EXAMPLE OF A COMPLETE DOCUMENTATION OF THE HISTORY AND PHYSICAL EXAMINATION

CC: J.S. is a 30-year-old male who complains of "a bad sore throat" for one week duration.

HPI: J.S. was in good health until one week ago when he noted the gradual onset of a burning pain in his throat, which was worse in the morning. Mr. S. used throat lozenges with little improvement in the pain. Two days ago he became unable to eat because of an increased burning in his throat. He is able to swallow liquids with difficulty.

Yesterday Mr. S. noticed the pain began to radiate into his neck and jaw. He felt hoarse and noticed he was wheezing. He especially had difficulty taking a deep breath and felt "something was closing off his airway." He noted shortness of breath when lying flat or when exerting himself. Mr. S. complained of a fever which he measured orally at 102°, and it was accompanied by chills. He used Ibuprofen 600 mg every 6-8 hours with some improvement in throat pain and fever.

Today Mr. S. notes an increasingly "raspy" voice and an aching pain in his throat. He also complained of swelling in his neck. He has been unable to lie down because he feels "his throat will shut off." He has had a shaking chill alternating with drenching sweats throughout the day. Mr. S. enters the ER for evaluation.

PMH:

1. Adult medical conditions – Hypertension, diagnosed 3 yrs ago.
2. Major Childhood illnesses – mumps, chicken pox.
3. Current medications – HCTZ 25 mg/day for hypertension
4. Surgical Procedures – bilateral inguinal hernia repair at age 1; T & A (tonsillectomy and adenoidectomy) at age 7
5. Injuries – broken arm at age 11
6. Hospitalizations for surgeries above
7. Immunizations – tetanus six (6) years ago, +PPD at age 11, treated with INH for one year.
8. Allergies – Sulfa (hives)

FH:

Maternal grandmother:	deceased at age 80, unknown cause
Maternal grandfather:	deceased at age 85, heart attack
Paternal grandmother:	83, hypertension
Paternal grandfather:	80, osteoarthritis
Father:	62, hypertension, hypothyroidism
Mother:	52, rheumatoid arthritis
Siblings:	Brothers, 25 and 21 alive and well, sister, 18, alive and well

No Hx of DM, hypertension, cancer, arthritis, alcoholism, psychiatric illness, known genetic illness.

SH: Mr. S. was born in Milwaukee, Wisconsin, and obtained a B.S. from Harvard. He has been in medical school at UW for two years. During the summers he works as a research assistant. He has been married for four years, and has one daughter. He attends classes from 8 a.m. to 3 p.m. daily and studies another 2-3 hours each evening. He is a vegetarian, and conscious of eating enough protein, with a basic diet of beans, rice and vegetables. He sleeps about 6-7 hours/night, and enjoys cross-country skiing and sailing. He always uses seat belts. He states he never drinks alcohol or recreational drugs, does not smoke cigarettes, nor does he drink coffee or pop. He drinks herbal teas.

Mr. S. has been monogamous for the past 6 years, and does not feel he is at risk for any STIs, including HIV. His wife works; he is under the normal stress of being in medical school. He denies any history of violence in his life.

ROS:		
	General:	See HPI
	Skin:	(-) rashes, pruritus, skin or hair changes
	Eye:	uses contact lenses; (-) pain, redness, dryness
	Nose/Sinuses:	(-) rhinorrhea, sinus tenderness
	Ears:	(-) pain, ringing, decreased hearing
	Mouth/Throat:	See HPI
	Neck:	See HPI
	Respiratory:	See HPI (-) cough, hemoptysis
	Cardiac:	(-) chest pain, murmur, palpitations
	GI:	(-) nausea, vomiting, abd pain, change in bowel movements, jaundice
	GU:	(-) urgency, pain, hesitancy
		(-) hernia, testicular pain
		(-) discharge or sores on genitalia
		(-) sexual problems
	MSK:	(+) occ. right knee pain with jogging, (-) swelling, redness of joints
	Neuro:	(-) headaches, seizure, fainting, abnormalities of sensation, weakness
	Psychiatric:	(-) depression, mania, psychosis, anxiety, sleep disturbance
	Endo:	(-) thirst, cold or heat intolerance
	Heme:	(-) easy bruisability, anemia, history of transfusions

PE: Mr. S. is diaphoretic and in obvious pain. He is hoarse and appears short of breath.

