Standardized patient (examination and treatment algorithm)

Neurotic, stress-related and somatoform disorders

(ICD 10 F40-48)

1. To greet and identify the patient.

2. To prepare the necessary medical documentation;

3. To provide isolation from the influence of various stimuli during the conversation (outside conversations, phone calls, etc.);

4. To reveal the patient's complaints

5. To collect anamnesis vitae:

(heredity, development, disease in childhood and adulthood, bad habits, living and eating conditions, allergic reactions, blood transfusions, health of relatives, close relatives, children) and enter data in the relevant section of medical records.

6. To collect a history of the disease:

- the onset of the disease;
- the course of the disease;
- the presence of general disorders;
- the complaints and data on the course of the disease to make in the relevant section of medical records.

7. To make a preliminary diagnosis.

8. To evaluate an anamnestic data:

- to identify the main complaints that dominate the history;
- to establish the relationship of complaints, to combine symptoms into syndromes;
- to determine the nature of the disease (acute, chronic);
- to suggest the most probable causes that could have caused the disease.

9. To prescribe the treatment.