

THE MEDICAL WRITE-UP CONTENT AND SEQUENCE 2007-08

The medical history and physical exam write-up described here is the standard to be used for teaching and evaluation in the ICM-III course. A sample of the written H&P is provided in the syllabus and on the course website. It contains the basic historical information necessary in the initial comprehensive evaluation of a patient in either an in-patient or outpatient setting. Clinical experience in the third and fourth year rotations will provide the opportunity to learn and utilize the other formats used in more focused settings.

CHIEF COMPLAINT

States the reason the patient is presenting to the physician in their own words. Avoid including any diagnosis in this statement.

HISTORY OF THE PRESENT ILLNESS

The HPI is the patients' story of all the relevant events in appropriate detail relating to their chief complaint. Relevant means information that is necessary to further clarify an understanding of the presenting problem and will contribute to the diagnosis and treatment (example: a history of previous deep venous thrombosis is relevant for a patient presenting with acute shortness of breath).

The problems should be investigated in appropriate detail, using a chronological approach (logical sequence - first episode to present) and describe the effect on the patient and the contribution to their presentation.

Appropriate detail means a full **characterization of the patient's symptom**, to include both the primary and associated symptoms. We are using the "OPQRST" format for characterizing a presenting complaint. Please recognize this is a GENERAL FRAMEWORK for the interview, and not ideal for every situation. The fall back line of questioning to characterize a symptoms is simply to answer; who, what, when, where, why, and how. Be curious and ask follow up questions!

- ❖ **O Onset:** *When did it start? How did it start (suddenness of onset, what were you doing)?*
- ❖ **P Palliating/Provoking Factors:** *What makes it better/worse? When do you get it? What brings it on? What have you tried to relieve it?*
- ❖ **Q Quality:** *What does it feel like (get a clear description)? How severe (use a numerical scale)?*
- ❖ **R Region/Radiation:** *Where is it located (get a precise location; if necessary have patient point to the area)? Does it move or radiate to another region?*
- ❖ **S Symptoms (associated):** *What other symptoms have you noticed when it occurs?*
- ❖ **T Temporal aspects:** *Has anything changed since the first time you had the symptom? Are things better, worse, or about the same? How often does it happen? How long does it last?*

Personal, life style, travel, environmental, or job information that may be of etiologic importance should be reported in addition to aspects of the past medical history or review of systems that are directly related to the presenting symptoms.

PAST MEDICAL HISTORY

This section deals with major problems that have resolved, are currently inactive, or are active but stable. This represents a relatively complete list, and does not necessarily need to be included or reported with every interview. For example, the Gynecologist will be very interested in the number of pregnancies, live births, etc... for each patient, whereas the Psychiatrist may not consider this information relevant to their interview. Again, for purposes of this course, we provide you with all the tools you need to be comprehensive with your interviews and presentations, and will rely on further teaching and experience to understand how the context and audience effect which items are included as relevant.

- **Childhood Illness**

Pay particular attention to conditions that could have long term complications and effect current or future health (e.g. Inherited disorders, chronic conditions, infections like rheumatic fever, developmental delays, previous trauma or fractures, etc...)

- **Adult Illnesses**

List all current active and/or chronic diseases and characterize them in appropriate detail relevant to the chief complaint. Looking at their current medications is a way of helping identify and verify their current illnesses.

- **Gynecological and Obstetrical History**

Age of menarche, last menstrual period

Pregnancies (gravidity (G) [total # pregnancies], parity (P)[# of pregnancies carried to viability - 20 weeks or more]), complications (premature delivery), live births, types of deliveries, abortions (May use the system that includes under parity the number of term pregnancies, premature deliveries, abortions, and living children. Example: G₆P₃₂₁₄ = 6 pregnancies, 3 term pregnancies, 2 premature deliveries, 1 abortion, 4 living children)

- **Psychiatric History**

Diagnosis, hospitalizations, medications, course, outcome

- **Transfusions**

Number, dates (if unsure, ascertain if before or after 1990)

- **Trauma**

Major, dates, outcomes

PAST SURGICAL HISTORY

- Procedures, dates, anesthetic reactions, complications, outcomes

MEDICATIONS

- Generic name, dose, duration, and reason for use
- Recent changes to dose, recent additions, and/or recent medications stopped and why
- Herbal medications and over the counter medications used

ALLERGIES

- Drug allergies to include contrast dye and the reactions
- Seasonal and food allergies with reactions

FAMILY HISTORY

- Health and ages of parents, siblings, and children. Age and cause of death of family members where applicable. Presence among family members of specific diseases related to present illness as well as other conditions including diabetes, cancer, rheumatologic disease, diabetes, renal disease, hypertension, atherosclerotic disease, and emotional disorders. Use of a three generation genetic pedigree may be helpful. A family history of substance abuse (tobacco, ETOH, drugs), and/or verbal, sexual, and/or physical abuse as a child or spouse should also be investigated.

