

TITLE: “Training level” + “Setting” **History & Physical**

IDENTIFICATION (ID): Include: name, age, gender, state of health, (e.g. “75 y.o. male with multiple chronic medical problems”, “15 y.o. female with Type I diabetes”, “43 y.o. previously healthy male”) and mode of presentation (e.g. clinic, emergency room, ambulance). If pertinent, include: race, culture, residence, occupation.

CHIEF COMPLAINT (CC): State the patient’s primary reason for seeking care (in his/her own words) and specify the duration of the complaint (with respect to the day of presentation).

REASON FOR ADMISSION/CONSULT/VISIT:
(If different than CC.)

**PRIMARY and/or REFERRING PHYSICIAN:
SOURCE and RELIABILITY OF HISTORY:**

PROBLEM LIST may be included here or as a separate document. Follow an outline format characterizing both active and chronic problems as in the PMH.

HISTORY OF PRESENT ILLNESS (HPI):

The purpose of the HPI is to summarize the patient’s narrative, data from the medical record and information from other sources. It should specifically answer questions to rule in or out the diagnoses on your differential. When the patient’s complaints relate to different processes, this section should be organized by different problems, each being explored independently and chronologically. Fully characterize each complaint, addressing the following:

- Quality
- Location
- Severity
- Chronology (onset, duration, frequency)
- Baseline status vs. current status
- Provocative / palliative factors
- Associated symptoms
- Therapeutic interventions and responses
- Effect on lifestyle / activities
- Attributes (patient’s beliefs re: etiology / diagnosis / prognosis)
- “Iatrogenic stimulus” (what made the pt. present *now*?)
- Pertinent risk factors (e.g. cardiac risk factors for chest pain, HIV risk factors for opportunistic infection)
- ROS of the organ system involved
- Pertinent positives and negatives for all diagnoses in your differential

PAST MEDICAL HISTORY (PMH):

Medical Problems: Include all current and prior diagnoses and medical problems not described in the HPI. Each should be characterized as follows:

- Date of onset / symptom at onset
- Date of diagnosis / means of diagnosis
- Sequelae / complications
- Tests / studies
- Markers / parameters
- Therapeutic interventions
- Progression and current status

Surgical History: List all surgeries, trauma, and injuries. Include date, indication, complications, need for transfusions.

Current Medications: Include dosages, over-the counter medications, alternative therapies.

Allergies: Meds, food, animals. Note specific reaction.

Habits: Tobacco, alcohol, drugs, caffeine, exercise, diet. Note attempts at behavior modification.

Reproductive/sexual history:

- Gender/number of sexual partners (men, women, both)
- Contraception / STD prevention
- Sexual function / dysfunction
- Menses / menarche / menopause
- Pregnancies (gravida, para, full term, premature, abortions, living) and complications

Health Maintenance:

- Immunizations
- Screening (testicular, mammogram, Pap smears, breast exam, flexible sigmoidoscopy, cholesterol)
- Preventive therapy (aspirin, calcium)

Family History: Use family tree if appropriate.

Social History: Include: military history, travel history, marriage, domicile and living situation, insurance, employment, hobbies, “likes and dislikes,” caretaker, community support.

Family Violence Screening: (Ask when pt is *alone*.) Has anyone ever hit, slapped, kicked or otherwise physically hurt you or forced you to have sex. Is anyone threatening you, putting you down, or trying to control your behaviors?

Advanced Directives: Durable power of attorney, code status, extended life support, POLST.

REVIEW OF SYSTEMS (ROS): Ask the following as triggers to better reveal the history. If appropriate, the information obtained should be reported in the PMH or HPI.

