The Orthopedic History and Physical Exam

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The History

- Welcome the patient - ensure comfort and privacy
- Know and use the patient's name - introduce and identify yourself
- Set the Agenda for the questioning
The History

- Elicit the Patient's Story
- Ask open-ended questions
- Encourage with silence, nonverbal cues, and verbal cues
Components of the History

- Biodata: Name, age, gender, hand dominance (in upper limb conditions)
- Chief complaint
- History of Present Illness
- Past Medical History
- Past Surgical History
- Allergies
- Medications
The Components

- Social History
- Family History
- Review of Systems
Chief Complaint

This is why the patient is here in the emergency room or the office

Examples:
Common Examples

- Pain
- Stiffness
- Swelling
- Deformity
- Weakness
- Instability
- Loss of function
- Change in sensibility
History of Present Illness

This is the detailed reason why the patient is here.

It is the why, when and where, etcé

Use the OPQRSTA approach to cover all aspects of information
History of Present Illness

Å OPQRSTA

ï Onset
   Å When did the chief complaint occur

ï Prior occurrences of this problem

ï Progression
   Å Is this problem getting worse or better
   Å Is there anything that the patient does that makes it better or worse

ï Quality
   Å Is there pain, and if so what type? How would the patient describe it in their words
History of Present Illness

ÅOPQRSTA (continued)

- Radiation
  ÅDo the symptoms radiate to anywhere in the body, and if so, where?

- Scale
  ÅOn a scale of 1 to 10, how bad are the symptoms?

- Timing
  ÅWhen do the symptoms occur?
    - At night, all the time, in the mornings, etcé
History of Present Illness

Å OPQRSTA (cont)

ï Associated symptoms

Â Any other info about the chief complaint that has not already been covered

Â Ask if there is anything else that the patient has to tell about the chief complaint
neoplastic and infectious symptoms

Å constant pain, night pain
Åfever, night sweats
Åanorexia, fatigue, weakness, weight loss
Past Medical History

These are the medical conditions that the patient has chronically and that they see a doctor for.

Blood Transfusions

Examples:

- Hypertension, GERD, Depression, Congestive heart failure, hyperlipidemia, Diabetes, Asthma, Allergies, Thyroid problems, etcé
Past Surgical History

These are any previous injuries or operations. When?

Examples:
- Tonsillectomy, Hysterectomy, Appendectomy, Hernias, Cholecystectomy.
Medications

Include all meds the patient is on even over the counter meds and herbals.
Try to include the dosages and frequency.
Corticosteroids.
Allergies

Ask about latex, food, drugs and seasonal allergies
Social History

Things to include:

- Occupation.
- Marriage status
- Tobacco use—how much and for how long
- Alcohol use
- Illicit drug use
- If pertinent, sexually transmitted disease history
Family History

Ask if the patient’s parents, grandparents, siblings or other family members had any major medical conditions

Examples:

- Heart disease, heart attacks, hypertension, hyperlipidemia, diabetes, sickle cell disease
The review of systems is just that, a series of questions grouped by organ system including:

- General/Constitutional
- Skin/Breast
- Eyes/Ears/Nose/Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Neurologic/Psychiatric
- Allergic/Immunologic/Lymphatic/Endocrine
Physical Exam

- General examination and vital signs.
- Musculoskeletal
- Heart
- Lungs
- Abdomen
- HEENT
- Neck
- GU if pertinent to the chief complaint
Physical Exam

Develop a systematic approach for doing the physical exam
MUSCULOSKELETAL EXAMINATION

Requirements:
Å Tape measure
Å Goniometer
Å Patella hammer
Å Sharp point and cotton wool
MUSCULOSKELETAL EXAMINATION

• LOOK
• FEEL
• MOVE
LOOK

Å SKIN: SCARS, BRUISES, SINUSES, COLOUR CHANGES.
Å SWELLING
Å MUSCLE WASTING
Å DEFORMITY
Å POSITION
FEEL

SKIN: warm/cold, dry/moist.
SOFT TISSUES: SWELLING, PULSES
BONES AND JOINTS
TENDERNESS
EFFUSION
MOVE

Å ACTIVE MOVEMENT: Pt. Moves without your assistance.
Å PASSIVE MOVEMENT: Examiner moves pt.
Å NEUROLOGICAL EXAMINATION: MOTOR AND SENSORY FUNCTION
SPECIAL TESTS

Å Dependent on problem.
Assessment and Plan

This is what you think is wrong with the patient, and what you plan to do initially.

INVESTIGATIONS:
Diagnostic Imaging
Laboratory