

ENZYMES: 1. LFTs-ALT/AST (hepatocellular injury)
2. Bilirubin (Biliary obstruction)
3. Pancreatic enzymes-Amylase/Lipase

You can write down everything in one row: AST/ALT/Bilirubin/Amylase/Lipase

OTHERS:

1. Renal function tests
2. HIDA→ after U/S, if U/S doesn't establish the Dx of acute cholecystitis
3. Noninvasive H. Pylori: 3.1. Antibodies testing (good for establishing the Dx, but not to document cure)
   3.2. Urease breathing test (to document eradication)
4. Pregnancy tests: 4.1. Urine hCG
   4.2. Serum hCG (quantative) for Ectopic pregnancy
5. Laparoscopy:
   -ectopic pregnancy (gold standart)
   -ruptured ovarian cyst
   -ovarian torsion
   -PID+/- tubo-ovarian abscess
   -appendicitis

Musculoskeletal

Routine CBC with diff, ESR
IMAGING: X-ray, MRI (rotator cuff tear)
Joint aspiration for culture/ sensitive, cytology, crystals
Rheumatic factor, HLA-B27,
Serum uric acid levels
Antinuclear antibodies, anti dsDNA
Muscle biopsy

Endocrine

Routine CBC with diff, ESR
Blood sugar
Serum electrolytes
Serum calcium
Thyroid screen T4/T3/TSH
24hr urinary catecholamines and metabolites
Urine for ketones and sugar.

Psychiatry

CBC and ESR
CT and MRI of brain
Thyroid screen
Electrolytes
Urine analysis

Drug screen / HIV

COMMON DISIASES AND WORKUPS FOR THEM

Pneumonia-CXR, bronchoscopy (to help Dx in severe and refractory cases)

Meningitis-LP-CSF analysis

Meningococcal Meningitis: 1. LP-CSF analysis
2. Platelets/PT-PTT/D-dimer/fibrin split products/fibrinogen
3. CBC culture with diff, blod culture, UA and urine culture

UTI: 1. UA and culture
2. U/S-renal→ look for anatomical abnormalities that predispose to UTI
3. Voiding cystourethrography→ look for vesicoureteral reflux

Otitis media: 1. Pneumatic otoscopy
2. Tympanometry 3. Physical exam

O**ccult bacteremia:** 1. CBC with diff, Blood culture
2. UA and urine culture

Brain abscess: CT-scan

Brain hemorrhage: CT-scan

Viral URI: serum Antibodies titers

Scarlet fever: Throat culture

Fifth disease: B19 IgM antibody

Varicella: 1. Skin lesion scraping (Varicella antigens-PCR, Tzanck smear)
2. Varicella antibodies titers

MM: CBC, SPEP

Diabetic neuropathy (automonic, vascular dis, and medication-induced): nerve conductions studies

DM: serum glucose, HbA1c + U/A + ophthalmoscope

Orthostatic hypotension: Orthostatic vital signs, Electrolytes, FOBT

Meniere's syndrome: RPR/VDRL + head trauma

BPPV: Dix-Hallpike maneuver=tilt test

Labyrinthitis: ask for URI

Depression: clinical diagnosis

Hypothyrodism: TSH

Sleep apnea (obstructive): Ambulatory nocturnal pulse oxymetry, Polysomnography

Anemia: CBC, iron level, TIBC, ferritin, serum B12

DI: U/A, electrolytes, MRI-brain, DDAVP (Desmopressin Acetate) nasal spray test

Myasthenia gravis: Tensilon test

Domestic violence: clinical diagnosis

PanCrEAs: Amylase/Lipase, Glucose (endocrine dysfunction), stool for fecal fat, tumor markers (CEA, CA 19-9)

Prostate: (BPH, prostate cancer): rectal exam, U/S transrectal, PSA, CT-abdomen/pelvis

Kidneys: (urolithiasis, glomerulonephritis, cancer): UA (assesses hematuria, pyuria, bacteriuria), BUN/Cr, U/S-abdomen, CT-abdomen

UTI: U/A, urine culture

Bladder: urine cytology (bladder cancer), U/S-abdomen, CT-abdomen/pelvis

Hypogonadism: 1. Testosterone level for SCREENING, if the levels are low→ 2. LH/FSH levels (high in testicular pathology, no T to inhibit them, and decreased in the setting of pituitary or hypothalamic disease) 3. Hypogonadotropic hypogonadism (decreased LH/FSH in the setting of pituitary or hypothalamic disease) Pts should be screen for Prolactin and TSH for other pituitary abnormalities 4. Ferritin levels-high in the settings of hemochromatosis with iron deposition in the pituitary causing hypogonadotropic hypogonadism 5. MRI-brain to rule out pituitary and hypothalamic lesions in Pts presenting with hypogonadotropic hypogonadism.

