History and Physical Examination Write-up

Purpose of Written History and Physical

- Record patients story in a concise legible and well-organize manner
- Demonstrate your fund of knowledge and problem-solving skills
- Serve as a legal document concerning your patient's health care

Organization of History and Physical

- Prioritized problem list
- Identifying Information/Chief Compliant
- History of Present Illness
    - Clear Chronology with detailed descriptive symptoms
    - Includes pertinent positives and negative including risk factors and diagnostic tests related to chief complaint
- Past Medical History
- Medications and Allergies
    - Generic names of all medications including Complementary and Alternative Medications
    - Dosages and frequency when possible
    - Include specific reasons for allergies
- Family History- genogram or outline form
- Social History
- Review of Systems- includes details of positive responses
- Physical Examination
    - Starting with vital signs and then a general description
    - Organize by organ system in outline format
- Labs/Data
- Summary
    - 1-3 sentences highlighting key elements of history and physical findings.
    - Include 3 or so major differential diagnostic possibilities
- Impression
    - includes key elements of history and physical exam findings to argue for and against 3 most likely diagnoses
    - Conclude with statement about what is most likely
- Plan
    - Includes Diagnostic and Therapeutic plan

By the end of the second year students are expected to:

- Accurately and completely write up a patient history and physical
- Identify and synthesize the important findings- both positive and negative, into a summary and articulate a 3 item differential diagnosis
- Outline an organized approach to the patient's problem that reflects a review of the pertinent literature
- Articulate how various possibilities suggested by the differential diagnosis apply to the patient's history and physical