B. Guide to the Comprehensive Adult H&P Write-Up

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Chief Complaint	Include the primary symptom causing the patient to seek care. Ideally, this should be in the patient's words.
Source & Reliability	If the patient is not the source of the information state who is and if the patient is not considered reliable explain why (e.g., "somnolent" or "intoxicated")
History of Present Illness	First sentence should include patient's identifying data, including age, gender, (and race if clinically relevant), and pertinent past medical history Describe how chief complaint developed in a chronologic and organized manner Address why the patient is seeking attention at this time Include the dimensions of the chief complaint, including location, quality or character, quantity or severity, timing (onset, duration and frequency), setting in which symptoms occur, aggravating and alleviating factors and associated symptoms Include the patient's thoughts and feelings about the illness Incorporate elements of the PMH, FH and SH relevant to the patient's story. Include pertinent positives and negative based on relevant portions of the ROS. If included in the HPI these elements should not be repeated in the ROS The HPI should present the context for the differential diagnosis in the assessment section
Past Medical History	Describe medical conditions with additional details such as date of onset, associated hospitalizations, complications and if relevant, treatments Surgical history with dates, indications and types of operations OB/Gyn history with obstetric history (G,P – number of pregnancies, number of live births, number of living children), menstrual history, birth control Psychiatric history with dates, diagnoses, hospitalizations and treatments Age-appropriate health maintenance (e.g., pap smears, mammograms, cholesterol testing, colon cancer) and immunizations Describe any significant childhood illnesses
Medications	For each medication include dose, route, frequency and generic name Include over the counter medications and supplements; include dose, route and frequency Do not use abbreviations
Allergies	Describe the nature of the adverse reaction
Family history	Comment on the health state or cause of death of parents, siblings, children Record the presence of diseases that run in the family (e.g., HTN, CAD, CVA, DM, cancer, alcohol

	addiction)
Social history	Include occupation, highest level of education, home situation and significant others Quantify any tobacco, alcohol or other drug use Include relevant sexual history Note any safety concerns by the patient (domestic violence, neglect) Note presence of advance directives (e.g., living will and/or health care power of attorney) Assess the patient's functional status – ability to complete the activities of daily living Consider documentation of any important life experience such as military service, religious affiliation and spiritual beliefs
Review of Systems	Include patient's Yes or No responses to all questions asked by system Note "Refer to HPI" if question responses are documented in the HPI **<u>Review of Systems</u>***:* *Include in a bulleted format the pertinent review of systems questions that you asked. Below is an example of thorough list. In a focused history and physical, this exhaustive list needn't be included.* ***skin*** *bruising, discoloration, pruritus, birthmarks, moles, ulcers, decubiti, changes in the hair or nails, sun exposure and protection.* ***hematopoietic*** *spontaneous or excessive bleeding, fatigue, enlarged or tender lymph nodes, pallor, history of anemia.* ***head and face*** *pain, traumatic injury, ptosis.* ***ears*** *tinnitus, change in hearing, running or discharge from the ears, deafness, dizziness.* ***eyes*** *change in vision, pain, inflammation, infections, double vision, scotomata, blurring, tearing.* ***mouth and throat*** *dental problems, hoarseness, dysphagia, bleeding gums, sore throat, ulcers or sores in the mouth.* ***nose and sinuses*** *discharge, epistaxis, sinus pain, obstruction.* ***breasts*** *pain, change in contour or skin color, lumps, discharge from the nipple.* ***respiratory tract*** *cough, sputum, change in sputum, night sweats, nocturnal dyspnea, wheezing.* ***cardiovascular system*** *chest pain, dyspnea, palpitations, weakness, intolerance of exercise, varicosities, swelling of extremities, known murmur, hypertension, asystole.* ***gastrointestinal system*** *nausea, vomiting, diarrhea, constipation, quality of appetite, change in appetite, dysphagia, gas, heartburn, melena, change in bowel habits, use of laxatives or other drugs to alter the function of the gastrointestinal tract.* ***urinary tract*** *dysuria, change in color of urine, change in frequency of urination, pain with urgency, incontinence, edema, retention, nocturia.*

	genital tract (female) *menstrual history, obstetric history, contraceptive use, discharge, pain or discomfort, pruritus, history of venereal disease, sexual history.* ***genital tract (male)*** *penile discharge, pain or discomfort, pruritus, skin lesions, hematuria, history of venereal disease, sexual history.* ***skeletal system*** *heat; redness; swelling; limitation of function; deformity; crepitation: pain in a joint or an extremity, the neck, or the back, especially with movement.* ***nervous system*** *dizziness, tremor, ataxia, difficulty in speaking, change in speech, paresthesia, loss of sensation, seizures, syncope, changes in memory.* ***endocrine system*** *tremor, palpitations, intolerance of heat or cold, polyuria, polydipsia, polyphagia, diaphoresis, exophthalmos, goiter.* ***psychologic status*** *nervousness, instability, depression, phobia, sexual disturbances, criminal behavior, insomnia, night terrors, mania, memory loss, perseveration, disorientation*
Physical examination	<u>Describe what you see, avoid vague descriptions such as "normal"; The PE that relates to the chief complaint may need to be MORE detailed than the sample below; record any "advanced" findings/lack of findings that are pertinent (for example, presence or absence of egophany, shifting dullness, HJR)</u> Physical Examination: Always begin with the vital signs. These should include; o Temperature o Pulse o Blood pressure o Respiratory rate o Pain (10-point scale rating) Pulse oximetry when available: include the percentage of supplemental O2. If room air, document this. *EXAMPLE:* *O2 Saturation: 88% on room air, 95% on 2 liter nasal canula.* General appearance: include information on the patient's overall condition. It is appropriate to comment on level of comfort or distress, as well as general grooming and hygiene. Example: • Mr. Smith is a well appearing elderly gentleman in no acute distress. • Mr. Smith is a frail appearing elderly gentleman in significant respiratory distress at the time of examination. Next should follow the individual body systems in discreet subheadings. Traditionally, systems are listed in a top down fashion when performing a full physical examination. This may vary in subspecialty examinations such as ophthalmology or orthopedics.

