"Curation of the patient with cor pulmonale"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complaints of the patient with cor pulmonale (pay attention to the complaints connected with the decompensate of the right borders of the heart
5. Take the anamnesis of the patient with core pulmonale (pay attention to the duration of lung disease, if the patient took prescribed medicines correctly
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the examination of the patient (skin, mucosa ,investigation of respiratory system, cardio-vascular system (dilated heart borders to the right, liver enlargement due to heart failure)
10. Interpretation of the laboratory findings
    ---interpretation of general blood analyses (increasing of the RBC and HB.)
    ---interpretation of the ECG (deviation of the electrical axis of the heart to the right, hypertrophy of the right parts of the heart, right Hiss bandle block)
    ---interpretation of X-ray of the chest (deviation of the heart, lung tissue changes.)
    ---interpretate the results of spirography (obstructive, restructive, combin types of vent violation .
    ---interpretate the saturation of blood in patients with corpule pulmonale.
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

Curation of the patient with peptic ulcer disease"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Take the complaints of the patients with peptic ulcer disease (pay attention on pain and dyspeptic syndromes peculiarities)
5. Take the anamnesis of the patients with peptic ulcer disease (pay attention on the nutrition character, smoking, presents of stress, taking of NSAD, heredity, frequency and seasonality of exacerbation)
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the exanimation of the patients and show the changes, which characterize the peptic ulcer (to investigate of skin and mucosa membrane (pale, dryness) tongue (presents of white covering; atrophy of the papilla), superficial (mucous defense) and deep palpation (painless during palpation in epigastria region and pyloroduodenal area), to determinate of Mendelya's syndrome)

10. The interpritation of laboratory and instrumental methods results:
evaluate of gastroscopy result (presents of ulceration of mucosa)
evaluate of digestive tract X-ray examination result (direct an indirect sings)
evaluate of IEA (determination of Hp antibody) (antibody's titer to Hp antigen)
evaluate the Gregersen test results
evaluate of pH-metry results (functional interval)
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with the leukemia"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complain patient with leukemia (pay attention on peculiarities of anemic and prolipherative polyadenopathy, immunodeficiency syndrome and nevroleukemia).
5. Take the anamnesis in patients with leukemia (pay attention on the heredity presents contacts with toxic, chemical and others poisons substances).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Exanimate the patient and show the changes charactering for leukemia (pallor and skin eruption, palpation of lymphatic nodes, liver and spleen present of sternalgia).
10. Interpret the laboratory and instrumental methods results:
- to evaluate the general blood tests changes (Anemia, thrombocytopenia, blastemia, leukopenia common for acute leukemia. Leukocytosis, absolute lymphocytosis, Botkin- Gumpreht's shade common for chronic leukemia. Leukocytosis, presence of myelocytes, myeloblasts, basophilic and eosynophlic dissociation common for myeloid leukemia.)
- to scow changes in myelogram (presents of blastemia, hypo-and hyperprolipheration of bone marrow, more than 30 % blasts as criterium of acute lekemia, leukocytosis amd more than 40 % lymphocytes as criteria of chronic lympholekemia, lekocytosis and proliferation of cells of myeloid rowto myeloblasts)
- to evaluate of results of ultrasound examination of the liver and the spleen
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with anemia"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect complains of the patient with anemia (pay attention of the peculiarities of anemic and sideropenic syndrome).

