

COMPREHENSIVE H&PE: ITS EXECUTION AND RECORDING

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Most professions have a primary tool or skill that is essential to function and success. While these examples may be debated, they make the point. Psychologists need good interviewing and listening skills. Carpenters need to be able to wield a hammer and saw. Executives need excellent organizing and management skills. Singers need to be able to control their voices well. What does a physician need?

While physicians need to be good interviewers, listeners, organizers, voicers, and sometimes even carpenters, however, I suggest that one basic, essential stock in trade is the **Comprehensive History and Physical**.

You may not know all that you would like to know about every disease process and medication, but at the end of a properly done H&PE, you will have a good idea about how to approach the diagnostic evaluation, what to research, and possibly even some of the therapy. More valuable than that is the establishment of a doctor/patient relationship that will allow you to have the credibility to proceed with the evaluation and therapy. This last is NOT a minor point.

Well done H&PE's will earn you the respect and admiration of your physician colleagues. Do not underestimate the importance and power of this. It is part of your ticket to success. Alternatively you can do slipshod work and be regarded as a risk. Your choice.

Sir William Osler said, "The good physician treats the disease; the great physician treats the patient who has the disease".

You have been taught how to examine every organ system and part of the body. I am not going to rehash that here. The problem is that the details need to be attended to and it all has to be recorded. We are not camping out. This is real life. You are to leave no stone unturned in your exams and workups. Be especially cautious about computer generated workups with check boxes. It is a poor idea to do any computer H&PE's until a fully comprehensive workup can be done, without template reminders, and recorded by hand in a fashion that is nicely formatted and readable. You are not in a hurry. These will take 3 - 4 hours, and you will need to do hundreds of them. Speed will come, but not at the price of shoddy workups.

As you consider recording your work, be sure that everything you record is something you did. If a detail was omitted, then go back and do it to complete the work. This is one danger of computerized records and checkboxes. It is too easy to check a box, implying an evaluation of whatever, when it never took place. This would stain one's professionalism. Never risk it.

These issues are covered in the first chapter of Bates'. Read it carefully now and pay attention to every detail. There is nothing in that chapter that is not crucially important to your future function as an excellent physician.

Accompanying this article is a handwritten H&PE of a fictitious patient by me. This is the workup I do on 100% of my patients in geriatrics. It is formatted slightly

differently than the textbook, but everything is there. It has additional sections that reflect the geriatrics milieu. You can add new, but never skip essential items.

The University of California at San Diego has an excellent website dedicated to this topic: <http://meded.ucsd.edu/clinicalmed/write.htm>. It was written by Charlie Goldberg, MD, UCSD School of Medicine and VA Medical Center, San Diego, California 92093-0611. I have made frequent reference to his statements in this article because they agree so well with my own opinions. I have also included a pdf file from the University of Florida, Department of Medicine. It also explains the technique of the H&PE "write-up".

Initial Information

Start off by labeling the whole thing in large letters: **HISTORY AND PHYSICAL**. You may call it Admission History and Physical, Hospital History and Physical, or even Student History and Physical. Just make this clear.

You will want to include the patient's name. Other details recommended by Bates' include, date, time, date of birth, age, gender, and the source of the information in the history. This is a place to mention the reliability of the informant. The U of Fla article suggests that labeling the patient a "poor historian" is a "red flag for a poor interviewer". I agree. If this is really true, then elaborate about why this is so.

I also recommend including the name of the primary care physician and previous specialists. This will help when you need to make referrals or hand care back to the community physician.

Finally the responsible party needs to be listed. This could be the patient, but in all cases list the name and numbers of whoever should be called if things go badly.

Chief Complaint

Traditionally this is the statement in the patient's own words of why he is there. It may not make sense, but even that is important to know. "My stomach hurts," is direct and helpful. Some of my geriatric patients cannot talk. One lady who fell and fractured her hip told me, "My daughter won't let me live alone anymore."

See Bates' and the included articles on this issue. You can make a simple sentence stating the real reason if the patient is out in right field. Do not give the details of the chief complaint here.

The purpose of the chief complaint is to focus attention on the issue that concerns the patient. You may have other agendas, based on your knowledge and exam findings, but the patient's complaint must be addressed or you have fallen short. This comes under the heading of Goals of Care. It also sets the stage for another reader of your workup to know where you are headed.

Present Illness

This is a complete, clear, chronological account of the events leading to the seeking of care from you. If there are more problems than one, then give each a paragraph. The problems are characterized by 8 standard attributes (at least 4 must be included). They are:

- location: Where is the problem on the body?
- quality: What is the discomfort like? Aching? Sharp? Burning?
- severity: How bad is it? How has it changed lifestyle?
- duration: When did it start? What was the onset?
- timing: Is it continuous? Intermittent?
- context: Under what circumstances did it, or does it, occur?
- modifying factors: What makes it better? Worse?
- associated signs and symptoms: What other symptoms accompany it?

This reminds me of the mnemonic for pain that I have used since medical school from DeGowin and DeGowin (my Bates'):

- P - palliative or pejorative factors
- Q - quality
- R - region affected
- S - symptoms associated, severity
- T - timing including onset (how and where), duration of symptom, intermittency

Include pertinent positives and negatives here from the Review of Systems if they relate to the problem. Also related data from the Past Medical History, Family History, and Social History can be included here and do not have to be repeated.

The patient may give the story in a disjointed fashion, or you may be able to figure it out only after the exam and speaking with the family or other physicians. You still organize it here in a logical, sequential form to help future caregivers to understand easily what has transpired.

PFSH

The Past History, Family History, and Social History are handled in a myriad of ways by different physicians. It really does not matter as long as it is all there, well labeled, logical, and comprehensive. Even Bates' is blurry on this point (I suspect a heading is missing on top of page 9). My hand written sample is formatted the way I do it. I am going to use the U of Fla pattern here for you.

Past Medical History

- This is a listing of all **past illnesses**. Dates, resolutions, and therapies can be included with each disease or condition. Pertinent investigations from the past could be included here as well.
- The **medication list** goes here. It needs a clear label. The meds should be linked to diseases or conditions. I often find additional PMH illnesses from the medication list. Include the generic names, strengths, and dosing instructions.
- The **allergies** go here as a list with a very clear label. This will be referred to repeatedly by others. Many things people claim as allergies are not such.

Mention the nature of the reaction with each allergy if possible. It is often so that the patient wishes to avoid a medication he is afraid of or that a friend reacted to.

- A separate, well labeled, section of all **past surgery** should also be included as a separate item in the PMH. It is nice, but not essential to have the year of the surgery. People do not always know this about themselves.
- A separate **preventive care** section goes here too. Once again, well labeled, so it can be found easily. It outlines the immunizations: Flu, Pneumovax, tetanus, and zoster. Current recommendations are for a Tdap to be given to practically everyone. Also include information of prostate evaluations, mammograms, PAP's, eye care, dental care, and GI surveillance here.

Family History

Here we list all of the illnesses that are in the family that pose a potential risk to the patient. I believe that the patient himself can be included. Certainly all 1st degree relatives (parents, siblings, children, ?double first cousins?) should be included. Focus on illnesses that may have genetic components:

- malignancy
- coronary artery disease
- diabetes mellitus
- stroke
- dementia
- hypertension
- depression

Bates' has a much more extensive list. You decide what is important here. Note that stating that the Family History is "non-contributory" is hogwash and is not the kind of thing you ever want to say.

Social History

I agree 100% with the U of Fla physician who says that "this part of the write-up distinguishes the above average students from the average". He goes on to say that "a thoughtful and detailed social history demonstrates a curiosity and humanitarianism . . . found present in 'master clinicians'". Include at least:

- living situation (alone, spouse, family, assisted living, nursing home)
- marital status
- work history (not just "retired")
- educational status
- religion
- number of children raised & number living

This is also where the habits go, but never make the mistake of listing tobacco, ethanol and street drugs as the entire social history. That is a sign of a sloppy workup. Do list the kind of tobacco used, the amount, and stop date. Cigarettes are often quantified in pack years. For ethanol, list the type, intensity of use, and stop date. Ask about street drugs and prescription drug abuse. It is common.

ROS - Review of Systems

The Review of Systems is a major part of any workup. It is time consuming and it takes up as much space as the physical itself. The physical is at most about 20% of the entire effort. The meat is often in the history portion.

The main headings below are the 14 systems officially recognized by the federal government, when bean counters evaluate your work. They expect at least 10 systems in every comprehensive, complete H&PE. We do such excellent work that we never have to concern ourselves with such things. Cover it all because it is the right thing to do.

The individual items in each system are not mandated in any way except your feeling of what is valuable. You will see my list in the hand written sample. The list below includes the entire set of recommendations from the University of California at San Diego Department of Medicine merged with Bates' and myself.

It is not necessary to include any item more than once even though it applies to multiple systems. Weight gain or loss applies to General (or Constitutional) as well as Endocrine and others. Dizziness can be swimmyheadedness or true vertigo and must be carefully delineated when present. It applies to the Ears as well as Neurologic.

The patient is asked about these things using common parlance, but you may use proper medical terms to list them (such as those I have used below). This saves space and clarifies. Prior disorders can be asked of every system and subsystem. The specific disorders get listed by you. Each positive must be delineated and will lead to other findings. If the patient has anhedonia or anxiety, then we need to know the PQRST attributes. For depression we would need to have the anhedonia all day for most days, for example.

This list has about 180 items with a few items listed multiple times. You need to select 5 or so from each group to make about 100 that you know, understand, and ask every time. To learn this well and to preserve your medical integrity and professionalism, list every item in your list every time as positive or negative. Saying that the "remainder of the ROS is negative" is meaningless at best and a lie at worst. Who would ever know which ones you really asked? Write each system heading and then indicate positive and list all positives. Then indicate negative and list all negatives for that system. Once again this is a serious ethical risk for computer use. When you start checking off boxes on the EMR ROS, you are using someone else's list. Be sure it is adequate, that you asked about those specific things, and that none were left out that you value.

