

## ICM-III

### Sample Written History and Physical Exam

***This is an example of the level of detail required for the written component of the ICM-III patient encounters. Unique content will obviously be based on the specific patient, depth of the interview and comprehensiveness of the physical examination. Please use the guidelines for the write-up provided in the course syllabus.***

**Chief Complaint:** 34 year-old African-American female, active duty Navy E-7, presents with complaint of "I can't stop coughing" for the last two weeks.

#### **HPI:**

The patient was in her usual state of health until two weeks prior to this appointment when she noticed the gradual onset of cough. Initially her cough was intermittent and non-productive, with no associated dyspnea. However, over the next several days she noted the cough becoming more frequent, and became productive of clear sputum. At this time, she also noted the onset of generalized malaise, feeling intermittently warm and cold, and a having a few chills.

Seven days prior to presentation, a physician prescribed a course of doxycycline. However, over the ensuing week, she noted further worsening of her cough, which is now almost constant and keeps her from sleeping. She also notes her sputum is now yellow and occasionally green, of which she brings up several tablespoons daily. She denies any bloody or rust colored sputum.

Approximately 3 days ago the cough became associated with some stabbing pain over the right lateral chest that has persisted, and states it is non-radiating and worse with deep inspiration. She denies any exertional chest pain or dyspnea, but has stopped exercising, and has been minimally active since becoming ill. Two days prior to this appointment she had experienced nausea and poor appetite that has since persisted. She has vomited twice, with the last episode this morning, but is still able to keep down liquids and small quantities of bland foods. She has no associated abdominal pain or diarrhea.

The patient presented for evaluation today because "I'm just not getting better". She has tried echinacea as well as Nyquil, but has not had any relief from the cough. Of note, she traveled to Singapore and the Persian Gulf six months previously, but does not report any recent sick contacts and has been well since returning. She denies any exposure history for tuberculosis or HIV, and received a flu shot in October and had a negative PPD at that time. She denies any history of asthma or previous pulmonary infections, but does have a 13 pack/year smoking history.

#### **Past Medical History:**

##### **Childhood Illnesses:**

She reports the "usual" childhood illnesses with no recurrent or significant childhood illnesses. She denies any history of Asthma or other lung diseases as a child. She is unaware of any prenatal or perinatal illnesses.

##### **Adult Illnesses:**

1. Mononucleosis: Diagnosed at age 17 when she presented with fatigue. She reports no complications and recovered in about two weeks. She denies any history of splenic injury.
2. "Heartburn": The patient was seen for retrosternal burning chest pain two years previously. She reports having a normal EKG, and was treated with an unknown medicine for two months. Her symptoms resolved, and she's experienced no recurrence since then.

**Gynecologic/Obstetrical History:**

- Menarche age 12
- LMP two weeks ago
- G<sub>3</sub>P<sub>2012</sub>
  - First child by SVD (age 23)
  - Second child by C-section

**Psychiatric History:**

None

**Transfusions:**

None

**Trauma:**

Patient reports left medial meniscus injury (see PSHx). Otherwise, no significant trauma history

**Past Surgical History:**

1. Caesarian section at age 26 for breech position. Healthy baby delivered after an uncomplicated procedure.
2. Arthroscopic surgery, age 18. Repair of her left medial meniscus after a skiing injury. She was admitted overnight because of a fever, but had an uneventful recovery otherwise.
3. D&C, age 28. After a spontaneous fetal loss. Uncomplicated procedure.

**Medications:**

1. Doxycycline 100mg twice daily. Completed 7 of 10 days. Reports good adherence with no missed doses.
2. Tylenol 325mg tablets; 1-2 tablets bid/tid for two weeks
3. Echinacea (dose unknown) 2 tablets tid for two weeks since becoming ill
4. Nyquil one teaspoon qhs for three days

No use of other herbal or OTC medications. No history of sleep medications, vitamins, or supplements.

**Allergies:**

1. Penicillin: Patient was told she had a "rash" as a child, but does not recall any details. Does not believe she was hospitalized or had any respiratory symptoms related to penicillin. She has never been treated with penicillin to her knowledge.
2. No known food allergies
3. No known eczema or atopic skin reactions

**Family History:**

Both parents are alive.