5. Collect anamnesis of patient with anemia (pay attention on the nutrition character, smoking, presence of the bleeding in the past).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform examination of the patient and show the changes which characterized the anemia (investigation of the skin and mucous (pallor and dryness of skin), tongue (covered by white incrustation, smoothing of the papilla), tachycardia, systolic murmur, dilatation of the heart border).
10. Interpret the results of laboratory and instrumental methods of examination:
- evaluate the gastroscopy results (presents of gastritis, erosion, ulceration of the mucous);
- evaluate the biochemical blood test results (iron and iron-connecting serum possibility);
- evaluate the Gregersen test;
- evaluate the pH-metry results (functional interval).
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with hemorrhagic diathesis"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complains of the patient with hemorrhagic diathesis (pay attention on the peculiarities of anemic and hemorrhagic syndrome, type of hemorrhagic).
5. Collect anamnesis of patient with hemorrhagic diathesis (pay attention on the nutrition character, smoking, presence of hemorrhages in patients or there relatives).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform examination of the patient and show the changes which characterized the hemorrhagic diathesis (investigation of the skin and mucous, garrote test, bandage test).
10. Interpret the results of laboratory and instrumental methods of examination:
- evaluate the general blood test (thromboctes less than 150×10^9 /l.;
- evaluate the coagulogram's result and blood clotting time.
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with chronic renal failure"

1. Friendly facial expression and smile.

2. Gentle tone of speech.
3. Greeting and introducing.
4. Take the complaints of patient with the chronic renal failure(CRF) (pay attention on anemic and hemorrhagic syndromes special features)
5. Patient with the chronic kidney failure should be asked for effectiveness and regularity main disease treated which was cause CRF, peculiarities it course.
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Examine a patient carefully and documented typical CRF changes(examine skin and mucous outers: pallor and drying skin, swelling, take blood pressure(hypertension), diuresis (olygouria, anuria).
10. Interpret results laboratory-instrumental methods examine
-evaluation result general urine analyze (proteinuria, gypoisostenuria)
-evaluation result general blood analyze (decrease RBC, haemoglobin),
-evaluation result biochemical blood analyze (increasing of createnine level, uria, K, P, decreasing Ca level),
-evaluation result ultrasound examination of kidneys (decreasing size of kidneys, its indurations)
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with pneumonia"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complains of the patient (pay attention to the intoxication syndrome, pain and bronchoobstructive syndrome).
5. Take the anamnesis of the patient (pay attention to the cofactors: respiratory infection, harmful work condition).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the examination of the patient, show the changes which characterize this disease (pallor, acrocianosis), to count the frequency of breathing rate, palpation of the chest, percussion of the chest, auscultation (bronchial breathing, crepitation).
10. Interpretation of the laboratory findings: the interpretation of the general blood analyze(leycocytosis, neutotrophilosis, increasing of ESR);
-the interpretation of the X-ray results (focus of darkening);
-the interpretation of the spirography results (restuctive type of respiratory failure)
-the interpretation of picfluomethry results (decreasing of PVS);
-the interpretation of the sputum analyze results (micro- and macroscopic changes, antibioiticogramm).

11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with ischemic heart disease".

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complains of the patient (pay attention to the pain syndrome – localization, duration, irradiation, reaction of the pain to nitroglycerin).
5. Take the anamnesis of the patient with ischemic heart disease (to define the reason of the disease, harmful habits of the patient, disturbances of the life – rhythm, duration of the disease, periods of the exacerbation of the disease, previous treatment and results, presence of arterial hypertension, obesity, diabetes mellitus, liver disease).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the examination of the patient (general investigation, general condition, position in bed, skin and mucous color, cyanosis; palpation of the chest, to pay attention to the painful spine points; percussion and auscultation of lungs; define the pulls properties (frequency, deficiency, rhythm), measuring of arterial blood pressure on both arms using Korotkov method, percussion of the heart; auscultation of the heart in 5 classical points of auscultation; examination of abdomen (presents of ascitis), superficial and deep palpation of abdomen, examining of limb edemas.
10. Inerpritation of the laboratory findings:
-the interpretation of the general blood analyze;
-the interpretation of the biochemical analyze, coagulograme, lipidograme;
-the interpretation of the ECG (rhythm, heart beat rate, electrical axis of the heart, sings of the ---heart insufficiency, presence of the arrhythmias).
-the interpretation of the EchoCG.
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with bronchial asthma"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complains of the patient with bronchial asthma (pay attention to the character of dyspnea, shows the sins of the respiratory failure.
5. Take the anamnesis of the patient with bronchial asthma (pay attention to the investigation of skin, mucosa (pallor of the skin, acrocyanosis)), investigation of the respiratory system (present of changes, characterizing the chronic lung disease), investigation of the cardiovascular system (dilation of the heard borders to the right, enlargement of the liver, appearance of the edemas as a syndrome of the heart failure)