Constitutional

Weight gain or loss

Fatigue

Weakness

Debility

Malaise

Recent medical evaluations or treatments

Chronic pain

Eyes

Eye disorders

Double vision

Eye drainage

Glasses

Eye pain

Blurred vision

Double vision

Glaucoma

Cataracts

HENT

Head & Neck

Head and neck disorders

Neck pain

Headache

Trauma

Lymphadenopathy

Goiter

Neck stiffness

Ears

Hearing loss

Ear pain

Drainage

Tinnitus

Dizziness: Vertigo vs Swimmyheadedness

Nose & Sinuses

Nasal discharge

Post nasal drip

Stuffiness

Epistaxis

Sinus pain

Mouth & throat

Change in voice/hoarseness

Dental pain

Caries

Edentulousness

Loose dentures

Dry mouth

Oral ulcers

Masses

Cardiovascular (C/V)

Cardiovascular disorders

Chest pain

Angina

Dyspnea on Exertion

Hypertension

Rheumatic Fever

Murmurs

Edema

Orthopnea

PND - Paroxysmal Nocturnal Dyspnea

Syncope

Palpitations

Claudication

Ulcers on feet

Pulmonary

Pulmonary disorders

Dyspnea

Asthma

Wheezing

Pleurisy

Cough

Pulmonary congestion

Hemoptysis

Sputum

Snoring

Apnea

Gastrointestinal

GI disorders

Heartburn

Anorexia

Hemorrhoids

Abdominal pain

Colostomy

Dyspepsia

Gastroesophageal reflux

Dysphagia

Nausea

Vomiting

Abdominal distention

Jaundice

Hepatitis

Hematemesis

Tarry stools

Bloody stools

Constipation

Diarrhea

Genito-Urinary

GU disorders

Hematuria

Dysuria

Foley

Suprapubic cystostomy

Phimosis

Circumcised

Nocturia

Urinary Incontinence

Urgency

Frequency

Hesitancy

Incomplete voiding

Genito-Urinary (continued)

Hernias
Urethral discharge
Genital sores
Testicular pain
Testicular lumps
Scrotal pain
Menstrual Hx
Hot Sweats
Vaginal Discharge
Sexual partners
Type of sexual activity
Sexual function
GPA (#pregnancies, live births, losses)
Hx STDs

Musculoskeletal

Known disease
Arthritis
Lower extremity pain
Upper extremity pain
Stiffness
Gout
Myalgia
Joint swelling
Inflammation
Amputations
Back pain
Weakness
Limited Motion
Trauma

Skin and Breasts

Hair Loss
Decubiti
Rashes
Growths
Lesions
Nonhealing sores
Moles changing in size, shape, or color
Itching
Nail diseases
Breasts
lumps
pain
nipple discharge

Neurological

Known disease
Paralysis
Paresthesias
Fainting
Seizures
Numbness
Weakness
Dizziness
Unsteadiness
Headache
Tremor
Dysarthria
Aphasia

Psychiatric

Mental disorders
Anhedonia
Anorexia
Alcohol abuse
Substance abuse
Anxiety
Memory loss
Hallucinations
Confusion
Insomnia
Suicidal thoughts
Racing thoughts

Endocrine

Endocrine disorder s
Polyuria, polydipsia, polyphagia
Fatigue
Cold intolerance
Sweating
Weight loss
Weight gain
Change in glove or shoe size

Hematology/Oncology/Lymphatic

Heme/Onc disease s
Fevers, chills, sweats
Weight loss
Abnormal bleeding
Bruising
Tumors
Lymphadenopathy

Hematology/Oncology/Lymphatic (continued)

Edema

Hypercoaguability

Anemia

Transfusions (?reactions)

Allergy/Immunologic

Hay fever

Frequent URI's

Urticaria

Food allergies

Fevers, chills, sweats

Functional Status

In geriatrics, we acknowledge that cure is not always in the cards, so this section is next for me. It defines the patient's ability to carry out ADL's. You would not do badly to put this section in any adult workup. Some might argue that it belongs elsewhere.

Mental Status

This is another section that is not standard. It could easily be a part of the physical under the neurological heading. Here it serves to say something about the reliability of the patient as the source of information for the previous history. I like it this way. You should probably put yours in the Physical.

Physical

The physical exam is not going to be rehashed here. You know how to do each part. Do it all on every comprehensive exam. The physical portion of the record should be announced with a clear heading. The same 12 organ systems for the ROS are used here. In my sample workup, I obviously collected some of these under headings that are called "body areas" by the feds. I like the flow of this. You may invent your own style as long as nothing is left out and it is orderly and logical.

Start off the Constitutional Section with Vital Signs including height and weight. Label each one with at least a letter: T P R BP Ht Wt. I always include a BMI. This gives you a clue about how to sum up the patient in the next line.

It has been traditional for many years to conclude the Constitutional Section with a statement describing the patient's appearance:

This is a well (poorly) developed, well (poorly) nourished, white (other race) male (female) who is in (no) acute distress.

Being well developed has to do with physical condition. Nourishment speaks for itself and is helped by looking at the BMI you just calculated. This is the only place in the record that I refer to race. It has no proper purpose except as an objective finding to relate to racially related, inherited diseases and medication responses. The gender reference is clear enough. Finally, is the patient in distress and what from? This can be abbreviated: WDWNWMNAD (well developed, well nourished, white male in no acute distress). Most medical people understand this.

Then launch into the sections of the physical. Each should be labeled. The data should be entered without the use of esoteric abbreviations. Little pictures are sometimes helpful as in my sample workup. I drew one for pulses and one for reflexes. The purpose here is communication to everyone.

Do not neglect to check breasts, rectums, and genitals. Have a chaperone present. It is not acceptable to skip these things. Stating that such an exam is "deferred" is a mark of a lazy practitioner who is at risk of delivering substandard care.

Most physicians include a section at the end of the Physical for Labs. This is good style in my estimation and I commend this practice to you.

Assessment

In my workups, the next section is a summing up of what I have heard, seen, and found. It is a single sentence (perhaps 2) that summarizes it all.

Problem List

Next comes a numbered, prioritized list of all of the problems from worst to least. In my workups we often include a list of Functional Problems to list ADL deficiencies. We also include a list of Inactive Problems to list significant, but resolved past problems such as a malignancy that has apparently been eradicated. The Active Problem List includes every abnormal thing you found. Remember that a diagnosis does not have to be made for each thing. It is always correct to list a symptom in lieu of a presumed diagnosis.

Plans

Next comes a numerical listing of problems and is numbered independently of the Problem List. Each problem will have a discussion regarding the differential diagnosis, workup needed, and even therapeutic actions needed. There may be problems that do not need addressing presently and some that are already adequately managed. You may commit here to what diagnosis you think is most likely for each problem.

I always include in my plans references to diagnostic studies needed, therapeutic actions that seem prudent, rehabilitation plans, nursing care orders, preventive care orders, and podiatry care.

Additional Sections

In my work in long term care, it seems prudent to add four more small sections. The first is **Goals** where the goals of care as expressed by the patient and family are clearly delineated. This includes comfort and improvement of function as well as plans to go home eventually if possible. The second is **Prognosis** in which I state simply whether the prognosis is good to poor and perhaps why. We usually have rehabilitation for our patients, so I list **Rehab Potential** to show that I think it might, or might not, work.

Finally we include a section on End of Life Care called the **EOL Treatment Status**. This is a section that you need to include in your workups too. It clearly states whether the patient or his surrogate wishes to have a resuscitation attempted if he dies. This is called a DNR (do not resuscitate). The alternative to a DNR is a FULL CODE. You will always be glad you clarified this for your patients. They do not mind discussing it and you will be respected for bringing it up. Other aspects of this section are whether the patient wants hospitalization with aggressive management of illnesses and symptoms, or just comfort and palliative care. In this context I also clarify whether my patients wish to have feeding tubes under any circumstances. Students might want to include this in the Plan list as an additional numbered entry.

Signature

After producing this marvelous document and clearing it with your attending physician, you want to sign it proudly and indicate who you are.

For further reading and clarification of these issues there follow several articles from the most excellent University of California at San Diego website and another from the University of Florida, Department of Medicine. In reading these, it will be clear that style varies. Quite frankly I find some of the examples from the UCSD School of Medicine difficult to read and difficult to follow. Many of the abbreviations are obtuse and I prefer prose to lists. Take from each what is best and make your own work excellent.

Write Ups

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The University of California at San Diego has an excellent website dedicated to this topic: <http://meded.ucsd.edu/clinicalmed/write.htm>.

The written History and Physical (H&P) serves several purposes:

1. It is an important reference document that gives concise information about a patient's history and exam findings at the time of admission. In addition, it outlines a plan for addressing the issues which prompted the hospitalization/visit. This information should be presented in a logical fashion that prominently features all data immediately relevant to the patient's condition.
2. It is a means of communicating information to all providers who are involved in the care of a particular patient.
3. It allows students and house staff an opportunity to demonstrate their ability to accumulate historical and examination based information, make use of their medical fund of knowledge, and derive a logical plan of attack.
4. It is an important medical-legal document.

The H&P is not:

1. An instrument designed to torture Medical Students and Interns.
2. Meant to cover unrelated bits of historical information.
3. Should neither require the killing of more than one tree nor the use of more than one pen to write!

