

Chest pain:

	<u>Nature of Patient</u>	<u>Nature of Symptoms</u>	<u>Associated Symptoms</u>	<u>Precipitating/Aggravating Factors</u>	<u>Ameliorating factors</u>
Angina Pectoris	<ul style="list-style-type: none"> • Adult 	<ul style="list-style-type: none"> • Achy, dull, tight, severe, pressing • Not usually sharp or sticking • Substernal 	<ul style="list-style-type: none"> • Women more likely to have atypical symptoms (back pain, nausea, fatigue) 	<ul style="list-style-type: none"> • Exertion (including sexual activity) • Cold exposure • Emotional stress • Recumbency often 	<ul style="list-style-type: none"> • Nitroglycerine • Rest • Valsalva's Maneuver
Gastroesophageal reflux	<ul style="list-style-type: none"> • Any age 	<ul style="list-style-type: none"> • Burning, tightness • May be identical to symptoms of angina 	<ul style="list-style-type: none"> • Water brash • "Heartburn" 	<ul style="list-style-type: none"> • Overeating • Recumbency (may awaken from sleep) • Occasionally precipitated by exertion 	<ul style="list-style-type: none"> • Antacids • Proton pump inhibitors
Pericarditis	<ul style="list-style-type: none"> • Any age 	<ul style="list-style-type: none"> • Sharp or dull • Protracted duration 	<ul style="list-style-type: none"> • Fever • Recent viral infection 		
Pneumonia	<ul style="list-style-type: none"> • Classical presentation less common in infants and elderly 	<ul style="list-style-type: none"> • Classic presentation: rapid onset with fever, chills, cough and pain in the side / chest, often so severe as to limit respiratory movements • May also have shortness of breath 	<ul style="list-style-type: none"> • Fever • Cough that produces sputum; may contain blood • Physical exam: egophony, dullness on percussion, rales • Symptoms vary with extent of disease 	<ul style="list-style-type: none"> • Risk factors include smoking, alcohol abuse, asthma, immunocompromised pt 	
Pulmonary Embolism	<ul style="list-style-type: none"> • Usually adult 	<ul style="list-style-type: none"> • Sharp, severe, often pleuritic • Often heavy & steady 	<ul style="list-style-type: none"> • Tachypnea (rapid breathing) • Hemoptysis (blood in sputum) 	<ul style="list-style-type: none"> • Prolonged immobilization (DVT) • Oral contraceptives (esp. in smokers) • Worse with changes in position 	

Questions to ask:

- OPQRST
- Worse with eating? Eating certain types of food? (GERD)
- Worse with exercise or exertion? Climbing stairs? (Angina, maybe GERD)
- Any long periods of sitting still recently? Plane trips, car rides? (DVT --> PE)
- Any fever, cough, recent illness? (pericarditis or pneumonia with cough). Any blood in your sputum? (PE)

Abdominal pain:

	<u>Location</u>	<u>Presentation</u>	<u>Timing</u>	<u>Precipitating / aggravating factors</u>	<u>Ameliorating Factors</u>	<u>Associated Symptoms</u>
Appendicitis (acute inflammation of vermiform appendix)	<ul style="list-style-type: none"> Pain epigastric or periumbilical Shifts to RLQ after a few hours 	<ul style="list-style-type: none"> Classical presentation (appear in <50% patients): <ul style="list-style-type: none"> epigastric/periumbilical pain followed by brief nausea, vomiting, anorexia pain shifts to RLQ after a few hours RLQ direct and rebound tenderness at McBurney's point Non-classical: variations are common; pain may not be localized (infants & children), tenderness may be diffuse or absent 	<ul style="list-style-type: none"> Acute onset Changing symptoms over time (see Presentation) 			<ul style="list-style-type: none"> Low-grade fever common (100-101 F) Nausea, vomiting
Cholelithiasis (presence of 1+ calculi / gallstones in gallbladder)	<ul style="list-style-type: none"> RUQ (or elsewhere in abdomen) Often poorly localized May radiate into back or arm 	<ul style="list-style-type: none"> 80% asymptomatic (biliary colic findings described here) Pain usually severe enough to send pt to ED RUQ or epigastric tenderness may be present; peritoneal findings absent (no rebound tenderness) 	<ul style="list-style-type: none"> Episodic: episodes begin suddenly, intensify within 15m-1h, remain at steady intensity for 6-12h, gradually disappear over 30-90m, leaving dull ache Pts feel well between episodes 			<ul style="list-style-type: none"> Nausea, vomiting Fever and chills only if cholecystitis has developed
Gastric ulcer (peptic ulcer)	<ul style="list-style-type: none"> Middle of upper abdomen 	<ul style="list-style-type: none"> Indigestion, heartburn-type symptoms Pain or discomfort Bloating, early sense of fullness with eating 30% of pts awakened at night 	<ul style="list-style-type: none"> Heals & recurs Pain may occur for days/weeks then wane/disappear (symptom free for weeks or months) Pain typically soon after eating 	<ul style="list-style-type: none"> May be worse a couple of hours before or after meals NSAID use (esp. aspirin), high caffeine intake, alcohol/tobacco use, stress can contribute to gastric ulcer formation 	<ul style="list-style-type: none"> Drinking milk / eating Antacids (not always) Pain returns 	<ul style="list-style-type: none"> Nausea Loss of appetite Weight loss GI bleeding (vomit blood or blood in stool)
Intestinal obstruction	<ul style="list-style-type: none"> Often described as periumbilical 	<ul style="list-style-type: none"> Abdominal pain (crampy) Abdominal distension 	<ul style="list-style-type: none"> Paroxysms of pain every 4-5 minutes 	<ul style="list-style-type: none"> Surgery (post-operative) 		<ul style="list-style-type: none"> Nausea / vomiting

(small bowel obstruction)		<ul style="list-style-type: none"> • Obstipation (severe & obstinate constipation) • Inability to pass flatus 	<ul style="list-style-type: none"> • Colon requires 12-24 hrs to empty after onset of bowel obstruction, so flatus & passage of feces may continue after onset of symptoms 	adhesions / hernias)		<ul style="list-style-type: none"> • Fever and tachycardia if strangulating
Pancreatitis	<ul style="list-style-type: none"> • Acute upper abdominal pain (mid-epigastrium, RUQ, or diffuse) • Band-like radiation to back (50% pts) 	<ul style="list-style-type: none"> • Usually severe enough to elicit ED visit, admission to hospital 	<ul style="list-style-type: none"> • Unlike cholelithiasis, can last for days • Acute, rapid onset (max intensity in 10-20m) • If related to alcohol, may occur 1-3 days after binge or cessation of drinking • May be recurrent 		<ul style="list-style-type: none"> • Bending forward 	<ul style="list-style-type: none"> • Nausea / vomiting • Restlessness, agitation • Fever, tachycardia

Questions to ask:

- OPQRST
- Nausea / vomiting / fever? (common to all conditions here but probably still important)
- Location of pain & any movement / radiation especially important
- Timing also especially important (episodic / first time, how often).
- Does the pain wake you up at night?
- What medicines do you take regularly? How much (esp. NSAIDs - aspirin, ibuprofen, naproxen)? (gastric ulcer)
- Alcohol / tobacco use? (gastric ulcer)
- Recent surgeries? (small bowel obstruction)
- Any blood (brown or red) in vomitus or stool? (gastric ulcer)
- Rebound tenderness? (appendicitis)

Shortness of breath:

