Introduction to clinical medicine course syllabus

1. History taking
    1.1. The steps of clinical examination
    1.2. Definitions
        1.2.1.Symptoms
        1.2.2.Signs
        1.2.3.Disease
        1.2.4.Syndrome
    1.3. The role of history taking
    1.4. Principles of history taking
        1.4.1.Medical communication
        1.4.2.Non-verbal communication
        1.4.3."Bad news" communication
    1.5. The steps of history taking
        1.5.1.General data – name, surname, age
        1.5.2.Reason for admission = chief complaint
        1.5.3.History of present illness
        1.5.4.History of past diseases + hospitalizations
        1.5.5.Current medication therapy
        1.5.6.Allergies
        1.5.7.History of family diseases
        1.5.8.Socio-economic background

2. General physical examination
    2.1. The tools: inspection, palpation, percussion, auscultation.
    2.2. Inspection
        2.2.1.Motor activity
        2.2.2.Body build
        2.2.3.Anatomic malformations
        2.2.4.Nutritional status
        2.2.5.Appearance of illness
        2.2.6.Behaviors
        2.2.7.Speech-neuro examination

2.2.8. Inspection with special tools: ophathalmoscope, otoscope, nasoscope, laryngoscope, bronchoscope, gastroscope, anoscope, colonoscope, thracoscope, peritoneoscope, gonioscope, cystoscope.

2.3. Palpation

2.3.1. Swelling/lumps – location, consistency, regularity/irregularity, shape, painful/hot, shape, margins.

2.3.2. Skin palpation

2.3.3. Crepitus

2.3.4. Vocal fremitus

2.3.5. Light palpation

2.3.6. Deep palpation

2.3.7. Palpation of solid abdominal viscera

2.3.8. Palpation of solid content of hollow viscera

2.3.9. Palpation of lymph nodes

2.4. Percussion

2.4.1. Definitions – tympanism, resonance, dullness, hyperressonance

2.4.2. Lungs percussion

2.4.3. Liver and spleen percussion

2.4.4. Ascites percussion

2.5. Auscultation

2.5.1. Structure of the statoscope – diaphragm, bell

2.5.2. Auscultation of the neck

2.5.2.1. Carotid bruits

2.5.3. Auscultation of the lungs

2.5.3.1. Breath sounds

2.5.3.2. Rales

2.5.3.3. Friction rub

2.5.4. Auscultation of the heart

2.5.4.1. Heart beats

2.5.4.2. Murmurs

2.5.4.3. Pericardial rub

2.5.5. Auscultation of the abdomen

2.5.5.1. Bowel sounds

2.5.5.2. Murmurs (bruits)

3. Particularities in general physical examination

3.1. Levels of consciousness – Glasgow score, etiologies of coma, syncope/pre-syncope.

3.2. Psychiatric (mental) status

3.2.1. Mood – depressed, anxious, good

3.2.2. Manic-depressive, bipolarity

3.2.3. Abnormal thinking

3.2.4. Hallucinations

3.2.5. Schizophrenia

3.3. Somatotype/habitus

3.4. Position- attitude

3.4.1. Gait – ataxia, antalgia, apraxia

3.4.2. Romber's sign

3.4.3. Drop-foot

3.4.4. Tremor, fasciculation, myoclonic jerks, chorea, dystonia, dyskinesia, hypotonia, hypertonia, clonus.

3.4.5. Reflexes

3.4.5.1. Deep tendon reflexes

3.4.5.2. Superficial reflexes

3.5. Face

3.5.1. Acromegaly, adenoid face, down's syndrome

3.5.2. Myxedema

3.5.3. Cushing syndrome

3.5.4. Scleroderma

3.5.5. Lupus erythematous

3.5.6. Xantelasma

3.6. Neck – thyroid

3.7. Skin and mucosa

3.7.1. Color – redness, liver palms, cyanosis, jaundice, hyperpigmentation, hemochromatosis, vitiligo.

3.7.2. Elasticity – skin turgor

3.7.3. Humidity

3.7.4. Lesions – primary and secondary.

3.7.5. Hemorrhagic – purpura, hematoma, chymosis, parechiae.

3.8. Nails and hair

3.8.1. Alopecia

3.8.2. Clubbing fingers

3.9. Subcutaneous tissue

3.10. Muscle, joints – rheumatologic examination

3.11. Temperature, fever, hypothermia

3.11.1. Edema – Anasarca, ascites, hydrothorax, hydropericardium, hydrocele

3.11.2. Fever

3.11.3. Collateral circulation

4. Respiratory disorders

4.1. Dyspnea

4.2. Cough

4.3. Sputum

4.4. Hemoptysis

4.5. Chest pain

4.6. Wheezing

4.7. General examination of the respiratory system

4.8. Abnormal findings

4.8.1. Barrel chest

4.8.2. Kyphosis, scoliosis

4.8.3. Pectus carinatum

4.8.4. Pectus excavatum

4.9. Particularities

4.9.1. Respiratory rate

4.9.2. Breathing patterns

4.9.3. Vocal resonance

4.9.4. Vocal fremitus

4.9.5. Percussion

4.9.6. Auscultation

4.10. Main syndromes

4.10.1. Consolidation syndromes

4.10.1.1. Pneumonia, bronchopneumonia, aspiration pneumonia

4.10.1.2. Pulmonary thromboembolism, infarction

4.10.1.3. Lung tumor

4.10.2. Pleural syndrome

4.10.3. Bronchoobstructive syndrome

4.10.4. Cavitary syndrome

4.10.5. Mediastinal syndrome

4.10.6. Respiratory failure

5. Kidneys and urinary tract examinations

5.1. Symptoms – dysuria, pain, renal colic

5.2. Changes of micturition – frequency, urgency, polyuria, oliguria, anuria, nocturia, pneumaturia, urinary incontinence, hematuria, proteinuria.

5.3. Giordano sign

5.4. Renal syndromes

5.4.1. Glomerular

5.4.2. Tubulo-interstitial

5.4.3. Vascular

5.4.4. Renal failure

6. Cardiovascular

6.1. Key features of anamnesis

6.1.1. Chest pain

6.1.2. Dyspnea

6.1.3. Palpitations, dizziness, syncope

6.2. Key features of clinical examination

6.2.1. Vital signs – blood pressure, hear rate, respiratory rate

6.2.2. Inspection

6.2.3. Auscultation

6.2.3.1. Heart sounds – S1, S2, S3, S4

6.2.3.2. Murmurs

6.2.3.3. Rubs

6.2.4. Valvular heart diseases

6.2.5. Infectious endocarditis

6.2.6. Coronary heart diseases

6.2.7. Cardiomyopathy

6.2.8. Heart failure

6.2.9. Rate and rhythm disturbances

6.2.10. Syncope

6.2.11. Systemic hypertension

6.2.12. Aortic diseases

6.2.13. DVT and pulmonary embolism

7. Gastrointestinal system

7.1. Esophageal syndrome

7.2. Abdominal pain

7.3. Peptic ulcer syndrome

7.4. Gastric outlet obstruction

7.5. Peritoneal syndrome

7.6. Acute abdomen

7.7. Intestinal obstruction syndrome

7.8. Appendicular syndrome

7.9. Diarrhea syndrome

7.10. Constipation syndrome

7.11. GI tract hemorrhage syndrome

7.12. Portal hypertension

7.13. Ascites syndrome

7.14. Cholestasis syndrome

7.15. Jaundice syndrome

8. Hematology

8.1. Anemic syndrome

8.2. Hemorrhagic syndrome