Knowing what to include and what to leave out will be largely dependent on experience and your understanding of illness and pathophysiology. If, for example, you were unaware that chest pain is commonly associated with coronary artery disease, you would be unlikely to mention other coronary risk-factors when writing the history. Until you gain experience, your write-ups will be somewhat poorly focused. Not to worry; this will change with time and exposure. Several sample student write-ups can be found at the end of this section.

Chief Complaint or Chief Concern (CC):

One sentence that covers the dominant reason(s) for hospitalization. While this has traditionally been referred to as the Chief Complaint, Chief Concern may be a better description as it is perhaps less pejorative/confrontational sounding.

"Mr. Smith is a 70 year old male admitted for evaluation of increasing chest pain."

History of Present Illness (HPI):

The HPI should provide enough information without being too inclusive. Traditionally, this covers all events leading to the patient's arrival in the ER (or the floor, if admission was arranged without an ER visit). Events that occurred after arrival are covered in a separate summary

paragraph that follows the pre-hospital history. Some HPIs are rather straight forward. If, for example, you are describing the course of an otherwise healthy 20 year old who presents with 3 days of cough, fever, and shortness of breath, you can focus on that time frame alone. It gets a bit more tricky when writing up patients with pre-existing illness(es) or a chronic, relapsing problem. In such cases, it is important to give relevant past history "up front," as having an awareness of this data will provide contextual information that will allow the reader to better understand the most recent complaint. If, for example, a patient with a long history of coronary artery disease presents with chest pain and shortness of breath, it might be written as follows:

"Mr. S is a 70 yr old male with known coronary artery disease who is:

-Status Post 3 vessel CABG in 4/82.

-Suffered recurrent chest pain in 12/93 which ultimately lead to catheterization and stent placement in a mid-LAD lesion.

-Recathed in 1/95 for recurrent chest pain at rest; at that time there was no significant change compared to cath of 12/93; patient was therefore continued on medical therapy.

-Known to have an Ejection Fraction of 30% with inferior and lateral akinesis by echo in 2/96

-No prior episodes of heart failure.

-Last Exercise Tolerance Test was performed in 1/97 and showed no ischemia at 10 METS of activity.

Mr. S was well until last week (9/97), when he began to experience recurrent episodes of chest pain, exactly like his past angina, after walking only one block. This represented a significant change in his anginal pattern, which is normally characterized as mild discomfort which occurs after walking vigorously for 8 or 9 blocks. In addition, 1 day prior to admission, the pain briefly occurred while the patient was reading a book. He has also noted swelling in his legs over this same time period and has awakened several times in the middle of the night, gasping for breath. In order to breathe comfortably at night, Mr. S now requires the use of 3 pillows, whereas in the past he was always able to lie flat on his back without difficulty. Mr. S is known to have poorly controlled diabetes and hypertension. He currently smokes 2 packs of cigarettes/day. He denies fevers, chills, cough, wheezing, nausea vomiting or other complaints."

That's a rather complicated history. However, it is obviously of great importance to include all of the past cardiac information "up front" so that the reader can accurately interpret the patient's new symptom complex. From a purely mechanical standpoint, note that historical information can be presented as a list (in the case of Mr. S, this refers to his cardiac catheterizations and other related data). This format is easy to read and makes bytes of chronological information readily apparent to your audience. While this data is technically part of the patient's "Past Medical History," it would be inappropriate to not feature this prominently in the HPI. Without this knowledge, the reader would be significantly handicapped in their ability to understand the patient's current condition. Knowing which past medical events are relevant to their area of current concern takes experience. In order to gain insight into what to include in the HPI, continually ask yourself, "If I was reading this, what historical information would I like to know?" Note also that the patient's baseline health status is described in some detail so that the level of impairment caused by their current problem is readily apparent to the reader.

The remainder of the HPI is dedicated to the further description of the presenting complaint. As the story teller you are expected to put your own spin on the write-up. That is, the history is

written with some bias. You will be directing the reader towards what you feel is the likely diagnosis by virtue of the way in which you tell the tale. If, for example, you believed that the patient's chest pain was of cardiac origin, you would highlight features that supported this notion (e.g. crushing chest pain with activity, relieved with nitroglycerin, preponderance of coronary risk factors etc.). These are referred to as "pertinent positives." This is not misleading; all of the details written are based on facts and no important features have been omitted. The reader retains the ability to provide an alternative interpretation of the data if he/she so wishes. A brief review of systems related to the current complaint is generally noted at the end of the HPI. This also includes "pertinent negatives" (i.e. symptoms which the patient does not have). If present, these symptoms might lead the reader to entertain alternative diagnoses. Their absence, then, lends support to the candidate diagnosis suggested in the HPI.

Occasionally, patients will present with two (or more) dominant, truly unrelated problems. First, spend some extra time and effort assuring yourself that they are truly unconnected and worthy of addressing in the HPI. That being the case, present them as separate HPIs, each with its own paragraph.

Past Medical History (PMH):

This should include any illness (past or present) for which the patient has received treatment. Items which were noted in the HPI (e.g. the cardiac catheterization history mentioned previously) do not have to be re-stated. You may simply write "See above" in reference to these events. All other historical information should be listed. Detailed descriptions are generally not required. If, for example, the patient has hypertension, it is acceptable to simply write "HTN" without giving an in-depth report on the duration of this problem, medications used to treat it, etc. (unless this has been a dominant problem, requiring extensive evaluation...as might occur in the setting of Secondary Hypertension resulting from Renal Artery Stenosis). Also, get in the habit of looking for the data that supports each diagnosis that the patient is purported to have. It is not uncommon for misinformation to be perpetuated when past write-ups are used as the template for new H&Ps. When this occurs, a patient may be tagged with (and perhaps even treated for) an illness which they do not have! For example, many patients are noted to have Chronic Obstructive Pulmonary Disease (COPD). This is, in fact, a rather common diagnosis but one which can only be made on the basis of Pulmonary Function Tests (PFTs). While a Chest X-Ray and smoking history offer important supporting data, they are not diagnostic. Thus, it is not unusual to see "COPD" repeatedly appear under a patient's PMH on the basis of a suggestive CXR and known smoking history, despite the fact that they have never had PFTs! So, maintain a healthy dose of skepticism when reviewing old records and get in the habit of checking on the primary information yourself.

Past Surgical History (PSH):

All past surgeries should be listed, along with the rough date when they occurred.

Medications (MEDS):

Includes all currently prescribed medications as well as over the counter and non-traditional therapies. Dosage and frequency should be noted.

Allergies/Reactions (All/RXNs):

Identify the specific reaction that occurred with each medication.

Social History (SH):

This is a broad category which includes:

- Alcohol Intake: Specify the type and quantity.
- Cigarette smoking: Determine the number of packs used per day and the number of years which the patient has smoked. When multiplied this is referred to as "pack years." If they have quit, make note of when this occurred.
- Other Drug Use: Specify type, frequency and duration.
- Marital Status:
- Sexual History:
- Work History (type, duration, exposures):
- Other (e.g. travel, pets, hobbies):

Family History (FH):

This includes history of illnesses within the patient's immediate family. In particular, search for a history of cancer, coronary artery disease or other heritable diseases among first degree relatives.

Obstetrical History (where appropriate):

Review of Systems (ROS): As mentioned previously, the most important ROS questioning (i.e. pertinent positives and negatives related to the chief complaint) is generally noted at the end of the HPI. The responses to a more extensive review which covers all organ systems are placed in this "ROS" area of the write-up. In actual practice, most providers do not document such an inclusive ROS. The ROS questions, however, are the same ones that, in a different setting, are used to unravel the cause of a patient's chief complaint. Thus, at this stage of your careers it is probably a good idea to practice asking all of these questions as well as noting the responses so that you will be better able to use them for obtaining historical information when interviewing future patients.

Physical Exam:

Generally begins with a one sentence description of the patient's appearance.

Vital Signs:

HEENT: Includes head, eyes, ears, nose, throat, oro-pharynx, thyroid.

Lymph Nodes:

Lungs:

Heart:

Carotids:

Abdomen:

Rectum:

Genitalia/Pelvic:

Extremities, Including Pulses:

Neurologic:

- Mental Status
- Cranial Nerves
- Motor Strength
- Sensation (light touch, pin prick, vibration and position)
- Reflexes, Babinski
- Cerebellar Function, Observed Ambulation

Lab Results, Radiologic Studies, EKG Interpretation, Etc.:

Assessment and Plan:

It's worth noting that the above format is in no way written in stone. When you're exposed to other styles, think about whether the proposed system is logical and readily comprehensible. Then incorporate those elements that make sense into your future write-ups.

SAMPLE WRITE UP #1

01/27/98 MEDICAL SERVICE STUDENT ADMISSION NOTE

Location: A-GM

Mr. "B" is a 72 yo man with h/o CHF and CAD, who presented with increasing lower extremity edema and weight gain.

HPI: Mr. "B" has a long history of CHF subsequent to multiple MI's last in 1991. Cardiac cath at that time revealed occlusions in LAD, OMB, and circ with EF of 50%. ECHO in 1996 showed a dilated LV, EF of 20-25%, diffuse regional wall motion abnormalities, 2+MR and trace TR. His CHF has been managed medically with captopril, Lasix, metolazone, and digoxin. Over the past 6mos he has required increasing doses of Lasix to control his edema. He was seen 2 wks ago by his Cardiologist, at which time he was noted to have leg, scrotal and penile edema. His Lasix dose was increased to 120 bid without relief of his swelling.

