A practical guide to clinical communication with patients in English and Danish

created by

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The ability to communicate with patients in the Czech language is one of the basic prerequisites for the study of clinical medicine. It is difficult for foreign students to learn our language properly for many reasons. Therefore, based on our experience in examining patients, we have prepared this practical guide which we believe will help them to become more proficient in clinical - especially Internal medicine - communication. The guide follows the natural steps in a clinical examination. The text contains an example of a medical record.

Authors

The project "Practical Guide to Clinical Communication with Patients" was originally created by Barbora Makešová and Jan Brož in 2021 and aims to facilitate clinical communication for students studying or interning in countries where a language other than their mother tongue is spoken.The other language versions were kindly translated by many medical students.

About the authors

Sayaka Yamato is a 5th year international student of the Second faculty of Medicine of charles University. Although she was born and raised in Japan, she went to gymnasium in Denmark and had clinical internship there. Ever since she started her medical study in Czech Republic, she has dreamt and planned to be a doctor in Denmark in the future. Currently she finds pediatrics significantly fascinating.

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Example of taking patient history

Godmorgen hr./fru. _____, Jeg er medicinstuderende. Jeg er kommet for at stille dig nogle spørgsmål og undersøge dig.
Det tager cirka 30 minutter.
Denne undersøgelse er en del af min lægeuddannelse.
Sæt/læg dig ned og gør det behageligt for dig selv.

Good morning Mr./Mrs. _____, I am a __ year medical student. I came to ask you a few questions and examine you.
It will take approximately 30 minutes.
This examination is a part of my medical studies.
Please sit down/lie down, and make yourself comfortable.

«Personlige oplysninger»
Hvad er dit navn?
Hvor gammel er du? /Hvilket år blev du født?

«Personal information»
What is your name?
How old are you? / What year were you born?

Fru J.N., født i 1943 (76 år)

Mrs. J.N., born in 1943 (76 years)

«Kort årsag og tidspunkt for indlæggelse»
Hvornår blev du indlagt på hospitalet?
Hvordan kom du til hospitalet?
Er du selv kommet, eller har nogen taget dig hertil?
Har du tilkaldt en ambulance?
Var du indlagt et andet sted, før du kom til denne afdeling?

«Briefly cause and time of admission»
When were you admitted to the hospital?
How did you get to the hospital?
Did you come alone or did someone bring you?
Did you call an ambulance?
Were you admitted anywhere else before coming to this department?

«Årsag til indlæggelse»
For det første vil jeg gerne spørge dig: Hvad er din grund til at komme til hospitalet?
Hvad var din største klage? Hvornår begyndte det?

«Cause of admission»
Firstly, I would like to ask you: what is your reason for coming to the hospital?
What was your main complaint? When did it start?

Hun blev indlagt på internmedicinsk afdeling den 12. april 2019 kl. 17.00 på grund af brystsmerter, der varede i 2 timer. Hun blev indlagt af ambulancetjenesten, som hendes datter havde ringet til.

She was admitted to the Internal Medicine Clinic on April 12, 2019 at 5 pm for chest pain lasting 2 hours. She was brought by an emergency service, which was called by her daughter.

«Dispositioner»
Nu skal jeg stille dig nogle spørgsmål om din familie...
Er dine forældre i live?
Hvis ja →
Hvor gammel er din far/mor?
Fejler de noget?
Hvis nej →
Hvor gammel var din far/mor, da han/hun døde?

Hvad var dødsårsagen?
Har du nogen søskende? Yngre eller ældre?
Er de sunde og raske?

«Family history»
Now I will ask you about your family …

Are your parents alive?
if they do →
How old is your father/mother?
Do they have any health problems?
if they don't →
At what age did your father/mother pass away?

What was the cause of death?
Do you have any siblings? Younger or older?
Are they healthy?

Har du børn? Hvor mange?	Do you have children? How many?
Hvor gamle er de?/Hvor gammel er han/hun?Er han/hun rask?	How old are they?/How old is he/she?Is he/she healthy?
Er der nogen i din familie, der har diabetes/hypertension/psykisk sygdom/tumorer eller andre sygdomme? I hvilken alder?	Does anyone in your family have diabetes/hypertension/psychiatric disease/neoplastic or other disease? At what age?
Er der nogen i din familie, der har haft et hjerteanfald/slagtilfælde?	Has anyone in your family had a heart attack/stroke?