- Father (59):type 2 diabetes and hypertension.
- Mother (60):"rheumatism" and hypertension.
- Two older brothers: both in good health.
- Two children (ages 8,11) are well.
- No family history of malignancy.
- Paternal grandfather:"kidney problems" and a stroke.
- Maternal grandmother died from a heart attack.

**Psychosocial History:**

**Alcohol:** Drinks 1-2 servings of wine or beer about twice a month. C (-) A (-) G(-) E(-)

**Illicit Drugs:** None

**Smoking:** Smokes ~1 ppd of cigarettes only since age 21 (13 pack-years). She has been interested in cessation in the past, but is concerned about gaining weight.

**Occupation:** Active duty E-7, working in intelligence. No occupational exposure to inhaled toxins or sick contacts

**Diet:** Eats three meals daily. "Normal" diet prior to illness without restrictions. Had tried the "Adkins" diet for weight loss a year ago, but has resumed her normal diet. No history of eating disorders.

**Social Support:** Married since age 20 to another active duty member who is also 34 y/o and in good health. Stationed together this tour, but families live on the west coast.

**Exercise:** Works out at the gym 2-3 times weekly prior to "PT tests", but is otherwise sedentary.

**HEALTH MAINTAINANCE:**

**Immunizations:** Had usual "overseas clearance" immunizations within the last year, but does not recall specifics. Flu shot and negative PPD in October.

**Mammogram:** Never been done.

**Pap:** four months ago; normal

**Glucose/Lipid:** checked annually. Reports results have been "normal"

**Skin survey:** Reports she has never had

**Dental exam:** Annually, last 11 months ago

**Blood pressure:** Annually, last checked 4 months ago and "normal"

**Military History:**

She has served 16 years of enlisted duty in the Navy, and currently works in a supervisory role in a "high-stress" environment. She was in the Persian Gulf for six months earlier this year. She has had two ship cruises during her career.

**REVIEW OF SYSTEMS:****General Review Of Systems (ROS)**

- Denies night sweats or weight gain/loss
- Complains of subjective fevers and intermittent chills

**Dermatologic ROS**

- No rash, dryness, or new skin lesions

**Head And Neck ROS**

- Occasional "tension" headaches-unchanged over 15 years
- Denies neck pain or neck stiffness.

**ROS for Ears**

- Denies hearing loss, ear pain, ringing in ears or earaches.

**ROS for The Nose & Sinuses**

- Denies sinus pains or pressure
- Denies nasal discharge or epistaxis

**ROS for Throat & Oral Cavity**

- Denies sore throat or hoarseness

**ROS for Eyes**

- No changes in vision (corrected x10years with contact lenses),
- No double vision or blurred vision
- Complains of “broken blood vessel” in left eye with coughing

**Breast ROS**

- Denies lumps, masses, or nipple discharge

**Pulmonary ROS**

- See HPI

**Cardiovascular ROS**

- See HPI
- Denies palpitations
- Reports swelling in both feet monthly associated with menstrual cycle

**Abdominal ROS**

- See HPI
- Denies dysphagia or odynophagia
- Reports occasional “heartburn”
  - Worse after taking aspirin or lying supine
- Reports occasional (x2 year- last 3 months ago) hematochezia
  - Reports hemorrhoids with pregnancy
  - Denies history of melena
- Denies history of jaundice or easy bruising

**Urinary ROS**

- Denies increased urinary frequency, urgency, dysuria, or hematuria

**Gynecological ROS**

- Reports regular menstrual cycles

**Sexual History ROS**

- Reports being sexually active in a monogamous relationship
- No sexual interest since onset of current problem
- Uses “patch” for prevention, no condom use

**Musculoskeletal ROS**

- Denies joint pain, stiffness, or swelling
- Denies muscle weakness or discrete tenderness.
- Reports generalized “achiness”

**Neurologic ROS**

- Denies any numbness or tingling
- Denies dizziness, balance problems, or loss of consciousness

**Psychiatric ROS**

- Denies symptoms of anxiety or depression.

## PHYSICAL EXAM:

### Vitals:

BP 137/72 right arm seated P 100, regular  
T 100.5 (otic) RR 18, regular  
HT 67in Wt 134lb

**General:** Mildly ill appearing female who appears her stated age. Alert and conversant, becomes SOB when speaking more than two sentences. Patient is not using accessory muscles, mucous membranes are moist.