	In general, the format should be as follows HEENT: Neck: Heart: Lungs: Abdomen: Extremities: Neurological: MSK Vascular: Skin: Example: HEENT: Head: no evidence of trauma Nares: normal pink mucosa, no discharge Eyes: no scleral icterus, normal conjunctiva Ears: TM's show normal light reflex, no erythema, normal l landmarks OP: moist mucus membranes; OP with no erythema or exudate. Oral exam with no lesions. Neck: Supple, No thyromegaly, no lymphadenopathy, normal range of motion; JVP estimated to be 7 cm. Heart: PMI nondisplaced and normal size; No thrills or heaves; RRR, S1S2 with no s3 or s4, no murmurs, rubs or gallops Lungs: No increase work of breathing, lungs clear to auscultation, no wheezes or crackles Abdomen: Non distended, no scars, normoactive bowel sounds, no bruits, non-tender to palpation, no hepatosplenomegaly, no masses Exteremities: No clubbing, cyanosis or edema; Vascular: pulses are 2+ bilaterally at carotid, radial, femoral, dorsalis pedis and posterior tibial; no bruits Neuro: alert and oriented x 3 (person, place and time), CN II-XII intact; Motor 5/5 in all

	extremities. Reflexes 3+ and equal throughout. Sensory testing normal to light touch, pinprick, proprioception, and vibration. Finger-nose and Heel to shin/point to point testing normal. Rapid alternating movements normal; Gait: normal get up and go, normal heel-toe and tandem gait MSK: good tone throughout, no swelling/synovitis or limitation of flexion at any joint Skin: normal texture, normal turgor, warm, dry, no rash
Data collection	Include lab and radiological data appropriate for the HPI (include YOUR interpretation, not just copy/paste from medical record report) Labs: Chest xray or other xrays/scans EKG:
Problem List	List all problems, most important first; You will use this to then begin to combine/lump problems to then create your Assessment/Plan by problem list For example: Problem list: Chest pain Fever Shortness of breath Hemoptysis Elevated creatinine
Summary Statement	Label as summary **(" *In summary….)*** Include 1-2 sentence impression restating basic identifying information (***The patient is a 45 year old male****),* Most pertinent information related to the medical/family/social history (***with a history of tobacco use and family history of early CAD****),* Expanded chief complaint and most pertinent review of systems on presentation (***who presents with substernal chest pressure, nausea and diaphoresis***) Most important findings on physical, labs, data (***and is found to have an S4, bilateral rales, and JVD on exam with evidence of pulmonary edema on CXR***) **Pertinent information is that which contributes directly to building the case for your differential diagnosis….** ***In summary, the patient is a 45 year old male with a history of tobacco use and family history of early CAD who presents with substernal chest pressure, nausea and diaphoresis and is found to have an S4, bilateral rales, and JVD on exam with evidence of pulmonary***

	edema on CXR… ***Key phrases and structure for summary statement:*** ***In summary, this is a …*** ***With a history of…*** ***Who presents with….*** ***And is found to have…***
Assessment/Plan	**<u>Organize plan by problem: Label, Assessment/Plan by problem list</u>** **Include at least 3 diagnoses for your differential potentially associated with the patient's chief complaint** **Include the Most Likely diagnosis/diagnoses on your differential** **Include the DO NOT MISS diagnoses on your differential** **Order your differential to reflect most likely diagnoses or most serious diagnoses first** For each diagnosis discuss physiologic disease basis relevant to the patient and elements from the patient's history and physical that either support or refute the diagnosis. For each item on your differential, explain what makes it likely AND what makes it less likely. It is OK to include less likely items on your differential – explain why it is important to consider but less likely the diagnosis (*PE may be considered frequently when a patient presents with shortness of breath and should be on the differential because it is a Do Not Miss diagnosis – but if the patient has a high white count, cough with sputum and infiltrate on exam, it is LESS likely)* For each problem, discuss the diagnostic plan, treatment plan and patient education. *Outline of what this should look like…* **Summary Statement…** **A/P by Problem List:** 1. **Problem # 1:** **Differential Dx includes…. List at least 3 items for your differential, explain what is most likely and why, what is a must not miss, and what is less likely and why….** **Diagnostic Plan will be…** **Treatment plan will include…** **Patient education…. Instructions to patient include…** 2. **Problem # 2:** **Differential….** **Diagnostic Plan…** **Treatment plan…**

	Patient education 3. **Problem # 3:** **Differential…** **Diagnostic plan…** **Treatment plan…** **Patient education…** For the main problem(s) identified in your problem list, you are expected to identify a **topic or clinical question** that would help you advance your knowledge in that specific area to help you provide better care of patients presenting in a similar way in the future. The topic or clinical question can focus on an epidemiologic, diagnostic, therapeutic, pharmacologic, etc. aspect of patient care. In order to review the topic/answer your question, you should: 1) perform a literature or textbook review to answer your clinical question, 2) incorporate your findings into the assessment and plan of your write-up in the form of 1-2 paragraphs and 3) list the resources used. COM Library resources are strongly encouraged, for suitable resources based on topic of interest please see P2 LibGuide.
Format	Goal is a concise write up with your thought processes documented in logical and organized manner Avoid spelling or grammatical errors Use only commonly accepted abbreviations
HIPAA	Remove patient identification from write up (e.g., name, address, medical record number, etc.)