THE HISTORY AND PHYSICAL (H & P)

I. Chief Complaint

Why the patient came to the hospital
Should be written in the patient's own words

II. History of Present Illness (HPI)

a chronologic account of the major problem for which the patient is seeking medical care
according to Bates' A Guide to Physical Examination, the present illness ". . . should include the onset of the problem, the setting in which it developed, its manifestations, and any treatments. The principal symptoms should be described in terms of their (1) location, (2) quality, (3) quantity or severity, (4) timing (i.e., onset, duration, and frequency), (5) the setting in which they occur, (6) factors that have aggravated or relieved them, and (7) associated manifestations. Also note significant negatives (i.e., the absence of certain symptoms that will aid in differential diagnosis)."
that part of the review of systems that pertains to the organ system involved in the problem for which the patient is seeking medical attention should be included in the present illness. It is not necessary to repeat this information in the review of systems later in the write-up.

III. Past medical history (PHx)

A. Childhood illnesses
include measles, rubella, mumps, whooping cough, chicken pox, rheumatic fever, scarlet fever, polio

B. Immunizations
ask about DPT (diphtheria, pertussis, tetanus), including
1. whether the immunizations were complete during childhood
2. when the last tetanus booster was given

ask whether polio, measles, rubella, mumps vaccinations are up to date (for measles, include the number of immunizations received and the age at which the first immunization was given).
ask whether the patient has received any other vaccinations, particularly (for adults)
1. pneumococcal
2. hepatitis B
3. influenza (yearly)

C. Adult illnesses
give the type of illness, the dates it occurred, whether hospitalization was required (if so, where?), and a very brief summary of the illness (should be limited to one or two phrases if possible)

D. Operations
include what procedure was done, why it was done, when and where it was done, and whether or not there were any complications

E. Allergies
to what medications? Describe the type of reaction and how soon it occurred after the dose of medicine
to what foods? Describe type of reaction.

F. Medications
names of the medications
doses that the patient takes
how long they have been on the medicines and for what reasons (if there are multiple indications for which the medication may be used)

G. Complimentary Treatments
massage, acupuncture, herbals, vitamins, etc.

IV. Family history

include information about parents, siblings, maternal and paternal grandparents and aunts and uncles
major diseases of importance: diabetes, hypertension, ischemic heart disease, stroke, kidney disease, tuberculosis, cancer, arthritis, hematologic disorders, mental illness

V. Social history

education, occupation, who the patient lives with, financial situation
travel
cigarette smoking expressed in number of pack years (number of packs smoked per day multiplied by the number of years that the patient has smoked gives you the number of pack years); if the patient has quit smoking, note how long ago.
alcohol (what kind of liquor patient drinks, how much is drunk daily, and for how long has this pattern been going on)
illicit drugs of any kind
sexual history