Dispositioner:
Far - døde i en alder af 65 på grund af hjerteanfald, hypertension, DM type 2.
Mor - døde i en alder af 71 på grund af generaliseret brystkræft.
2 søstre - 68 år, i live, tilstand efter kolecystektomi og 72 år, hypertension.
2 børn - en datter, 45 år, har astma og en søn, 40 år, rask.

Family history:
Father - died at the age of 65 from MI, hypertension, DM type 2.
Mother - died at the age of 71 from generalized mammary carcinoma.
2 sisters – 68 years old, alive, condition after cholecystectomy, and 72 years old, hypertension.
2 children – daughter, 45 years old, bronchial asthma and son, 40 years old, healthy

«Socialt»	*«Social history»*
Nu skal jeg spørge dig om dit arbejde...	*Now I will ask you about your work ...*
Arbejder du? / Er du pensioneret?	Do you work? / Are you retired?
Hvilket år gik du på pension?	What year did you retire?
Hvad arbejder/arbejdede du med?	What is/was your occupation?
Er/var det stillesiddende/stressende?	Is/was it sedentary/stressful?
Er/var det manuelt arbejde?	Is/was it manual work?
Er der nogen sundhedsproblemer forbundet med det?	Are there any health problems associated with it?
Er du gift?	Are you married?
Hvor bor du?	Where do you live?
Bor du i et hus eller en lejlighed?	Do you live in a house or a flat?
Hvilken etage bor du på?	What floor do you live on?
Er der trapper? Er der en elevator?	Are there stairs? Is there an elevator?
Bor du alene eller sammen med nogen? Har du brug for hjælp?	Do you live alone or with someone? Do you need help?
Har du nogen kæledyr?	Do you have any pets?

Socialt:
Pensioneret (på grund af alder), bor alene, enke, lejlighed på 4. sal med elevator. Hendes datter tager sig af hende. Arbejdede som revisor.

Social history:
Retired (old age), lives alone, widow, apartment on the 4th floor of a building with elevator. Her daughter takes care of her. She used to work as an accountant.

«Medicin»	*«Pharmacological anamnesis»*
Tager du nogen medicin?	Are you taking any medication?
Kan du huske navnet på den?	Do you remember the name of your drugs?

Hvor mange piller tager du? Hvor ofte? Hvor længe?
Tager du nogen kosttilskud/vitaminer?

How many do you take? How often? Since when?
Are you taking any food supplements/vitamins?

Medicin (Pharmacological anamnesis):
Anopyrin 100mg 1-0-0
Vasocardin 50mg ½-0-½
Glucophage 500mg 1-0-1
Lipostat 20mg 0-0-1
Enap 5mg 1-0-1

«Allergier»
Har du nogen allergier?
Er du allergisk over for noget mad/pollen/antibiotika/kontrastmidler?
Hvordan var den allergiske reaktion?

«Allergic anamnesis»
Do you have any allergies?
Do you have an allergy to food/pollen/antibiotics/contrast media?
What did the allergic reaction look like?

Allergier:
Penicilin: exantem i 1998

Alergies:
Penicilin: exanthema in 1998

«Gynækologisk anamnese»
Jeg er nødt til at spørge dig om din gynækologiske historie...
Hvor gammel var du, da du fik din første menstruation?
Er din menstruation regelmæssig?
Hvornår var din sidste menstruation?
Er du kommet i overgangsalderen? I hvilken alder?
Er du i hormonbehandling?
Tager du hormonelle præventionsmidler?
Hvor mange gange har du været gravid?
Har du haft en abort/kaisersnit?

«Gynaecological anamnesis»
I need to ask you about your gynaecological anamnesis …
At what age did you get your first period?

Are you having your period regularly?
When was your last period?
Have you been through menopause? At what age?
Are you taking hormonal replacement therapy?
Are you taking hormonal contraceptives?
How many times have you been pregnant?
Have you had a miscarriage/caesarean section?

Gynækologisk anamnese:
Menstruation siden 14 år, 2 fødsler (1 kejsersnit), 0 aborter, menopause ved 55 år, ingen hormonsubstitution, regelmæssige gynækologiske kontroller (seneste 07/2018)

Gynaecological history:
Menses since 14 years, 2 births (1 caesarean section), 0 miscarriage, menopause at 55 years, no hormone replacement, regular gynaecological check-ups (last one 07/2018)

«Tidligere sygdomme»
Fejler du noget? Siden hvornår?
Hvad bliver du behandlet med?
Har du forhøjet blodtryk/diabetes/højt kolesteroltal/fordøjelsesproblemer/hjerteproblemer/åndedrætsproblemer/problemer med stofskifte...?

