المجلس الطلابي

The Art of History Taking & Physical Examination

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1. History taking

PERSONAL INFORMATION:

- Name:
- Age:
- Gender:
- Nationality:
- Known case of:

CHIEF COMPLAINT:

- Route of Admission:
- Time of Admission:
- Complaining of:
- When did it start?

HISTORY OF PRESENTING ILLNESS:

- Site: (localized/diffuse)
- Onset:
  - Sudden or gradual?
- Character:
  - (pressure/colicky/dull)
  - Increase, decrease or constant?
  - Comes and goes or persistent?
  - Affected by respiration?
- Radiation:
- Time: (does it come at specific time or after some activity?)
- Exacerbated by:
- Relived by:
- Severity:
  - Rate from 1 to 10:
  - Awake you from sleep?
  - Interfere with daily life? (if yes how?)

History of Presenting Illness

- Associated Symptoms: (take details for each one using SOCRATES)
- Important negatives: (According to which system are the patient complaining of)
- Constitutional symptoms (FFLLNN)
    - Fever:
    - Fatigue:
    - Loss of wight:
    - Loss of appetite
    - Nausea:
    - Night sweat:

Important
"always mention the positive symptoms first then the negative!"

Example

- MOHAMMED IS A 50 YEARS OLD SAUDI GENTLEMAN WHO LIVES IN RIYADH, WORKS AS A TEACHER AND HE IS A KNOWN CASE OF DIABETES FOR THE PAST 10 YEARS.
- CAME TO THE ER 5 DAYS AGO COMPLAINING OF CHEST PAIN FOR 12 HOURS PRIOR TO ADMISSION.
- MOHAMMED SUFFERED FROM A RETROSTERNAL PAIN. IT STARTED SUDDENLY AND WAS PERSISTENT AND INCREASING WITH TIME. THE PATIENT DESCRIBED THE PAIN AS PRESSURE ON HIS CHEST, RADIATING TO THE LEFT SHOULDER AND WASN'T AFFECTED BY BREATHING. IT EXACERBATED BY ACTIVITY LIKE CLIMBING THE STAIRS OR DOING EXERCISE AND RELIEVED BY REST AND DIDN'T FOLLOW ANY PERIODIC PATTERN. IT WAS 6 OUT OF 10 IN SEVERITY AT TIME OF ONSET BUT AT TIME OF ADMISSION IT'S 8 OUT OF 10, AWAKENED HIM UP TWICE, AND HE WASN'T ABLE TO GO TO THE MOSQUE. THE PAIN WAS ASSOCIATED WITH PALPITATION, DYSPNEA, DIAPHORESIS, AND DIZZINESS WHICH ALL STARTED SIMULTANEOUSLY WITH THE PAIN. REGARDING THE PALPITATION IT WAS FAST WITH REGULAR RHYTHM AND LASTED FOR AN HOUR AFTER HE HAD SOME REST. THE DYSPNEA WAS FAST AND PAINFUL AND LASTED FOR 20 MINUTES. THE DIAPHORESIS WAS SO SEVERE THAT HE HAD TO CHANGE HIS CLOTHES BUT WAS GONE AFTER SEVERAL MINUTES. REGARDING HIS DIZZINESS HE FELT AS THE ROOM WAS ROTATING AROUND HIM BUT IT WENT RIGHT AWAY AFTER HE SAT DOWN. THERE WAS NO COUGH, SPUTUM, ORTHOPNEA, PND, INTERMITTENT CLAUDICATION, PERIPHERAL EDEMA. THERE WAS NO FEVER, GENERALIZED FATIGABILITY, NAUSEA, NIGHT SWEAT, LOSS OF WEIGHT OR APPETITE.

1. History taking

PREVIOUS EPISODE:

- When?
- What did they do during the episode?
- What relieved it?

HOSPITAL COURSE:

- Investigations:
- Diagnosis:
- Treatment:
- Regarding his …….. It is ……. Over the last……

PAST MEDICAL HISTORY:

- Diabetes mellitus
    - Since
    - Diagnosed in
    - Medications
    - Compliance
    - Glucometer at home
    - Last reading
    - complications
- Hypertension (if yes detail the same as diabetes)
- Hyperlipidemia
- Thyroid disease
- Cancer
- Autoimmune disease
- Dental procedure

PREVIOUS SURGERY/ADMISSION:

- Why?
- When?
- Where?
- Was there any complication?