	<u>Nature of Patient</u>	<u>Nature of Symptoms</u>	<u>Associated Symptoms</u>	<u>Precipitating/Aggravating Factors</u>	<u>Ameliorating factors</u>
Asthma	<ul style="list-style-type: none"> Most common cause of recurrent dyspnea in children 	<ul style="list-style-type: none"> Acute dyspnea Episodic May rarely be dyspneic only at night Physical findings: bilateral wheezing; sibilant, whistling sounds; prolonged expiration 	<ul style="list-style-type: none"> Cough (indicates asthmatic bronchitis) 	<ul style="list-style-type: none"> Allergens Exercise Noxious fumes Respiratory tract infections Recumbency Exposure to cold Beta-blockers 	
Congestive Heart Failure	<ul style="list-style-type: none"> Older patients 	<ul style="list-style-type: none"> Chronic dyspnea with gradual onset Paroxysmal nocturnal dyspnea Dyspnea remains long after stopping exercise Physical findings: edema, shallow respirations, hepatomegaly, elevated JVP, 3rd heart sound, basilar rales 	<ul style="list-style-type: none"> Edema 	<ul style="list-style-type: none"> Exercise Beta-blockers or Ca-channel blockers Recumbency Trauma, shock, hemorrhage, anesthesia 	<ul style="list-style-type: none"> Nocturnal dyspnea may be relieved by sitting
COPD	<ul style="list-style-type: none"> Older patients (rarely < 30yo) Most often smokers 	<ul style="list-style-type: none"> Chronic dyspnea Dyspnea with exertion Physical findings: rapid, shallow respirations 	<ul style="list-style-type: none"> Fast recovery to normal respiration after stopping exercise 	<ul style="list-style-type: none"> Smoking Exertion Postural changes have little or no effect 	<ul style="list-style-type: none"> Leaning forward while seated
Emphysema (a type of COPD)		<ul style="list-style-type: none"> Progressive dyspnea precedes onset of cough Usually no dyspnea at rest Physical findings: "pink puffers"; hyperventilated lungs, hyperresonance, decreased breath sounds & diaphragmatic movement, increased anteroposterior chest diameter 		<ul style="list-style-type: none"> Smoking 	
Pneumonia	<ul style="list-style-type: none"> Classical presentation less common in infants and elderly 	<ul style="list-style-type: none"> Classic presentation: rapid onset with fever, chills, cough and pain in the side / chest, often so severe as to limit respiratory movements May also have shortness of breath 	<ul style="list-style-type: none"> Fever Cough that produces sputum; may contain blood Physical exam: egophony, dullness on percussion, rales Symptoms vary with extent of disease 	<ul style="list-style-type: none"> Risk factors include smoking, alcohol abuse, asthma, immunocompromised pt 	

Acute dyspnea after exercise: think: is it pulmonary or cardiac? Pulmonary: fast rate of recovery to normal respiration; cardiac: remain dyspneic much longer after cessation of exercise. Heart range changes with exercise last longer, too, in a pt with cardiac dyspnea.

Questions to ask:

- OPQRST
- Smoking history?
- Cardiac history?
- Does it get worse with exertion? What kind of exertion? How quickly does it pass afterwards? (CHF = takes long time to recover)
- Coughing? (pneumonia, COPD, asthmatic bronchitis) Blood in sputum? (pneumonia)
- Any fever? Signs of infection? (pneumonia)
- Worse at any particular times of the year? Worse in certain places (environmental exposures --> asthma)?
- Does sitting up (CHF) or leaning forward (COPD) make it better? Does laying down make it worse (asthma, CHF)?

