This is not a real patient, but I wrote this to show you how to do a complete "American Style History and Physical Exam". Please note that there is no best single way to do this. This is my "style". The important thing is to develop your ***own*** style that you can perform easily and without effort so that every H&P you do is complete.

History

CC: "My belly hurts"

HPI: The patient is a 27year old white male who was in his usual state of good health until 2 days ago when he noticed the gradual onset of abdominal pain. The pain is described as dull, constant and began in the epigastric area. Over the last 12-24 hours he notices it more in the right lower quadrant. The pain has gradually increased in intensity as well, and has remained dull in nature. It does not radiate, but stays localized in the right lower quadrant. The pain is aggravated by movement. Nothing makes it better. He has had 2 episodes of vomiting in the last 24 hours, without hematemesis. He reports anorexia. His last bowel movement was 36 hours ago, and was normal in quality for him. He has not noticed any fever, chills, or night sweats. He has no recent weight loss. He has never had abdominal surgery in the past.

PMH: **M**eds: None
Illness: None
Surg: None
Injuries: None
Allergies: NKDA
[Gynecology: gravida, para, menarche, menopause, PAP smear, mammogram]

FH: Both parents alive, mother is 55yo and father is 60yo. No diseases run in the family such as cancer, heart disease, pulmonary disease. He has a brother age 30 who is alive and well.

SH: Occasional alcohol, he does not smoke and does not use illegal drugs. He is employed as a computer programmer. He is heterosexual, and has a steady relationship at this time.

コメント [A1]: This uses the patient's own words. The rest of the H&P is in medical terms.

コメント [A2]: This is standard wording for the start of HPI, with identification information. It is chronologic from the beginning of the problem to the time the H&P is done

コメント [A3]: Pain is described in terms of location, onset, quality, intensity, radiation, aggravating and relieving factors (7 things)

コメント [A4]: Note that these items are really "Review of systems". This is intentional. The review of systems for the affected system (here, GI Tract) is in the HPI

コメント [A5]: Past Medical History contains these 5 items: Remember **MISIA**! Also Gyn for women.

コメント [A6]: No known drug allergies

コメント [A7]: Family history should always include both parents and any siblings. Discuss any diseases that run in the family

コメント [A8]: Contains drinking (amount, time), drugs, tobacco (years, amount), employment, sexual orientation, education, employment as indicated

ROS:

General: no weight loss, fatigue, weakness, change in apetite, no fever, chills, sweats

Skin: no rash, pruritus, bruising

HEENT: no change in vision, wears glasses, no change in hearing, no tinnitus, pain, no change in smell or sinus problems. No gum bleeding or oral problems

Neck: no difficulty in swallowing

Chest: no SOB, hemoptysis, cough, sputum, pneumonia hx

Heart: No chest pain, orthopnea, dyspnea on exertion, PND, murmurs, claudication, palpitations

Abdomen: Until this problem, no pain, no change in bowel habits, no change in apetite, no weight loss, no hematemesis, hematochezia, hemorrhoids, jaundice or fatty food intolerance.

GU: no hematuria, no pain, no frequency, urgency, polyuria, nocturia, incontinence, discharge

Gyn (women): Gravida / para, abortions, last menstrual period, menarche, menopause, dysmenorrheal (can be put in PMH above)

Extr: no weakness, edema, claudication

Neuro / Psychiatric: no loss of sensation, no memory problems, syncope, seizures, sleep pattern, depression, headache, weakness

Physical Examination

VS: Temp 38.3C, BP120/82, P104, BMI

Gen'l: WDWN wm in NAD

Skin: normal

HEENT: NC AT, PERRLA. No oral lesions, nose nl. No sclera icterus, EOMI.

Neck: no masses, no bruits, nl range of motion, no JVD

Lymph: no palpable nodes axillary, supraclavicular, inguinal, cervical

Chest: clear to AP bilaterally, no rales, rhonchi, wheezes, rubs

Breasts: (mandatory in women, OK in men)

Cor: RRR S1S2 w/o MGR

Abd: soft, tender RLQ with moderate guarding only in RLQ. + Rovsing sign, + Obturator sign. No bowel sounds heard. No masses palpable. He has rebound tenderness in the RLQ and referred rebound pain to the RLQ.

Rectal: tone nl, no blood, no masses, prostate nl

コメント [A9]: Head to toe list of organ systems and any symptoms in the systems. This is separate from Physical Exam, because it is history, not physical findings

コメント [A10]: Shortness of breath

コメント [A11]: Paroxysmal nocturnal dyspnea

コメント [A12]: Remember that the physical exam consists of things that you find on exam, and not things that the patient tells you (history)

コメント [A13]: Always include vital signs here

コメント [A14]: pulse

コメント [A15]: General description. WDWN means "well developed well nourished"

コメント [A16]: White male

コメント [A17]: No Acute Distress

コメント [A18]: Head, Eyes, Ears, Nose, Throat

コメント [A19]: Normocephalic, . . .

コメント [A20]: Pupils Equal, Round . . .

コメント [A21]: Extra-Ocular . . .

コメント [A22]: Jugular venous . . .

コメント [A23]: Auscultation and . . .

コメント [A24]: Cor = Heart

コメント [A25]: Regular Rate and . . .

コメント [A26]: Without murmur, gallop . . .

コメント [A27]: Right Lower Quadrant

Gen: normal male genitalia, no masses, no hernia
Extr: no cce, pulses +2/2 radial, femoral, popliteal, DP,PT. Full ROM
Neuro: MS nl, CN II-XII nl, sense, str, DTR all intact

Laboratory Studies

CBC WBC 12.5, Hct 45
U/A: Negative for cells, bacteria
(note that we only checked the laboratory tests that this patient needed!)

Assessment / Plan

This 27yo male has a 2d history of abd pain that has migrated to the RLQ, along with anorexia. His PE shows peritoneal signs in the RLQ (guarding, rebound, + Rovsing's), and a low grade fever. WBC is mildly elevated. This is a classic case of appendicitis and the patient will be brought to surgery for laparoscopic appendectomy.

コメント [A28]: Cyanosis, clubbing or edema

コメント [A29]: Dorsalis pedis, post tib

コメント [A30]: Range of motion

コメント [A31]: Neuro has 5 parts: Mental Status, Cranial nerves, sensation, strength, and deep tendon reflexes

コメント [A32]: Mental status

コメント [A33]: Cranial Nerves

コメント [A34]: Deep tendon reflexes

コメント [A35]: This should summarize the significant findings of the history, physical, lab studies and then discuss the logic of the care plan