ComprehensiveClinicalCases

Surgery case proformas

1. Varicose vein.

Patient particulars.

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.

Irregular swelling of the lower limbs.
Constant dull aching pain
Dragging pain in the lower limbs
Ulcer ,eczema,bleeding.

History of present illness.

*Pain
Onset
Duration
Progression
Nature of pain

Radiation
Aggravating factor
Releving factors
More during night time
Associated night leg cramps.

*varicosities of veins /complications.
H/o swelling at ankle/calf
Itching of the leg
Pigmentation
Eczema
Venous ulcers

*ulceration
Follow ulcer case proforma

*pigmentation and discoluration.

*fever with calf pain

*Distention Of abdomen.
*pregnancy.
*Any condition with raised.intra abdominal pressure.

*smoking
*diagnosed comorbities
*prolonged drug intake.

Past history.

H/o similar complaints in the past.
H/o Hypertension,diabetes mellitus.
H/o chest Pain etc.

Treatment history

History of allergy to food and any drug.

Menstrual history (in females)

Marital and obstetric history. (In females)

Family history.

H/o hypertension,diabetes,tuberculosis,malignancy.
H/o similar complaints in the family (in case of malignacies)

Personal history.

Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse-smoking,alcohol.

Environmental history

Socio-economic history.

Summary after history.

General physical examination.

Patient is conscious /not ,comparative/not.
Orientation to time ,place ,person.

Built
Nourishmnet.

Vitals:

Pulse :rate ,rhythm,volume,equality ,character,
condition of the arterial wall,Radio-Radial delay,radio-femoral delay, pse deficit if any,peripheral pulses.

Blood pressure.:right arm ,supine position.

Respiratory rate,rhythm,type.

Temperature.

Pallor ,
icterus,
Cyanosis
clubbing,
edema,
lymphadenolathy(site ,size,shape,number,consistency,mobility ,matted ,ulceration)
Leukonychia

Height
Weight
BMI.

Head to toe examination

Local examination.

Inspection
Attitude of the limb

Varicose vein
Limb involved-bilateral or unilateral.
Medial aspect or posterior-lateral
Site
Extent
Describe the course

Swelling
Localised or generalised

Skin
Colour change
Texture
Stretched /shiny
Eczema/pigmentation
Ulceration
Scar formation/healed scar
Loss of hair
Ischemic changes.

Morrissey's test

Comment on healthy limb.

Palpation
All the inspectory findings should be confirmed
Local rise of temperature
Tenderness
Edema
Impulse on coughing
-brodietrendlenberg test for sapheno-femoral valve and communicating system.
-torniquet test

-perthe's test
-modified perthe's test
-schwartz test
-Pratt's test
-Morrissey's cough impulse test
-Fegan sign-ro indicate the sites of perforators

Percussion-schwartz sign

Ascultation.

Examination of regional lymph nodes:inguinal lymph nodes.

Examination of other limb.

Systemic examination.

Carsiovascualr system
Respiratory system
Abdomen
Central nervous system
Locomotory system

Provisional diagnosis

Summary

Investigation

Treatment -Medical,surgery.

Follow-up.

Prognosis

2.Hydrocoel

Patient particulars
Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.

Swelling in the scrotum

History of present illness

Onset
Duration
Progression.
When did it appear first
How did it started.
Does it reduce in size while lying down
Does it appear to increase in size on coughing ,exertion.
Associated pain
Any aggregating factor/ Releving factors
H/o trauma
H/o fever
H/o infertility
H/o dyspareunia
H/o difficulty to get up ,walking.

H/o cough,fever(evening rise of temperature) sweating .

Past history.

H/o similar complaints in the past.
H/o Hypertension,diabetes mellitus.
H/o trauma
H/o past surgeries and medical interventions etc.

Treatment history

History of allergy to food and any drug.

Family history.

H/o hypertension,diabetes,tuberculosis,malignancy.
H/o similar complaints in the family (in case of malignacies)

Personal history.

Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse-smoking,alcohol.

Environmental history

Socio-economic history.

Summary after history.

General physical examination.

Patient is conscious /not ,comparative/not.
Orientation to time ,place ,person.
Built
Nourishmnet.

Vitals:

Pulse :rate ,rhythm,volume,equality ,character,
condition of the arterial wall,Radio-Radial delay,radio-femoral delay, pse deficit if any,peripheral pulses.

Blood pressure.:right arm ,supine position.

Respiratory rate,rhythm,type.

Temperature.

Pallor ,
icterus,
Cyanosis
clubbing,
edema,
lymphadenolathy(site ,size,shape,number,consistency,mobility ,matted ,ulceration)
Leukonychia

Height
Weight
BMI.

Head to toe examination:(mention the positive findings)
Skin,Head, Hair ,Eyes,ears ,nose ,face ,oral cavity ,teeth ,tongue

,palate,throat,chest ,abdomen ,upper and lower limbs ,genitals,spine,.

Local examination.

Inspection
Inspection
Swelling.(comment on both right and left side)
Site/location
Extension
Number
Size
Shape
Surface/skin over the swelling
Surrounding area
Dilated veins
Ulceration
Edge

Impulse on coughing
Reducibility
Visible peristalsis
Visible pulsation.

Position of penis(suspected inguinal /groin hernias)

Opposite scrotum.

Palpation.
All the inspectory findings should be confirmed.
Local rise of temperature
Tenderness

Swelling
*Size,Shape
Location
Extension,
Mobility
Number
Skin over the swelling
Surrounding area
Dialated veins
Ulceration .
Reducibility-reducible/irreducible.
Consistency-doughy ,elastic,tense&tender
Fluctuation
Translucency
Impulse on coughing
Visible peristalsis
Pulsations over swelling -+/- _transmitted or expansile.

To get above the swelling

Relation to scrotum and spermatic cord.

Cough impulse.

Percussion

Examination of spermatic cord,testis,epididymis.

Examination of inguinal lymph nodes

Examination of to be of abdominal muscles.

Systemic examination.

Carsiovascualr system
Respiratory system
Abdomen
Central nervous system
Locomotory system

Provisional diagnosis

Summary

Investigation

Treatment -Medical,surgery.

Follow-up.

Prognosis

3.Swelling

Patient particulars

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.
Lump
Or swelling.

History of present illness.

Swelling,lump.
Mode of Onset-sudden/insidious
Duration
Progression
Exact site
Pain:onset,duration ,progression
Site,nature,type,radiation,aggrevating factor, Releving factors .
Fever
Presence of any other lumps
Secondary changes
Impairment of function-movement,disfiguring,dyspnea,dysphagia.
Recurrence of the swelling.
Loss of body weight

Trauma

Past history.
H/o similar complaints in the past.
H/o recurrence of the swelling
H/on trauma
H/o hypertension,diabetes,tuberculosis,malignancy.
H/o surgical and medical interventions in the past.

Treatment history

History of allergy to food and any drug.

Menstrual history (in females)

Marital and obstetric history. (In females)

Family history.
H/o hypertension,diabetes,tuberculosis,malignancy.
H/o similar complaints in the family (in case of malignacies)

Personal history.
Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse-smoking,alcohol.

Environmental history

Socio-economic history.

Summary after history.

General physical examination.

Patient is conscious /not ,comparative/not.
Orientation to time ,place ,person.
Built
Nourishmnet.

Vitals:
Pulse.
Blood pressure.:right arm ,supine position.

Respiratory rate,rhythm,type.

Temperature.

Pallor ,
icterus,
Cyanosis
clubbing,
edema,
lymphadenolathyLeukonychia

Height
Weight
BMI.

