

ICM 200  
July 24, 2007

## AN EXAMPLE OF HOW THE HISTORY AND PHYSICAL SHOULD BE WRITTEN

**Chief Complaint:** "Pain in my chest"

### **Present Illness:**

This 43 year old man was in his usual state of health until 5 days prior to admission. At that time, while mowing the grass, he noted retrosternal tightness that did not radiate and was not associated with nausea or diaphoresis. He stopped mowing and sat down after the pain had been present for about 2 minutes. The pain resolved within 5 minutes of sitting down. He then completed the mowing job without recurrence of pain. He did not have further episodes of pain until the evening of admission, at which time he experienced retrosternal tightness while watching the ten o'clock news. On this occasion, the pain felt as though someone were sitting on his chest. The pain radiated into his left arm, but not into his jaw. There was no associated nausea, vomiting, or diaphoresis. The patient sat quietly, although anxiously, and the pain spontaneously resolved within ten minutes. He was very concerned about this episode and had his wife bring him to the emergency room.

The patient has not had chest pain precipitated by meals, emotion, or exposure to cold. There is no history of nocturnal chest pain. He has not had palpitations, orthopnea, or paroxysmal nocturnal dyspnea. He has not had cough, sputum production, or fever. He has not had peptic ulcer disease, epigastric discomfort, melena, hematochezia, or food intolerance. There is no recent history of chest trauma. The pain is not precipitated by movement and he has no point tenderness over the chest. The patient has a history of hypertension which was diagnosed 3 years prior to admission. He has been on hydrochlorothiazide for the past 2 years. He has a 40 pack year history of cigarette smoking. He does not know his cholesterol level, and does not have diabetes. His father died at age 59 years from a heart attack. His mother does not have heart disease. He has three older brothers, all of whom have had heart attacks before they were 45 years old.

### **Past Medical History:**

Childhood illnesses. Measles, chickenpox and mumps. No history of rheumatic fever, scarlet fever, or polio.

Immunizations. Received and completed childhood immunizations including rubella, mumps, and pertussis; dates unknown. Has had only one shot of measles vaccine. Last tetanus booster 7 years ago. Has not received the pneumococcal, influenza or hepatitis B vaccine.

Adult illnesses. Pneumonia at age 37 years, requiring hospitalization for 3 days. Says he received penicillin IV for 2 days, and was then changed to oral penicillin for another 2 weeks. Does not know what kind of pneumonia he had. Appendectomy at age 15, without complications.

Allergies. Penicillin (skin rash developed after 6 days of therapy; no respiratory symptoms, acute urticaria, or hypotension).

Medications. Hydrochlorothiazide 50 mg daily (for the past 2 years).

Family History. See present illness. No history of diabetes, hypertension, kidney disease, tuberculosis, cancer, arthritis, hematologic disorders, or mental disease.

Social History. 40 pack year history of cigarette smoking. Has 1-2 mixed drinks each night of the weekend. Does not smoke marijuana; uses cocaine at a party about once a year; does not take illicit drugs by mouth or intravenously. Married with 2 children. No history of homosexual or bisexual activities. Works as an accountant. No admitted financial problems.

**Review of Systems:**

General. No recent weight change, weakness, fatigue, fever, night sweats. Some anorexia and occasional malaise over the past 2 months, but no other associated features.

Skin. No noticeable color changes, pruritus, petechiae, infections, rashes, sores, changes in moles, changes in hair or nails, or easy bruising.

Head. No unusual headaches or recent head injury.

Eyes. No use of glasses or contact lens, and cannot remember last eye exam. No pain, excessive tearing, double vision, floaters, loss of any visual fields, history of glaucoma or cataracts. Some redness in eyes in mornings over the past 2 years, with resolution by mid-day.

Ears. No hearing loss, change in hearing, tinnitus, or infections.

Nose and sinuses. No frequent colds, nasal stuffiness, hay fever, nosebleeds, sinus trouble, obstruction, discharge, pain, change in ability to smell, sneezing, post-nasal drip, or history of nasal polyps.

Mouth and throat. No soreness in mouth, dryness, pain, sore tongue, pyorrhea, sore throat, hoarseness, history of strep throat or rheumatic fever. No problem with dental caries, chronic mouth ulcers, or bleeding gums.

Neck. No unusual lumps, swollen lymph nodes or glands, goiter, or neck pain.

Lymphatics. No swollen nodes in his neck, axillae, epitrochlear area, or inguinal area.

Breasts. No discharge, pain or enlargement of breasts.

Pulmonary. No cough, trouble breathing, wheezing, hemoptysis, pleuritic chest pain, cyanosis of lips or nail beds, hx of TB exposure, hx of previous TB skin test, recurrent pneumonia, or hx of known environmental exposure.

Cardiovascular. See present illness. No history of heart murmurs or palpitations.

Gastrointestinal. No trouble swallowing, pain with swallowing, hematemesis, food intolerance, indigestion, early satiety, rectal bleeding, melena, abdominal pain, excessive eructations or flatulence, jaundice, gallbladder problems. No nausea and vomiting, constipation and diarrhea, or change in bowel habits.

Urinary. No hematuria, dysuria, frequency, suprapubic pain, CVA tenderness, nocturia, polyuria, stones, inguinal pain, trouble initiating urinary stream, incontinence, or history of urinary tract infections.