HISTORY OF TRAUMA, ALLERGY OR BLOOD TRANSFUSION:

- When
- Where
- Was there any complication

Medication Hx

MEDICATIONS:

- Drug:
- Reason of taking the drug:
- Route of Administration:
- Dose:
- Duration:
- Complications:
- Compliance: Yes/No (if no, Why?)
- Herbal medications

Example

- HE HAD SIMILAR EPISODES MONTHS AGO WHEN HE EXERCISED BUT IT WAS LESS SEVERE AND WENT AWAY WITH REST.
- IN THE ER HE HAD AN ECG , HEART ENZYMES, AND CBC. HE WAS GIVEN ASPIRIN AND IV FLUIDS AND WAS TAKEN TO THE CATH LAB. EVENTUALLY HE WAS DIAGNOSED WITH STEMI. REGARDING HIS SYMPTOMS IT IS DECREASING OVER THE LAST 4 DAYS.
- HE IS DIABEIC FOR THE PAST 10 YEARS, HE WAS DIAGNOSED HERE IN KKUH AND IS ON GLUCOPHAGE 500MG ORAL TWICE A DAY SCENE HE WAS DIAGNOSED. HE IS NOT COMPLIANT WITH THE DRUG AND HIS LAST VISIT TO THE DOCTOR WAS 6 MONTHS AGO AND HIS HBA1C WAS 8. HE HAS GLUCOMETER AT HOME AND HIS LAST READING WAS 210. HE DIDN'T SUFFER ANY KNOWN DIABETIC COMPLICATION SUCH AS DIABETIC FOOT OR NEUROPATHY OR ANY COMPLICATION FROM THE DRUG.
- HE IS NOT KNOWN TO HAVE HYPERTENSION, HYPERLIPIDEMIA, CANCERS, THYROID OR AUTOIMMUNE DISEASES. AND HE HASN'T UNDERGONE DENTAL PROCEDURE RECENTLY.
- HE HAD AN APPENDECTOMY DUE TO APPENDICITIS 35 YEARS AGO IN KKUH WITHOUT COMPLICATIONS.
- HE HAD NO HISTORY OF TRAUMA, ALLERGIES, OR BLOOD TRANSFUSION.
- HE IS NOT ON ANY MEDICATIONS OTHER THAN DIABETES DRUGS (HE IS ON GLUCOPHAGE 500MG ORAL TWICE A DAY SCENE HE WAS DIAGNOSED WITH NO KNOWN SIDE EFFECT). HE DIDN'T USE ANY HERBAL MEDICATIONS.

1. History taking

FAMILY HISTORY

- His father (passed away at the age of .. because of ..../ is alive and in good health)
- His mother (passed away at the age of .. because of ..../ is alive and in good health)
- His Siblings:
- Similar episode in the family:
- Chronic Conditions (DM, HTN, Cancer, Autoimmune disease, Congenital anomalies...):

SOCIAL HISTORY

- Marital Status:
- Number of Children:
- Occupation:
- Smoker/Ex-smoker/Secondhand smoker: (if Yes, Calculate Pack Years)
- Contact with sick person with same symptoms: (if you suspect Infectious Disease)
- Vaccines:
- Pets:
- Exercise :
- Dite, fast food, coffee consumption:
- Recent travel:
- Sexual activity:
- Alcohol:
- Recreational drugs:

OB/GYNE (IF THE PATIENT WAS A FEMALE)

- Menarche:
- Last Cycle:
- Flow: (Regular\Irregular) - (Heavy\Moderate\Light)
- Pain:
- Numbers of pregnancies:
- Number of deliveries:
- Any complications:

