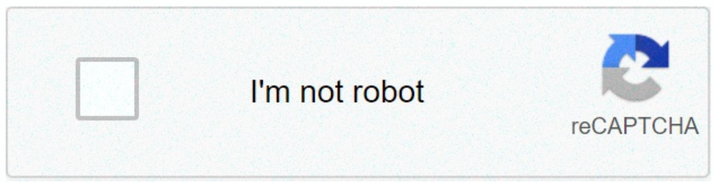

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Medical anamnesis template

Information about the patient received by the doctor Is not to be confused with the History of Medicine. For the journal, see Medical History (magazine). The medical history, history of the case or history (from Greek: ἀνά, aná, open and μνήσις, mnesis, memory) of the patient is information received by the doctor, asking specific questions, neither the patient nor other people who know the person and can give relevant information, in order to obtain information useful for formulating the diagnosis and providing medical care to the patient. Medical complaints reported by the patient or other people familiar with the patient are called symptoms, as opposed to clinical signs that are clarified by a direct examination by medical staff. Most health appointments will lead to some form of history. Medical histories vary in depth and focus. For example, ambulance paramedics tend to limit their history to important details such as name, complaint history, allergies, etc. By contrast, psychiatric history is often lengthy and in-depth, since many details about a patient's life are relevant to the formulation of a plan to manage a psychiatric illness. The information obtained in this way, together with a physical examination, allows the doctor and other healthcare professionals to form a diagnosis and treatment plan. If the diagnosis cannot be made, a preliminary diagnosis may be formulated, and other possibilities (differential diagnoses) may be added, listed in order of probability under the convention. The treatment plan may include further research to clarify the diagnosis. The method by which doctors collect information about a patient's past and present state to make informed clinical decisions is called history and physical (for example, H& P). History requires a clinician to be qualified to ask relevant and relevant questions that may give them some insight into what the patient may feel. The standardized history format begins with a head concern (why is the patient in a clinic or hospital?), followed by a history of the current disease (to characterize the nature of symptoms (s) or anxiety), past medical history, past surgical history, family history, social history, their medications, their allergies, and a review of systems (where a comprehensive study of symptoms potentially affecting the rest of the body is not long missed). [1] Once all important questions of history have been asked, a purposeful physical exam is usually done (that is, one that includes only that concerning the main concern). Based on information obtained from H&a; P, laboratory and imaging tests are ordered and medical or surgical treatment is administered if necessary. Example process Practice usually asks questions to get the following information about patient: identification and demographics: name, age, height, weight. The main complaint (CC) is the main health or anxiety problem and its time course (e.g. chest pain in the last 4 hours). The history of the current disease (IPS) – details about complaints, which are indicated in the CC (also often referred to as the history of filing a complaint or CPSU). Past medical history (PMH) (including major illnesses, any previous surgeries/surgeries (sometimes distinguished as past surgical history or PSH), any current current disease, such as diabetes). Review systems (ROS) A systematic survey on different organ systems Family diseases – especially those related to the main complaint of the patient. Pediatric diseases are very important in pediatrics. Social history (medicine) – including living conditions, profession, marital status, number of children, drug use (including tobacco, alcohol, other recreational drug use), recent overseas trips and exposure to environmental pathogens through recreational activities or pets. Regular and acute medicines (including prescribed by doctors, and others obtained without a prescription or alternative medicine) Allergy – to medicines, food, latex and other environmental factors Sexual history, obstetric / gynecological history, etc., if necessary. Conclusion and Closing History can be a comprehensive history capture (a fixed and wide range of questions are asked, as only health care students practice, such as medical students, doctor's assistants or trainee nurse students) or iterative testing of hypotheses (questions are limited and adapted to the rules or from probable diagnoses based on information already received, as practiced by busy clinicians). Computerized history can be an integral part of clinical solution support systems. A further procedure is initiated at the beginning of the disease to record details of future progress and results after treatment or discharge. This is known as catamnesis medically. System Overview Main article: Review systems Regardless of a particular system a specific condition may seem limited, all other systems are usually considered in a comprehensive history. Review systems often include all the underlying systems in the body that can provide