Head to toe examination.
Local examination.
Inspection
Situation
Site,relation to bony point
Size

Shape-oval/spherical/irregular
Surface-smooth/ulcerated/lobulated/fungated
Extension
Colour
Edge-well defined/ill defined.
Number
Pulsation
Viaible Peristalsis
Dilated veins
Movement with respiration
Impulse on coughing
Movement with deglutition
Movement with protrusion of tongue
Skin over the swelling.
-red,edematous,tense,venousprominence,blackpunctum,scar,pigment,ulcer.
Any pressure effect
Surrounding area.

Palpation.
All the inspectory findings should be confirmed
Local rise of temperature
Tenderness
Size
Shape
Extent
Surface
Edge
Consistency-soft/firm/hard/bony hard
Mobility
Fluctuation
Fluid thrill
Translucency
Impulse on coughing

Reducibilty
Compressibility
Pulsatility-expanisle,transmitted.
Sign of moulding/indentation
Fixity to underlying structure.
Relation to surrounding structures.

State of regional lymph nodes

Percussion.

Ascultation.
Measurement
Movement.
Any pressure effect.

Systemic examination.
Carsiovascualr system
Respiratory system
Abdomen
Central nervous system
Locomotory system

Provisional diagnosis

Summary

Investigation

Treatment -Medical,surgery.
Follow-up.
Prognosis

4.Breast lump

Patient particulars

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.
Lump in the the breast

History of present illness.

*H/oLump.
Onset
Duration
Progression.
Rate of growth
H/o trauma
Ulceration
Skin over the lump
Pain
-Onset
-Duration
-Progression
-Nature of pain
-Radiation
-Cyclical variation.
-Aggregating factor

-Releving factor.
*Discharge from the nipple
*Retraction of nipple
*Ulceration or any skin changes noticed
*Lump noticed any where else in the body
*Loss of weight.

Past history.
H/o similar complaints in the past.
H/o Of diabetes,hypertension,asthma,malignancy,Tuberculosis in the past.
H/o surgery and medical interventions.
H/o Drug allergy or allergy to food.

Menstrual history.
Age of attainment of menarche
Regualrity cycles, duration of cycle
How many days of flow
Usage of pads/tampons/cloths-how many /day
Associated dysmenorrhea,passage of clots

Marital history and obstetric history.
Married since how long
Consanginous/non-consanguinous marriage
What is husband's occupation.
Parity index.
Number of children
Gender
Age
Immunized till date.
Any antenatal/natal /postnatal complications.

Family history.
H/o similar complaints in the family

h/o diabetes,hypertension,asthma,malignancy,Tuberculosis in the past.

Personal history.
Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse

H/o allergy to any drug ,food

Environmental history
Lives in pakka/kchcha house
How many rooms in the house.
Number of people in the house.
Vector breeding areas around house
Areas of water stagnation.
Adequate light and ventilation.
Cooking with LPG/fire wood
Water supply
Drinking water.
Sanitation
Waste disposal

Socioeconomic history
Head of the family
Number of people in the house
Total income of the family
Per capita income

Summary after history.

General physical examination:

Patient is conscious,cooperative,well oriented to Time place and person.
Built(Skeletal frame work and height)
Nourishment(muscle mass/BMI)

Vitals:
Pulse

Blood pressure

Respiration.

Temperature.

Pallor
Icterus,
Cyanosis
Clubbing
Edema
Lymphadenolathy

Head to toe examination.

Local examination .

Inspection. Right Left

Breasts

Position
Size and shape
Any puckering or dimpling.

Skin over the breast.
Colour
Texture
Engorged veins
Dimple ,retraction,puckering
Peau d' orange appearance.
Nodules
Ulceration and fungation.

Nipple
Presence
It's position
Number
Size and shape
Surface
Discharge

Areola
Colour
Size
Surface
Texture

Arm and thorax.
Look for Skin changes.
Browny edema
Cancer en crirasse

Axilla and supraclavicular area

Patient asked to raise her arms above her head.