VI. Review of Systems

General: Usual weight, recent weight change, weakness, fatigue, fever, night sweats, anorexia, malaise
Skin: Color changes, pruritus, bruising, petechiae, infections, rashes, sores, changes in moles, changes in hair or nails
Head: Headache, head injury
Eyes: Vision, glasses/contact lens, date of last eye examination, pain, redness, excessive tearing, double vision (diplopia), floaters (spots in front of eyes), loss of any visual fields, history of glaucoma or cataracts
Ears: Hearing loss, change in hearing, ringing in ears (tinnitus), ear infections
Nose and Sinuses: Frequent colds, nasal stuffiness, hay fever, nosebleeds (epistaxis), sinus trouble, obstruction, discharge, pain, change in ability to smell, sneezing, post-nasal drip, history of nasal polyps
Mouth and throat: Soreness, dryness, pain, ulcers, sore tongue, bleeding gums, pyorrhea, teeth (caries, abscesses, extractions, dentures), sore throat, hoarseness, history of recurrent sore throats or of strep throat or of rheumatic fever
Neck: Lumps, swollen lymph nodes or glands, goiter (thyroid enlargement), pain
Lymphatics: Swollen lymph nodes in neck, axillae, epitrochlear areas, or inguinal area
Breasts: Lumps, pain, nipple discharge, self-examination, enlargement in men or children (gynecomastia)
Pulmonary: Cough (duration, association with sputum production), change in chronic cough, trouble breathing (dyspnea), wheezing, coughing up blood (hemoptysis), pain with taking a deep breath (pleuritic chest pain), blue discoloration of lips or nailbeds (cyanosis), history of exposure to TB, history of a previous TB skin test and the results if done, recurrent pneumonia, history of environmental exposure
Cardiovascular: Chest pain (including details), dyspnea, paroxysmal nocturnal dyspnea (abbreviated "PND"; patient will describe shortness of breath that improves when he or she sits up and dangles feet off the bed), orthopnea (patient has to sleep on pillows to prevent shortness of breath; quantitate by the number of pillows that the patient sleeps on), edema, palpitations, hypertension, known heart disease, history of a murmur, history of rheumatic fever, syncope or near syncope, pain in posterior calves with walking (claudication), varicosities, thrombophlebitis, history of an abnormal electrocardiogram
Gastrointestinal: Trouble swallowing (dysphagia), pain with swallowing (odynophagia), nausea, vomiting, vomiting blood (hematemesis), food intolerance, indigestion, heartburn, change in appetite, sensation of filling up earlier than usual (early satiety),frequency and character (formed vs. loose) of bowel movements, changes in bowel pattern, rectal bleeding, passing black tarry stools (melena), constipation, diarrhea, abdominal pain, excessive belching or passing of gas, hemorrhoids, jaundice, liver or gallbladder problems, history of hepatitis
Urinary: Blood in urine (hematuria), pain on urination (dysuria), frequency, suprapubic pain, costovertebral angle (CVA) tenderness, frequent urination at night (nocturia), passing large volumes of urine on a frequent basis (polyuria), stones, inguinal pain, trouble initiating urinary stream, incontinence, history of urinary tract infections
Genital tract (male): Penile discharge, lesions, history of sexually transmitted disease (STD), testicular pain, testicular swelling, scrotal mass, infertility, impotence, change in libido, sexual difficulties, hernias
Genital tract (female): Age of menarche, last menstrual period, cycle (number of days; how much bleeding, intermenstrual bleeding, postcoital bleeding, pain with intercourse (dyspareunia), vaginal discharge, pruritus, contraceptive use, history of STD's, last Pap smear and results, age at menopause, postmenopausal bleeding, infertility, change in libido, sexual difficulty, pregnancies (including live births and abortions - both spontaneous and induced, complications of pregnancy particularly if these are diabetes or hypertension
Musculoskeletal: Joint pains or stiffness, arthritis, gout, backache, joint swelling or tenderness or effusion, limitation of motion, history of fractures
Neurologic: Fainting, blackouts, seizures, paralysis, local weakness, numbness, tingling, tremors, memory changes, headaches, vertigo or dizziness, muscle atrophy

Psychiatric: Anxiety, nightmares, nervousness, irritability, depression, insomnia, hypersomnia, phobias, tension. If there are any clues whatsoever that the patient may be suicidal, may have criminal or other sociopathic behavior, this should be pursued.

Endocrine: Thyroid trouble, heat or cold intolerance, excessive sweating or flushing, diabetes, excessive thirst or hunger or urination

Hematologic: Anemia, easy bruising or bleeding, past transfusions and reactions

VII. Physical examination

1. Vital signs
2. General appearance
3. Skin
4. HEENT
5. Neck
6. Nodes
7. Breasts
8. Chest
9. Heart
10. Abdomen
11. Back/spine
12. Extremities, including exam of pulses
13. Genitalia
14. Rectal
15. Neurologic
    a. Mental status
    b. Cranial nerves
    c. Motor
    d. Sensory
    e. Cerebellar; posterior column
    f. Reflexes

1. Vital signs: Blood pressure: Right and left arms; supine and standing (this needs to be done in only one arm)
   Pulse: including comments about whether regular vs. irregular respirations; temperature (document whether oral or by another route; you may take this from the chart)

2. General appearance: Should describe whether the patient appears acutely ill or not, whether patient is oriented (to time, place, and person)

3. Skin: Texture, turgor, rash, skin lesions (describe, including location and size if present); icterus, pallor edema, cyanosis

4. HEENT: Skull (normocephalic?, atraumatic?, any deformities?)*, scalp, hair, distribution. Lids (any ptosis?), sclerae (any icterus? muddy appearance?), conjunctivae (pale?, injected, or red?), cornea (opacified?), pupils (PERRLA - Pupils equal, round, react to light and accommodation), light reflex (both direct and consensual), visual acuity, fundoscopic exam (include description of optic disc, retinal vessels, retinal lesions). External auditory canal and tympanic membranes. Nasal septum and whether turbinates are enlarged or reddened, sinus tenderness to palpation and percussion. Lips, tongue, teeth, gums, oral mucosa, breath odor. Tonsils, posterior pharyngeal injection or exudates, uvula (in midline?, moves?)

5. Neck: Supple (mobile). Thyroid (palpable?, nodules or masses?, tender?) Trachea (midline?, stridor over it?). Carotids (volume, upstroke, bruits). Jugular venous distention.

