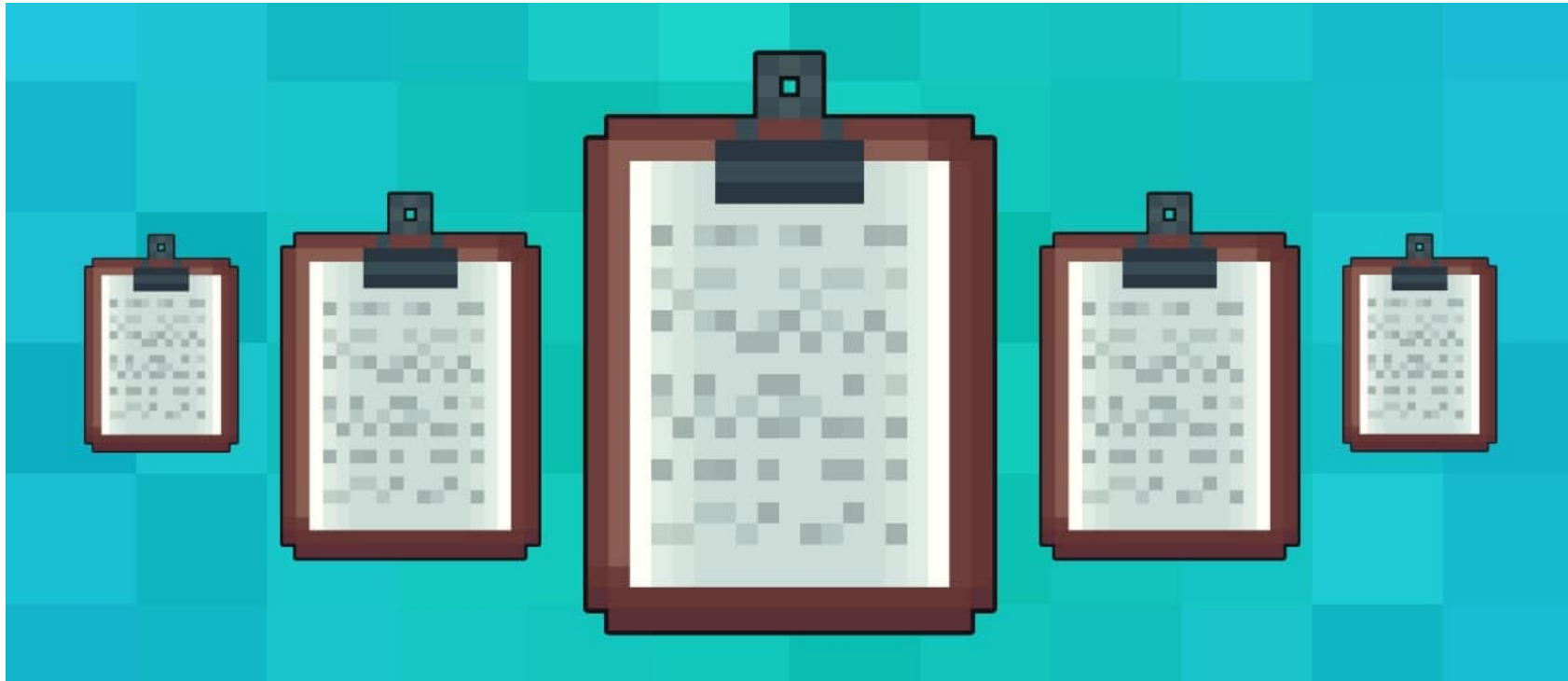


## Clerking 101

[geekymedics.com/clerking-101/](https://www.geekymedics.com/clerking-101/)

By

February 26, 2018



As a junior doctor, you will spend a lot of time writing out history and examination findings, so it is no wonder medical schools like to give us a lot of practice as a head start! This guide will help you decipher all the symbols, diagrams and shorthand you're likely to come across when reading patients notes, and give you a structure to effectively start clerking.

### Documentation basics

#### What should I use to write with?

**You need to use a pen with black ink** (as this is the most legible if notes are photocopied).

#### Patient details

**For every new sheet of paper your first task should always be documenting at least three key identifiers for a patient:**

- Full name
- Date of birth
- Unique patient identifier
- Patient's home address

If a patient label containing at least 3 identifiers is available then this can be used instead of writing out the information yourself.