Palpation.(right and left)

Local rise of temperature
Tenderness
Situation
Number
Size
Shape
Extent
Surface
Margin
Surrounding area
Consistency
Fluctuation
Transillumination
Fixity to the breast tissue
Fixity to the underlying fascia and muscles
Fixity to the chest wall
Palpation of the nipple.

Examination of ulcer if present

Examination of the lymph nodes.
Palpation of Axillary group of lymph nodes
Pectoral
Brachial
Subscalular
Central
Brachial
Apical

Palpation of cervical lymph nodes.

Systemic examination.
CNS

CVS
RS
Abdomen
Summary.

Provisional diagnosis

Differential diagnosis

Investigation

Treatment.

Follow up.

5.Ulcer

Patient particulars.

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.
Ulcer
Pain
Discharge.

History of present illness:

Ulcer.
Onset ,duration,progression,h/o trauma,h/o prior swelling/spontaneous,site,prior h/o burn.

Pain
Onset,duration,progression,nature of pain,site of pain,radiation,aggrevating and relieving factors.

Discharge.
Onset,Duration,colour,blood tinged/not,foul smelling/not,type of discharge(serous,purulant,seropurulant),quantity

Precipitating factor or associated disease:
Diabetes,tuberculosis,syphilis,nephritis,
or any nervous tissue diseases(tabesdorsalis,syringomyelia , peripheral neuritis ,traverse myelitis).

Past history.
H/o similar complaints in the past.
H/o recurrence of ulcer
H/on trauma
H/o hypertension,diabetes,tuberculosis,malignancy.
H/o surgical and medical interventions in the past.

Treatment history

History of allergy to food and any drug.

Menstrual history

Marital and obstetric history.

Family history.
H/o hypertension,diabetes,tuberculosis,malignancy.
H/o similar complaints in the family (in case of malignacies)

Personal history.
Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse-smoking,alcohol.

Environmental history

Socio-economic history.

Summary after history.

General physical examination.

Patient is conscious /not ,comparative/not.
Orientation to time ,place ,person.
Built
Nourishmnet.

Vitals:
Pulse :rate ,rhythm,volume,equality ,character,
condition of the arterial wall,Radio-Radial delay,radio-femoral delay, pse deficit if any,peripheral pulses.

Blood pressure.:right arm ,supine position.

Respiratory rate,rhythm,type.

Temperature.

Pallor ,
icterus,
Cyanosis
clubbing,
edema,
lymphadenolathy(site ,size,shape,number,consistency,mobility ,matted ,ulceration)
Leukonychia

Height

Weight
BMI.

Head to toe examination:(mention the positive findings)
Skin,Head, Hair ,Eyes,ears ,nose ,face ,oral cavity ,teeth ,tongue ,palate,throat,chest ,abdomen ,upper and lower limbs ,genitals,spine,.

Local examination.

Inspection.
Site
Size
Shape-
Number
Position
Extenaion
Edge-undermined/punched out/raised and beaded/everted /sloping.
Discharge-colour,amount,smell
Floor- red and granulation tissue seen/pale/sloughed off
Surrounding area-scar/edema/redness/pigmented.
Inspection of while limb if ulcer is present on the limbs.- for Deep vein thrombosis/varicosity/ peripheral vascular disease etc

Palpation.
All the inspectory findings should be confirmed
Tenderness
Local rise of temperature
Indurated/not
Edge
Margin
Base
Depth
Dimension

Bleeding
Mobility /dixity
Relation with deeper structures
Surrounding skin
-temperature,Tenderness,mobility of the skin,fixity ,loss of sensation etc

Examination of surrounding Lymphnodes

Examination for vascular insufficiency.

Examination for nerve lesion.

Systemic examination
Carsiovascualr system
Respiratory system
Abdomen
Central nervous system
Locomotory system

Provisional diagnosis

Summary

Investigation

Treatment -Medical,surgery.

Follow-up.

Prognosis

6.Thyroid

Patient particulars

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.
Swelling
Pain.
Pressure symptoms
Toxic symptoms.