Over the past week he and his wife have noticed an increase in his LE edema which then became markedly worse in the past two days. The swelling was accompanied by a weight gain of 10lb in 2 days (175 to 185lb) as well as a decrease in his exercise tolerance. He now becomes dyspneic when rising to get out of bed and has to rest due to SOB when walking on flat ground. He has 2 pillow orthopnea, denies PND. His chronic cough has worsened and is now productive of "transparent" sputum with no hemoptysis. He has occ audible wheeze. Denies CP/pressure/palpitations/diaphoresis. Occ nausea/no vomiting. He eats limited quantities but does not salt or fluid restrict--eating canned soup and drinking 6-8 glasses liquid/day. He has increased urinary freq. but decreased amount. He states he has been taking all prescribed medications.

PMH: CHF: as above
MI
Afib: on Coumadin
Pacemaker placed in 3/93 for afib/flutter and slow ventricular response

HTN
Chronic renal insufficiency: BUN/Cr stable on 1/21/98, 52/1.4
DM: controlled with glyburide. Admitted for hypoglycemia in 9/97.

PSH: Tonsillectomy

MED: Lasix 120 mg BID
Metolazone 5 mg gd
Captopril 50 mg TID
Digoxin 0.125 mg qd
KCl
Coumadin 4mg qd
Glyburide 2.5 mg BID
Colace 100 mg BID

ALLERGIES: No Known Drug Allergies

SMOKING None

ALCOHOL None

OTHER
SUBSTANCE USE None

SOCIAL
HISTORY: Married for 45 years, sexual active with wife. Three children, 2 grandchildren, all healthy and well; all live within 50 miles. Retired school teacher. Enjoys model car building. Walks around home, shopping but otherwise not physically active.

FAMILY
HISTORY + sister and mother with DM, father with CAD, age onset 50.
Brother with leukemia.

ROS If written, would be present here.

PE: VS: T 97.1, P65, BP 116/66, O2Sat 98% on 2L NC
GEN: elderly man lying in bed with head up, NAD
HEENT: NCAT, multiple telangiectasias on face and nose, EOMi, PERRL, OP-benign
NECK: thyroid not palpable, no LAD, carotid pulse 2+B, no bruits, no JVD
RESP: +dullness to perc at right base, +ant wheezes, +crackles 1/2 way up chest bilat.
COR: rrr, +2/6 holosystolic murmur at apex radiating to axilla, no gallops
ABD: +BS, distended, nontender, no HSM, liver percussed to 9cm at MCL
PULSES: 2+femoral B, 1+ PT/DP B
EXT: 3+ edema to lower back, abdomen including genitals,

hyperemia over ant., legs bilat, warm, non-tender; non clubbing, cyanosis
SKIN: 4 cm ulcer on R buttock with central scabbing, non-tender, no discharge
NEURO: AOX3; difficulty remembering events, dates; remainder of exam nonfocal

LABS/
DATA:

Na 138, C1 96, BUn 59, Glu 92, K 4.4, CO2 40.8, CR 1.4, WBC 7.9, PLT 349, HCT 43.9, pulses P73 L16 E3 B0
Alk phos 72, Tot prot 5.6, Alb 2.5 T Bili 0.5, AIT 17, AST 52, LDH 275, CPK 229

CXR: mildly prominent vessels. Minimal interstitial congestion. Cardiomegaly, no infiltrates.

ECHO 1/27: 1. LV mild dilated (ED=6.0 cm) severely depressed global systolic function with EF 20-25%. Extensive area thinning and akinesis: anterior, anteroseptal, anterolateral c/w old infarct
2. Mod 2-3/4 MR. LA size nl
3. No AS/AI
4. RV dilated with preserved fxn. 2-3/4 TR. PA pressure 36+ RA pressure.

ASSESSMENT/
PLAN

72 year old man with h/o CHF following MI, chronic renal insufficiency and venous stasis admitted with worsening edema and DOE. His symptoms are most consistent with increasing CHF-biventricular-which would account for both his pulmonary congestion as well as his peripheral edema. His renal disease is a less likely explanation for his extensive edema as his BUN/Cr has remained stable throughout. However, his low albumin which could contribute to his edema may be due to renal losses.

So if his edema is due to CHF, why has it become gradually and now acutely worse? Possibilities include: 1) worsening LV function, 2) another MI, 3) worsening valvular disease, 4) poor compliance with medications or 5) excess salt and water intake. His ECHO today shows no change in his EF, but there is marked wall motion abnormalities with akinesis. There is no evidence in his history, EKG, or enzymes for current ischemia/infarct. He does have MR and TR and his valvular disease may in part account for his worsening symptoms though his estimated PA pressure is unchanged and his LA is not dilated. The most likely precipitant of his failure is a combination of poor compliance with medication and fluid overload from excessive intake. We will continue to investigate the possibility of a structural precipitant for his deterioration and treat his current symptoms.

1. Pulm: his wheezing, crackles, and oxygen requirement are all likely due to pulmonary congestion from LV dysfunction. He has no signs, symptoms of pulm infection.
 - o O2 to maintain sat greater than 95%
 - o treat cardiac disease as below
2. Cardiac: As above his picture is consistent with CHF with no clear precipitant. Will continue to evaluate structural disease as precipitating factor and treat fluid overload.
 - o Strict I/O's. Daily weights
 - o Fluid restriction to 1.5L
 - o Low salt diet
 - o Lasix 80mg IV with IV Metolatzone now and Q8. With goal diuresis of 2-3 L/day
 - o Increase digoxin to 0.25mg qd
 - o Continue captopril 50mg TID
 - o Check electrolytes, renal fxn and digoxin level in am
 - o Education about appropriate diet
 - o Repeat Echo and compare with old film
 - o Consider Cardiology consult if fails to improve, needs invasive hemodynamic monitoring or cath
3. GI
 - o Continue colace
4. Renal: We will continue to evaluate whether he could be losing protein from his kidney leading to his increasing edema.
 - o Check urine prot/cr ratio
 - o UA
5. DM: His sugars have been well-controlled on current regimen
 - o Continue glyburide
 - o ADA 2100 calorie diet
 - o FS BS qac and qhs

Signed by:

SAMPLE WRITE-UP #2

01/19/98, 21:44 MEDICAL SERVICE STUDENT ADMISSION NOTE

Location: A-GM

Mr. "S" is a 65 year old man with a history of Atrial Fibrillation, S/P Distant stroke, who has been off anticoagulation for 4 mos during evaluation of slow GI Bleed. He presents with 2 complaints:

1. Acute eye pain with difficulty seeing.
2. Several day history of a cough.

HPI: 1. Visual changes: Patient has a known history of atherosclerotic and hypertensive cerebrovascular disease: workup for dizziness/?TIA's in 94/95 revealed critical carotid stenosis and old R basal ganglia and L occipital infarcts on CT. A cerebral angiogram was complicated by a CVA manifested as R arm weakness with resolution. He subsequently had a R CVA in 1995 and no further TIA's.

Patient has had PAF for past 2+ years. ECHO in 1996 showed nl EF and marked LA enlargement (6cm) with mild-mod MR. He had been anticoagulated with Coumadin until last summer. Developed GIB and chronic iron def. anemia. Coumadin d/c'd prior to colonoscopy in Sept. and has not been restarted.

Yesterday morning while eating lunch patient had the sudden onset of sharp, R eye pain accompanied by decrease in vision. Pain was worse with coughing, unchanged by position, unrelieved by Tylenol, aspirin or Percocet. When the pain started, he "couldn't see the clock." He also had difficulty determining the numbers on the telephone. No blurred vision or diplopia. Vision is the same whether he covers right or left eye. He had nausea and vomiting x2--NB/NB at the onset of the pain. Was unable to give niece directions to hospital--unable to decide whether to make right or left turns. Pain and visual changes persisted through the night. No photophobia. No dizziness, weakness, dysarthria, CP, palpitations.

2. Cough: Patient has history of COPD with 60+ pack year smoking history and most recent PFT's showing mild deficits. Over the past few days he has noted increased dyspnea, wheezing, and sputum production. Sputum still clear, no hemoptysis and no fevers noted. No orthopnea or PND.

PMH: PAF
? CAD: ETT 7/96 6 min Bruce HR 134 showed 1mm upsloping ST seg depressions and MIBI with lg fixed anteroapical and anterinf defect
Carotid stenosis
CVA
Seizure disorder - though patient does not recall last event or details of evaluation
GI Bleed: Intermittent heme + stools. Colonoscopy on 9/97 showed 2 cm polyp. Biopsy showed adenoma. Patient declined polypectomy.
COPD
HTN
GERD
Anemia: Extensive workup consistently shows iron deficiency anemia with last HCT 12/97 at 30.
H/O asbestos exposure
Bilateral shoulder bursitis.

PSH: R CEA
R orchiectomy at age 5 for traumatic injury

Cataract s/p removal and implant placement on right

MEDS: Ecotrin 325 mg po qd
 Verapamil SA 180 po qd
 Lansoprazole 15 po qd
 Dilantin 300 po qhs
 Atrovent 4 puffs QID
 Vanceril 4 puffs BID
 Colace 100 mg po BID

ALLERGIES: No Known Drug Allergies

SMOKING 60 pack year hx, now 1 pack per day.

ALCOHOL Heavy use in past, quit 5 years ago. None current.

**OTHER
 SUBSTANCE
 USE** None

**SOCIAL
 HISTORY:** Lives with roommate in Rockland, MA. Heterosexual, not currently active. Never married, no children. Worked in past as architect, though currently on disability. Enjoys walking and reading.

**FAMILY
 HISTORY** Brother and father with CAD. Brother with CABG at age 55. Father with multiple strokes. Mother with DM.