«Personal history»
Do you suffer from any illness? Since when?
What are you being treated with?
Do you have hypertension/diabetes/high cholesterol/indigestion/heart problems/difficulties with breathing/thyroid problems…?

Hvornår begyndte det?
Tager du medicin for det?
Bliver du regelmæssigt undersøgt?
Har du tidligere haft alvorlige sygdomme?
Fejlede du noget i barndom?
Har du nogensinde været indlagt på hospitalet?
Er du blevet opereret?
Hvornår og hvorfor?
Har du været udsat for alvorlige ulykker/Har du tidligere brækket noget?
I hvilken alder?
Har du været i kontakt med nogen, der har en smitsom sygdom? Er du blevet vaccineret mod...Har du besøgt et tropisk land?

When did it start?
Are you getting any medication for it?
Do you get regular check-ups?
Have you had any serious disease in the past?
Did you have any common childhood diseases?
Have you ever been hospitalized?
Have you had any surgeries?
When and why?
Have you had any serious injuries/fractures?

At what age?
Have you been in contact with anyone with an infectious disease? Have you been vaccinated against...Have you visited a tropical country?

Har du tabt/taget på i vægt for nylig?
Hvor mange kilo? Over hvor lang tid?
Var det med vilje? Var du på slankekur?
Hvordan er din appetit?
Har du regelmæssig afføring?
Har du normalt syn?
Bruger du briller?
Har du problemer med din hørelse?
Hører du lige godt på begge øre?

Have you lost/gained weight recently?
How many kilograms? In how long?
Was it deliberate? Were you on a diet?
What is your appetite like?
Do you have regular bowel movements?
Do you see well?
Do you wear glasses?
Do you have any problems with hearing?
Are both ears the same?

Misbrug:
Ryger du? I hvor lang tid?
Har du røget tidligere?
Hvornår holdt du op?
Hvor mange cigaretter/pakker om dagen?
Drikker du alkohol? Hvor ofte?
Drikker du øl/vin/spiritus?
Drikker du kaffe? Hvor mange kopper om dagen?
Har du nogensinde taget stoffer?

Abusus:
Do you smoke? For how long?
Have you ever smoked?
When did you quit?
How many cigarettes/packets a day?
Do you drink alcohol? How often?
Do you drink beer/wine/hard liquor?
Do you drink coffee? How many cups a day?
Have you ever used illicit drugs?

OA:
Běžné dětské nemoci.
Operace: tonzilektomie v r.1955, appendektomie v r.1980, sectio caesarea v r.1979.
Úrazy: pád v r.1989 s frakturou distálního radia.
Od r.1990 léčena pro hypertenzi.
Od r.1996 léčena pro hypercholesterolémii.
DM 2. typu, diagnostikován 1998, kompenzován nejdříve dietou, od r.2005 terapie PAD.
IM spodní stěny v r.2009, provedena PTA s aplikací stentu.
Renální, plicní, neurologické, gynekologické, významnější infekční, jaterní ani jiné gastrointestinální onemocnění neprodělala. CMP 0.
Tělesná váha stabilní (86 kg, BMI 31).
Návyky: bývalá kuřačka - 20 cigaret denně, od 25 do 65 let, přestala po infarktu. Alkohol 1 sklenička vína/měsíc. Nelegální drogy nikdy neužívala ani neužívá, abusus léků neguje. Káva 1x denně

Tidligere sygdomme:
Almindelige børnesygdomme. Operationer: tonsillektomi i 1955, blindtarmsoperation i 1980, sectio caesarea i 1979. Skader: fald i 1989 med distal radiusfraktur. Siden