History of present illness.

Swelling.
Onset
Duration
Progression
Associated symptoms like pain,dysphagia.
Any other palpable swelling Any where in the body.

Pain.
Onset
Duration
Progression

Nature of pain
Radiation.
Aggrevating factor
Releving factors

Pressure symptoms.
Dyspnea
Dysphagia
Hoarseness of voice
Signs of Horner's syndrome.
-Ptosis
-Miosis
-Enophthalmos
-Anhydrosis

Toxic symptoms
1)CNS toxicity
-Preference to cold
-Intolerance to heat
-Weighloss
-Excessive sweating
-Excjtability/Nervousness
-Irritability/Insomnia
-Tremors of hand
-Muscle weakness.
2)CVS toxicity.
-Palpitations
-Pedal edema
-Dyspnoea on exertion.
-Chest pain.
3)Eye symptoms.
-Diplopia
-Difficulty in closing the eyes.

4)GI symptoms.
-Weight loss
-Diarrhea

Symptoms of hypothyroidism.
1)Increase in weight in spite of poor appetite
2)Cold intolerance.
3)Loss of hair.
4)Muscle fatigue/Lethargy
5)Failing memory
6)Menstral irregularity.

Regular drug intake.

Past history.
H/o similar complaints in the past.
H/o Of diabetes,hypertension,asthma,malignancy,Tuberculosis in the past.
H/o surgery and medical interventions.
H/o Drug allergy or allergy to food.

Menstrual history.
Age of attainment of menarche
Regualrity cycles, duration of cycle
How many days of flow
Usage of pads/tampons/cloths-how many /day
Associated dysmenorrhea,passage of clots.
Amenorrhea or menorrhagia.

Marital history and obstetric history.
Married since how long
Consanginous/non-consanguinous marriage
What is husband's occupation.
Parity index.

Number of children
Gender
Age
Immunized till date.
Any antenatal/natal /postnatal complications.

Family history.
H/o similar complaints in the family
h/o diabetes,hypertension,asthma,malignancy,Tuberculosis in the past.

Personal history.
Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse

H/o allergy to any drug ,food

Environmental history
Lives in pakka/kchcha house
How many rooms in the house.
Number of people in the house.
Vector breeding areas around house
Areas of water stagnation.
Adequate light and ventilation.
Cooking with LPG/fire wood
Water supply
Drinking water.
Sanitation
Waste disposal

Socioeconomic history

Head of the family
Number of people in the house
Total income of the family
Per capita income

Summary after history.

General physical examination:

Patient is conscious,cooperative,well oriented to Time place and person.
Built(Skeletal frame work and height)
Nourishment(muscle mass/BMI)
Facies
Mental state and intelligence
Skin

Vitals:
Pulse

Blood pressure

Respiration.

Temperature.

Pallor
Icterus,
Cyanosis
Clubbing
Edema
Lymphadenolathy

Head to toe examination.

Local examination.
Inspection
Situation
Size
Surface.
Surrounding area.
Extension
Colour
Edge
Number
Pulsation
Dilated veins
Impulse on coughing
Movement with deglutition
Movement with protrusion of tongue
Skin over the swelling.
-red,edematous,tense,venousprominence,blackpunctum,scar,pigment,ulcer.
Any pressure effect
Position of trachea
E/o retroaternalgoitor

Palpation.
All the inspectory findings should be confirmed
Local rise of temperature
Tenderness
Size
Shape
Extent
Surface
Edge
Consistency
Mobility

Fluctuation
Fluid thrill
Translucency
Impulse on coughing
Pulsatility-expanisle,transmitted.
Sign of moulding/indentation
To get below the swelling
Position of trachea.
Kocher's test
Common carotid artery pulsation(Berry's sign)

State of regional lymph nodes

Any pressure effect

Any toxic manifestations.

Percussion.

Ascultation.
Measurement
Movement.
Any pressure effect.