Peyronie's disease: genital exam (look for scars and plaque formation), Doppler U/S-penis (to assess blood flow in the cavernous arteries)

HTN and Hyperlipidemia (longitudinal care): BUN/Cr, Electrolytes, cholesterol, UA, ECG

Patient Note

CC:
HPI: - start writing

ROS: any other symptoms besides the main complain
PMH:

ALL:
MEDs:

PSH:
FH:

SexHx:
SocialHx:

NORMAL FINDINFS ON PHYSICAL EXAM for any case:
Patient is not in acute distress.
VS: WNL
CHEST: Clear breath sounds bilat
HEART: RRR; normal S1/S2; no gallops, rubs, and murmurs
ABDOMEN: Soft, Nondistended, Nontender, + BS, no hepatosplenomegaly
+
more physical finding depends on the case.

DIFFERENTIAL DIAGNOSIS

The best is to use mnemonics. Try to write down 3 DD. If you remember more write them down too, but if not keep moving to the workup plan and closure of the encounter. Remember that another PS is coming.

WORKUP

1. START with the exams you cannot do, only write:
    -Rectal exam, if blood + fecal occult blood test
    -Female breast exam
    -Genitourinary exam
    -Pelvic exam
2. BLOOD:
    -CBC with diff, ESR + leukocytes (if infection)
    -Peripheral smear (Megaloblastic anemia)
    -Cholesterol panel

3. IMAGING:
    -X-ray→specify on which part of the body… like CXR (+bronchoscopy in severe and refractoroy cases of pneumonia), XR-abd/pelvis, XR-R shoulder and arm
    -U/S→ U/S abd/pelvis; Transthoracic and Transesophageal ECHO (for Heart)
    -CT-scan→again write which part… like CT scan-abd/pelvis, CT-chest, CT-head (brain abscess and hemorrhage)
    -MRI→MRI-abd/pelvis, MRI-brain
    -Upper endoscopy (GERD)
    -Colonoscopy (most sensitive), Flexible proctosigmoidoscopy, Anoscopy + Biopsy
    -Barrium Enema (double contrast)
4. ENZYMES:
    -ALT/AST/Bilirubin/Amylase/Lipase
    -Cardiac enzymes: CPK/CPK-MB/Troponin
5. MICRO:
    STOOL: C. diff., fecal leukocytes
    THROAT: Rapid streptococcal antigen, Throat culture (Scarlet fever), Monospot test, Anti-EBV antibody
    -viral antibodies test (URI-viral)
    SPUTUM: sPutum studies (culture/sensitivity, gram stain, AFB[acid-fast bacilli])
    LUNGS: Urine Legionella Antigen, Serum Mycoplasma PCR, cold agglutinin measurement
    BLOOD: HIV antibody and viral load
        -Blood culture, UA/Urine culture+CBC with diff (occult bacteremia)
        - Varicella antibody titer
    HEAD: LP-CSF analysis
        - Electrolytes/Ca2+/glucose/BUN and Cr for hypernatremia, hyper-calcemia, hyperglycemia, uremia
    UT: U/A and culture+U/S renal (for anat. Problems)+voiding cystourethrogram (for vesicourethral reflux)
    SKIN: Skin lesion scraping (Varicella→PCR, Tzanck smear)
    KIDNEY: U/A, urine microalbumin, BUN/Cr
6. Others:
    - ECG; Cardiac catheterization
    - Pulse oximetry and ABG
    - Bronchoscopy with bronchoalveolar lavage
    - Pneumatic otoscopy and Tympanometry (Otitis media)

Closure

1. Transition: All right, Mr/Mrs.___ , thank you so much for your cooperation.
   -Now, I'd like to give you my clinical impression (about your condition).
2. Transition: First let me summarize.
   LOOK AT THE NOTES YOU TOOK TO SUMMARIZE.
   2.1. You just told me that ___ and ___. Also, you said that___, **is that right?**
   2.2. According to the information I got from you and the examination, I am considering a few possibilities.
   2.3. It may be __ (your probable diagnosis) or possibly __ (differential diagnosis).
3. …but we are not quite sure at this point.
   -I need to run some tests in order to find out what exactly the problem is/establish the final diagnosis. BE RAEDY TO GIVE QUICK, VERY GENERAL INFORMATION ABOUT THE MOST COMMON TESTS. Say: We will do tests like…test for your blood cells, picture of your chest, etc.
4. As soon as I get the results, we'll meet again and go over everything.
   -At that time, I'll explain the details and we will talk about your options for treatment?
   -Does this sound OK?

The final questions

1. Miss ___ , do you have any concerns or questions you'd like to ask before I go?

2. Ok then, I 'm glad that I was able to work with you. **I will do my best to make you feel better.**

3. Thanks for your cooperation, have a good day. (Bye for now, take care).