Genital tract. No penile discharge, history of STD, testicular pain, testicular swelling, scrotal mass, infertility, impotence, change in libido, sexual difficulties, hernias.

Musculoskeletal. No joint pain or stiffness, arthritis, gout, backache, joint swelling, tenderness, effusion, limitation of motion, or history of fractures.

Neurologic. No paralysis, local weakness, numbness, tingling, tremors, vertigo or dizziness, muscle atrophy or seizure history. No history of changes in mental status.

Psychiatric. No anxiety, nightmares, insomnia, hypersomnia, phobias, tension, or depression.

Endocrine. No thyroid trouble, heat or cold intolerance, excessive thirst or hunger.

Hematologic. No history of anemia, or blood transfusions. Easy bruising following trauma since childhood, with occasional bleeding from gums.

**Physical Exam:**

Vital Signs: BP (supine) 170/110, (standing) 158/106; pulse 128 and regular; respiration 20; temperature (oral) 37.2 C; Height 5' 11"; Weight 182 pounds.

General appearance: Ambulatory man in no apparent distress. Oriented to person, place, and time.

Skin: Texture and turgor normal. No icterus, pallor, edema, or cyanosis. No skin lesions or loss of hair.

HEENT: No evidence of skull deformity or trauma. Scalp and hair distribution normal. No ptosis. Sclera non-icteric; no conjunctival erythema. Cornea non-opacified. Pupils equal, round, briskly reactive to light and accommodation. Direct and consensual light reflex present. Visual acuity 20/20 in both eyes. No visual field deficits. Sharp optic discs; copper wiring and AV nicking, but no exudates or hemorrhages. External auditory canal without erythema or exudates. Nasal septum midline and without discharge. Maxillary and frontal sinuses nontender; tympanic membranes with good light reflex. Lips, gums, and tongue without lesions. Dentition without obvious caries. Tonsils and posterior pharynx without erythema or exudates. Uvula midline and mobile.

Neck: Supple; trachea midline; no thyromegaly present. No masses palpable. Carotid pulses 2/4 bilaterally, with normal upstroke. No bruits. No JVD.

Nodes: No submandibular, submental, pro- or post-auricular, occipital, anterior or posterior cervical, supraclavicular nodes, inguinal, axillary or epitrochlear nodes palpable.

Breasts: Breasts nontender to palpation; no masses or discharge.

Chest: Symmetrical movements with respiration, no deformities. No increased fremitus. Resonance on percussion. No crackles or wheezes.

Heart: No visible heaves or PMI. No shocks, thrills, or lifts. PMI palpable in 5th left intercostal space at midclavicular line. Regular rhythm with a normal S<sub>1</sub> and physiologically split S<sub>2</sub>; S<sub>4</sub> present but an S<sub>3</sub>. No clicks, murmurs or rub.

Abdomen: Thin, non-protuberant abdomen without scars or abnormal contour. Normal bowel sounds over all quadrants; no bruits. Tympany on percussion without shifting dullness or fluid wave. Liver percussed at 10 cm at right midclavicular line, with sharp liver edge one cm below costal margin. Spleen not palpable. No abdominal masses. No abdominal hernia.

Back/Spine: Mobility, curvature, posture normal. No point tenderness or CVA tenderness.

Extremities: Upper and lower extremities symmetrical. No cyanosis. Tinea unguis present in nails on lower digits. No clubbing or edema. Full range of motion in all joints with no swelling, deformities, tenderness, warmth, erythema, effusions.

Pulses: Carotids, brachial, radial, femoral, dorsalis pedis, and posterior tibial pulses 2/4 bilaterally. Popliteal pulses not palpable bilaterally. No carotid or femoral bruits.

Genitalia: Normal distribution of pubic hair; no visible penile or scrotal lesions. No discharge present. No testicular atrophy or masses. No scrotal tenderness.

Rectal: No anal lesions. No Hemorrhoids, fissures, or fistulae. Good sphincter tone; prostate non-tender, not enlarged, and of normal consistency. Rectal vault without palpable lesions; stool heme negative.

Neurologic: Cranial nerves: II intact by consensual reflexes and visual acuity; III, IV, VI intact by extraocular movements; V1, V2, and V3 intact by stimulation of skin on facial areas, and motor component of V intact by muscles of mastication; VII with no drooping of eyelids or corners of mouth; VIII with grossly normal auditory acuity; IX and X intact by gag reflex; XI intact by sternocleidomastoid test and positive should shrug; XII intact by tongue protrusion. Muscle strength 5/5 in upper and lower extremities. No atrophy or fasciculations. No pain on palpation. Pinprick, light touch, two-finger-to-nose, or heel-to-shin. Intact vibratory sensation and position sense; negative Romberg. Deep tendon reflexes 2+ in biceps, triceps, brachioradialis, knee jerk, ankle jerk bilaterally. Babinski, Wartenberg, Hoffman, grasp and snout reflexes are absent.

**Problem List:**

1. Chest pain with radiation
2. Hypertension
3. 40 pack year tobacco history
4. Family history of coronary disease
5. Tachycardia; fourth heart sound
6. Tinea unguis
7. Penicillin allergy
8. H/O pneumonia
9. S/P appendectomy

**Differential Diagnosis:**

Acute coronary syndrome (angina or myocardial infarction)  
Pulmonary embolism  
Musculoskeletal pain  
Pneumonia