6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the examination of the patient and show the changes, characterizing bronchial asthma (investigation of the skin, mucous. To count the frequency of breathing movement, to perform the palpation of the chest, percussion and auscultation of lung)
10. Interpretate laboratory finding show the changes in the general blood test, which characterize pulmonary hypertension
- interpretate the sputum investigation (micro- and macroscopic)
-shows the type and stage of respiratory failure according to the spirogram results (signs of bronchial obstructin - PVS and VFE 1 less than 80 %, day variability PVS and VFS1 more than 20 %. Expressed reverse bronchial obstruction – PVS and VFE1 more than 15 % or 200 ml according to resulys of pharmacological test with β_2 agonists)
-show the sings of pulmonary hypertension
-interpret the results of the X-ray of the chest
-find the complications of bronchial asthma according to the results of the X-ray investigation
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

" Curation of the patient with pollute bronchitis"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complaints of the patient with pollute bronchitis (pay attention to the connection of the disease with unhealthy conditions at work)
5. Take the professional anamnesis of the patient with pollute bronchitis (to detect the harmful conditions of work ,place of work.)
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the investigation of the patient and to show the changes, which is characteristic of pollute bronchitis. (examination of the skin, chest, to perform the percussion, auscultation, lung excursion.)
10. Interpretate the results of the laboratory findings.
--interpretate the x-ray changes
--show the ECG changes, characterizing the pulmonary hypertension of the patient with pollute bronchitis
--interpretate the sputum examination
--interpretate the results of spirography of the patient with pollute bronchitis

11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation the patient with osteoarthritis"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Take the complaints the patients with osteoarthritis:
   - presence of swelling, deformation, limitation of movements in joints
   - presence of start pain
   - presence of crepitation oleo ring
   - presence of Geberdeen and Busharg nodules
   - ability to self service and other activity
5. Take the anamnesis of the patients with osteoarthritis:
   - what pathogenetical and symptomatical treatment had the patient before the admission to the hospital
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Objective examination :
   - to establish the main clinical form of osteoarthritis (coxarthrosis, gonarthrosis, osteoarthritis of interphalanges joints)
   - to assess the state of the joints
   - to recover the signes of reactive synovitis in involved joints (swelling, local increasement of temperature)
   - to recover deformation (changed configuration of the joints)
   - volum of active and passive movements (flexio, anteflexio, rotation, supination, rotation) in involved joints and define the stage of functional insufficiency of joints – FZJ: Ist. - professional ability is saved; IIst. - professional ability is lost; IIIst. – self-service ability is cost
10. Interpretation of the results of laboratorial and instrumental methods of investigations:
   - estimation of GBC (in case of synovitis – signes of inflammation; leucocytosis; increased ESK)
   - estimation of the X-Rays of joints with definitions of x-Kay-stage: I stage – mild narrowing of intraarticular spaces; II – moderate intraarticular subchondral sclerosis, ostiophytes; III – severe intraarticular, subchondral sclerosis, many ostiophytes; IV – intraarticular spaces are almost ascent, severe subchondral sclerosis, many ostiophytes complete degeneration of cartilage.
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with rheumatoid arthritis"

1. Friendly facial expression and smile.

2. Gentle tone of speech.
3. Greeting and introducing.
4. Take complaints in patients with rheumatoid arthritis:
- presence of swelling, deformation, limitation of movements in joints
- presence of morning stiffness and it is duration
- what joints first of all were involved in the process
- presence of wrist joints involvement
- presence of symmetrical involvement
- presence of rheumatoid nodules
- number of involved joints

5. Take anamnesis in patient with rheumatoid arthritis
- duration of arthritis
- ability to do self-service or other activity
- what pathogenetic and symptomatic treatment had the patient before the admission

