H&P Template for CDL Cases

	Description	Example
Chief Complaint	Primary symptom(s) in which patient seeks medical care, usually in patient's own words	*CC: Not feeling well*
History of Present Illness	First sentence includes patient's identifying data such as age, sex, race (if clinically relevant), and pertinent PMH Describes details of chief complaint in a chronologic and organized manner. This includes: • Location, quality/character, radiation,severity (if applicable) • Timing (onset, duration, frequency) • Setting/context when symptoms started • Aggravating and alleviating factors • Associated symptoms • Incorporate elements of relevant PMH, FH, SH • Include pertinent positive and negative review of systems (see below)	*Mr. S, a 71-year-old male with a PMH significant for moderate aortic stenosis, hypertension and type II diabetes mellitus, presents to his primary care physician with complaints of low-grade fevers, fatigue and generalized malaise, for the last two months. He has also noticed shortness of breath, but only during exertion. He cannot remember exactly when his fevers began, but he is certain that he now "runs a temperature" every day. He also complains of unintentional weight loss and night sweats during this period. Most nights he wakes up drenched in sweat and has to change his pajamas and sometimes the bedding because of it. He denies chest pain, palpitations, cough or respiratory symptoms; denies urinary symptoms or changes in his bowel function. He has no skin infections or rashes, no ill contacts or recent travel. This past year he had a few visits to his dentist for periodontal disease that required tooth extractions. He is finally done with that.*
PMH	• Medical conditions – date of onset, and any pertinent details • Hospitalizations • Significant childhood illnesses • Surgical History with dates • Obstetric history (if applicable) • Psychiatric history (if applicable)	***PMHx:*** *Hypertension x 20 years, well controlled* *Type II Diabetes Mellitus diagnosed at age 58, last HgA1c 7.8%* *Moderate aortic stenosis: last echocardiogram 6 months ago, moderate calcific aortic stenosis, stable valve area.* *Osteoarthritis of the hands and knees* *GERD* ***Past Surgical Hx:***

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		Inguinal Hernia repair at age 52, Appendectomy at age 1
Medications	Dose, route, frequency (generic name) Including otc meds and supplements and as needed meds	*Medications:* *Hydrochlorothiazide 12.5 mg by mouth daily* *Amlodipine 10 mg by mouth daily* *Metformin 1000mg by mouth twice a day* *Tylenol 500mg by mouth every 4-6 hours as needed.*
Allergies	Medication and type of adverse reaction If none, should note "NKDA" – No known drug allergies	*NKDA*
FH	State of health or cause of death of first-degree family members – parents, siblings, children	
SH	• Occupation • Home situation – who do they live with? • Significant others/partners – any relevant Sexual history • Quantify any tobacco, alcohol, or any other drug use • Consider documentation of any important life experiences (ie military service, religious affiliation/spiritual beliefs)	*Social Hx: Retired landscaper, lives with wife of 35 years. Has 3 grown children and 7 grandchildren. Active lifestyle works around the house and on small landscaping projects. Former smoker (1ppd x 20 years), quit over 20 years ago. Drinks 1 drink a day most days, typically beer or wine. Denies recreational or IV drug use*
Review of Systems	• A systematic approach to gathering information about the patient's symptoms across various body systems, pertaining to the chief complaint	*ROS (example):* *Respiratory tract – Patient DENIES cough, sputum production, change in sputum, wheezing.* *Cardiovascular system – see HPI*

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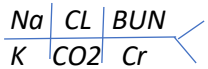
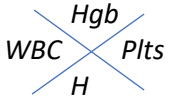
	• Include patient's Yes or No responses. May omit if already addressed in HPI	
Physical Exam	Vitals, followed by head-to-toe approach of exam findings. In general, the format should be as follows: HEENT: Neck: Heart: Lungs: Abdomen: Extremities: Neurological: MSK Vascular: Skin:	*Physical Exam:* *Vital signs: T = 101.5°F, P = 110/min, RR = 18/min, and BP = 165/60 mm Hg.* *HEENT: Pupils are equal, round and reactive to light and accommodation (PERRLA), fundoscopic exam (Figure 1.3). Oral exam without lesions, mucous membranes are moist* *Neck: supple, no lymphadenopathy palpable, normal jugular venous pulsations (JVP)* *Lungs: clear to auscultation bilaterally, no crackles or wheezes* *CV: prominent PMI, regular rate and rhythm, normal S1 and S2, no S3 or S4. New 2/6 diastolic murmur heard loudest over left upper sternal border (accessory aortic valve area).* *Abdomen: Non-tender, non-distended, normal bowel sounds. Moderate hepatosplenomegaly noted on palpation.* *Extremities: warm to the touch, no edema. Several painful, tender nodules noted on patient's fingertips (figure 1.2) as well as reddish-brownish streak seen on patient's nailbeds (figure 1.1).* *Neuro: alert and oriented x 3. CN II-XII intact, no motor, sensory or cerebellar deficits no*
Data Collection/Diagnostic Studies	Include Pertinent lab and radiological data appropriate for the learning objectives of the case. Utilize the template for primary data with normal ranges. If applicable, can utilize conventional CBC and BMP display.	 

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	Include image of relevant radiologic data and interpretation report if applicable to the LO of the case.	