an opportunity to recall symptoms or fears that a person may not have mentioned in history. Healthcare professionals can structure the review of systems as follows: The cardiovascular system (chest pain, shortness of spasticity, swelling of the ankle, heartbeat) are the most important symptoms, and you can ask for a brief description for each of the positive symptoms. Respiratory system (cough, hemoptis, epistaxia, wheeds, pain localized in the chest, which can increase with inspiration or expiration date). Gastrointestinal system (weight change, flatulence and heartburn, dysphagia, sorophagy, hematemesis, ground, hematosis, abdominal pain, vomiting, intestinal habit). Genitourin system (frequency in pain in mycturation (dysuria), urine color, any discharge from the urethra, altered bladder control, as urgency in urination or urinary incontinence, menstruation and sexual activity). The nervous system (headache, loss of consciousness, dizziness and dizziness, speech and related functions such as reading and writing skills and memory). Symptoms of cranial nerves (vision (amorosis), diplopia, facial numbness, deafness, orogasingia dysphagia, motor or sensory symptoms of the limbs and loss of coordination). Endocrine system (weight loss, polydipsy, polyuria, increased appetite (polyphagy) and irritability). Musculoskeletal system (any pain in the bones or joints, accompanied by swelling of the joints or tenderness, exacerbation and removal of pain factors and any positive family history in joint diseases). Skin (any skin rash, recent change in cosmetics and the use of sunscreen when exposed to the sun). Inhibiting factors Factors that inhibit the adoption of a proper medical history include the patient's physical inability to communicate with a doctor, such as unconsciousness and communication disorders. In such cases, it may be necessary to record such information that can be obtained from other people who know the patient. In medical terms, it is known as heteroanamonesis, or collateral history, as opposed to a history of reporting itself. Taking anamnesis of the disease can also be affected by various factors that impede the proper relationship between the doctor and the patient, such as transitions to doctors unfamiliar to the patient. The history of taking questions related to sexual or reproductive medicine may be hampered by the patient's reluctance to disclose intimate or uncomfortable information. Even if such a question is on the patient's opinion, he or she often does not begin to talk about such an issue without a doctor initiating this topic with a specific question about sexual or reproductive health. Some familiarity with the doctor tends to make it easier for patients to talk about intimate issues such as sexual subjects, but for some patients a very high degree of dating can cause the patient to be reluctant to disclose such intimate issues. [2] When visiting a healthcare professional about sexual problems, the presence of both partners of the couple present is often necessary, and usually good, but can also prevent the disclosure of certain subjects, and, according to one report, increases stress levels. [2] Computer history that takes systems through computer history has been available since the 1960s. [3] However, their use remains variable across all health systems. [4] One of the advantages of using computerized systems as an auxiliary or even primary source of medical information is that patients may be less susceptible to social undesirability bias. For example, patients may be more likely to report that they have engaged in unhealthy lifestyle behaviors. Another advantage of using computerized systems is the that they allow easy and high accuracy accuracy electronic medical certificate. Also, the advantage is that it saves money and paper. One drawback of many computerized medical history systems is that they cannot detect a non-verb connection that can be useful for highlighting anxieties and treatment plans. Another drawback is that people may feel less comfortable communicating with a computer, unlike humans. In a sexual history in Australia via computer interview, 51 per cent of people were very comfortable with it, 35 per cent were comfortable with it and 14 per cent were either uncomfortable or very uncomfortable with it. [5] Evidence that computer capture systems are rare or against them. As of 2011, there have been no randomized control trials comparing computer assistance against traditional oral and written family history, taking into account the identification of patients at increased risk of developing type 2 diabetes. [6] See <a0><a1> What is a American Medical Association. This was announced on October 24, 2020. ↑ a b c Quilliam, S. (2011). Cringe Report: Why patients do not dare to ask questions, and what we can do about it. Journal of Family Planning and Reproductive Health. 37 (2): 110–2. doy:10.1136/jfprhc.2011.0060. PMID 21454267. Maine, JG; Bill, W; Scholz, Mon., (1968). On the way to automating the history of the disease. Mayo Clinic proceedings. 43 (1): 1–25. 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