1990 behandlet for hypertension. Siden 1996 behandlet for hyperkolesterolæmi. Type 2 DM, diagnosticeret i 1998, i første omgang kompenseret med diæt, siden 2005 behandling med orale antidiabetika. Inferior hjerteanfald i 2009, PTA med stentindsættelse. Ingen nyre-, lunge-, neurologiske, gynækologiske, infektiøse, hepatiske eller andre gastrointestinale sygdomme. CVA 0. Kropsvægt stabil (86 kg, BMI 31, som 20-årig havde hun et BMI på 25, som 50-årig var det 29). Misbrug: tidligere ryger - 20 cigaretter om dagen, fra 25 til 65 år, holdt op efter hjerteanfald. Alkohol 1 glas vin/måned. Har aldrig brugt eller misbrugt ulovlige stoffer, negerer misbrug af medicinske stoffer. Kaffe 1x/dag

«Aktuelt»

Hvornår startede det præcist? / Hvor længe har du været generet af det?
Var det om morgenen/ om dagen/ om dagen/ om aftenen/ om natten?
Startede det pludseligt eller gradvist?
Hvad spiste du før?
Har du haft høj temperatur/ feber/ kuldegysninger/ rystelser?
Er du svimmel?
Var du bevidstløs?

Har du haft lignende problemer før?
Har du været til læge med det?
Har du taget medicin? Har det hjulpet?

Beskriv smerter:

Har du smerter?
Hvor gør det ondt? Er det et enkelt sted eller et større område?
Hvornår begyndte smerterne?
Hvad lavede du, da smerterne begyndte?
Startede det pludseligt eller gradvist?
Hvor længe varede det?
Vågner den du af det om natten?
Spreder smerten sig nogen steder?
Hvornår er det bedre/værre?
Er det bedre om morgenen/ om aftenen/ efter måltider/ på tom mave?
Har du det bedre i en bestemt position?
Har du det under fysisk træning/bevægelse?
Hvordan vil du beskrive smerten?
Er det stikkende/ slibende/ trykkende/ stikkende?
Hvor ondt er smerten - på en skala fra 1 til 10?
Har du taget smertestillende medicin? Har det hjulpet?

Detaljeret beskrivelse af de forskellige systemer:

Gastrointestinal:

Har du regelmæssig/normal afføring?
Hvad er farven/konsistensen/hvor ofte?
Var der blod eller slim i afføringen?
Hvordan er din appetit? Hvor meget spiser du?

«Current disease»

When exactly did it start? / How long has it been troubling you?
Was it in the morning/during the day/in the evening/at night?
Did it start abruptly or gradually?
What did you eat before?
Did you have a high temperature/fever/chills/ shivering?
Are you dizzy?
Were you unconscious?

Have you had similar problems in the past?
Have you visited a doctor because of it?
Did you take any medication? Did it help?

Describing pain:

Are you in any pain?
Where does it hurt? Is it one spot or a larger area?

When did the pain start?
What were you doing when the pain started?
Did it start suddenly or gradually?
How long does/did it hurt?
Does it wake you up at night?
Does the pain spread anywhere?
When does it get better/worse?
Is it better in the morning/in the evening/after meals/on an empty stomach?
Do you feel better in a particular position?
Do you have it during physical exercise/movement?
How would you describe the pain?
Is it sharp/dull/pressing/stinging?
How strong is the pain - on a scale from 1 to 10?
Did you take any painkillers? Did they help?

Detailed description of difficulties by systems:

Gastrointestinal:

Do you have regular bowel movements?
What is the colour/consistency/frequency?
Was there blood or mucus?
What about your appetite? How much do you eat?

Har du ondt i maven? Efter måltider eller på tom mave?
Er det svært eller smertefuldt at synke?
Har du diarré? Hvor mange gange om dagen?
Er du forstoppet? Hvornår har du sidst haft afføring?

Har du kvalme?
Har du kastet op? Hvor mange gange? Hvordan så det ud?
Har du halsbrand?

Do you have stomachache? After eating or on an empty stomach?
Have you experienced odynophagia and dysphagia?
Do you have diarrhoea? How many times a day?
Do you have constipation? When was the last time you passed stool?
Do you feel nauseous?
Did you vomit? How many times? How did the content look?
Do you get heartburn?

Urogenital:
Har du problemer med at tisse?
Vågner du, fordi du skal tisse?
Hvor ofte tisser du?
Er det smertefuldt (stikkende/stikkende) / presserende? Lider du af urininkontinens?

Hvilken farve er din urin?
Har du bemærket nogen mærkelig lugt?
Hvor meget væske drikker du om dagen?

Urogenital:
Do you have any problems urinating?
Do you wake up because of urination?
How often do you urinate?
Is it painful(burning cutting)/urgent? Do you suffer from incontinence?