PSYCHOSOCIAL HISTORY

- Alcohol and “recreational” drug use - CAGE questions if indicated
 - Understand the limitations of the CAGE questions, and pursue other avenues to identify alcoholism (e.g. history of DUI, work or relationship problems, etc...) if you still suspect an alcohol problem despite a negative CAGE screen.

1. “Do you drink alcohol?” (or “Do you drink beer, wine or whiskey?”)
2. If yes, then screen for potential alcohol problems with the **CAGE** Questions:
 - ❖ Have you ever felt you ought to CUT down on your drinking?
 - ❖ Have people ANNOYED you by criticizing your drinking?
 - ❖ Have you ever felt bad or GUILTY about your drinking?
 - ❖ Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (EYE OPENER)

- Occupational history; current work situation and previous occupational exposures
- Education: level of education completed, literacy
- Diet
 - Who prepares meals, eating history (composition, frequency, timing of meals, restrictions, excesses) & disorders (allergies, intolerance, [induced] vomiting) Changes in appetite and weight if not addressed in HPI. Coffee, tea, other xanthine containing beverages.
- Smoking - age of onset, duration, quantity (pack years = ppd x years smoked), when quit
- Social support system
 - Marital/relationship: duration, health and age of spouse; number, age, and occupation of children; proximity of family members.
- Exercise - type, frequency, intensity, duration

HEALTH MAINTENANCE (Most are gender and age related)

- Immunizations: Includes both primary and appropriate boosters
- Date & result last glucose test
- Cardiovascular screening
 - Date & result previous blood pressures
 - Date & result last cholesterol check
- Age-appropriate cancer screening
 - Date & result last mammogram
 - Date & result of last pap smear
 - Date & result last prostate exam including PSA test
 - Date & result last colon-rectal examination (colonoscopy, flexible sigmoidoscopy)
 - Date & result last “skin survey” (dermatology)
- Other screening examinations
 - Date & result of last chest X-ray, tuberculin skin test.
 - Date & result previous ECG's
 - Date & result last comprehensive eye exam (result)
 - Date & result last dental examination

Again, this is a complete list to give you all the tools you need for a comprehensive written H&P, and not all items need to be included for every patient. Work with your preceptor to help understand the relevance of each item for your patient.

MILITARY HISTORY

- Rank, responsibilities, and deployments
- Include geographic locations and environmental exposures
- Occupational Exposures

REVIEW OF SYSTEMS

This is a systematic approach to provide you with a list of questions organized by system that will provide a safety net to prevent you from missing important aspects of the patients' presentation you may not immediately deem relevant. All positive findings should be reported. Negative findings are only reported if it aids in narrowing the differential diagnosis, or is otherwise relevant to the presentation of the patient. Your preceptor will assist you in determining which ROS questions are relevant, as this requires a more in-depth degree of medical knowledge.

These questions generally have a yes/no response, and should be directed at a time frame not more than 6 months prior to the patients' presentation. While you need to perform the ROS using layman's terms, it is preferable to use medical nomenclature (dyspnea, hematochezia, etc.) in the written ROS.

A list of the complete ROS questions is provided elsewhere in this syllabus.

PHYSICAL EXAMINATION

You should begin this section with an opening statement that "paints a picture" of your patients' overall appearance addressing:

- level of consciousness (alert, obtunded, etc...)
- obvious features
- appearance/agreement with stated age
- level of distress
- affect
- estimate of nutritional status, weight

Avoid the phrase "well developed, well nourished". It has limited meaning, and conveys a lack of anything better to write. You do NOT need to include all of the above items in your description, as this is simply a guideline for you to create a more accurate description of the patient.

Your next statement should be a recording of the vital signs to include:

- pulse
- blood pressure
- respiration
- temperature

You then will report and describe your physical exam findings proceeding in an organized manner by system from head to toe. All patients should have a description of the heart, lung, and abdominal examination as these are core systems. The remainder of the physical exam should be reported in appropriate detail relevant to the chief complaint, associated symptoms, and presentation of the patient.

THE PROBLEM LIST

You are learning how to create a problem list based on a clinical vignette in ICR. Use the same format for creating a problem list in ICM.

This section is a list of the major symptoms, historical findings, and physical findings identified during the medical interview and physical examination. They should be listed in a hierarchal order (most to less important), and include all the abnormal historical and physical exam findings.