Example

- HIS FATHER PASSED AWAY AT THE AGE OF 60 FROM HEART ATTACK, HIS MOTHER IS 70 YEARS OLD ALIVE AND IN GOOD HEALTH.
- HE HAS 2 BROTHERS AND ONE SISTER.
- THERE WERE SIMILAR EPISODES IN THE FAMILY, HIS FATHER HAD THE SAME COMPLAINT AND WAS DIAGNOSED WITH MI 5 YEARS PRIOR TO HIS DEATH, AND HIS OLDER BROTHER WAS DIAGNOSED RECENTLY WITH ANGINA AFTER HE HAD SIMILAR SYMPTOMS.
- HIS FATHER AND BROTHER HAD HYPERTENSION AND DIABETES. BUT THERE WAS NO FAMILY HISTORY OF HYPERTENSION, CANCERS, AUTOIMMUNE DISEASES OR CONGENITAL HEART DISEASE.
- HE IS MARRIED AND HAS 2 BOYS AND A GIRL, LIVING WITH HIS FAMILY IN A FLAT ON THE SECOND FLOOR.
- HE WORKS AS A FINANCIAL MANAGER IN A MAJOR COMPANY.
- HE DOESN'T SMOKE AND HE HAS NO SIGNIFICANT CONTACT WITH ANY SMOKER.
- HE HASN'T CONTACTED ANYONE WITH SIMILAR SYMPTOMS RECENTLY.
- HE DOESN'T DRINK OR USE ANY RECREATIONAL DRUGS.
- HE DOESN'T EXERCISE , AND HIS DIET IS MAINLY RED MEAT. ALSO HE DRINKS AROUND 5 CUPS A COFFEE A DAY.
- HE TRAVELED RECENTLY TO THE US FOR A BUSINESS MEETING.
- HE DINED ANY SEXUAL ACTIVITY OUTSIDE OR BEFORE MARRIAGE.
- THERE ARE NO PETS AT HOME, AND AS FAR AS HE KNOWS HE HAS RECEIVED ALL THE MANDATORY IMMUNISATION BY MOH.
- “IF THE PATEINT IS FEMALE”:
    - SHE HAD MENARCHE WHEN SHE WAS 9, HER LAST PERIOD WAS 8 DAYS AGO AND IT WAS REGULAR WITHOUT ANY PAIN. SHE HAD 2 PREGNANCIES AND 1 DELIVERY SINCE ONE OF THEM WAS MISSCARIDGED FOR UNKNOWN REASONS, THE DELIVERY WAS NORMAL WITHOUT ANY COMPLICATIONS.

SYSTEMIC REVIEW

- CNS: Headache, vision problems, hearing problems, loss of consciousness, numbness, motor disturbance
- CVS: dyspnea, chest pain, palpitation, peripheral edema, intermittent claudication, orthopnea, paroxysmal nocturnal dyspnea, dizziness.
- Respiratory: dyspnea, cough, sputum, wheezing, hemoptisis, chest pain, hoarseness of voice.
- GI: dysphagia, odynophagia, heartburn, nausea, vomiting, appetite, abdominal pain, diarrhea, constipation, tenesmus, urgency, hematemesis, hematochezia, melena, jaundice, abdominal distention, bloating.
- Urinary: increase in volume or frequency, dysuria, change in color, urgency, nocturia, WISE (weak steam, intermittent flow, straining, emptying incomplete), frothy, discharge, dripping.
- Skin: rash bruising, dryness
- MSK: joint pain, bone pain, swelling.
- Endocrine: polydipsia, polyphagia, cold/heat intolerance, neck swelling.
- Hematology: bleeding, bruising.

Notes:

- Mention the system involved in the main complaint at the History of Presenting Illness, DO NOT mention it again in the systemic Review.
- Mention the positive symptoms first then the negative according to the system.
- Use different Vocabulary, and change your voice tone according to the importance of the information (It's like telling a story).
- Be confident!

Example

- ON SYSTEMATIC REVIEW OF THE CNS THE PATIENT DIDN'T HAVE HEADACHE, VISION PROBLEMS……ETC
- ON REVIEWING RESPIRATORY THERE WAS NO DYSPNEA, COUGH……ETC
- (WE SKIPPED CVS IN OUR PATIENT BECAUSE WE ALREADY MENTIONED IT IN THE HPI)

2. Physical Examination

GENERAL EXAMINATION

Note:
Throughout the examination we will mention the presentation if the patient is normal which your patient will be in most parts. There is a question mark before each part you need to check in your patient if he is really normal or not.

General appearance

- ……. Age, male/female , lying comfortably on the bed, not in pain, he is looking well …… body built, conscious and alert, oriented by time, place and person. He is not in respiratory distress, …… using accessory muscle, didn't look jaundice, cyanosed or pale. Connection: ……

Vital sign

- RR: BP: Temperature: SpO2: BMI:
- I took the puls and it was …… With a rate of …… betes/min. No radial-radial delay or radial-femoral delay. (In CVS mention : Water hammer……..)