What colour is your urine?
Have you noticed any strange odour?
How much fluids do you drink a day?

Kardiovaskulær og pulmonal:
Kan du trække vejret godt?
Hvor langt kan du gå, før du bliver forpustet?

Har du problemer, selv når du hviler/ går op ad en bakke/ op ad trapper?
Vågner du op om natten, fordi du er for åndenød?
Er du nødt til at sove med flere puder?
Har du hoste/ ondt i halsen/ forkølelse/feber?
Hoster du slim op? Hvilken farve er det?
Har du haft smerter i brystet? Hvor længe varer smerten?
Startede det under hvile/træning?
Er smerten brændende/trykkende/kløende/stikkende?
Spreder smerten sig nogen steder?
Havde du svært ved at trække vejret, da det skete?
Blev det bedre efter en kort pause?
Har du hjertebanken/uregelmæssighed?
Har du hævede ben? Er hævelsen symmetrisk?
Har du ondt i benene, når du går? Er du nødt til at stoppe? Efter hvor mange meter?

Cardiovascular and pulmonary:
Can you breathe well?
How far can you walk before you are short of breath?
Do you have difficulties also at rest/walking up the hill/up the stairs?
Do you wake up at night due to dyspnea?
Do you have to sleep with several pillows?
Do you have a cough/sore throat/cold/fever?
Do you cough up sputum? What color is it?
Have you had chest pain?How long does the pain last?
Has it started while you were resting/sporting?
Is the pain burning/pressurising/itching/stinging in nature?
Does the pain spread anywhere?
Did you have difficulty breathing when it happened?
Was it better after a short rest?
Do you get heart palpitations/irregularity?
Do your legs swell? Are the swellings symmetrical?
Do you have pain in your legs while walking? Do you have to stop? After how many meters?

Aktuelt:
Den 12. marts omkring kl.15.00 fik hun hvilende, intense, trykkende retrosternale smerter med udstråling til nakken og venstre øvre lem, ledsaget af kvalme uden opkastning, sved og åndenød (hun sad i en stol). Patienten tog 1 tablet Nitroglycerin under tungen og 1 tablet Aspirin, hvilket lindrede smerterne noget, men de var vedvarende. Kl. 16.45 ringede hendes datter til alarmcentralen, og hun blev derefter indlagt på koronarafdelingen. Ingen andre smerter, ingen svimmelhed, hun var ikke bevidstløs, appetitten er god, afføringen er regelmæssig, ingen patologisk blanding, og hun tisser uden besvær.

Current complains:
On March 12, around 3 pm, she developed resting, intense, pressive retrosternal pain, with irradiation to the neck and left upper limb, accompanied by nausea without vomiting, sweating and shortness of breath (she was sitting in a chair). The patient took 1 tablet of Nitroglycerin under the tongue and 1 tablet of Aspirin, which relieved her pain somewhat, but it persisted. At 16:45, her daughter called the emergency and she was then admitted to the coronary care unit.
No other pain, no vertigo, she was not unconscious, appetite is good, stool is regular, no pathological admixture, and she urinates without difficulty.

Physical examination

Nu skal jeg undersøge dig.

Jeg skal stille dig nogle meget enkle spørgsmål, som er en del af en normal undersøgelse.
Hvad er dit navn?
Ved du, hvilken dato vi har i dag?
Ved du, hvor du befinder dig? I hvilken by/hospital?

Sætninger, der skal bruges, når du undersøger en patient:

Generelt:

Kan du sidde ned/stå op?
Gå til døren og tilbage
Stå med samlede fødder.
Stil dig nu med lidt afstand mellem fødderne og stå stille.
Luk øjnene, og løft begge arme foran dig. Stå sådan i et stykke tid/ 30 sekunder.
Læg dig på ryggen og luk øjnene. Løft benene op og bøj hofter og knæ i en ret vinkel.
Drej rundt.
Vær venlig at knappe skjorten op.
Tag venligst skjorte/bukser/underbukser af.
Hvornår har du fået dette ar?
Må jeg tage din puls?
Må jeg tage dit blodtryk?