1. General: fevers, chills, sweats, “lumps or bumps,” weight change, exercise tolerance, “energy” level.
2. Functional Status: Activities of Daily Living (ADLs): (“BATTED”) Bathing, Ambulating, Toileting, Transfer, Eating, Dressing. Instrumental ADLs: shopping, cooking, mode of transportation, telephone use, laundry, housekeeping, responsibility for meds/finances. Falls. Functional assist devices.
3. Dermatologic: rashes, pruritus, changing moles, lesions.
4. HEENT: headache. Eyes: vision, glasses, diplopia, inflammation, pain, date of last exam. Ears: hearing, tinnitus, hearing aids. Nose: epistaxis, obstruction. Mouth: dental care, dentures, sores, gums, sore throat.
5. Respiratory: dyspnea, dyspnea on exertion, pleuritic pain, cough, sputum (description), wheezing, asthma, hemoptysis, cyanosis, snoring, apnea, tuberculosis or exposure to it, date of last PPD or CXR (and results).
6. Cardiac: chest pain, angina, dyspnea on exertion, paroxysmal nocturnal dyspnea, orthopnea, peripheral edema, hx. of murmur, palpitations, risk factors for atherosclerotic heart disease (i.e. HTN, diabetes, tobacco, hyperlipidemia, family history, physical inactivity).
7. Breast: lumps, discharge, pain, swelling.
8. Vascular: claudication, gangrene, cold feet, skin changes on extremities, DVTs, aortic aneurysm.
9. Gastrointestinal: appetite, digestion, heartburn, nausea, vomiting, hematemesis, coffee ground emesis, melena, hematochezia, change in bowel habits, color of stool, diarrhea, constipation, fecal incontinence, abdominal pain, odynophagia, dysphagia, hemorrhoids, hx of ulcer, pancreatitis, jaundice, gall bladder disease or hepatitis.
10. Genitourinary: dysuria, nocturia, polyuria, frequency, urgency, hesitancy, trouble passing urine, urinary incontinence, hematuria, uterine prolapse, vaginal or urethral discharge, sores, dyspareunia. Hx. of gonorrhea, chlamydia, syphilis, herpes, HPV, trichomonas, prostate disorders, UTIs, renal stones, renal disease.
11. Musculoskeletal, rheumatic and connective tissue: back pain, joint pain/swelling/stiffness/deformity (list affected joints), muscle aches, bone disease, gout, arthritis, foot problems. Osteoporosis risk factors.
12. Neurological: handedness, dizziness, vertigo, tremors, syncope, loss of coordination, motor weakness, strokes, memory changes, speech, seizures, paresthesias.
13. Emotional/Psychiatric: depression, sadness, sleep disturbance, crying spells, anorexia or hyperphagia, anhedonia, suicidal/homicidal ideation, loss of libido, anxiety, PTSD, eating disorders (anorexia nervosa, bulimia, dissatisfaction with body image), hallucinations, delusions, behavioral changes, recognized emotional problems, treatments.
14. Hematologic: anemia, easy bruisability, difficulty clotting, heavy menstruation, petechia.

15. Endocrine: diabetes mellitus or symptoms (i.e. polyuria, polydipsia, blurred vision, peripheral neuropathy), goiter or sx. of hypo/hyperthyroidism (i.e. change in skin/hair texture, energy level, bowel habits, palpitations, irritability, menses, heat/cold tolerance), feminization/virilization (i.e. gynecomastia, galactorrhea, hirsutism, baldness, change in voice, change in muscle).
16. Infectious disease: HIV risk factors (i.e. IV drug use, male homosexual sexual activity, transfusions prior to 1985, sexual contact with prostitute, sexual contact with partner with HIV risk factor, sex while using illicit drugs). Exposures (i.e. sick contacts, travel, water, pets).

PHYSICAL EXAMINATION

GENERAL: general appearance, apparent state of health, nutrition, development, stature, gross deformities, skin coloration, level of distress.

VITAL SIGNS: temperature and method, respiratory rate and quality, pulse and regularity, BP (orthostatics and bilateral pressures if indicated), weight, height.

HEENT: *Eyes:* visual acuity, visual fields, conjunctivae and sclerae, appearance of fundi. *Ears:* hearing, discharge, appearance of tympanic membranes. *Nose:* obstruction, septal deviation / perforation, discharge. *Mouth:* sores, dentition, mucosa, tongue, gums, floor of mouth; appearance of tonsils, pharynx, uvula, palate.

NECK: flexibility, masses, thyroid, tracheal deviation.

LYMPHATICS: cervical, submandibular, supraclavicular, axillary, epitrochlear, inguinal, femoral, (qualified by enlargement, consistency, mobility, tenderness).

PULMONARY/CHEST: Inspection. Palpation: mobility of chest wall, fremitus. Percussion: clarity, diaphragmatic excursion. Auscultation: character of breath sounds, adventitious sounds (rales, rubs, wheezes, post-tussive changes, egophony).

