WRITING H&P NOTES

12 Tips for Documenting a History & Physical

1 Chief Complaint (CC)

- Write a concise statement describing the symptoms that caused a patient to seek medical care.
- Try to document in the patient's words, such as "I've been having trouble breathing."

2 History of Present Illness (HPI) - Step #1

Template for the 1st Sentence:

PATIENT NAME is a AGE year-old GENDER with a history significant for Pertinent PMH/PSH/FHx/SHx who presents to the HOSPITAL/CLINC with CHIEF COMPLAINT for DURATION.

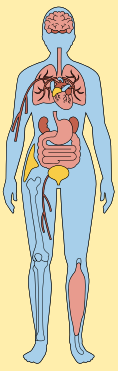
HPI - Step #2

Continue with the info below:

- Pertinent data from OLDCARTS.
- ROS info relating to case & repeat in ROS section.
- If patient has more than one complaint, repeat all step for each one.
- Don't forget! Use complete sentences and check grammar, spelling and terminology.

3 Review of Systems (ROS)

List Review of Systems' symptom endorsements and denials. (See page two of the Patient Interview Checklist for more details.)



4 Document Past Medical History (PMH)

Include all known, past medical diagnoses for the patient in a bulleted list or paragraph format.

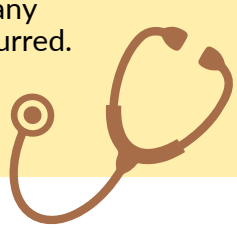
- When was disease diagnosed?
- Is condition well or poorly controlled?
- Any changes since last visit?
- Lifestyle modification?
- Medications?

5 Past Hospitalizations (PHx)

- Include all known, past hospitalizations for the patient in a bulleted list or paragraph format.
- Indicate length of time of stay, location in the hospital, and treatment received.

Past Surgical History (PSH) 6

- Include the previous surgeries or procedures in a bulleted list or paragraph format.
- Include date and indication (if known) for the surgical procedures.
- Indicate whether any complications occurred.



7 Medications (Med/Meds)

- List ALL medications – prescribed, herbal, or over the counter in a bulleted list.
- Include doses, routes, how often (schedules), and indications.
- Note whether patient is taking meds as prescribed (adherence).

Allergies (ALL) 8

- It is critical that all allergies be documented.
- Make sure to document the type of allergic reaction and severity. For example: hives or anaphylaxis.

9 Family History (FHx)

- Includes any pertinent medical conditions in the patient's biological relatives.
  - 1st degree - Siblings, Parents, Children
  - 2nd degree - Aunts, Uncles, Grandparents
- If concerned for a genetic predisposition, ask whether specific conditions are present in extended family members so you can draw out a pedigree.

Social History (SHx) 10

- The portion of the general medical history that addresses occupational, familial, and recreational aspects of the patient's personal life that may be clinically relevant and significant.
- There are several components to the social history:
  - Home
  - Education/Employment
  - Activities
  - Diet
  - Drugs (includes tobacco, alcohol, and marijuana)
  - Sexuality
  - Suicide/Depression
  - Safety

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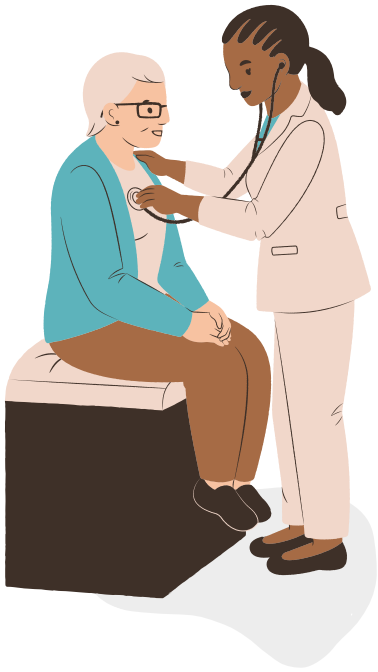
Physical Exam

- Use this template to record the findings from the physical exam. Document only the systems examined. Write “not examined” where applicable.

General Appearance:
Vitals:
Head, Eyes, Ears, Nose, Throat (HEENT):
Neck:
Breast:
Heart:
Lungs:
Abdomen:
Genital/Rectum:
Back:
Extremities:
Skin:
Neurological system:
Psychiatric system:



Assessment & Plan

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- Summarize why the patient is at the clinic or medical center.
- Include the top 2-3 differential diagnoses with justification of each differential using evidence from the history, physical exam, and labs/imaging if available.

Begin the assessment section with:
“In summary, this is a (AGE, GENDER, and highly relevant PMH who comes with PSH, PMH, RHx, SHx).”

Then continue by describing:

- The primary symptom using sematic qualifiers. Use info from CC and HPI.
- Highly relevant diagnostic data using clinical symptoms when possible drawn from vitals,, physical exam, labs, and imaging studies.

Template for differentials:

- “Based on this information, my top differential is ___ because the patient endorses ___ symptom and has ___ findings on physical exam.
- “Second on my differential is ___ because ___ that is less likely because ___ (negative ROS, negative ROS findings).
- “Third on my differential is ___ because...

So, what’s the plan?

- The plan is the next steps to address the problem or narrow down the differential diagnosis, whether that is more testing and/or treatment.
- For each problem how you will manage it.
- For each differential indicate what labs, tests, or imaging will done, also include management where appropriate.