Headache:

	<u>Nature of Patient</u>	<u>Nature of Symptoms</u>	<u>Associated Symptoms</u>	<u>Precipitating / Aggravating Factors</u>	<u>Ameliorating factors</u>
Tension (muscle contraction) headaches	<ul style="list-style-type: none"> • Most common cause of headache at any age • More common in females 	<ul style="list-style-type: none"> • Recurrent or chronic • Usually or psychogenic origin <ul style="list-style-type: none"> ◦ Children: stress, anxiety, depression • Adults: usually dull, non-throbbing, persistent low intensity • Timing varies with cause of tension • May awaken with headache in morning but rarely at night • May last a few days • Severity may increase as day progresses and then decrease towards evening • Usually occipital, suboccipital, bilateral • Described as constrictive band around head or tightness of scalp • Rarely awakens pt from sleep 	<ul style="list-style-type: none"> • Fatigue 	<ul style="list-style-type: none"> • Emotional / physical stress • Abnormal neck position (esp. extension) • Prolonged mental concentration • Withdrawal of analgesics or tranquilizers • Dental malocclusion or poorly fitting dentures • Bruxism (nighttime grinding of teeth) • Withdrawal of analgesics used chronically to treat headaches 	<ul style="list-style-type: none"> • Stress reduction
Classic Migraine	<ul style="list-style-type: none"> • More common in women • Incidence: 1.4% < 7 yr, 5% @ 17 yr, 17% postpubescent males, 20% postpubescent females; 50% of adults with migraines have onset of symptoms earlier than age 20 	<ul style="list-style-type: none"> • Recurrent or chronic • Prominent aura • Prodrome: has abrupt onset <ul style="list-style-type: none"> ◦ Lasts 15-20 min ◦ Precedes headache by 15-30 minutes ◦ Often contralateral to headache • Headache <ul style="list-style-type: none"> ◦ Severe, throbbing, unilateral ◦ Supraorbital / frontal region ◦ Gradual onset ◦ Intensity increases steadily & rapidly ◦ Lasts 2-8 days 	<ul style="list-style-type: none"> • Visual auras (scotomata, transient blindness, blurred vision, hemianopsia) • Nonvisual auras (weakness, aphasia, mood disturbances, photophobia) • Nausea and vomiting • Anorexia • Sonophobia, photophobia • Irritability • Dizziness • Fluid retention • Abdominal pain • Sleepiness 	<ul style="list-style-type: none"> • Menstruation • Emotional stress • Fatigue • Bright lights • High altitude • Weather changes • Exercise • Certain foods • Fasting • Hypoglycemia 	<ul style="list-style-type: none"> • Sleep • Triptans
Common Migraine (without aura)	<ul style="list-style-type: none"> • More frequent in children 	<ul style="list-style-type: none"> • Recurrent or chronic • Vague or absent aura and prodrome • Gradual onset • Lasts up to 72 hours • Not always unilateral • Usually in frontotemporal or supraorbital region 	<ul style="list-style-type: none"> • Those of classic migraine • General malaise, fatigue • Chills • Diarrhea • Urticaria • Motion sickness 		<ul style="list-style-type: none"> • Sleep • Triptans

<p>Tumor (increased intracranial pressure)</p>		<ul style="list-style-type: none"> • Progressive, chronic headache (becoming more and more severe) • Change from usual headache pattern • Onset of severe headaches > 50 yo 	<ul style="list-style-type: none"> • Neurologic dysfunction • Projectile vomiting without nausea • Localized pain prevents sleep • Headache worse in the morning <p>Physical findings: papilledema</p>	<ul style="list-style-type: none"> • Coughing • Sneezing • Straining at stool 	
---	--	---	---	---	--

Questions to ask:

- OPQRST
- Sensitivity to light? Sound?
- Any changes in your vision along with the headache? Any changes in speech?
- Nausea or vomiting?
- Has it been getting worse recently or staying about the same?
- Is it worse when you cough, sneeze, or have a bowel movement?
- Does it wake you up at night?