6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Objective examination of the patient with rheumatoid arthritisto establish the number of involved joints (monoarthritis, oligoarthritis,polyarthritis), presence of symmetrical involvement, arthritis of the wrists, presence of rheumatoid nodulesto assess state of the involved joints:
- establish signes of inflammation of joints (swelling, local increasement of temperature)
- Establish presence of deformations (subluxations, ankilosis)
- establish volum of active and passive movements (flexio, anteflexio, rotation, supination, rotation) in involved joints and establish the stage of functional insufficiency of joints – FZJ: Ist.
- professional ability is saved; IIst. - professional ability is lost; IIIst. – ability to self-service is lost
-to assess the state of the paraarticular muskuls (presence of atrophies)

10. Interpretation of laboratorial and instrumental results:
- assess results of GBC, establish stage of activity of disease (after, ESR: below 20mm|h – Ist.; 20-40 mm|h – IIst.; over 40mm|h – IIIst.)
- assess acute phase protein (CRP + - ++++ due to the stage of activity), presence of rheumatoid factor (positive RF – seropositiveRA, negative RF – seronegative RA)
- interpretation of the x-ray of the joints with estimation of the x-Kay-stage: I stage – decreaserment of intraarticular spaces, osteoporosis around the joints; II – decreaserment of intraarticular spaces, osteoporosis around the joints, some erosions; III - decreaserment of intraarticular spaces, osteoporosis around the joints, some erosions, multiple erosions and sublucxations; IV - decreaserment of intraarticular spaces, osteoporosis around the joints, some erosions, multiple erosions and sublucxations, ankilosis.

11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with rheumatism"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Take complaints of the patients with rheumatism:
   - presence of nasopharyngeal infection before the on cat of disease
   - presence of fever
   - presence of joints involvement character and duration of joints syndrome
   - presence of cardio-vascular complaints: breathlessness, pain in heart area, palpitation, discomfort in right past of the abdomen, edema of the legs
   - presence of skin signes (erythema marginatum, subcutaneous nodules)
   - presence of neurological complaints
5. Take the anamnesis of the disease in patient with rheumatism
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Objective examination of the patient with rheumatism:
   - establish signes of skin syndrome (erythema marginatum, subcutaneous nodules)
   - establish involvement of nervous system (sydenhamers chorea)
   - establish joints syndrome (pain, swelling, local increasement of temperature, limitation of movements)
   - perform percussion and auscultation of heart (signes of carditis: increased heart borders, palpitation, heart murmurs)
   - establish signes of AF(cyanosis of lips, congestion of lungs)
10. Interpretation of laboratorial and instrumental results in patient with rheumatism:
   - assess results of GBC, acute phase proteins, define stage of activity of the disease: CRP +++, ESR 40 mm|h and more, leucocitosis – activity of III st.; CRP ++, ESR 20 -40 mm|h - activity of II st.; CRP + , ESR < 20mm|h - activity of I st.
   - assess results of ECG (rythm, voltages, duration and amplitude of the waves, duration of P-Q and Q-T, complex QRS). Possible changes: sinus tachycardia, AV – bloc and intaventricular block.
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with the chronic obstructive pulmonary disease (COPD)"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect complaints in patient with CORD (pay attention on the expression and periodically of dyspnea, frequency its arise, causal factors-gradually steady increasing of dyspnea, which connected with smoking; expressions of cough; character of the sputum- moist cough)