PE: VS: T 100.2, P89, irreg irreg BP 139/63, RR 35 O2 Sat 98% RA
 GEN: Obese, pale man turning his head side to side to see us with labored breathing.
 HEENT: NCAT, pupils L larger than R. Both reactive to light. Discs sharp. EOMI. Left Homonymous hemianopia. Temporal arteries nontender. Conjunctiva clear. Decreased hearing of high freq on left. OP-benign
 NECK: CEA scar on right. No LAD. No JVD. Carotid pulse 2+ on right, 1+ on left.
 RESP: CTP. + audible wheeze. Good aeration. Occ. Wheezes on ausc throughout. Coarse insp crackles at bases
 CAR: PMI at L lower sternal border. nl s1/s2. II/VI systolic crescendo-decrescendo murmur at LUSB.
 ABD: Obese + nl BS. Soft. Nontender. Liver nonpalpable. Liver 10cm at MCL.
 RECTAL: OV neg in ER
 MS: Decreased ROM at shoulders
 PULSES: Fem R 2+ L +1. DP 2+ B. PT 1+ B
 EXT: ? clubbing, no cyanosis. No edema. Warm, well-perfused.
 NEURO: AOX3; Able to see clock, unable to tell time. Unable to give directions from home to grocery store. Speech intact. Naming intact. Drawing clockface required prompting to put in numbers on left side. Min neglect for left side.

CN: II: as above
III, IV, VI: as above
V: decreased light touch on right, MM 5/5 B
VII: muscles of facila expression intact
IX, X: palate symmetric
XI: SCM, Trap 5/5
XII: Tongue midline
Motor: Strength 5/5:biceps, triceps, grip, quad, hamstring,
plantarflex, dorsiflex. F-N slight int. tremor on left. RAM: slowed
on left. ? pronator drift on left. Gait: unsteady. Able to walk on
heels not toes.
Sensory: Slightly decreased light touch on right. Romberg neg.
Reflexes: Biceps/triceps/brachio: 1+ B. Knee/ankle: 0 Toes
equivocal.

LABS/
DATA:

Labs 1/19. Na 138, C1 106, BUn 13, Glu 99, K 4.5, CO2 25.4, CR
0.7, WBC 12.2, PLT 597, HCT 22.4, MCV 72.5, pulses P73 L16
E3 B0
Alk phos 72, T prot 7.2, Alb 3.1, ALT 9, AST 14, Alk phos 75,
LDH 123, TB 0.5, Dilantin Less than 2.5, PT 13.5, INR 1.3, PTT
21.1

Head CT: new well-demarcated infarct in R occipitoparietal region.
Old lacunar infarcts and L occipital infarct. No evidence
hemorrhage. No shift in midline.

ASSESSMENT/
PLAN:

65 year old man with h/o PAF, HTN, CVA now presents with
visual field deficits and spatial perception difficulty. Story of the
sudden onset of neurologic deficits while awake, eating lunch in the
setting of chronic intermittent atrial fibrillation is most consistent
with embolic stroke. Infarction was confirmed with CT showing
lesion in R PCA distribution. Patient has multiple risk factors for
cardiogenic embolization from afib: h/o previous stroke,
hypertension, age over 65, increased LV size, and valvular disease.
Given his carotid disease artery-artery embolization is possibility
but less likely because 1) less common than cardiac embolization
and 2) his current infarct is in the posterior circulation.

Visual disturbances could also be caused by temporal arteritis:
though he does have a temporal headache, he has no tenderness and
his visual defect is a bilateral loss of the left visual fields which is
consistent with a cortical as opposed to a retinal injury.

1. Neuro: story and imaging consistent with ischemic stroke to
R PCA. Currently no signs of cerebral edema increased
ICP.
 - o Head of bed elevated 30 degrees

- Given duration of symptoms and location of infarction would not anticoagulate immediately. Will discuss when to restart Coumadin to prevent further embolization.
 - Continue aspirin
 - Monitor level of consciousness
 - Monitor electrolytes for signs SIADH
 - Consult occupational therapy for assistance with managing deficits
 - Continue Dilantin for ?seizure disorder
 - Tylenol for headache
 - OOB with assistance only
2. Pulm: Currently febrile and with increased SOB and cough, all suggestive of Bronchitis/COPD flare.
- Continue inhalers
 - Bactrim DS 1 tab bid
 - Prednisone 60 mg qd
 - Re-evaluate CXR this am. Consider change to IC abx if clear infiltrate
 - Encourage to stop smoking while in hospital
3. CVS
- Continue verapamil for hypertension
 - A Fib well rate controlled
 - Anti-coagulation as discussed above and below
4. GI
- Arrange for Colonoscopy/EGD during this evaluation to complete evaluation GIB. Can use this information to make most informed decision about safety of reinitiating anti-coagulation
 - Continue lansoprazole
 - Guaiac all stools and follow for signs/sx ongoing GI bleeding
5. HEME: Longstanding anemia now significantly worse. Given cerebral infarction and worsening dyspnea will transfuse for HCT over 30..
- Transfuse two units PRBC's
 - Start multivitamin
 - Check CBC in am
6. ID: Currently febrile. Likely due to COPD flare.
- Start Bactrim
7. Rheum: Shoulder pain consistent with subacromial bursitis.
- Offer subacromial steroid injection.

Signed by:

A Few Thoughts Before You Go...

The start of your clinical rotations provides you with an opportunity to finally get involved with patient care and begin in earnest the process of becoming a doctor. You'll be amazed at the speed with which you move from outsider to functioning participant amidst the swirl of activity that is clinical medicine. It is, unfortunately, quite easy to lose your sense of perspective while working in this very intense environment. In fact, you'll recognize this as a common problem among many in the medical field. A few things to think about before you get started (and perhaps refer back to as you make your journey):

1. Treat patients as you would want yourself or a family member to be cared for. This should cover not only the technical aspects of health care but also the quality and nature of your interpersonal interactions.
2. Try to avoid viewing the medical training process as a means to an end. As medical education is a lifelong undertaking, you've got to enjoy the journey. If not, stop and think why.
3. Do the right thing. This applies to patient care and your dealings with colleagues and other health care workers. If something feels wrong, it probably is! The rules which govern your behavior in the world outside of medicine still apply, regardless of what others say or how they might act! This can be challenging, particularly when you are fatigued, in a subordinate position or working with others who don't have the same interests.
4. Mistakes will happen. The oft referred to: "Primum Non Nocere (first do no harm)" probably sets an unreasonable expectation. You will all do harm to someone at various points in your careers. Those who claim otherwise have either not taken care of enough patients or are not being truthful. We are all human and thus all fallible. When errors occur, acknowledge them, discuss them with colleagues and the patient, make efforts to correct the fall out, and move on. Above all, try to learn from what happened and don't allow yourself to forget any relevant lessons (without at the same time torturing yourself unnecessarily). This should help you to maintain a healthy dose of humility and become a better doctor. Remember also that anyone can be a genius in retrospect. Using this information in a manner that promotes education and growth requires a sensitive touch.
5. Never be afraid to ask questions. If those that you are currently working with are unreceptive, make use of other resources (e.g. house staff, students, nurses, health care technicians, staff physicians). You can learn something from anyone.
6. There is no substitute for being thorough in your efforts to care for patients. Performing a good examination and obtaining an accurate history takes a certain amount of time, regardless of your level of experience or ability. In addition, get in the habit of checking the primary data yourself, obtaining hard copies of outside studies, mining the old records for information, re-questioning patients when the story is unclear, and in general being tenacious in your pursuit of clinically relevant material. While this dogged search for answers is not too sexy, it is the cornerstone of good care.
7. Learn from your patients. In particular, those with chronic or unusual diseases will likely know more about their illnesses than you. Find out how their diagnosis was made, therapies that have worked or failed, disease progression, reasons for frustration or

gratitude with the health care system, etc. Realize also that patients and their stories are frequently more interesting than the diseases that inhabit their bodies.

8. Become involved (within reason) in all aspects of patient care. Look at the x-ray, examine the sputum, talk with the radiologist, watch the echo being performed. This will allow you to learn more and gain insight into a particular illness/disease state that would not be well conveyed by simply reading the formal report. It will also give you an appreciation for tests and their limitations. Caring for patients is not a spectator sport. As an active participant in the health care process (rather than simply a scribe who documents events as they occur) you will not only help deliver better medical care but will also find the process to be more rewarding and enjoyable.
9. Follow up on patients that you care for in the ER, are transferred to other services, seen by sub-specialists or discharged from the hospital. This should give you a better sense of the natural history of some disease processes and allow you to confirm (or adjust) your clinical suspicions. This is particularly relevant today as patients are shuttled through the system with great speed, affording us only snap shot views of what may be complex clinical courses.
10. Keep your eyes open for other interesting things that might be going on elsewhere in the hospital/clinic. If there is a patient on another service with an interesting finding, go over and investigate, assuming it doesn't interfere with your other responsibilities and is OK with the patient and their providers. This will give you the opportunity to expand your internal library of what is both normal and abnormal.
11. Pay particular attention when things don't seem to add up. Chances are someone (you, the patient, the consultant) is missing something, a clue that the matter needs further investigation. Challenge yourself and those around you by continually asking "Why... ?"
12. Before deciding that another provider is an "idiot" for adopting what seems an unorthodox or inappropriate clinical approach, assume that it is you that are short some important historical data. Give others the benefit of the doubt until you've had an opportunity to fully explore all the relevant information. And in those instances when it becomes apparent that mismanagement has occurred, focus on communication and education rather than derision and condescension.
13. Become comfortable with the phrases, "I don't know" and "I need help."
14. Try to read something medical every day. This will help you to stay abreast of new developments and provide an opportunity to become reacquainted with things that you've learned and forgotten. Medicine is less about achieving mastery then it is about reinforcing old lessons. Our individual "knowledge tanks" leak information on a daily basis. There is no way to plug the hole. Instead, you must continually replenish by adding to the top.
15. Realize that, ultimately, you are responsible for you. The quality of care that you provide is a direct result of the time and effort that you invest in the process. The distinction between good and bad medicine is generally not a function of oversight by the patient, colleagues, or the legal system. For the most part, it's dependent on your willingness to push and police yourself.
16. You are not automatically endowed with the historical wisdom of a particular institution merely by walking through its doors. Nor does this knowledge necessarily arrive with your white coat, degree or other advanced title. Rather, this is something that's learned and earned, often on a daily basis.

