The Documentation of the Complete Medical History and Physical

Content and Format

The preferred format for recording a patient's medical history and physical exam varies from clinic to clinic, and among hospitals. Comprehensive documentation is of educational value early in medical training. As proficiency and familiarity with the clinical method deepens, documentations become more concise. In general, there are four principle parts of the patient encounter, which should be included to some extent in the physician's documentation. They are:

1. History
2. Physical findings and diagnostic tests
3. Assessment / Impression of the problem(s)
4. Plan

For any complete documentation, there may be sections you did not complete, either due to time constraints, lack of access to records or the patient's ability to give a complete history. If that occurs, then state "*not obtained*" for that section.

I. **The Patient's History**. This is the patient's experience of his/her illness, and should not contain the physician's observations (included in physical exam) or interpretations (included in the assessment).

A. Identifying Information:

- Patient's initials (for confidentiality) and age.

B. Chief Concern (CC):

- The patient's principle concern or concerns, concisely summarized in one sentence.

C. History of Present Illness (HPI):

- Detailed characterization of the patient's current problem in paragraph form. Include all aspects of the HPI. The history should be described in chronological order.

D. Past Medical History (PMH): Whereas the HPI is recorded in paragraph form, it is important to keep the PMH in list form, and brief. Within each category, information should be in chronological order. Include the following:

1. Adult Medical Conditions
2. Major Childhood Illnesses
3. Current Medications with dosage. This should include prescription medications, over-the-counter medications, vitamins, oral contraceptives, and complementary medicine. Make sure that you know why the patient is taking each medication. This is a good way to uncover more details of the past medical history.
4. Surgical Procedures
5. Injuries
6. Hospitalizations
7. Immunizations
8. Allergies

E. Family History (FH):

- A complete family history should include information from at least 3 generations.
- Indicate ages and state of health of family members. For deceased family members, note age at the time of death and cause, if known. Specifically mention diabetes, hypertension, coronary artery disease, cancer, arthritis, alcoholism, psychiatric illness, unusual or early deaths, or known genetic illnesses (e.g. sickle cell).
- May be expressed in either tabular form or as a genogram.

F. Social History (SH):

- Usually the social history is recorded in paragraph form, although this will vary, depending on amount of information obtained. This section is important to understand more about who the patient is, apart from the illness. It is also a record of health habits that could potentially improve or worsen the patient's health—and a signal to you and other providers of future topics to discuss and negotiate with the patient. It should include the following:

1. Born, raised, resides
2. Current lifestyle
   - living situation
   - relationship
   - support system
   - daily activities
   - leisure
   - cultural/spiritual beliefs
   - alternative health care practices
   - other
3. Risk factors
   - health habits
     (nutrition, caffeine, exercise, sleep, safety, exposures, tattoos/piercings)
   - tobacco, alcohol, recreational drugs
   - sexual risks
   - economic risks
   - stress
   - violence
   - advanced directives

G. **Review of Systems (ROS):** Organize in a head-to-toe sequence. Record positive and negative findings. List each system separately, rather than running the information together. *Symptoms that relate to the CC, should be included in the HPI as pertinent positives and negatives*. The following categories of info should be included:

•	general	•	cardiac
•	skin	•	gastrointestinal
•	eyes	•	peripheral vascular
•	nose/sinuses	•	genitourinary
•	ears	•	musculoskeletal
•	mouth/throat	•	neurologic
•	neck	•	mental health
•	breasts	•	endocrine
•	respiratory	•	hematologic

II. **THE PHYSICAL FINDINGS** – While you have likely completed your examination by regions for comfort and convenience of the patient, you will record your findings by system.

