**Patient complaints.**

Complaints need to be clarified. Reflecting grievances (eg, pain sensations) means locating, prevalence, strength, nature, time of occurrence, causes, and condition of attenuation, and asking. The main claims are first reported, followed by the additional (general complaints). In addition to the patient's own complaints, complaints should be actively sought by a physician. In addition to the described system claims, the main complaints should be about the condition of the organisms or systems using additional questions. Systems complaints are made using the following form:

       On the part of the respiratory system: shortness of breath (expiratory, inspiratory and mixed), cough (dry, with sputum, constant, seizures), painful sensations in the chest (when breathing, coughing), nature of sputum (size, color, smell, consistency, blood inclusions) .

        Cardiovascular system: shortness of breath (with tension, tension, seizures), heart palpitations (frequent, irregular, irregular), pain in the region of the heart (nature, duration, prevalence, cause, subsidence, etc.); swelling (location, time of appearance).

         On the part of the digestive system: loss of appetite (decrease or increase), dyspeptic symptoms (nausea, vomiting, nausea, nausea), pain in the abdomen (nature, location, cause of spread), diarrhea, constipation, dryness, duration.

        Urinary system: pain in the lumbar region, difficulty urinating, change in color, frequency, swelling.

        Nervous system: decreased performance, fatigue, sleep disturbance (how many hours you sleep, fast falling asleep, fast wakefulness, use of sleeping pills), headaches.

**History of the disease (anamnesis morbi).**

It is necessary to identify features of the onset of the disease, sudden or gradual onset of symptoms; their flow, cause, development; the treatment used, its effectiveness, the causes of the latter deterioration.

     Chronic illness record - the year or years from the onset of which the patient considers himself to be sick, from the first symptoms in chronological order to the first hospital admission; periods of attenuation and complications, frequency of complications. Therapeutic and preventive measures, their effectiveness; what are the direct causes of the current hospitalization? It is necessary to indicate the treatment received by the patient.

**Life history (anamnesis vitae).**

To do this, the patient must be informed about the characteristics of the body and their response to various irritants, as well as some of the causes that contribute to the development of a particular disease.

The main sections of the life history are: brief biographical information about the patient (where, when he was born, how he grew up, how old he went to school, did not lag behind his fellow students; how many years he graduated, served in the army, studied at a university, specialty).

Life conditions

Occupation.

Social and living history

Lifestyle: diet, the physical activity.

alcohol abuse, smoking

Family history

Reproductive history

Gynecological anamnesis for women: menstruation onset, frequency, pregnancy, number of births, abortions, menopause, age, and manifestations.

Heredity: the health of the parents, the causes of the death of the parents, siblings. Particular attention should be paid to the disease, which is important for the disease.

Allergic anamnesis: medicines, foods, smells, etc. inability to accept. If you are allergic to a drug, look for its manifestations: urticaria, swelling of the face or throat, shock.

Epidemiological anamnesis:

Insurance history: for acute diseases - from what date was issued the certificate of illness; how many days he was disabled for a year due to his current illness. A disability group is a group of disability.

**General examination of the patient (in sequence).**

General condition of the patient.

Determine the patient's condition in bed.

Assessment of the patient's condition.

Define the (constitutional) type of body.

Identification of anthropometric data (height (cm), body weight (kg).

Assess the condition of the skin and visible mucus;

Assessment of subcutaneous fat condition.

**Examination by systems**

Respiratory system

Cardiovascular system

Renal system

Musculoskeletal system

Nervous system