Hoved og nakke:

Gør det ondt, når jeg rører/trykker her?
Løft øjenbrynene. Rynk panden. Smil. Pust dine kinder op, lav trutmund.
Åbn øjnene/luk øjnene.
Du skal ikke bevæge hovedet og følge min finger.
Nu skal jeg lyse først i det ene øje og derefter i det andet.
Åbn munden. Sig "Aaaa".

Stik tungen ud.
Nu skal jeg lytte til pulsårerne i din hals.
Svælg/Synk (undersøgelse af skjoldbruskkirtlen).

Thorax:

Sæt dig op.
Jeg skal lytte til dine lunger/hjerte.
Må jeg løfte din skjorte op?
Træk vejret roligt.
Træk vejret ind/ud.
Hold vejret.
Tag dybe indåndinger.

Now I will examine you.

I am going to ask you a few questions that are very simple and part of a regular examination.
What is your name?
Do you know what the date is today?
Do you know where you are? In which city/hospital?

Phrases to use when examining a patient:

General:

Can you please sit/stand?
Walk to the door and back.
Stand with your feet close together.
Now put your feet slightly apart and stand still.
Close your eyes and raise both your arms in front of you. Stay like this for a while/30 sec.
Lie on your back, close your eyes. Raise your lower limbs and keep them flexed at the hip and knee to a right angle.
Turn around.
Please unbutton your shirt.
Take off your shirt/trousers/underwear, please.
Where did you get this scar?
Can I measure your heart rate?
Can I measure your blood pressure?

Head and neck:

Does it hurt when I tap/push here?
Lift your eyebrows. Frown. Smile. Purse your lips/whistle.
Open/close your eyes.
Do not move your head and watch my finger.
Now I'm going to shine the light first in one eye and then in the other.
Open your mouth. Say ‘Ahhhh’.

Stick out your tongue.
Now I will listen to the arteries in your neck.
Swallow. *(thyroid gland examination)*

Thorax:

Sit up.
I will auscultate your lungs/heart.
Can I pull up your shirt?
Breathe calmly.
Inspire/Expire.
Hold your breath.
Take deep breaths.

En fuldstændig undersøgelse omfatter en brystundersøgelse. Kan jeg gøre det?

Mave:
Læg dig på ryggen.
Kan du trække dine bukser/underbukser ned?
Bøj benene.
Stræk armene ud langs siden af kroppen.
Bevæg dig lidt op/ned/til siden.
Drej til højre/venstre side.
Hvor har du ondt i maven?
Nu skal jeg trykke dig i maven
Nu skal jeg mærke/lytte til din mave.
Fortæl mig, hvis det gør ondt.
En komplet undersøgelse omfatter også en rektal undersøgelse. Kan jeg gøre det?

Ryg:
Læn dig frem.
Læn dig tilbage.
Læn dig til siden.

Lemmer:
Luk øjnene. Jeg vil nu røre ved dit ben/din fod.
Fortæl mig, hvornår og hvor du føler, at jeg rører dig.
Har du ondt i benene, når du går?
Hvor langt kan du gå, før det gør ondt?

Nu skal jeg mærke efter pulsationer i pulsårerne.

Ratschow test:
Læg dig på ryggen og løft benene.
Bøj din fod op og ned.
Sig til, når du mærker smerter i læggene.
Sæt dig op, og lad benene hænge over sengekanten.

Sig farvel til patienten:
Tak for dit samarbejde, og jeg håber, god bedring.
Hav en god dag, farvel.

A proper examination also includes a breast examination. Can I have it done?

Abdomen:
Lay on your back.
Can you pull your pants/underwear down?
Bend your legs.
Extend your arms along your body.
Move a bit up/down/to the side.
Turn to your right/left side.
Where exactly does your stomach hurt?
Now I will tap on your abdomen.
Now I will palpate/listen to your abdomen.
Tell me if this hurts.
A proper examination includes also an examination of the rectum. Can I have it done?

Spine:
Lean forward.
Lean backward.
Lean to the side.

Limbs:
Close your eyes. I will touch your leg/foot.
Tell me when and where you feel my touch.
Do your legs hurt when walking?
What distance can you walk before you feel any pain?
Now I will check for pulsations in the arteries.

Ratschow test:
Lay on your back and lift your legs in the air.
Flex and extend your foot.
Tell me when you feel any pain in your calf.
Sit up and let your legs hang over the side of your bed.

Saying goodbye to the patient:
Thank you for your cooperation, I hope you get better soon. Have a nice day, goodbye.

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