1. General Statement about overall health status of the patient and general appearance.

2. Vital Signs:
   - Height/Weight/BMI
   - Temp.
   - Pulse
   - Resp Rate
   - BP (*note if seated, supine, or standing*)

3. Skin & nails:
   - Skin color, texture, temperature
   - Presence and description of skin lesions
   - Nail configuration, condition, presence of clubbing

4. Head & Hair:
   - Facial symmetry, involuntary movement, color
   - Hair texture, distribution

5. Eyes:
   - Acuity
   - Visual fields
   - Eyebrows, eyelids, lacrimal glands, sclera, conjunctivae
   - Pupils - shape, reaction to light & accommodation
   - Extraocular movements
   - Fundi - optic disc margin, retinal vessel changes, hemorrhages, exudates

6. Ears:
   - Outer ear
   - Acuity
   - Canals (*cerumen, foreign body*)
   - Tympanic Membranes (*color, landmarks*)
   - Rinne and Weber tests

7. Nose & sinuses:
   - Outer nose
   - Nasal mucosa (*presence of discharge, polyps, edema*)
   - Nasal septum (*alignment*), turbinates
   - Sinus tenderness (*note which examined*)

8. Mouth & pharynx:
   - Lips, tongue, buccal and oral mucosa (*appearance*)
   - Condition of teeth and gums
   - Pharynx, tonsils (*appearance*)
   - Movement of tongue, palate

9. Neck:
   - Occipital, post-auricular, pre-auricular, tonsillar, submandibular, submental and supraclavicular lymph nodes (*note presence, size, tenderness*)
   - Thyroid (*size, nodules tenderness*)

10. Chest:
   - Chest expansion, symmetry

11. Lungs:
   - Percussion findings: quality and symmetry of percussion notes
   - Auscultation findings: characteristics of breath sounds (*rales, rhonchi, wheezes, egophony*)
   - Presence of tactile fremitus, egophony, whispered pectoriloquy (*if lung abnormality suspected*)

12. Breasts:
   - Presence of masses, scars, tenderness, thickening or dimpling
   - Nipples, areolae

13. Axilla:
   - Axillary lymph nodes (*note presence, size, tenderness*)

14. Cardiac:
   - PMI (*point of maximal impulse*), location & quality
   - Auscultation findings: characteristics of S_1 and S_2, presence of murmurs, rub or S_3 and S_4 (*description by timing, location, radiation, intensity, pitch and quality*)

15. Vascular:
   - Carotid pulse, presence of bruits
   - Jugular venous pulsations and jugular venous pressure
   - Hepatojugular reflux (*if heart failure suspected*)
   - Aorta (*note width and presence of bruits*)
   - Presence of bruits over renal or femoral arteries
   - Amplitude of pulses (brachial, radial, femoral, popliteal, posterior, tibial and dorsal pedis) (*Describe on a scale of 1-4*)
   - Presence of edema or varicosities of lower extremities

16. Abdomen:
   - Contour, scars, skin lesions, pulsations
   - Bowel sounds & bruits
   - Percussion findings: liver span, spleen
   - Palpation findings: abdomen quadrants, liver, spleen
   - Irritation of obturator or iliopsoas muscle, rebound tenderness (*if abdominal pain is present*), shifting dullness, fluid wave (*if ascites is suspected*)

17. Musculoskeletal:
   - Spine alignment and presence of tenderness
   - Range of motion of neck, shoulders, elbows, wrists and fingers. Presence of pain with movement.
   - Range of motion of hips, knees and ankles. Presence of pain with movement.

18. Neurologic:
- Mental status (*describe using SLUMS 0/30*)
- Cranial nerves, specific findings for each
- Motor strength (*describe on a scale of 0-5*)
- Sensory function (*light touch, pinprick, temperature, vibration, joint position sense*)
- Coordination (*rapid alternative movements, finger to finger, heel to shin*)
- Reflexes (*describe on a scale of 0-4*)
- Babinski, clonus
- Presence of pronator drift
- Gait, Romberg

19. Genitalia & Rectum:

Female -
- External genitalia
- Vagina
- Cervix
- Uterus
- Adnexa
- Rectovaginal exam

Male -
- Penis
- Scrotum
- Hernia
- Anus
- Rectum
- Prostate

III. ASSESSMENT/IMPRESSION

Begin with a concise one-sentence summary of the problem.

For each acute problem, include:
- statement of the problem
- differential diagnosis
- clinical reasoning

For each chronic problem, include:
- statement of the problem
- status of the problem
- clinical reasoning

IV. PLAN

The plan should separate problems by number and will often have 4 components:
- Diagnostic Testing
- Treatment Plan
- Patient Education
- Planned Follow-up