VS:	Ht. 6'0", Wt. 162 lbs; BMI = 22 kg/M^2; BP 120/80 RA, 110/75 LA, supine Pulse--100/min. & reg; resp--22/min.; temp--102° (oral)
Skin/nails:	diaphoretic skin--normal turgor, increased warmth. Nail beds pink without clubbing
Head:	normal hair, no scalp abnormalities
Eyes:	acuity 20/20 (R); 20/20 (L) Visual fields—full; eyes are aligned; lids, conjunctivae and sclera are normal; pupils are 3mm and equal; brisk response to light; extraocular movements (EOM) are intact; Fundi--sharp disc margin; no hemorrhage or exudates, no arteriolar narrowing
Ears:	outer ear without lesions; normal acuity; tympanic canals normal; tympanic membranes with normal light reflex, no erythema or bulge
Nose/Sinuses:	nasal mucosa inflamed; nasal septum is midline; no tenderness over maxillary or frontal sinuses
Mouth & Pharynx:	
	normal lips, tongue, gums and healthy teeth; pharynx is erythematous; tonsils meeting in midline with white exudates
Neck:	tender bilateral tonsillar and anterior cervical nodes; no occipital, auricular, submandibular, submental or supraclavicular nodes; trachea in midline; thyroid lobes not palpable
Chest:	normal to inspection; respiratory effort symmetric without use of accessory muscles
Lungs:	resonant percussion throughout
	breath sounds normal with no extra sounds

Cardiac: PMI non-displaced, at 5th interspace, mid-clavicular line
normal S_1 and S_2, no extra heart sounds and no murmurs

Vascular: 2+ carotid pulse bilaterally--no bruits
JVP at 5cm above right atrium
Aortic pulsation normal, no bruits over aorta, femoral or rental arteries
Pulses

	Radial	Femoral	Popliteal	D. Pedis	P. Tib
R	2+	2+	2+	2+	2+
L	2+	2+	2+	2+	2+

No lower extremity edema, no varicosities

Abdomen: flat contour; normal bowel sounds; liver span 10cm at midclavicular line; negative spleen percussion, no masses or organomegaly, no tenderness to palpation

Musculoskeletal:
full range of motion and normal appearance of all joints of upper and lower extremities

Neurologic: mental status normal--SLUMS 30/30
cranial nerves II-XII intact
motor strength 5/5 throughout and no increased tone
sensory function normal to light touch, pinprick, vibration and joint position sense
coordination normal
biceps, brachioradialis, triceps, knee, ankle reflexes 2+ bilaterally
Babinski negative, no clonus, gait normal, Romberg negative, no pronator drift

Genitalia: normal penis, scrotum; no scrotal masses

Rectal exam: normal prostate, guaiac (-) stool; no masses

Lab Data:

Hct 39%, WBC 12,500 with 76% seg. 10% bands UA normal
Na 135, K 3.6, Cl 100, HCO_3 22
CXR--normal

ASSESSMENT:

30 y/o male with sore throat and elevated WBC.

#1 Sore throat--swollen tonsils, fever, chills and cervical adenopathy suggests tonsillitis. With high fever, tonsillar exudates and elevated white count it is likely this patient has a strep tonsillitis. Infectious mononucleosis is also possible, but unlikely due to the short time course. Because of the marked enlargement of the tonsils, this patient may have developed a peritonsillar abscess, though his tonsillar enlargement appears symmetric.

#2 Hypertension is well controlled on medication since blood pressure is normal.

PLAN:

#1 Sore Throat:
Obtain throat culture. Treat with PCN VK 500 mg every 6 hours.
He will follow up with his primary care clinic tomorrow if his symptoms are not improving.

#2 Hypertension: Continue HCTZ 25mg/day.