Example

- **ON GENERAL EXAMINATION** THE PATIENT IS MIDDLE AGED, MALE , LYING COMFORTABLY ON THE BED, NOT IN PAIN, HE IS LOOKING WELL NORMAL BODY BUILT, CONSCIOUS AND ALERT, ORIENTED BY TIME, PLACE AND PERSON. HE IS NOT IN RESPIRATORY DISTRESS NOT USING ACCESSORY MUSCLE, DIDN'T LOOK JAUNDICE, CYANOSED OR PALE. HE IS CONNECTED TO AN IV CANNULA ON HIS RIGHT HAND NOT CONNECTED TO ANYTHING
- RR IS 15 BREATH/MIN
- BP IS 130 OVER 70
- TEMPERATURE IS 37 DEGREES
- SPO2 97
- HIS BMI IS 30
- I TOOK THE PULS AND IT WAS REGULAR WITH A RATE OF 80 BEATS/MIN. NO RADIAL-RADIAL DELAY OR RADIAL-FEMORAL DELAY. AND NO WATER HAMMER PULSE.

Hands, Arms, Head, Back, and lower limbs

Hands:

- There was no? clubbing, leukonychia, koilonychia, splinter hemorrhage. Capillary refill was normal within 2s.
- There was no? Skin lesions like (osler nodes, janeway lesions).
- No scars were noted, no muscle wasting.
- There was no? Tendon xanthomas or palm xanthoma, no skin changes such as palmar erythema, pigmentation or nicotine staining.
- There was no dupuytren's contracture, flapping tremor or prominent vein.
- No peripheral cyanosis.
- In Renal cases mention: terry nails, mee's line, and because lines, AV fistula and tenderness.
- In Respiratory cases mention: hypertrophic pulmonary osteoarthropathy.

Arms

- No? Bruising, petechiae, spider nevi, acanthosis nigricans or scratch marks. Epitrochlear lymph nodes are not palpable.
- In Renal cases mention: AV fistula, uremic frost.

Head

- Normal hair disturbance with no flushed cheeks.
- **Eye**: no? yellowish discoloration on the sclera, corneal arcus or xanthelasma, and normal non pale conjunctiva.
    - In GI cases mention: no? kayser-fleischer ring or iritis
    - In renal cases mention: band keratopathy.
    - In respiratory cases mention: mitosis, ptosis, anhidrosis.
- **Mouth**: ……. oral hygiene , …… missing teeth, …….. central cyanosis, moist mouth with no? ulcer or bleeding.
    - No fetor hepaticus, urmic, fetor or cigarette smell.
    - In Respiratory cases mention: no? congested pharynx.
    - In CVS cases mention: high palate.
    - In GI cases mention: Angular stomatitis, enlarged tongue.
- **Nose**:
    - In Respiratory cases mention: no nasal septal deviation.
- **Neck**:
    - JVP was normal about ……. cm from the sternal angle and -ve kussmaul sign.
    - No? Palpable lymph node in (cervical, supraclavicular, axillary and facial) -ve traiser sign.
    - No palpable neck masses.

Back:

- No? sacral edema.

Lower limbs:

- Peripheral pulses were palpable, equal and synchronised bilaterally. No? skin changes like ulcers, nail changes or clubbing.
- No? edema.