17. Every once in a while, push yourself to become an expert in something. Firsthand knowledge is a powerful tool, one that is available to anyone willing to take the time to read through the primary data. Become informed by delving into the original literature pertaining to a particular subject. You may find that the data is robust and the rationale for a clinical approach or treatment well grounded. As frequently, I suspect you'll find instances where the data is rather shaky, and the best path not as clear as guidelines or expert opinion might suggest.
18. Be kind... to others and yourself.
19. Have fun! Remember why you went into medicine. Keep this first and foremost in your mind and periodically readjust your course so that this is always in your sites.

There is magic in medicine. It does not, however, derive solely from technology, testing, or diagnostic aptitude. Rather it more often comes from your interactions with patients, a touch on the sleeve, sitting at the bedside and treating them (if only for a few minutes) as a fellow human being and not as, "That guy with Lupus." You are all capable, right now, without additional training, of being magicians. The challenge lies in not losing track of this as you make your way in the coming years.

The Medical Write-Up

by the University of Florida, Department of Medicine
(see URL at the end)

“This was a moment, this waiting on the threshold, that I would come to know well. One stepped into a limbus of time, a labium of space. This name on a new chart was like the title of a novel you had just bought, the jacket cover still pristine, the book new. Or else it was the title of an apocalyptic short story from an anthology of stories. The first paragraph had just grabbed you and you could not put it down.”

Abraham Verghese

My Own Country (1994)

(Highly recommended reading)

Every patient has an interesting story to tell. The most successful write-ups are those that tell the story rather than report a list of facts. Be specific and descriptive with your language. Avoid using diagnoses in the HPI and physical examination (e.g. “angina” instead of “chest pressure” or “abdominal aortic aneurysm” instead of “pulsatile abdominal mass”). This requires significant discipline but will save you from leaping to erroneous conclusions. Abbreviations are permissible as long as they are not ambiguous and are of standard acceptance. The following is the traditionally and most widely accepted approach to writing the H&P (note the unambiguous abbreviation). Refer to Sapira’s *The Art and Science of Bedside Diagnosis*, chapter 4, for an outstanding explanation, with examples, of writing the case record if you would like further guidance.

The Chief Complaint

For the purist, this is the patient’s own words in quotations. It is generally singular. (If there is more than one CC, then you need more than one HPI.) Often physicians use a modified version of this by providing the basic patients demographics, the patient’s own words (possibly edited a bit) and the duration. (e.g. 46 yo wm w/ “a stabbing pain in my back” for 2 days). Sometimes patients do not know why they were sent to the hospital or cannot communicate. In this case the CC is the physician’s reason for admission (e.g. “Mr. Jones is referred to STH by his nephrologist for treatment of acute renal transplant rejection.”).

Most physicians would like you to provide a little additional context in the CC. The following is an acceptable format:

Mr./Ms. (name of patient) is a (age)- year-old (race, ethnic group, occupation, and/or very pertinent PMH), who is admitted to the hospital for the ___th time with a chief complaint of “(symptom, not a sign or diagnosis)” of (number followed by a unit of time) duration.

Avoid the very bad habit of listing a patient’s entire PMH before giving the chief complaint (e.g. “Mr. Jones is a 53 year-old retired Marine with a history of COPD, HTN, DM, arthritis, tobacco abuse, GERD, hyperlipidemia, and pneumonia who is admitted with a chief complaint of “worsening leg pain” for the past 4 days.”). This does not allow the reader to “select a program” in which to organize their thoughts.

At some point early in the history, you should comment on the source of the information and its reliability. This can occur in the CC or HPI (some people like to include a line before the HPI labeled “source:”). Do not try to cover up lazy interviewing by labeling the patient “poor historian”. Most patients who are alert and not demented can tell you their history. The label “poor historian” is a red flag for a poor interviewer. If the patient is a poor historian, you should provide a brief explanation of why (e.g. history limited by patient’s poor attention span).

The History of Present Illness (HPI)

The HPI should be a chronological history of the chief complaint. It can be organized in relation to the date of admission (4 days PTA...) or in relation to the first onset of relevant symptoms (In 1996...). Be as specific as possible when describing symptoms, using the patient’s own words whenever possible and quantifying whenever possible. (‘Mr. J could walk a mile one month ago without getting SOB, but over the past month his DOE has gradually progressed to the point that he cannot walk 50 feet without stopping to catch his breath.’)

Information obtained from a chart review, outside records, or a referring physician should fit into the HPI. Make sure you include any treatments and the effects they had. It is acceptable to refer to diagnoses made by other physicians in your HPI. However, you should reserve your diagnostic impression to the ‘impression’ (or ‘assessment’) portion of the write-up. (Just because a “doctor” gave a diagnosis; don’t assume it is correct. Keep your mind open.) Pertinent positives and negatives are usually included in a separate paragraph after the description and elaboration of the symptoms. Most pertinent positives can easily fit into a well-organized history and do not need to be listed separately. However, many specialists have particular ‘risk factors’ or ‘pertinent data’ that they like included in this section.

Pertinent negatives are factors that, if present, would have suggested a different diagnosis. A general rule is to use pertinent positives and negatives only when they are relevant to your differential diagnosis. Parts of the PMH, FHx, and SHx that are pertinent to the present illness and differential diagnosis should be included in the HPI. Finally, you should include some comments about how this current problem is affecting the patient’s life and any specific concerns the patient may have (i.e. a patient with chest pain may have recently had a friend die of a heart attack). These ‘hidden’ fears or agenda items will also need to be addressed and are easily (and often) overlooked if you don’t specifically ask.

The Past Medical History (PMH)

This portion of the write-up addresses past disease and illness rather than symptoms. It is typically documented as a numbered list. It should include major diseases (conditions for which they are followed by a doctor), OB/GYN hx (LMP, pregnancies, childbirth experiences), hospitalizations, and operations. Try to include the dates and location of the hospitalizations. Some medical conditions should have some further details provided. (For example, for patients with CHF, it is very helpful to know when that had their last ECHO and what it showed.)

Medications and allergies should be included in the PMH, but can have their own headings. All medications (including OTC and supplements) should be listed with the

dosage. (As a student, it is an excellent idea for you to note what each medication is for, though you will not do this routinely in practice. It will help you learn the drugs faster.) Allergies should always include a brief description of the reaction. (Nausea is not an allergy; it is an 'intolerance' or an 'adverse reaction' and should be listed as such.)

Preventive Health History

This is very important particularly in the outpatient setting and can be included in the PMH or even as a separate section. (I describe it separately in my practice for practical reasons.) However, dental check-ups and seat belt use are not usually the most pressing issues during an acute hospitalization. Most preventive health issues that are pertinent would be included in the HPI (e.g. In a patient with weight loss, you would definitely want to include their cancer screening history...but in the HPI). Immunizations are probably the one area that should always be addressed, particularly the Pneumovax in the elderly and immunocompromised as this is such a large portion of our patients (and pneumonia is still one of the 10 leading causes of death in our country!).

The Family History (FHx)

You should obtain the FHx for a patient's first -degree relatives at the minimum. You should also get in the habit of asking routinely about common conditions that have a genetic component (e.g. CAD, HTN, breast cancer, colon cancer, diabetes, prostate cancer, high cholesterol, depression, alcoholism). Usually this information can be listed. However, if there seems to be a disease that has affected several generations, a family tree may be a more efficient way to present the data.

The Social History (SHx)

In my experience, this is one part of the write-up that distinguishes the above average students from the average. A thoughtful and detailed social history demonstrates a curiosity and humanitarianism that I have found present in "master clinicians". At the bare minimum, you should address the patient's marital status, who is living at home, social supports, education, occupation(s), and of course habits (tobacco, alcohol, drugs, and sexual history). You are strongly encouraged to learn something about your patient's daily activities, hobbies, and interests. (If you do this consistently, I guarantee that this information will give you a key insight into a patient's diagnosis one day and make you look like a star. Not to mention your patients will like you better if they think you care about them and not just their disease.)

The Review of Symptoms/Systems (ROS)

This is organized by organ system but is really a catalogue of symptoms. You do not need to list all the negatives (all pertinent negatives would be in the HPI already). All positives should be listed. Potentially serious positive findings should be elaborated upon. For example, if a patient presents with a productive cough but during the ROS mentions that she's had black, tarry stools, you shouldn't merely list "black, tarry stools". You need to elaborate on this (perform a mini-HPI and consider including it in the HPI if it is serious enough). Do not repeat information you already included in the HPI or PMH here as it is redundant.

The Physical Examination (PE)

Always begin with a general description of the patient. Try to provide a description that would allow your attending to go from room-to-room and identify who is your patient. You should also include pertinent observations related to the patient's presenting complaint when applicable. For example, if your patient presents with shortness of breath, it is very useful to know right away whether he is 'lying flat with unlabored breathing' or 'sitting forward in the bed breathing rapidly through pursed, blue lips using accessory muscles'.

The vital signs come next. There is no definite order in which you need to present this. However, most attendings are used to seeing it in the order the nurses record it in the charts (T, P, BP, R, O2 sat with FIO2). You should note from which orifice the temperature was taken and from which arm the BP was taken. Other than temperature, you should confirm all the vital signs yourself. (They are vital and unfortunately usually are obtained by a CNA or PCA) You will be a star if you comment on the regularity of the pulse and the character of the respirations. Orthostatics or other special maneuvers like pulsus paradoxus are included with the vitals.

