

ANAMNESIS COLLECTION

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Abstract: In this article, we examined the methods of collecting Anamnesis

Key words: Anamnesis, Medical history, collection.

Anamnesis (in Greek - Anamnesis – means “memory”) is a collection of information collected about the disease with the help of a patient or his loved ones to carry out diagnosis, appropriate treatment and preventive measures. Anamnesis is one of the main components for the clinical examination of the patient.

Having determined the complaints of the patient, the doctor investigates the origin of the disease. The history of the origin and development of the disease helps to come to a general conclusion about it.

It should include the following questions:

- when he got sick;
- where and under what conditions he was infected;
- how the disease started (acute or gradual);
- the patient is asked what is the cause of the disease in his opinion. The possibility of influence of external factors (household, professional, weather and climate factors), physical, mental-emotional stress, intoxications, infectious diseases in the origin and development of the condition;
- the first symptoms of the disease;
- when and where first aid was provided, what was its result;
- the dynamics of complaints (what changes have occurred in the patient's condition since the onset of the disease until now);
- if the disease is chronic, its recurrence, symptoms and periods of remission, their duration should be shown in sequence;
- which additional inspections were conducted, what were their results;
- Ambulatory card, excerpts from the medical history, x-ray,
- use of EXOKG (echocardiogram), ECG (electrocardiogram) and other documents;
- what treatment measures were used in the stages of the disease and their effectiveness;
- the reason for the deterioration of the last condition (the main signs and their manifestations should be indicated in full);

- changes in the patient's condition during hospital stay or outpatient treatment (indicating the degree of clear manifestation of symptoms).

The history of the development of the disease should reflect the patient's condition from the time of its first symptoms to the present. It is necessary to thoroughly ask the patient about the first symptoms of the disease, and then ask about the development and remission period (in chronic diseases) and their duration. In this interval, if the patient has undergone additional examinations, to analyze the results and to obtain information about the previously performed treatment measures and their results. At the end, the reason for the last hospitalization will be determined.

Mental and physical development of the patient in childhood, nationality, place of birth. The last two data sometimes make it possible to suspect endemic and congenital diseases. In order to determine mental development, it is important to know the age at which he went to school and the level of mastery. At the same time, it is necessary to know the patient's puberty period, the period of family life and its characteristics.

Household conditions.

Living conditions, economic status, nutritional differences, regularity and duration of sleep, physical education and sports is taken into account. Where the patient lived during his life is also of particular importance.

Bad habits.

It includes smoking, alcohol, drugs, stimulants and toxic substances at what age and how much.

Professional anamnesis includes all stages of labor activity, including the period of military service (if in service). The age at which they started working, their profession, position, whether they have a disability group or not, and the reason for it are entered. At the same time, the patient should have information about labor activity. In this case, it is necessary to pay attention to the presence of negative physical, chemical and bacteriological factors, the sanitary condition of the workplace. It will be determined whether he has experienced diseases, injuries, surgical operations or not. Allergological anamnesis begins with determining whether the patient or his relatives have allergic diseases. In this case, it is tried to determine if there is urticaria, Quincke's edema, anaphylactic reactions, swelling of the nasal mucosa and vocal cords, bronchospastic syndrome and which allergens they are related to (drugs, food, etc.). Obstetric anamnesis includes women's pregnancy period and childbirth process and related problems, age of first menstruation, its duration, number of pregnancies, abortions, births, their course,

symptoms, complications, gynecological diseases, includes the answer to a number of questions, such as the period when menopause begins. During pregnancy, a woman undergoes a medical examination with special attention, and in this process, in some cases, many hidden diseases (heart defects, pyelonephritis, diabetes, etc.) are detected. In addition, in recent years, special computer-programmed questionnaires have been used in the process of anamnesis collection (chest pains, allergies, acute abdominal pains). But through these programs, it is very important information: it is impossible to solve the problems related to the patient's personality and mental state. Its objective examination or "assessment of its general condition at the same time" (status praesens) consists in determining the state of the whole organism, individual organs and systems. In this case, it should be remembered that the disease of certain organs calls for changes in the whole organism. In order for the objective examination of the patient to be perfect and systematic, it is necessary to work on the basis of a certain plan. First, a general examination, then by palpation, percussion, auscultation and other examination methods are used to examine breathing, cardiovascular, digestive, urinary, locomotor, endocrine and nervous systems, as well as lymph nodes. After that, based on the instructions, laboratory-instrumental testing methods are carried out.

References:

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