2. Physical Examination

Example

- **ON EXAMINING THE HANDS :**
  - THERE WERE NO CLUBBING, LEUKONYCHIA, KOILONYCHIA, SPLINTER HEMORRHAGE. CAPILLARY REFILL WAS NORMAL WITHIN 2S.
  - THERE WERE NO SKIN LESIONS LIKE (OSLER NODES, JANEWAY LESIONS).
  - NO SCARS WERE NOTED, NO MUSCLE WASTING.
  - THERE WAS NO TENDON XANTHOMAS OR PALM XANTHOMA, NO SKIN CHANGES SUCH AS PALMAR ERYTHEMA, PIGMENTATION OR NICOTINE STAINING.
  - THERE WAS NO DUPUYTREN'S CONTRACTURE, FLAPPING TREMOR OR PROMINENT VEIN.
  - NO PERIPHERAL CYANOSIS.
- **ON EXAMINING THE ARM:**
  - NO BRUISING, PETECHIAE, SPIDER NEVI, ACANTHOSIS NIGRICANS OR SCRATCH MARKS. EPITROCHLEAR LYMPH NODES ARE NOT PALPABLE.
- **ON EXAMINING THE HEAD:**
  - THERE WAS NORMAL HAIR DISTURBANCE WITH NO FLUSHED CHEEKS.
  - THERE WAS NO YELLOWISH DISCOLORATION ON THE SCLERA, CORNEAL ARCUS OR XANTHELASMA, AND NORMAL NON PALE CONJUNCTIVA.
  - ON EXAMINING THE MOUTH THERE WAS GOOD ORAL HYGIENE , NO MISSING TEETH, CENTRAL CYANOSIS, OR HIGH PALATE. AND IT WAS MOIST WITH NO ULCER OR BLEEDING.
  - ON EXAMINING THE NECK JVP WAS NORMAL ABOUT 4 CM FROM THE STERNAL ANGLE AND -VE KUSSMAUL SIGN.
  - NO PALPABLE LYMPH NODE IN (CERVICAL, SUPRACLAVICULAR, AXILLARY AND FACIAL) -VE TRAISER SIGN.
  - NO PALPABLE NECK MASSES.
- THERE WAS NO SACRAL EDEMA WHILE **EXAMINING THE BACK.**
- **ON THE LOWER LIMB EXAM** THE PERIPHERAL PULSES WERE PALPABLE, EQUAL AND SYNCHRONISED BILATERALLY. NO SKIN CHANGES LIKE ULCERS, NAIL CHANGES OR CLUBBING.

Local Examination

Note:
mention the system related to your case first.
Some of the findings were mentioned twice in two systems (such as apex beat). Mention it in the system related to your case only.

CARDIOVASCULAR

- On inspection:
  - There was no? chest deformity, such as pectus excavatum or carinatum
  - No? Scars (sternotomy).
  - No? Device was connected (pacemaker,ICD).
  - Apex beat was ……. Vesible.
- On palpation:
  - Apex beat was……. over the …… with …… character.
  - No? parasternal heave, no? Thrills and no? tenderness (costochondritis)
- On auscultation:
  - Normal audible 1st and 2nd sounds with no? Added sounds or murmurs.
  - I also auscultated over the carotid and there were no? bruits.
  - On auscultating over the sacral edema there was no? Crackles

Example

- **ON INSPECTION:**
  - THERE WAS NO CHEST DEFORMITY, SUCH AS PECTUS EXCAVATUM OR CARINATUM
  - NO SCARS,NOR DEVICE WAS CONNECTED. APEX BEAT WAS NOT VISIBLE.
- **ON PALPATION:**
  - APEX BEAT WAS PALPABLE OVER THE 5TH INTERCOSTAL SPACE WITH NORMAL CHARACTER.
  - NO PARASTERNAL HEAVE, THRILLS AND NO TENDERNESS.
- **ON AUSCULTATION:**
  - NORMAL AUDIBLE 1ST AND 2ND SOUNDS WITH PANSYSTOLIC MURMUR HEARD OVER THE MITRAL AREA WHICH WAS RADIATING TO THE LEFT AXILLA. NO OTHER SOUNDS WERE NOTICED
  - I ALSO AUSCULTATED OVER THE CAROTID AND THERE WERE NO BRUITS.
  - ON AUSCULTATING OVER THE SACRAL EDEMA THERE WAS NO CRACKLES

RESPIRATORY

- On inspection:
  - The chest was symmetrical and moved freely with inspiration.
  - ……. type of breathing and not? Using accessory muscles/
  - No?scars or chest wall deformity (barrel chest).
  - Apex beat was …….. Visible in ……..
  - No device (chest tube).
- On palpation:
  - Trachea was …… located, with no? Tracheal tug
  - Apex beat was palpable in …….
  - No? sign of rib fracture.
  - Chest is normal with bilateral equal chest expansion and tactile vocal fremitus is equal over all lung fields.

2. Physical Examination

- On percussion:
  - Bilateral …… percussion over all lung fields
- On auscultation:
  - Bilateral …….. Breath sounds with no ? added sounds.
  - Normal? Bilateral vocal resonance and whispered pectoriloquy.