Musculoskeletal:

	<u>Location</u>	<u>Presentation</u>	<u>Timing</u>	<u>Associated Symptoms</u>
Gout	<ul style="list-style-type: none"> Fingers: DIP Classic: pain, edema, inflammation in metatarsal-phalangeal joint of great toe Also ankle, wrist, knee 	<ul style="list-style-type: none"> Superficial inflammation (tendon sheaths & bursae) & soft tissue swelling Single joint with erythema (redness) of the joint, warmth, tenderness, or combination of symptoms Asymmetric edema May see tophi (extra-articular deposits of monosodium urate crystals) along Achilles tendon, ear helix, olecranon bursa, prepatellar bursa May see degenerative changes in joint 	<ul style="list-style-type: none"> Intermittent pattern Episodic; intervening periods free of joint symptoms 	
Rheumatoid Arthritis	<ul style="list-style-type: none"> Typically symmetrical (at least bilateral; may lack absolute symmetry) Target: synovial membrane Usually polyarthritis (3+ joint areas out of MCPs, wrist, PIPs, knee, MTP, shoulder, ankle, cervical spine, hip, elbow, TMJ in order of frequency) DIP joints usually spared 	<ul style="list-style-type: none"> Inflammatory arthritis - inflammation with swelling, tenderness, warmth, decreased range of motion Atrophy of interosseous muscles Ulnar deviation, boutonniere and swan-neck deformities, hammer toes can result from joint / tendon destruction Pain with motion, especially at extremes of motion Doughy or boggy synovial membrane 	<ul style="list-style-type: none"> Insidious onset (may begin with systemic features, then overt joint inflammation) About 10% have abrupt onset Spontaneous remission uncommon Often have morning stiffness (around joints, ~1 hr of especially stiff) 	<ul style="list-style-type: none"> Malaise, fatigue Fever Arthralgia (joint pain) Weakness Lack of ability to do normal ADLs (activities of daily living) Episcleritis and scleritis occasionally
Rotator Cuff Tendonitis	<ul style="list-style-type: none"> Pain in deltoid region of shoulder 	<ul style="list-style-type: none"> Pain worse with overhead motion of arm Tenderness in subacromial region Pain in mid-arc of active abduction Range of passive shoulder abduction exceeds active shoulder abduction 	<ul style="list-style-type: none"> May describe shoulder pain when sleeping on affected side May occur as result of recognizable injury (throwing) or insidiously (repeated impingement on overlying bones) 	
Trochanteric Bursitis	<ul style="list-style-type: none"> Classic presentation: point tenderness in greater trochanteric region of lateral hip Pain may radiate down into lateral aspect of ipsilateral thigh but <i>not</i> all the way into foot 	<ul style="list-style-type: none"> Most common cause of hip region pain May be associated with a limp Pain may awaken pt at night Increases with walking, squatting, climbing stairs, lying on ipsilateral side, increased activity or exercise Decreases at rest Pain may limit pt strength, make legs feel weak 	<ul style="list-style-type: none"> Most commonly follows repetitive / cumulative trauma (repetitive contraction of gluteus medius during walking, running) 	

- May also follow acute trauma (fall, tackle) or develop spontaneously
- Onset can be **insidious** or **acute**

Questions to ask:

- OPQRST
- Any recent trauma?
- Does the pain wake you up at night?
- Any fever? Weakness? Feeling more tired than usual?
- Affecting your daily activities?
- Both sides or just one?

Counseling for behavior change:

	Features	How to counsel
<u>Contemplation</u>	<ul style="list-style-type: none"> • Thinking about change but ambivalence is core feature • Patient aware of pros, cons, both have value • Can get stuck in this stage • Discussion leads to emotional arousal, resistance • Gap between value and behavior 	<ul style="list-style-type: none"> • Listen for words of ambivalence • Respond with reflection (one one hand it seems like... but on the other...is that right?) & empathy (distress of dilemma) • Offer support & partnership
<u>Relapse</u>	<ul style="list-style-type: none"> • Tried to quit but failed • May be discouraged, demoralized 	<ul style="list-style-type: none"> • Reflective listening • Try to elicit things learned from this attempt: what worked, what didn't • Show empathy • Arrange follow-up for support & encouragement to try again