Examination of the eye.
1.Lid retraction
2.Lid lag
3.Exophyhalmos
4 Difficulty in convergence.
5.Staring look and infrequent blinking of eyes.

Systemic examination.

Carsiovascualr system
Respiratory system
Abdomen
Central nervous system
Locomotory system

Summary
Sloitary/Mumtinodular/Diffuse
Benign/Malignant
Toxic/Non Toxic
Pressure symptoms present/not.

Provisional diagnosis

Differential diagnosis

Investigation

Treatment -Medical,surgery.

Follow-up.

Prognosis

7.Chronic abdomen.
(And Mass per abdomen)

Patient particulars

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.
Pain
Palpable lump/mass
Flatulence dyspepsia
Nausea mad vomiting
Jaundice
Urinary complaints
Bowel habits
Appetite.
Fever

History of present illness.

Pain
Onset
Duration
Progression

Site
Type
Radiation
Number of Episodes and lasts how long
Severity
Aggrevating factor
Releving factors
Relationship with food intake.

Swelling,lump.
Mode of Onset-sudden/insidious
Duration
Progression
Exact site
Pain:onset,duration ,progression
Site,nature,type,radiation,aggrevating factor, Releving factors .
Fever
Presence of any other lumps
Secondary changes
Impairment of function-movement,disfiguring,dyspnea,dysphagia.
Recurrence of the swelling.
Loss of body weight
Trauma

Flatulence dyspepsia.
Fullness after food
Belching

Nausea and vomiting.
Onset
Number of episodes
Character
Amount

Frequency
Relation with food intake

Hemetemesis and malena
Onset
Duration
Progression
Number of episodes
Aggrevating factor
Releving factors
Associated tenesmus

Jaundice
Onset
Duration
Progression
Itching/pain

Urinary complaints.
Increased frequency
Burning /Painful micturition.
Hematuria
Decreased urine output

Bowel habit
Distention of abdomen
Constipation

Appetite
Loss of appetite

Past history.
H/o similar complaints in the past.

H/o jaundice,typhoid,malaria,tuberculosis,
malignancy in the past.

Menstrual history.(for female patient)
Age of attainment of menarche
Regualrity cycles, duration of cycle
How many days of flow
Usage of pads/tampons/cloths-how many /day
Associated dysmenorrhea,passage of clots

Marital history and obstetric history. (for female patient)
Married since how long
Consanginous/non-consanguinous marriage
What is husband's occupation.
Parity index.
Number of children
Gender
Age
Immunized till date.
Any antenatal/natal /postnatal complications.

Family history.
H/o similar complaints in the family
h/o diabetes,hypertension,asthma,malignancy,Tuberculosis in the past.

Personal history.
Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse

H/o allergy to any drug ,food

Environmental history
Lives in pakka/kchcha house
How many rooms in the house.
Number of people in the house.
Vector breeding areas around house
Areas of water stagnation.
Adequate light and ventilation.
Cooking with LPG/fire wood
Water supply
Drinking water.
Sanitation
Waste disposal

Socioeconomic history
Head of the family
Number of people in the house
Total income of the family
Per capita income

Summary after history.

General physical examination:

Patient is conscious,cooperative,well oriented to Time place and person.
Built(Skeletal frame work and height)
Nourishment(muscle mass/BMI)

Vitals:
Pulse

Blood pressure

Respiration.

Temperature.

Pallor
Icterus,
Cyanosis
Clubbing
Edema
Lymphadenolathy

Head to toe examination.

Local examination .

Abdomen examination.