5. Collect anamnesis in patient with COPD(pay attention on frequent overcold and disposition to cold, smoking, present of occupation harmful)
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. To perform of examination this patient and show change, which characterized the CORD (investigation of the skin and mucous (pallor skin, acrocyanosis), changes of the hand (Hippocratic fingers, nails like watch glass), change the chest-shape (barrel-shaped, taking part of intercostals muscles), comparative and topographic percussion of the lungs (finding, which confirm emphysema), comparative and topographic auscultation (finding of diffuse emphysematosic changes), auscultation(respiratory sounds, which confirm bronhoobstructive, emphysematous changes)
10. Interpret the results of laboratory and instrumental methods:
- evaluate of spirograms results values which show the obstructive or restrictive type of ventilate disorders
- evaluate the X-ray examination of the chest (fibrosis changes of lungs roots, increasing of - pneumatisation of the lung area)
- evaluate the pickphloumethry results (dynamic of the OFV_1)
- evaluatea micro- and macroscopic investigation of the sputum (character, consistency, cellular composition)
- indicate Doppler echocardiometry's, which characterize pneumoconiosis (the thickness of the heard wall and right chambers, myocardial contractility, diastolic filling, mean average pressure in pulmonary artery)
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with pneumoconiosis"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect complaints of the patient with pneumoconiosis (pay attention on the evidence and periodically of dyspnea its, frequency, provocative factors gradual increase of dyspnea, cough evidence – periodically dry cough)
5. Take anamnesis in patient with pneumoconiosis (pay attention on the occupational hazard which)
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the examination and show the changes, which characterize of for pneumoconiosis (investigation 0f the skin and mucous (pallor of the skin, acrocyanosis), changes of the hand (Hippocratic fingers, nails like watch glass), comparative and topographic percussion of the lungs (finding, which confirm diffuse

change of the lung tissue), comparative and topographic auscultation (respiratory sound, which confirm diffuse affection of the lung tissue)
10. Interpritate the laboratory–instrumental results.
– to evaluate of X-ray examination (peculiarities of diffuse changes of the lung tissue)
– to evaluate of spirograms results values which show the obstructive or restrictive type of ventilate disorders
– to evaluate of the sputum (character, consistency, cellular composition)
– to indicate Doppler echocardiometry's, which characterize pneumoconiosis (the thickness of the heard wall and right chambers, myocardial contractility, diastolic filling, mean average pressure in pulmonary artery)
– to evaluate the pickphloumethry results (dynamic of the OFV_1)
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with chronic pancreatitis"
1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect complains of the patient with chronic pancreatitis (pay attention of the peculiarities of pain and dyspeptic syndrome).
5. Collect anamnesis of the patient with chronic pancreatitis(pay attention on the nutrition character, smoking, stressful factors, taking the alcohol, heredity, frequency and seasonal of exacerbation).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform examination of the patient and show the changes characterizing the chronic pancreatitis (to investigate the skin and mucous (pallor, dryness of skin), tongue (covered by white incrustation), superficial (local muscular defense) and deep palpation (pain during palpation in paraumbilical region, Shofar's zone).
10. Interpret the results of laboratory and instrumental methods of examination:
- evaluate the ultrasound examination of the pancreas (enlargement of the gland, induration, infiltration, presence of the cysts and pseudocysts).
- evaluate the biochemical blood test (amylase, alkaline phosphatase)
- evaluate the results of urine diastaze
- evaluate the coprogram results.
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with chronic hepatitis"
1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.

4. Collect complains of the patient with chronic hepatitis (pay attention on the peculiarities of pain, dyspeptic and astenovegetative syndrome).
5. Collect anamnesis of patient with chronic hepatitis (pay attention on the nutrition character, smoking, stressful factors, taking the alcohol, heredity, transfusion of the blood).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform examination of the patient and show the changes characterizing the chronic hepatitis (to investigate of the skin and mucous (pallor and dryness of skin, jaundice, teleangioektazy, hemorrhages), tongue (covered by white or yellow incrustation), superficial(local muscular defense) and deep palpation (pain during palpation in left and right hypochondrias regions, size of the liver, characteristic of the liver lower border).
4. Interpret the results of laboratory and instrumental methods of examination:
- evaluate the ultrasound examination of the liver (enlargement, induration, change of echostructure, presents of node, fibrose);
- evaluate the gastroscopy results;
- evaluate the results of biochemical blood test (ALT, AST, alkaline phosphatase, bilirubine unconjugated, conjugated, protein, creatinine, urea, Na, Ca, Cl, K).
- evaluate the coprogram's results;
- evaluate the serologic's results (virus antigenic marker).
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with liver cirrhosis".

