# Clinical case history of a patient with infectious disease

*Tutorial for students*

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## General Information

1. Age
2. Sex
3. Occupation
4. Admission date
5. Primary (outpatient) diagnosis
6. Admission diagnosis
7. Clinical diagnosis
8. Discharge date

Do not include any personal data (name, address, working places).

## History of present complaints

In this part of case history major health problems or concerns should be described with highest possible level of specification. If a patient does not present any complaints nor shows any typical signs of studied illness, then one must note it.

## Epidemiological history

This part of case history is especially important. Presence or absence of epidemiologically significant factors of possible infectious and non-infectious diseases should be mentioned in this part.

For instance, a patient with jaundice should be questioned about a possible contact with icteric person, including indirect exposure via third persons and history of prior parenteral drug use. Possible transmission route should be mentioned, when infectious disease with seasonal peak of incidence being suspected (e.g.

leptospirosis, yersiniosis etc). Probability of disease also should be assessed by taking into account a maximal duration of incubation period.

Epidemiological history normally includes a specification concerning:

1. Contacts with febrile patients during a month before onset of current disease. Contacts with patients who had gastrointestinal symptoms during the previous week. Characteristics and duration of contacts.

2. Presence of similar symptoms among relatives, neighbours, colleagues during a month prior to the onset of a disease.

3. Water consumption conditions (sources, history of drinking of a non-boiled water from doubtful sources).

4. Traveling to other regions, duration of traveling, contacts with persons from other regions/countries (e.g. guests from foreign countries etc).

5. Parenteral transfusions, including blood transfusion. History of intravenous drug use.

6. History of vaccination against infectious diseases, date and number of doses received.

**History of present illness**

Clinical course of present disease and previous diagnostic findings (if any) should be specified in this part.

**Social and past medical history**

1. Living conditions.

2. Working conditions and environment (possible occupational hazards).

3. Level of personal hygiene.

4. Possible bad habits (e.g. alcohol abuse, tobacco, illicit drug use).

5. Marital status. Gynecological history (for women).

6. Past medical history. Regularly taken and occasionally used medications (frequency and doses).

7. Possible allergies to medicines and/or food, history of blood transfusions.

### Current condition (status praesens objectivus)

A current condition of the patient should be described, indicating factors which determine the severity of his state. Describe thoroughly those body parts, systems and organs, which may be damaged or have a pathological manifestations (rash, stool abnormalities, changes in lymph nodes, etc., depending on a disease).

### Results of workup

Results of laboratory, imaging and functional studies of a patient should be mentioned. Attention should be payed to studies needed for the confirmation and justification of a suspected diagnosis.

### Clinical diagnosis justification

Specify only those patient's complaints, epidemiological, clinical, laboratory and workup criteria, which allow you to confirm the possible diagnosis. Justification should be concise and compelling. It should be confirmed with a supervisor's signature.

### Differential diagnosis

Differential diagnosis should be performed with 2-3 diseases (infectious and noninfectious) with a similar leading syndrome. It should include epidemiological, clinical and laboratory-instrumental criteria, and be relevant for a patient. It is strongly advised to present this section in a form of logical reasoning; a reproduction of tables from books or other sources is not allowed.

### General treatment approaches (diet, medications, medical procedures)

Write down an entire treatment regimen, which is required for your patient, and the way it should be provided, taking into account a recent treatment protocols and guidelines. Divide all drugs taken by a patient into three groups: etiotropic, pathogenic and symptomatic therapy, clearly identify the dosing regimens.

### Medical supervision

Daily state and complaints of a patient should be described in 2-3 diaries, according to the standard scheme (date, body temperature, hemodynamic indicators, overall state, complaints, medications with doses). Every diary should be signed by a supervisor.

**Summary (epicrisis)**

It is a summary of a case history, which contains the following information:

1. Full name, date of birth;

2. A place and date of hospitalization;

3. A clinical diagnosis;

4. Laboratory results and findings of instrumental methods;

5. Performed treatment;

6. If by the end of supervision patient continues his treatment, a case history should include the required criteria for his discharge and it starts being called a landmark case history. If the patient had already been discharged by the end of supervision, a record that “patient was discharged upon reaching the appropriate discharge criteria” should be made;

7. Prescriptions and follow-up recommendations given to a patient at a discharge;

8. Possible future complications and disease course prognosis;

9. Any additional clinically significant information.