Inspection.
Skin and subcutaneous tissue.
Umbilicus
Contour of the abdomen.
Movements.
-Respiratory
-Peristaltic
-Pulsatile
-Swelling if any ,
Situation
Site,relation to bony point
Size
Shape-oval/spherical/irregular
Surface-smooth/ulcerated/lobulated/fungated
Extension
Colour

Edge-well defined/ill defined.
Number
Pulsation
Viaible Peristalsis
Dilated veins
Movement with respiration
Impulse on coughing
Skin over the swelling.
Any pressure effect
Surrounding area.
Hernial sites

Palpation.
Local rise of temperature
Tender spot
Shifting dullness
Palpation of abdominal organs.
-Liver
-Spleen
-Stomach
-Gall bladder
-Pancreas
-Kidney
-Colon

Palaption of the lump
All the inspectory findings should be confirmed
Local rise of temperature
Tenderness
Size
Shape
Extent
Surface

Edge
Consistency-soft/firm/hard/bony hard
Mobility
-Does the swelling move with respiration or not
-Is the swelling movable in all the directions
- Is the swelling ballotable
Swelling parietal or intra abdominal.
Impulse on coughing
Pulsatility-expanisle,transmitted.
Hernial sites

Percussion.

Ascultation.
Bowel sounds.
Arterial bruit
Venous hum.

Examination of left supraclavicular lymph nodes

State of regional lymph nodes

Examination of external genital organs.

Per rectal and pervaginal examination:-

Systemic examination.
Cardiovascular system
Respiratory system
Abdomen
Central nervous system

Summary

Provisional diagnosis

Differential diagnosis

Investigation

Treatment -Medical,surgery.

Follow-up.

Prognosis

8.Hernia

Patient particulars

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.
Swelling in the area of groin(nguinal region/scrotum/inguinoscrotal)/abdomen/ near umbilicus.

History of present illness.
Onset
Duration
Progression.
When did it appear first
How did it started.
Does it reduce in size while lying down
Does it appear to increase in size on coughing ,exertion.
Associated pain
-onset,duration,progression,nature of the pain,radiation,aggrevatingfactor,relieving factor.
Associated pain abdomen,nausea -vomiting,constipation,bloatingsensation,abdominal Distention.
H/o mass per abdomen,obesity,prolonged heavy work (rule of increased intra abdominal pressure)
H/o past abdominal surgeries,trauma.

Past history.
H/o similar complaints in the past.
H/o Hypertension,diabetes mellitus.
H/o trauma
H/o past surgeries and medical interventions etc.

Treatment history

History of allergy to food and any drug.

Family history.
H/o hypertension,diabetes,tuberculosis,malignancy.
H/o similar complaints in the family (in case of malignacies)

Personal history.
Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse-smoking,alcohol.

Environmental history

Socio-economic history.

Summary after history.

General physical examination.

Patient is conscious /not ,comparative/not.
Orientation to time ,place ,person.
Built

Nourishmnet.

Vitals:
Pulse :rate ,rhythm,volume,equality ,character,
condition of the arterial wall,Radio-Radial delay,radio-femoral delay, pse deficit if any,peripheral pulses.

Blood pressure.:right arm ,supine position.

Respiratory rate,rhythm,type.

Temperature.

Pallor ,
icterus,
Cyanosis
clubbing,
edema,
lymphadenolathy(site ,size,shape,number,consistency,mobility ,matted ,ulceration)
Leukonychia

Height
Weight
BMI.

Head to toe examination:(mention the positive findings)
Skin,Head, Hair ,Eyes,ears ,nose ,face ,oral cavity ,teeth ,tongue ,palate,throat,chest ,abdomen ,upper and lower limbs ,genitals,spine,.

Local examination.

Inspection

Swelling.(comment on both right and left side)
Site/location
Extension
Number
Size
Shape
Surface/skin over the swelling
Surrounding area
Dilated veins
Ulceration
Edge

Impulse on coughing
Reducibility
Visible peristalsis
Visible pulsation.

Position of penis(suspected inguinal /groin hernias)

Palpation.
All the inspectory findings should be confirmed.
Local rise of temperature
Tenderness

Swelling
*Size,Shape
Location
Extension,
Mobility
Number
Skin over the swelling
Surrounding area
Dialated veins

Ulceration .
Reducibility-reducible/irreducible.
Consistency-doughy ,elastic,tense&tender
Fluctuation
Translucency
Impulse on coughing
Visible peristalsis
Pulsations over swelling -+/- _transmitted or expansile.