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Collect the complains of the patient with liver cirrhosis (pay attention on the peculiarities of pain, dyspeptic and astenovegetative syndrome).
5. Collect anamnesis of patient with liver cirrhosis (pay attention on the nutrition character, smoking, stressful factors, taking the alcohol and drugs, heredity, frequency and seasonal of exacerbation, the onset, duration of the disease, transfusion of the blood, gastroenteral bleeding).
6. Find a contact with the patient and make an attempt to gain his/her trust.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform examination of the patient and show the changes which characterized liver cirrhosis (to investigate of the skin and mucous (pallor and dryness of skin, jaundice, teleangioektazy, hemorrhages), tongue (covered by white or yellow incrustation), edema on the legs, "caput medusae", superficial (local muscular defense, presence of

the free fluid in abdominal cavity) and deep palpation (pain during palpation in left and right hypochondrial region, liver size, spleen size).
10. Interpret the results of laboratory and instrumental methods of examination:
- evaluate the ultrasound examination of the liver(enlargement, induration, change of echostructure, presents of node, fibrose);
- evaluate the gastroscopy results;
- evaluate the results of biochemical blood test (ALT, AST, alkaline phosphatase, bilirubine, unconjugated, conjugated, protein, creatinine, urea, Na, Ca, Cl, K);
- evaluate the coprogram's results;
- evaluate the serologic's results (virus antigenic marker);
- evaluate the computer tomography.
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

"Curation of the patient with essential hypertension"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. To collect the complains of the patient with essencial arterial hypertension (pay attention to the hypertensive syndrome: age 30- 50 yaers, slow progress of the disease, asymptomatic duration of the disease till the complications appear).
5. To take the anamnesis of the patient with arterial hypertension (to find the reason of the increased blood pressure, to find co-morbidities such as ishemis heart disease, obesity, hereditary diseases, SCORE risk factors, duration of the hypertension, previous treatment, complications)
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. To perform the examination of the patient, to show changes which characterize arterial hypertension (measuring of the blood pressure on both arms, auscultation of heart, neck vessels)
10. To interpritate the results of laboratory findings:
    - to interpritate general urinalysis (erythrocytes, protein, casts)
    - to show the changes in biochemical blood analysis (cholesterol level, urea, creatinine, coagulograme)
    - to show ECG changes (hypertrophy of left ventricle, systolic and diastolic overload, rhythm disturbance, ishemic signs)
    - show the EchoCG changes (thickness of wall, dimensions of chambers, ejection fraction, diastolic filling)
    - to show the eye bottom changes (Salus- Gunn symptom, Gvist symptom)
    - to interpritate the results of 24-hours blood pressure monitoring of the patient with arterial hypertension (BP variability,time indexes of SBP, DBP, day indexes)
    - to interpritate the result of neurological examination
11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).

12. Conversation accomplishment.

"Curation of the patient with secondary blood hypertension"

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. To collect complains of the patient with secondary arterial hypertension (to pay attention to the peculiarity of the hypertensive syndrome- young age, abrupt output of the disease, increasing of the blood pressure to 180/120 mm. Hg, appearance of the symptoms which characterize secondary hypertension)
5. To take the anamnesis of the patient with secondary arterial hypertension (to define the reason of increasing blood pressure, co-morbidities, SCORE risk factors, duration of the disease, previous treatment and results)
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. To perform the examination of the patient (measuring of the blood pressure on both arms, auscultation of heart, neck vessels)
10. To interpritate the results of laboratory findings:

- to interpritate general urinalysis (erythrocytes, protein, casts)
- to show the changes in biochemical blood analysis (cholesterol level, urea, creatinine, coagulograme)
- to show ECG changes (hypertrophy of left ventricle, systolic and diastolic overload, rhythm disturbance)
- show the EchoCG changes (thickness of wall, dimensions of chambers, ejection fraction, diastolic filling, pulmonary hypertension)
- to show the eye bottom changes (Salus- Gunn symptom, Gvist symptom)
- to interpritate the results of 24-hours ECG monitoring of the patient with arterial hypertension
- to interpritate the result of nevrological, nephrological, endocrinological examination
- to interpritate Nechyporenko and Amburge analyses
- to interpritate Zymnyckiy analise, to define Shterngeymer- Melbin cells in urinalysis, active leucocytes in urine
- to interpritate results of 24-hours proteinuria measurement
- to intarpritate the results of ultrasound investigation of kidneys
- to interpritate the excretory urograme results
- to intarpritate the results of renal angiogramm common for secondary arterial hypertension
- to show the USI changes in adrenal glands, which characterize secondary hypertension
- to interpritate the levels of TTH, T_4 in biochemical blood analysis
- to interpritate the levels of adrenalin, dophamin, noradrenalin in patiens with secondary arterial hypertension

11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

“Curation of a patient with arrhythmia”

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Analyze chief complaints in a patient with arrhythmia. Pay specific attention to potential causes of arrhythmia, patient’s haemodynamic stability, his tolerance to physical exercise and main limiting factors (e.g., dyspnea, chest pain)
5. To take the anamnesis of the patient with arterial arrhythmia.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Please perform the physical exam of a given patient indicating specific findings for arrhythmia, e.g., regularly irrerular or irregularly irregular pulse, heart rate, pulse deficite, patient’s haemodynamic stability.
10. Interpreting laboratory and instrumental findings

-Please reveal the changes in total blood count in a patient with arrhythmia
Evaluate the urinalysis in a patient with arrhythmia
-Please indicate the changes in hematochemistry in a patient with arrhythmia, paying specific attention to electrolyte levels
-Please reveal and interprete the ECG signs of arrhythmia
-Please assess the echocardiographic findings in a patient with arrhythmia, paying specific attention to the presence or absence of structural heart disease
-Interprete the levels of thyreostimulating hormone (TSH) and thyroid hormones in a patient with heart failure
-Assess the values of an international normalized ratio (INR) in a patient with arrhythmia? in particular, in a patient with atrial fibrillation

11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.

«Curation of a patient with heart failure»

1. Friendly facial expression and smile.
2. Gentle tone of speech.
3. Greeting and introducing.
4. Please analyze chief complaints in a patient with heart failure syndrome. Pay specific attention to potential causes of heart failure, patient’s tolerance to physical exercise and main limiting factors (e.g., dyspnea, chest pain)
5. To take the anamnesis of the patient with heart failure syndrome.
7. Inform about the possibility of appearing of unpleasant feelings during the examination.
8. Prepare for the examination (clean warm hands, cut nails, warm phonendoscope, etc.).
9. Perform the physical exam of a given patient indicating specific findings for the heart failure syndrome: you should be able to reveal and to differentiate the signs characteristic of left- and/or right-sided heart failure.
10. Interpreting laboratory and instrumental findings

- Please reveal the changes in total blood count typical of the heart failure syndrome
- Please evaluate the urinalysis results, paying specific attention to the presence and the level of proteinuria
- Indicate the changes in hematochemistry in context of congestive heart failure. interprete the electrolyte levels, the levels of creatinine, urea, and the uric acid
- You should be able to reveal and to interprete the ECG changes in a patient with heart failure, paying specific attention to the possible signs of previous myocardial infarction, left or right ventricular overstrain
- Interprete echocardiographic findings in a patient with heart failure. Evaluate the patient's systolic function (ejection fraction) and myocardial diastolic performance
- Interprete the levels of thyreostimulating hormone (TSH) and thyroid hormones in a patient with heart failure
- If available, assess the levels of BNP, cardiospecific enzymes and INR in a patient with heart failure

11. Involve the patient into the conversation (compare present examination results with previous ones, clarify whether your explanations are clearly understood).
12. Conversation accomplishment.