The remainder of the physical exam follows the pattern of inspection, palpation, percussion, and auscultation as appropriate. There are two common mistakes made by students on this section of the write-up. First, students often do not provide an adequate description of their findings, or worse, write 'normal' 'WNL' ("we never looked"), or 'benign' without even specifying to which specific part of the exam they are referring. (For example, 'HEENT- normal'. Should one assume that this includes a fundoscopic exam?) Occasionally, it is acceptable to describe something as normal if it doesn't beg further description. But, this should not be a prominent feature of your PE reporting.

Second, students can often fall into the trap of performing the same exam on every patient. The physical exam should be tailored to the individual patient. If a patient is jaundiced or has known cirrhosis, you should specifically seek out stigmata of chronic liver disease and note their presence or absence. But for a patient with syncope, you don't need to do that; rather, you should perform a very thorough cardiac and neurological examination. (It is very embarrassing to admit a patient with hip pain and forget to exam the hip because it is not part of your 'routine exam'.)

Elderly patients should have a mental status exam performed. Delirium is very common in the hospitalized elderly and knowing their baseline mental status can help you recognize this life-threatening condition early. The MMSE (Mini-Mental Status Exam) or CAM (confusion assessment method) is a popular way to assess this. Other important aspects of the physical exam that are frequently short changed are breast exams, rectal exams, and an appropriate screening neurological exam (see the neurology clerkship handbook for further description of the very basic screening neuron exam).

Laboratory Data

List all the data that are available at the time you are formulating your differential diagnosis and assessment (wait for basic blood work and radiographs that come back quickly). Like the physical exam, describe your findings rather than give a diagnosis. (e.g. Rather than, 'CXR- RLL pneumonia with small pleural effusion', say 'CXR-

slightly underpenetrated PA/lat with patchy alveolar opacity in the RLL with blunting of the rt CP angle'). You are expected to make an effort to interpret your patients' ECGs and CXRs.

The Problem List

This causes many students confusion, but it is really rather simple. It is a ranked list (most to least important) of all a patient's active health problems. It should be complete, prioritized, and specific without being overly redundant. A problem list allows you to recognize patterns and helps make diagnoses that are less obvious or helps you focus your differential diagnosis in a complicated patient. For example, a young woman may come in with a complaint of chest pain. She may describe dark urine on a ROS and you note an oral ulcer and a pericardial rub on exam. Her labs reveal a mild hematuria, anemia, and thrombocytopenia. It would be easy to diagnosis her with 'pericarditis' and miss the fact that she probably has lupus, if you don't step back and look at all her active medical issues.

Furthermore, a problem list reminds you of important medical issues that may be distinct from the chief complaint but still need to be addressed. For example, a man with COPD may present with a cough and shortness of breath. In addition his admission labs show a mild microcytic anemia and an elevated glucose. It would be easy to treat him for pneumonia, watch him improve, and send him home without addressing the fact that he probably has diabetes and may be having blood loss from a potentially serious condition, like colon cancer.

The key to a successful problem list is to learn the skill of being complete and specific without being redundant. For example, a diabetic patient may present with chest pain; have bibasilar crackles, JVD, and an S3 on exam; have anterior ST elevations on ECG; interstitial infiltrates on CXR; and a hct of 30 with an MCV of 75, troponin T of 5.0, and glucose of 200. The following problem list would be incorrect:

While it is complete and somewhat prioritized, #5 & #6 are not specific and it is very redundant.

1. Chest pain
2. Bibasilar crackles
3. JVD
4. S3
5. Abnormal ECG
6. Abnormal CXR
7. Elevated troponin T
8. Low hct
9. Low MCV
10. Hyperglycemia

The following is a better example: This list is complete, prioritized, specific, and yet concise.

1. Acute anterior MI
2. CHF secondary to #1
3. Microcytic anemia
4. Type 2 DM

The Assessment and Plan

This is the place where you commit to a diagnosis, provide insight into your reasons, and recommend a plan for treatment or further evaluation. The organization of this portion of the write-up is the most flexible because each patient has a different number of active medical issues and a different level of complexity. The key is to choose a format that provides the most clarity and organization.

For example, the rare patient who is generally healthy and comes in with a very straightforward diagnosis may require only one line of assessment followed by your treatment plan. (A-“54 yo woman with LLE DVT precipitated by recent initiation of HRT. P- Heparin 80U/kg bolus, then 18U/kg/hr; heparin protocol; check platelets in 3d; warfarin 5 mg qd once PTT therapeutic”)

However, most patients you admit will have many problems and you may not be sure of the exact diagnosis. When you are unsure of the exact diagnosis, you should still commit to what you think is most likely and why. But you should follow this by commenting on the next 1-3 diagnoses that are also possible and why. Your differential diagnosis may include many more than 4-5 items but most of them are unlikely. A good rule of thumb is that you should provide specific comment about anything in your differential that you are planning to evaluate or address in some way. You need only add a comment that ‘W, X, Y, and Z are unlikely but should be considered if the initial work up is negative’. Do not include things in your differential that you know the patient doesn’t have. (e.g. splenic infarct in a patient with LUQ pain and remote history of splenectomy) It is very important to go through the exercise of generating as broad a differential diagnosis as you can for each patient. (This separates the master clinicians from the ordinary.) However, you do not need to include it as a separate list. It should flow as part of your assessment as described above.

For patients with multiple active problems, you need to address each problem.

(PLEASE NOTE: this is not the same thing as your problem list. In the assessment you are synthesizing and prioritizing the information from your problem list and often you can combine much of it into 1-2 diagnoses and problems that are unlikely to be active during the hospitalization can also be omitted from the assessment.) However, many of these problems may be related to prior diagnoses and, therefore, do not need a differential diagnosis and your detailed thought processes. They should be listed as diagnoses with a brief comment about acuity. (For example, HTN- well-controlled, type 2 DM with poor control, hypercholesterolemia- untreated). “Cards” is neither a diagnosis, nor a problem.

DO NOT ORGANIZE YOUR NOTES BY SYSTEMS NO MATTER WHAT YOU SEE OTHERS DO. In general, organizing by systems rather than problems and diagnoses leads to sloppy thinking because you lose sight of the symptom or problem you are treating and often do not prioritize the problems correctly. The plan can be incorporated into the assessment (A/P), listed in a separate paragraph, or a little of each. You will

decide based on which allows it to flow the most naturally. The plan should address both the diagnostic evaluation required and therapies. Be specific as if you were writing the orders yourself.

www.google.com/url?sa=t&rct=j&q=abraham%20verghese%20%22the%20medical%20write-up%22&source=web&cd=1&ved=0CCYQFjAA&url=http%3A%2F%2Fwww.medicine.ufl.edu%2F3rd_year_clerkship%2Fdocuments%2FThe_Medical_Write.pdf&ei=IrHSToLmGciltweV6fi pDQ&usg=AFQjCNF09Dh7Spw1QH5dOIMordS82xa9hw

PROGRESS NOTES: HISTORY & PHYSICAL ①

NAME Ned Delamar

ADMISSION # 765-43-210

Date	Time	
11/6/11		DOB: 6/24/13 Age 98 Male
		Responsible Party: Vivian Delamar, sister
		3362 Sandpiper Circle, Kinston, NC
		home 252-555-5555 cell 252-555-6565
		Reliability & Source: The patient is demented, but is the source of some information. His sister's hospital records are also used.
		Physicians: 1° Care - Dr. Frances Jones
		Orthopedist - Dr. Stephen Bones
		Cardiologist - Dr. Paul Goodheart
		Hospital: Community General
<u>Chief Complaint</u>		"I think I fell."
<u>Present Illness</u>		This man fell in his bathroom at his assisted living and sustained a right intertrochanteric fracture on 10/15/11. He was hospitalized and stabilized. Dr. Bones performed an ORIF on 10/17/11. Postop he developed CHF with a large right pleural effusion requiring a thoracentesis. He was eventually stabilized and sent to Orchid Garden Nursing and Rehab on 10/31/11 to have rehabilitation. He was occasionally agitated at night in the hospital.

PROGRESS NOTES: _____

②

NAME _____ ADMISSION # _____

Date	Time	
<u>Medications</u>		Aspirin 81 mg po qd
		Digoxin 125 mcg po qd
		Fluticasone 50mg/puff ii puffs each nostril qd
		Furosemide 40 mg i po qd
		Loratadine 10mg i po qd
		Amlodipine 5 mg i po qd
		Theophylline 300mg i po qd
		Ranitidine 150 mg i po qd
		Memantine 10 mg i po bid
		Acetaminophen TR 650 mg ii po q12h
		Diltiazem ER 180 mg i po q12h
		KCl 20 meq po q12h
		Haloperidol 1 mg po qhs
<u>Allergies</u>		Propoxyphene (confusion)
		Diazepam (confusion)
<u>Habits</u>		No use of tobacco, ethanol, nor street drugs
<u>Past Medical Hx</u>		Usual childhood illnesses & sequelae
		Atrial fibrillation, CHF, GERD, DJD, HTN,
		Osteoporosis, Anemia, Dementia, Macular
		degeneration, Kidney stones, Allergic rhinitis,
		Asthma, Agitation 2° Dementia

PROGRESS NOTES: _____

3

NAME _____ ADMISSION # _____

Date	Time	
<u>Past Surgical Hx</u>		Appendectomy
		Lithotripsy
		ORIF right hip
		Cataract extraction, bilateral, 2 implants
<u>Preventive Care</u>		Flu shot 2006 - none since
		Pneumovax - none
		Tdap - none recently
		Ophthalmology visit in 2011
		Edentulous - no dental care indication
		He does not see his physician for preventive care
<u>Family Hx</u>		CA - none
		CAD - father
		DM - mother
		CVA - none
		Dementia - self
<u>Social Hx</u>		He lives in assisted living at Rosewood
		Manor. He is a widower and had 2 children
		who are deceased. He worked as a school
		custodian. He attended school through the
		8 th grade. He is a Catholic.

