3.3 MEDICAL HISTORY AND PHYSICAL EXAMINATION

PURPOSE

To perform a complete, detailed history and physical examination for all refugees to ensure diagnosis and treatment of conditions not previously detected as well as those treated previously but ineffectively.

BACKGROUND

Refugees have diverse experiences with medical care prior to arrival in the United States. During the recent years many of the newly-arrived refugees have received health services in urban settings either in home country or in the country of first asylum. According to the UNHCR, about fifty percent of refugees live in urban areas and one third in camps. Some refugees may have received little or no medical care in the past. While the RHAP is a screening program, clinicians should be cognizant that their assessment may be the first full medical evaluation for some of refugee patients. Clinicians should therefore perform a general history and physical exam. It is recognized, however, that an extended history may not be necessary. Instead, clinicians should focus on historical elements which may be particular for refugees. These include, for example, migration history and history of trauma.

Clinicians should also recognize that the RHAP encounter may be a new cultural experience for refugees and will leave a profound first impression about health care in the United States. As such, sensitivity toward the patient's gender, culture, and similar issues is very important.

Because of societal marginalization of applicants for asylum, many asylees will not have a regular source of medical care. As is done for refugees, RHAP clinicians should assess the asylee patient for access to and utilization of primary care. The primary care physician will be able to follow up on neglected health needs as well as those newly identified during the RHAP. Some asylum recipients may already be well established in primary care, and resettlement agencies and RHAP clinicians will need to decide if a health assessment is appropriate for an individual asylee and his/her family. Under United States immigration law, asylum seekers must file their applications with the USCIS within one year from the date of last entry to the United States. Further, asylum applicants are not eligible for employment authorization until 180 days after the filing date of the asylum application. Consequently, current asylum recipients may have had fewer opportunities to engage in primary care before the RHAP.

In some ways, the health status of asylees (especially those with derivative visas arriving from overseas) may resemble

that of refugees. Asylees, like refugees, come to the United States often after having experienced significant psychological and physical trauma, particularly individual torture and rape victimization. At the time of the health assessment, shortly after arrival, most refugees are not experiencing symptoms of acute psychological distress. In contrast, psychological issues among asylees may be central in the struggles of their daily lives and compounded by the day-to-day challenges asylum applicants face.

Like refugees, it is expected that asylees will have high prevalences of latent tuberculosis infection, dental caries, eosinophilia (as an indicator of parasitic infections), anemia, chronic diseases such as diabetes and hypertension, and underimmunization. Some will also come from countries with endemic hepatitis B, HIV or parasitoses. While some parasitoses are typically self-limited, others such as schistosomiasis and strongyloidiasis may present particular long-term health risks to the patient. Parasitic infections may persist for years through transmission within refugee communities if not properly identified and treated. As is the case with refugees, asylee derivatives must complete a medical examination overseas. However, it is less likely that asylee derivatives receive pre-departure presumptive therapy for intestinal parasite or malaria.

PROGRAM REQUIREMENTS

In brief, the RHAP requires the following of providers:

1. Conduct a full, age-appropriate medical history and physical examination for all refugees.
   - ⇒ The history should be appropriate for the refugee experience and emphasize issues such as migration and trauma histories and overseas findings.
   - ⇒ History of adolescents and adults should include assessment of use of tobacco and alcohol, and other drugs as appropriate.
   - ⇒ Examination should be developmentally and age-specific and include vital signs and anthropometric measurements.

THE MEDICAL HISTORY

The aim of taking the medical history is to record any significant past or current medical condition or disability, as well as preventive care such as immunizations and dental work, and document any relevant family history. During this process, it may be possible to detect an obvious speech or hearing problem and to assess the patient's mental status. Clinicians should try to be concise about the sequence of historical events as they may provide clues to the refugee patient's risk for certain medical conditions, particularly

infectious diseases, psychological problems, and growth/nutritional abnormalities.

1. BIOGRAPHICAL DATA
   - Brief family tree as appropriate
   - Migration history, including stays in refugee camps

2. PRESENT HEALTH STATUS
   - Chief complaint, if any

3. CURRENT HEALTH DATA
   - Current medications: Type, Dosage, Problems
   - Allergies: Drugs, food, etc…
   - Last examination: Physical, Dental, Vision, Hearing, ECG, Chest X-ray, Pap smear
   - Immunization Status: Update, Due

4. PAST HEALTH STATUS

Summarize and record chronological data as completely as possible. The following list provides some examples for each category.

➢ Child devel. milestones	Speech, gross motor, fine motor, Socioemotional
➢ Childhood illnesses	Measles, rubella, mumps, pertussis, scarlet fever, chicken pox, strep. throat. Note: patient reports of a vaccine preventable disease other than chicken pox should never be used as proof of immunity.
➢ Serious or chronic illnesses	Malaria, chronic hepatitis, hypertension, diabetes, tuberculosis, asthma, kidney or cardiac problems, seizures, obesity, etc.
➢ Serious physical trauma	Head injuries, fractures, burns, trauma, torture

➢ Hospitalizations	Length of stay, and place
➢ Transfusions	Dates, indications
➢ Surgery	Year/age and place; female genital cutting, ritual scarring or branding
➢ Dental care	Prophylaxis, restorative work, use of fluoride in water and toothpaste, brushing, use of traditional stick brush, flossing
➢ Emotional stress/ mental illness	Symptoms, diagnoses, treatments, loss of family, exposure to war/other violence (see #6 below)
➢ Obstetrical hx	Number of pregnancies, births, still-births, abortions, complications

5. REVIEW OF SYSTEMS

6. PSYCHOSOCIAL AND TRAUMA HISTORIES

Refugees are at very high risk for depression, anxiety, post-traumatic stress disorder, and substance use. Assess the patient's feelings about him/herself, and ability to cope with resettlement: stress, losses, isolation, depression, insomnia, anorexia, drug/alcohol/smoking use and abuse, nightmares, flashbacks.