**Skin:** No rashes appreciated. Keloid formation noted on right forearm scar. No suspect moles.

**Head:** Normal appearance. Maxillary/frontal/ethmoid sinuses non-tender. Normal scalp and hair

**Eyes:** Conjunctiva non-injected. No icterus. Right sclera with bright red blood, left sclera without abnormal findings. EOMI. Visual acuity 20/20 bilaterally with Snellen card. Pupils 5mm, reactive equally to light and accommodation; Funduscopic exam show no papilledema. Normal venous pulsations. No Av nicking appreciated.

**Ears:** Hearing intact to whisper test. TMs and canals without erythema or exudates

**Nose:** Mucosa moist with no erythema. No septal deviation/perforation. No polyps appreciated

**Mouth:** Lips, tongue and buccal mucosa unremarkable. Normal hard/soft palate

**Teeth and Gums:** Normal dentition without visible caries. No gingival hypertrophy or obvious periodontal inflammation

**Throat:** No erythema or exudates. No visible post-nasal drip or cobblestoning. Normal tonsils. No masses seen

**Neck:** Supple with full ROM. Trachea midline. No lymphadenopathy. Thyroid difficult to palpate, but no nodules, goiter, or bruit appreciated

**Chest:** Symmetric chest excursions. Breasts with no skin dimpling or retractions. No palpable breast masses or nodules. No discharge or tenderness.

**Lungs:** Shallow respirations with some apparent splinting. Normal percussion noted bilaterally. Increased tactile fremitus in the right posterior mid-lung zones. Left lung clear to auscultation. Right lung with right mid-lung coarse inspiratory and expiratory crackles. Egophony is present over this area. No wheezes or rales appreciated.

**Cardiovascular:** Neck veins 4 cm above sternoclavicular joint at 30 degrees. Normal carotid pulsations without bruits. PMI on the mid-clavicular line. S1 and S2 normal with physiologic S2 split. No S3 or S4. 2/6 soft crescendo-decrescendo systolic murmur best heard over the left 3<sup>rd</sup> interspace. No radiation to neck or axilla. No change with inspiration, but quieter with Valsalva maneuver.

**Abdomen:** Non-distended abdomen. Well-healed caesarean scar without keloids. No visible venous collaterals. Normal active bowel sounds without renal or aortic bruits. Liver span 12 cm in mid-clavicular line. Spleen non-palpable and does not extend beyond ribs to percussion in right lateral decubitus position. Bladder is not percussable. On palpation, no tenderness, masses, guarding, rebound, ascites.

**Back:** Spine is straight. No vertebral or costo-vertebral angle tenderness. Full ROM

**Extremities:** Pulses: Radial, Brachial, femoral, popliteal, dorsal pedal, posterior pedal 2/2 equal and symmetrical. No femoral bruits.

**Joints:** wrist, elbow, shoulder, hip, knee, ankles full range of motion without pain. Hands-feet: full ROM, no pain palpation or deformities.

**Lymphatics:** No palpable posterior auricular, anterior/posterior cervical, submental, or supraclavicular adenopathy. No axillary lymph nodes palpated. 1-2 pea-sized mobile and non-tender bilateral inguinal lymph nodes are present bilaterally.

**Neurological:**

- MMSE: 30/30
- Cranial nerves II-XII intact
- Reflexes: biceps 2+, triceps 1+, knee 2+, Achilles 2+ equal and symmetrical. No Babinski present.
- Sensation: Light touch, pain, vibratory normal and symmetrical
- Proximal and distal muscle strength 5/5 equal and symmetrical
- Coordination/station/gait: No extended arm drift, finger to nose/heel to shin intact and symmetrical. Rapid alternating hand and finger movement intact.
- Romberg normal, gait normal (heel/toe tandem) able to walk on toes and heels.

**Genitalia:** Not examined

**Problem List:**

1. Productive Cough
2. Shortness of Breath
3. Pleuritic Chest Pain
4. Signs of Right Middle Lobe Consolidation (egophony, crackles, fremitus)
5. Low Grade Fever
6. Subjective Chills
7. Malaise
8. Nausea and Vomiting
9. Tobacco Use
10. Sub-conjunctival hemorrhage
11. Likely physiologic murmur
12. Heartburn
13. Hemorrhoids
14. Intermittent Lower Extremity Edema
15. Spontaneous Fetal Loss
16. Left Meniscal Tear
17. Keloids