PROGRESS NOTES: _____

4

NAME _____ ADMISSION # _____

Date	Time	
<u>ROS</u>		
<u>General</u>		+ wt loss, weakness, clothes looser, ↓ loss of stamina
<u>Skin</u>		+ dandruff - sores, itching, ↑ rash
<u>Eyes</u>		+ vision loss, glasses, tearing - diplopia & pain
<u>Nose</u>		+ itching, runny nose, congestion, ↑ hay fever
<u>Mouth</u>		+ edentulous, ↓ loose dentures - dryness & sores
<u>Neck</u>		- stiffness, pain, ↑ lumps
<u>Respiration</u>		+ wheezing, dyspnea - cough, chest pain, ↑ sputum
<u>Cardiovascular</u>		+ orthopnea, DOE, ↑ edema
		- angina, pain, palpitations, PND, ↑ claudication
<u>GI</u>		+ reflux & heartburn - constipation, diarrhea, ↑ pain
<u>GU</u>		+ incontinence - urgency, dysuria, hesitancy
		↑ frequency
<u>MS</u>		+ arthralgias (back, arms, & legs), weakness, stiffness, pain currently controlled
<u>Psych</u>		+ forgetfulness, ↓ anorexia
		- anxiety, anhedonia, ↓ insomnia
<u>Functional Status</u>		He could walk independently w/ walker prior to hip fracture, now unable to bear weight. He requires a full lift to get up. Incontinent x 2. He is able to feed himself, but needs assistance due to anorexia. He needs total care for toileting & dressing.

PROGRESS NOTES:

5

NAME _____

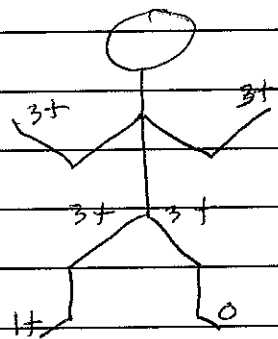
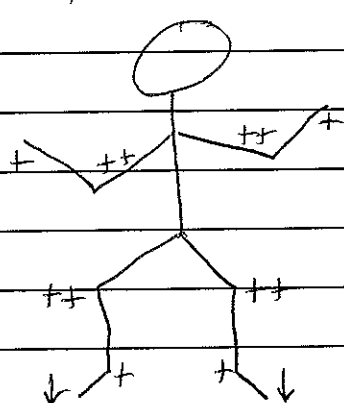
ADMISSION # _____

Date	Time	
Mental	Status	He is oriented to self. He knows what town we are in, but has no idea about this facility. He does not know the year or his age. He has no understanding of his illness or injury.
PHYSICAL VS		T 97.2 P 73 R 16 BP 130/72 wt 131.2 lb Ht 70.5 in BMI 18.6
		This is a well developed, poorly nourished, white male who is in no acute distress. He is calm and often confused
<u>HEENT</u>		- normocephalic eyes - appear normal, red reflexes +, corneas clear, pupils do not react, sclerae white, able to count fingers, Eom intact ears - able to hear, modest amount of wax, normal TM's & canals, pinnae normal nose - open, \bar{s} lesions, \bar{s} congestion mouth - edentulous, moist, no lesions, no tenderness
<u>Lungs</u>		clear to auscultation & percussion, no dullness
<u>Heart</u>		irregularly irregular rhythm \bar{c} controlled rate, no murmurs, no JVD, no edema
<u>Neck</u>		fair range of motion, no lymphadenopathy, thyroid not palpable, no carotid bruits
<u>Abdomen</u>		generally soft & nontender, liver edge at RCM, spleen percusses to 8 cm, no hernias, bowel sounds normal
<u>Genitals</u>		normal male, testicles normal, uncircumcised

PROGRESS NOTES: _____

⑥

NAME _____ ADMISSION # _____

Date	Time	
<u>PHYSICAL (cont)</u>		
	<u>Rectal</u>	No masses, no tenderness, prostate small & firm & tenderness, stool negative for occult blood (control checked)
	<u>Musculoskeletal</u>	Fair ROM to all 4 extremities & some stiffness, DJD changes extensively, poor pedal pulses, generally weak all over, no gangrene, severe onychomycosis of toenails
		 <p>Pulses</p>
		Back - straight = normal curve & no gross deformities
	<u>Lymphatics</u>	No lymphadenopathy palpable, no edema
	<u>Neurological</u>	Cranial nerves II - XII grossly intact No paralysis, sensation grossly intact
		 <p>Reflexes</p>
	<u>SKIN</u>	No rashes, no suspicious nevi, seborrhea is prominent on the scalp & face
	<u>Labs</u>	creatinine 0.7, Na 140, K 3.7, Hgb 12.2 MCV 100.2

PROGRESS NOTES: _____

7

NAME _____

ADMISSION # _____

Date	Time	
Assessment		This is a frail, 98 year old, demented man with a fractured right hip, SIP ORIF, who is anorexic, with weight loss and debility.
Function	Problem	Cognition deficits
		Inability to walk or move self
		Inability to manage his own ADL's
ACTIVE PROB	1)	Intertrochanteric fx right hip, SIP ORIF
	2)	Anorexia ± weight loss
	3)	SDAT (senile dementia, Alzheimer's type)
	4)	Atrial fibrillation
	5)	Systolic congestive heart failure
	6)	Hypertension
	7)	COPD ± asthma
	8)	DJD
	9)	Osteoporosis
	10)	Reflux esophagitis
	11)	Anemia
	12)	Debility
	13)	PVD (peripheral vascular disease)
	14)	Macular degeneration
	15)	Renal lithiasis
	16)	Allergic rhinitis
	17)	Seborrhea
	18)	Onychomycosis
	19)	Agitated behavior, episodic

PROGRESS NOTES: _____

⑧

NAME _____

ADMISSION # _____

Date	Time	
PLAN	S	1) Intertrochanteric fx rt. hip /ORIF - The pain is
		adequately controlled. PT & OT will assess him
		and treat. The dementia makes the likelihood of
		his improvement poor since learning requires memory.
		Long term care will most likely be needed.
		2) Anorexia with weight loss - The digoxin will be
		stopped as a likely cause of this. The diltiazem
		alone will control the atrial fibrillation rate. The
		digoxin has no real benefit to the CHF. He will
		be assisted in feeding and have Med Pass 120 ml
		tid between meals (720 calories total).
		3) SPAT - Current management is adequate with
		memantine. Other agents such as donepezil or
		rivastigmine could be added, but polypharmacy is
		an issue and the benefits do not outweigh the
		risk of worsening anorexia.
		4) Debility - This will be addressed by therapy and
		by ongoing mobilization and restorative care.
		5) PVD - This is stable and requires no
		further evaluation nor therapy now. The heels
		will be bridged off of the mattress with pillows
		under the calves.
		6) Atrial fibrillation - This is addressed adequately
		above
		7) Systolic CHF - This is currently stable and
		addressed adequately. A BMP will be done to monitor
		the diuretic. The KCl dose may be excessive (

PROGRESS NOTES: _____

9

NAME _____

ADMISSION # _____

Date	Time	
PLANS	8)	Hypertension - Addressed adequately
(cont)	9)	COPD = Asthma - This is currently stable, but the theophylline likely causes GI upset and may contribute to the anorexia. It will be stopped in lieu of Duoneb qid.
	10)	DJD - The arthritis pain is well controlled by acetaminophen.
	11)	Osteoporosis - This is unaddressed. He will start Citracal ii po bid (better absorbed form) and Vitamin D 5000 units twice weekly for 8 weeks and then q2 weeks. We will check a 25-OH Vitamin D level in 2 months. DEXA scanning is of no clinical utility in this setting. We will check a TSH.
	12)	Reflux esophagitis - The ranitidine is failing to work (predictably) and will be replaced by omeprazole 20 mg po qd
	13)	Anemia - This is untreated and unevaluated. We will get an Fe, TIBC, B12, and folic acid level. He will be treated accordingly.
	14)	Macular degeneration - There is no real medication for this. He will have optometry care. His vision is adequate for eating and daily functions.
	15)	Renal lithiasis - Addressed adequately
	16)	Allergic rhinitis - Addressed successfully with fluticasone and loratidine.
	17)	Seborrhea - He will have weekly shampoos with Ionil T Plus for the dandruff. The facial rash will resolve with HC 1/2% cream qd.

PROGRESS NOTES: _____

10

NAME _____ ADMISSION # _____

Date	Time	
PLANS (Cont)	18)	Episodic Agitation - Haloperidol will continue for the short term. The staff will obtain permission from him for interventions when giving care to preserve his dignity. Excessive stimulation and noise will be minimized.
	19)	Preventive Care - He will have yearly flu shots. We will now give a Pneumovax & Tdap. Eye care will be ordered. A dental consult will be arranged to reline the loose dentures, to help with eating. Podiatry will provide foot care due to PVD and onychomycosis. We will obtain a 2 nd opinion on decisional capacity for EOL care.

Goals He will be kept comfortable and function will be improved upon where possible.

Prognosis The prognosis is poor due to advanced dementia, anorexia, and weight loss, now complicated by a hip fracture & immobility.

Rehab Potential Marginal due to dementia

EOL Treatment He lacks decisional capacity so a 2nd opinion is sought. The family requests a DNR on his behalf. They expect hospitalization for serious illness, but decline g-tube use.

Family Contact I called his sister to discuss her concerns & to share my findings and recommendations.

S. Warren, MD (Edward S. Warren)