In children, non-specific somatic or behavioral symptoms may indicate problems such as depression, adjustment disorder, or post-traumatic stress disorder. These symptoms may include withdrawal, acting out, new fears, anorexia, somatic complaints, nightmares and sleep disturbances, separation fears, enuresis, or developmental regression.

See Section 3.4 for more discussion of mental health and required use of the RHS-15 screening instrument.

The RHS-15 and an instructional webinar recording (Part 1 and Part 2) are available from the Refugee Health Technical Assistance Center. While the RHS-15 is validated for use in multiple refugee populations for assessment of adolescents and adults, most standardized questionnaires for children are not validated for refugee populations. Out of necessity, clinicians may consider using other questionnaires to assess

mental health status of younger refugees if concerned about possible emotional or behavioral abnormalities. Examples of brief questionnaires for children that are commonly used in primary care settings include the Pediatric Symptom Checklist (free) and the Parents' Evaluation of Developmental Status (PEDS, licensed).

THE PHYSICAL EXAMINATION AND REVIEW OF SYSTEMS

The overseas medical evaluation is geared toward identifying excludable conditions in refugees. It is not a comprehensive physical for preventive medical care. Consequently, the RHAP starts the process of comprehensive care with an emphasis on primary care and preventive medicine. The physical exam should thus be general, not focused.

During the examination, providers should be considerate of refugees' cultural and religious beliefs and accommodate them as possible. For example, an Islamic woman may not wish to be examined by a male physician. The gender of the interpreters should similarly be considered, such that those of opposite gender from the patient may need to stand behind a curtain or screen, and that in some instances the patient may not wish to speak freely in front of an interpreter of different gender.

General	Fatigue, weakness, fever, sweats, frequent colds, infections or illnesses, ability to carry out activities of daily living, mobility, apparent anxiety, general hygiene, dress
Nutritional	Type of diet, hx of weight gain or losses, growth charts for children, body habitus
Skin	Skin lesions (wounds, sores, ulcers), tumors or masses, pruritus, edema, cyanosis, jaundice, nevi, hyper/hypopigmentation, scars (esp. consistent with torture, such as cigarette or electrical burn scars), pallor, tattoos, clinical signs of Hansen's disease
Head	Headache, syncope, dizziness, hx or sx of trauma

Eyes	Corneal opacity, cataracts, pterygium, nystagmus, jaundice, trauma; Visual acuity to be documented with the Snellen E chart
Ears/mouth	Otoscopy, inspection of mouth and throat, tooth loss, caries, ulcers, trauma
Neck	Node enlargement, masses, thyroid, stiffness
Breast	Pain or tenderness, nipple discharge, lumps
Cardiovascular	Chest pain, palpitations, dyspnea on exertion, orthopnea Exam: murmurs, rubs, gallops, pulses, perfusion, edema, blood pressure, heart rate
Respiratory	Chronic cough, sputum production, night coughing, dyspnea on exertion; Exam: Presence of rhonchi, rales, wheezes, rubs, clubbing of extremities; TB symptoms: night fever, cough, weight loss, night sweats, hemoptysis
Hematolymphatic	Anemia, bleeding, fatigue, lymph node enlargement
Gastrointestinal	Abdominal pain, nausea, vomiting, diarrhea, constipation, jaundice, change in bowel habits, ascites Record recent dietary and travel history in the presence of diarrhea and other symptoms Exam: check for hepatosplenomegaly and masses
Urinary	Dysuria, pyuria, hematuria, incontinence, enuresis, polyuria/polydypsia
Genital	STD history, discharges, pain, pruritus, burning Female: LMP, menarche/menopause, bleeding, female genital cutting Male: scrotal lumps, testicular self-examination

Musculoskeletal	Muscles, extremities, gait, bones and joints, gross disfigurement, sx of trauma Movement: gait, any limitation of movement or coordination, tremor, body symmetry
Nervous System	History of seizure, stroke, or speech problems, head trauma Evaluate cranial nerves, cerebellar function, sensorium, strength, reflexes, tone
Endocrine	Thyroid, diabetes

Write abnormal findings in the COMMENTS/REFERRALS section of the RHAP form. Because space is limited, do not record normal findings or non-specific symptoms that do not strongly suggest a probable diagnosis.

NOTE ON CHILDREN

When performing a history and physical examination on refugee children, it is important to remember that they will have the same levels of fear and anxiety encountered in U.S.-born children of the same ages. Attention should be paid to reassuring and calming the child as best as possible during the exam. In addition, as refugee children are at high risk for developmental delay and behavioral issues, whenever possible, the provider should incorporate an assessment of the child's developmental stage using standardized historical and exam milestones such as can be found in the Denver Developmental Screening Test* and the PEDS. Lastly, it is known that refugee children have high prevalences of malnutrition and growth retardation. Providers should use standardized growth charts* and refer families to WIC and other nutritional support programs for which they are eligible.

**See DDST and NCHS growth charts.*