To get above the swelling

Relation to scrotum and spermatic cord.

Cough impulse.

Zeiman's test

Deep ring occlusion test

Invagination test(?)

Percussion

Ascultation (bowel sounds heard-enterocoel)

Examination of spermatic cord,testis,epididymis.

Examination of inguinal lymph nodes

Examination of to be of abdominal muscles.
Systemic examination.
Carsiovascualr system

Respiratory system
Abdomen
Central nervous system
Locomotory system

Provisional diagnosis

Summary

Investigation

Treatment -Medical,surgery.

Follow-up.

Prognosis

9. Peripheral vascular disease

Patient particulars.

Name
Age
Gender
Address
Education
Occupation
Date of admission
Date of examination.

Chief complaints.
Pain in the limb
Ulcer
Discoluration

History of present illness.

Pain in the limb.
Onset
Duration
Progression
Nature of pain
Radiation
Timing-throughout the day /intermittent
Aggravating factor and Releving factors
Affected limb
Grade the claudication
Any tingling sensation and numbness over the affected area
Effect of heat and cold

Disclouration.
Onset
Duration
Progression

Ulcer: follow the ulcer case proforma

H/o swelling or redness

H/o blurring of vision,lightheadedness,chestPain,transientblackouts,weakness and parasthesia,abdominalpain,impotence.
H/o drug intake
Recurrent ulceration .
Hemoptysis/palpitations.
Syncopal attacks.

Past history.
H/o similar complaints in the past.
H/o Hypertension,diabetes mellitus.
H/o chest Pain etc.

Treatment history

History of allergy to food and any drug.

Menstrual history (in females)

Marital and obstetric history. (In females)

Family history.
H/o hypertension,diabetes,tuberculosis,malignancy.
H/o similar complaints in the family (in case of malignacies)

Personal history.
Vegetarian /non vegetarian
Appatite
Sleep
Bowel and bladder habits
Subactance abuse-smoking,alcohol.

Environmental history

Socio-economic history.

Summary after history.

General physical examination.

Patient is conscious /not ,comparative/not.
Orientation to time ,place ,person.
Built
Nourishmnet.

Vitals:
Pulse :
Blood pressure.:
Respirato
Temperature.

Pallor ,
Icterus,
Cyanosis
Clubbing,
Edema,
Lymphadenolathy

Leukonychia

Height
Weight
BMI.

Head to toe examinationLocal examination.

Inspection
*Attitude of the limb (compare with the other limb)
*Change in colour
*Signs of ischemia:thinning of skin,diminished growth of hair,loss of subcutaneous fat,shininess,trophic changes in the nails,minor ulceration in the pressure areas.
*Buerger's postural test.
*Capillary filling time.
*Venous refilling.
*in established gangrene,
-Extent and colour of the gangrenous area.
-type
-line of demarcation.
-limb above the gangrenous area.
Comment on the other normal toes and normal limb.

Palpation.
*skin temperature.
*Capillary filling
*Venous refilling
*Test.
Cross leg test(Fuchsig's test)
Cold and warm water test
Elevated arm test
Allen's test

Bramham's sign
Costoclavicular compression manoeuvre
Hylerabduction manoeuvre
Adsons test
*Gangrenous area
*Crepitus
*Limb above gangrenous area
*loss of sensation

*Palpation Of blood vessels.

right left
Posterior tibial ++/--
Dorsalis pedis
Popliteal
Femoral
Radial
Brachial
External carotid
Facial
Superficial temporal
*Examination of regional lymph nodes.

*Ascultation.
For Bruit

Systemic examination.
Carsiovascualr system
Respiratory system
Abdomen
Central nervous system
Locomotory system

Summary

Provisional diagnosis

Investigation

Treatment -Medical,surgery.

Follow-up.

Prognosis