Example

- **ON INSPECTION:**
  - THE CHEST WAS SYMMETRICAL AND MOVED FREELY WITH INSPIRATION.
  - ABDOMINOTHORACIC TYPE OF BREATHING AND NOT USING ACCESSORY MUSCLES.
- **ON PALPATION:**
  - TRACHEA WAS CENTRALLY LOCATED, WITH NO TRACHEAL TUG.
  - NO SIGN OF RIB FRACTURE.
  - CHEST IS NORMAL WITH BILATERAL EQUAL CHEST EXPANSION AND TACTILE VOCAL FREMITUS IS EQUAL OVER ALL LUNG FIELDS.
- **ON PERCUSSION:**
  - BILATERAL RESONANT PERCUSSION OVER ALL LUNG FIELDS
- **ON AUSCULTATION:**
  - BILATERAL VESICULAR BREATH SOUNDS WITH NO ADDED SOUNDS.
  - NORMAL BILATERAL VOCAL RESONANCE AND WHISPERED PECTORILOQUY.

ABDOMINAL

- On inspection:
  - The umbilicus was …….., the abdomen moving with respiration.
  - No? Scars were noted, no? Bulging flanks.
  - No? Skin discoloration, no skin lesions (century marks, stria, sister mary joseph).
  - No? Prominent vein (caput medusa) or obvious pulsation.
  - No? Local swelling or hernia, no cullen and grey turner sign.
- On palpation:
  - The abdomen was …… with no? Tenderness.
  - No superficial or deep masses or organomegaly.
  - Liver span was …… , kidney and spleen were ……. Palpable.
  - No? Murphy's sign and no? Rebound tenderness.
- On percussion:
  - The abdomen was tympanic all over with no? Sign of ascites such as shifting dullness and fluid thrill.
- On auscultation:
  - Bowel sounds were normal, no? bruit over the aorta, liver and renal artery, no venous hum.

Local Examination

- Examination of back:
  - No vertebral tenderness, -ve kidney murphy's punch
- Per-rectal and genetal exam were not performed

Example

- **ON INSPECTION:**
  - THE UMBILICUS WAS INVERTED AND THE ABDOMEN MOVING WITH RESPIRATION.
  - A SCAR IN THE LOWER RIGHT QUADRANT WAS NOTED AND IT WAS ATTRIBUTED TO THE APPENDECTOMY HE PREVIOUSLY HAD.
  - NO BULGING FLANKS ,SKIN DISCOLORATION OR SKIN LESIONS.
  - NO PROMINENT VEIN (CAPUT MEDUSA) OR OBVIOUS PULSATION.
  - NO LOCAL SWELLING OR HERNIA, NO CULLEN AND GREY TURNER SIGN.
- **ON PALPATION:**
  - THE ABDOMEN WAS SOFT AND LAX WITH NO TENDERNESS.
  - NO SUPERFICIAL OR DEEP MASSES OR ORGANOMEGALY.
  - LIVER SPAN WAS 10 CM, KIDNEY AND SPLEEN WERE NOT PALPABLE.
  - NO MURPHY'S SIGN AND NO REBOUND TENDERNESS.
- **ON PERCUSSION:**
  - THE ABDOMEN WAS TYMPANIC ALL OVER WITH NO SIGN OF ASCITES SUCH AS SHIFTING DULLNESS AND FLUID THRILL.
- **ON AUSCULTATION:**
  - BOWEL SOUNDS WERE NORMAL, NO BRUIT OVER THE AORTA, LIVER AND RENAL ARTERY, NO VENOUS HUM.
- **EXAMINATION OF BACK:**
  - NO VERTEBRAL TENDERNESS, -VE KIDNEY MURPHY'S PUNCH
- PER-RECTAL AND GENETAL EXAM WERE NOT PERFORMED.

3. Summary

Summary

- …… is ……. Old (gentleman / lady) known to have…….
- Presented with…….. For……..
- Associated with……(important positives and negatives)
- On physical : nothing significant except…….

Example

- MOHAMMED IS A 50 YEARS OLD GENTLEMAN KNOWN CASE OF DIABETES.
- PRESENTED WITH CHEST PAIN FOR 12 HOURS.
- ASSOCIATED WITH PALPITATION, DYSPNEA AND DIAPHORESIS WITH NO FEVER OR WEIGHT LOSS.
- ON PHYSICAL : NOTHING SIGNIFICANT EXCEPT PANSYSTOLIC MURMUR HEARD OVER THE MITRAL AREA WHICH WAS RADIATING TO THE LEFT AXILLA.

~ تم وبحمدالله ~