CARDIOVASCULAR: JVP. *Heart:* Inspection. Palpation: PMI, lifts, heaves. Auscultation: rate, rhythm, S1,S2, murmurs (systolic vs. diastolic, grade, character, location, radiation, maneuvers), rubs, gallops. *Pulses:* carotid, brachial, radial, femoral, popliteal, dorsalis pedis, posterior tibialis. (Note strength, character, bruits.)

BREASTS: appearance, asymmetry, tenderness, masses, nipple discharge.

SPINE/BACK: mobility, kyphosis, scoliosis, tenderness.

ABDOMEN: Inspection: distended/flat/scaphoid, abnormal movements, dilated veins, striae, scars. Auscultation: bowel sounds, bruits, rubs. Percussion: distention, organ size, rebound. Palpation: tenderness, guarding, ascites, masses, hepatosplenomegaly, hernia, aortic aneurism.

EXTREMITIES: varicosities, clubbing, edema, symmetry. *Skin:* color, temperature, texture. *Joint:* ROM, effusions, erythema, tenderness, synovial thickening, deformity.

GENITAL: *External:* development, sores, scars. *Male:* hydrocele, varicocele, testicular masses, tenderness, urethral discharge, hernias, circumcision. *Female:* appearance of vulva, perineum, vaginal walls, cervix, and vaginal discharge; cervical motion tenderness, size and position of uterus and adnexa; masses.

RECTAL: hemorrhoids, sphincter tone, fissures, prostate (size, texture, nodules, tenderness), masses, stool (color, consistency), fecal occult blood test.

SKIN: texture, rashes, lesions, pigmentation, hair distribution, nails, scars, tattoos.

NEUROLOGICAL: *Mental status:* level of consciousness, orientation, mood/affect, speech (naming, repetition, fluidity), recall (registration, short term, long term), attention, commands, abstractions, judgment, insight, delusions, hallucinations. *Cranial nerves:* pupils (symmetry, reactivity, size), corneal reflex, extra-ocular movements, facial sensation, movement and symmetry, air and bone sound conduction, gag reflex, shoulder shrug, sternocleidomastoid strength, tongue movement. *Motor:* atrophy, tone, fasciculations, tremor, strength (0-5 scale), pronator drift. *Sensory:* light touch, pain, temperature, vibration, proprioception. *Reflexes:* DTR's (symmetry, 0-4 scale), Babinski. *Cerebellar function:* rapid alternating movements, finger to nose, heel to shin. *Gait:* steadiness, symmetry, width, length of steps, "clearance," continuity, assistive devices. *Romberg.*

DATA BASE: List all initial laboratory and diagnostic studies, highlighting abnormal values.

SUMMARY: Give a one or two sentence summary of the pertinent positive and negative findings from the history, chart review, physical examination and laboratory results.

IMPRESSION / PLAN: Each significant problem should be numbered and discussed separately. Outline and discuss the differential diagnosis of each problem, providing supporting data for and against each diagnosis. Discuss severity / stability / prognosis for each problem. Include the initial plans for evaluation and management. Weigh risks and benefits of potential treatments.

Department of Internal Medicine

History and Physical Examination

Introductory Note

The artful science of clinical examination dates back 2500 years or longer. In medical school, it is likely the single most important fundamental skill a student learns. For all who share an enthusiasm for medicine, its true mastery takes a lifetime.

The following is a template for the comprehensive history and physical. Depending on the clinical setting and the training level of the examiner, one can use it to guide the interview and physical examination, to organize the data obtained or to standardize documentation. Clearly there is much appropriate variation in individual style - the purpose is to have a guide from which to develop.

This template includes the level of detail a medical student is expected to *obtain* when performing a complete H&P. A *written* complete H&P includes each of the sections listed, but can at times omit non-pertinent negatives. An *oral* presentation should be a concise version of only the pertinent information. When performing a *focused* history and physical, one needs to use judgment in the omission of specific sections.

At any training level or clinical setting a good history and physical is key to patient care. The information must be comprehensive, accurate and precise. In all, it should tell a story which ultimately leads to understanding the patient.

Third Edition, 2007. First edition, 1997, Nicolaidis, Hunter and the OHSU Department of Medicine Physical Examination Committee.