6. Nodes: Submandibular, submental, pre- and post-auricular, occipital, anterior and posterior cervical triangles, supraclavicular (these nodes should all be checked during the HEENT and Neck exams). During the remainder of the physical, check the following node groups: axillary, epitrochlear, inguinal (You may want to examine these when you are doing the exam of that particular region of the body. Include the description of these nodal regions with the other nodes listed after the "Neck" exam.)

7. Breasts: Inspection and palpation, for masses, discharge, or tenderness

8. Chest: Inspection: for symmetry of respiratory excursions; for deformities
Palpation: for fremitus
Percussion: for resonance, hyperresonance, or dullness
Auscultation: for normal breath sounds, crackles, wheezes, rhonchi, rubs

9. Heart: Inspection: abnormal outward pulsations; visible PMI
Palpation: for lifts, heaves, shocks (palpable heart sounds), thrills (palpable murmurs), PMI (point of maximal impulse, which should be described in regard to location on the chest, whether discrete or generalized, whether or not abnormally sustained)
Auscultation: rate, rhythm (regular or irregular), heart sounds (S1, S2, S3, S4), murmurs, gallops, rubs, clicks

10. Abdomen: Inspection: size, contour, scars, abnormal venous patterns
Auscultation: (should be done before palpation), bowel sounds, bruits
Percussion: tympany, shifting dullness, fluid wave, liver size (express in terms of number of centimeters of dullness)
Palpation: tenderness (rebound?, guarding?), liver, spleen, masses, aortic pulsations, hernia

11. Back/spine: mobility, curvature, posture, tenderness, CVA tenderness

12. Extremities: Upper and lower: symmetry, moisture, nails, cyanosis, clubbing, edema, tremor.
Joints: swelling, deformities, tenderness, warmth, erythema, effusions, range of motion.
Pulses: Carotids (May be listed in this section even though already mentioned under "Neck"), brachial, radial, femoral, popliteal, dorsalis pedis, posterior tibial - use *Peripheral Pulse
Grading Scale shown on page 5.

13. Genitalia: Male - distribution and amount of pubic hair, penile lesions or discharge, circumcised, scrotum, testes for masses or tenderness, epididymis, inguinal canal
Female - distribution and amount of pubic hair, external genitalia for lesions, discharge, or evidence of inflammation, vagina, cervix, uterus and adnexae (bimanual exam for masses and tenderness), rectovaginal

14. Rectal: External lesions, hemorrhoids, fissures, fistulae, sphincter tone, prostate for size and masses and tenderness, masses, stool (color, consistency, occult blood)

15. Neurologic: Mental status - level of consciousness, behavior, attention and concentration, language, memory, drawings, abstract reasoning (proverb interpretation, similarities, calculations)
Cranial nerves - II - XII (list the cranial nerve and the manner in which it was checked. For example: "Cr nn III, IV, and VI: Full EOM's; intact direct and consensual pupillary reflex"); visual fields
Motor - gait (regular, toe, heel, tandem), balance, involuntary movements (fasciculations, tremor, chorea, posturing), limb tone (spasticity, rigidity, cogwheeling, flaccidity), contracture, strength (grade on a scale of 0 - 5 using Bates' criteria **), muscle bulk (atrophy, hypertrophy), muscle tenderness
Sensory - pinprick, light touch, graphesthesia, sterognosis, double simultaneous touch
Cerebellar - gait for ataxia, finger-to-nose, heel-to-shin, rapid alternating movements; standing with feet together and eyes open
Posterior column - vibratory sensation, position sense, Romberg sign
Reflexes - Deep tendon reflexes: biceps, triceps, brachioradialis, knee jerk, ankle jerk ***
Pathologic reflexes: Babinski, digital reflexes (Wartenberg, Hoffman), grasp reflex, snout reflex

*Peripheral Pulse Grading Scale	**Muscle Strength Grading Scale	***Reflex Grading Scale
0 - absent, not palpable	0 - No muscular contraction	4+ - Very brisk, hyperactive; often associated with clonus
1 - diminished, barely palpable	1 - A barely detectable flicker or trace of C	3+ - Brisker than average
2 - expected	2 - Active movement of body part with gravity eliminated	2+ - Average; normal
3 - full, increased	3 - Active movement against gravity	1+ - Somewhat diminished; low normal
4 - bounding	4 - Active movement against gravity and some resistance	0 - No response
	5 - Active movement against full resistance without evident fatigues. (This is normal muscle strength.)	

VIII. Problem List

This is simply a list of all abnormal findings from the history and the physical exam. Related problems may be grouped together (e.g. "shortness of breath, tachypnea, and abnormal lung exam" could all be listed as part of the same problem.) The list should be organized such that the most serious problems are listed first.

IX. Differential Diagnosis

A list of diseases that you think can explain the major problems identified on the problem list. They should be organized such that the most likely diagnoses are listed first. Try to account for as many problems as possible with a single diagnosis