

CLINICAL EXAMINATION BY FIELD PHYSICIAN

CARDIOVASCULAR AND
RESPIRATORY SYSTEMS

LOCALITY

ID NUMBER

DATE

HOUR

PHYSICIAN

I CLINICAL HISTORY

possible

definite

Current medical
control
No Yes

- | | | | |
|---|---|--|---|
| 1. Myocardial infarction | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | yr. _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 2. Angina pectoris | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | since yr. _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 3. Congenital heart disease | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 4. Valvular heart disease
(acquired) | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | _____
sympt. rheum. <input type="checkbox"/> 1 luetic <input type="checkbox"/> 1 | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 5. Rheumatic fever | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 6. Arterial hypertension | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | since yr. _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 7. Heart failure | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | since yr. _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 8. Cardiac arrhythmia | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 9. Obstructive arterial dis-
ease of lower limb(s) | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |
| 10. Stroke | <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> 1 | _____
sympt. _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 1 |

	possible	definite		<u>Current medical control</u>	
				No	Yes
11. Other cardiovascular disease (specify)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	_____	<input type="checkbox"/> 0	<input type="checkbox"/> 1
		<input type="checkbox"/> 1	sympt. _____		
12. Bronchial asthma	<input type="checkbox"/> 1	<input type="checkbox"/> 2	since yr. _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1
		<input type="checkbox"/> 1	sympt. _____		
13. Chronic bronchitis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	since yr. _____		
		<input type="checkbox"/> 1	sympt. _____		
14. Pulmonary emphysema	<input type="checkbox"/> 1	<input type="checkbox"/> 2	_____	<input type="checkbox"/> 0	<input type="checkbox"/> 1
		<input type="checkbox"/> 1	sympt. _____		
15. Pulmonary tuberculosis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	yr. _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1
		<input type="checkbox"/> 1	sympt. _____		
16. Other chronic pulmonary disease	<input type="checkbox"/> 1	<input type="checkbox"/> 2	_____	<input type="checkbox"/> 0	<input type="checkbox"/> 1
		<input type="checkbox"/> 1	sympt. _____		

0 no history of diseases mentioned above

17. Symptoms, other details, comments:

PHYSICAL STATUS

Details, comments:

- 1 dyspnoea at rest
- 1 dyspnoea while dressing/undressing
- 1 use of accessory respiratory muscles
- 1 chest mobility restricted
- 1 proc. cric.-jugulum \leq 1 finger breadth(s)
- 1 expirium prolonged
- 1 hyperresonant percussion sound of lungs
- 1 expiratory wheezing
- 1 rhonchi
- 1 inspiratory fine moist rales
- 1 occasional premature beats
- 1 frequent premature beats
- 1 completely irregular rhythm
- 1 sound S2A clearly accentuated
- 1 sound S2P clearly accentuated
- 1 fixed splitting of S2
- 1 MOS (mitral opening snap)
- 1 S3
- 1 S4

Heart murmurs:

	location					radiation	timing in heart cycle				intensity					
syst.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
diast.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

1 = Aortic	syst:	1 = barely audible
2 = Pulmonic	1 = early syst.	2 = soft
3 = Apical	2 = mid-syst.	3 = moderately loud
4 = Sternal	3 = late syst.	4 = loud
5 = Other _____	4 = holosyst.	5 = very loud
		6 = loudest possible

	diast:
	1 = early diast.
	2 = mid-diast.
	3 = presyst.
	4 = holodiast.

Details, comments:

	dx	sin
a. dors. ped. not palpable	<input type="checkbox"/> 1	<input type="checkbox"/> 1
a. tib. p. not palpable	<input type="checkbox"/> 1	<input type="checkbox"/> 1
a. femoralis not palpable	<input type="checkbox"/> 1	<input type="checkbox"/> 1

BP:

syst. diast.

liver enlarged, tender	<input type="checkbox"/> 1
unilateral muscle weakness	<input type="checkbox"/> 1
limb contracture	<input type="checkbox"/> 1
dysphasia/aphasia	<input type="checkbox"/> 1

Details, comments:

0 No findings mentioned above

Details, comments:

III

FUNCTIONAL CLASSIFICATION OF CARDIOVASCULAR/RESPIRATORY DISEASES

no functional limitation	<input type="checkbox"/> 0
no functional limitation even in heavy <u>daily</u> activity	<input type="checkbox"/> 1
functional limitation in heavy daily activity	<input type="checkbox"/> 2
functional limitation in light daily activity	<input type="checkbox"/> 3
functional limitation in any physical activity or disabling symptoms even at rest	<input type="checkbox"/> 4
not classified because of marked limitation of mobility (caused by noncardiovascular/respiratory disease)	<input type="checkbox"/> 8
symptoms limiting functional capacity:	
dyspnoea	<input type="checkbox"/> 1
stenocardia	<input type="checkbox"/> 1
claudication	<input type="checkbox"/> 1
paresis	<input type="checkbox"/> 1
other _____	<input type="checkbox"/> 1

DIAGNOSTIC EVALUATION BY FIELD PHYSICIAN

	Diagnosis				Need of care/control		Adequacy of care/control				Need of new measures		
	possible	definite	previous	new	no	yes	no care/control	inadequate	proposed, not accompl.	adequate	general practitioner	specialist	control of finding(s) only
1. myocardial infarction	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. angina pectoris	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. congenital heart dis.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. luetic valvular dis.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. rheumatic valvular dis.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. other valvular dis.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. arterial hypertension	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. heart failure	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. hypertensive heart dis.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10. cor pulmonale	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
11. cardiac arrhythmia	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
12. occlusive arterial dis.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
13. cerebrovascular dis.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
14. other cardiovascular disease	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
no cardiovascular disease													<input type="checkbox"/> 0
15. bronchial asthma	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
16. chronic bronchitis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
17. pulmonary emphysema	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
18. pulmonary tuberculosis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
19. other chronic respiratory disease	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
_____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
no respiratory disease													<input type="checkbox"/> 0
disease of other system contributing to cardiovascular/respiratory symptoms or signs													<input type="checkbox"/> 1