## Location details

You should indicate the patient's location on the continuation sheet:

- Hospital
- Ward

**HOSPITAL:** GM Infirmary  
**WARD:** 23  
**CONSULTANT:** Dr Smith

**PATIENT NAME:** Sarah Green  
**DATE OF BIRTH:** 11/5/1984  
**HOSPITAL NUMBER:** X748493

DATE / TIME	DOCUMENTATION	

Patient identifiers

## Beginning your entry in the notes

At this point, you should already be holding a pen with black ink and you should have ensured the continuation sheet has at least three key patient identifiers at the top.

1. Add the date and time (in 24hr format) of your entry
2. Write your name and role as an underlined heading
3. Make your entry in the notes below this heading

**HOSPITAL:** GM Infirmary  
**WARD:** 23  
**CONSULTANT:** Dr Smith

**PATIENT NAME:** Sarah Green  
**DATE OF BIRTH:** 11/5/1984  
**HOSPITAL NUMBER:** X748493

DATE / TIME	DOCUMENTATION	
18/2/17 15:47	<u>Dr Raymond Elliott - F2</u>	

Beginning an entry

## Documenting the history

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Especially at the beginning, it's normal to forget some bits and jump around sections, so if your sections are in a different order, it doesn't matter too much, just make sure you have a clear heading so they're easy to spot! Some people also find it easier to write out all the headings before they start – but make sure you give yourself enough room.

## Presenting complaint (PC)

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The presenting complaint should be a few words describing the specific issue the patient has presented with (e.g. “chest pain”).

Make this short and to the point, there is space in the next section to expand.

## History of presenting complaint (HPC)

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This section allows you to expand on the presenting complaint, gathering more details about the presenting complaint.

If the symptom is some kind of pain you might use the SOCRATES structure to gather more details about it:

- **Site** – *where is the pain (e.g. central chest)*
- **Onset** – *sudden vs gradual onset*
- **Character** – *the type of pain (e.g. burning/sharp/aching)*
- **Radiation** – *does the pain move anywhere else?*
- **Associated symptoms** – *are there other symptoms that occur alongside the pain?*
- **Time course** – *duration of pain*
- **Exacerbating/relieving factors** – *does anything make the pain better or worse?*
- **Severity** – *on a scale of 0-10 how severe is the pain?*

## Past medical and surgical history (PMH)

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This section is where you document any medical conditions the patient is known to have, any significant hospital admissions and any surgical history (e.g. operations/procedures).

## Drug history (DHx)

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**This section is where you document:**

- Medications the patient is currently prescribed
- Medications the patient is buying over the counter (often referred to as OTC)
- Drug allergies
- Any compliance issues (e.g. if the patient is prescribed something but actually has chosen not to take it)

## Family history (FHx)

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Document any diseases that run in a patient's family (generally the focus should be on first degree relatives).

Drawing out a family tree can be useful to identify patterns of inheritance if the disease is genetic (*see below*).

## Social history (SHx)

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This section is where you document the various social aspects of the patient's life that may be relevant to their condition (e.g. health risk factors) and their safety at home.

**Topics can include:**

- Who the patient lives with
- Details of the patients home (e.g. *whether they have stairs*)
- Smoking history
- Alcohol history
- Recreational drug use
- Occupation

## Systems review (SR)

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A systems review involves screening for symptoms in other body systems which may or may not relate to their presenting complaint. It may be useful to start at the top of the body and move down, or you may have your own structure, do whatever works best for you.

## History abbreviations

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You're probably thinking – all this writing is going to take forever, there must be a better way. Some common abbreviations will help, but in general, you just get quicker at writing (this may be why doctors have such terrible handwriting...).

There are a lot of abbreviations, but there will always be some variation, especially with acronyms. TO be as clear as possible always write it out in full the first time with the acronym in brackets.

## History sections

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- PC = Presenting complaint
- HPC = History of presenting complaint
- PMHx = Past medical history
- SR = Systems review
- DHx = Drug history
- FHx = Family history
- SHx = Social history

## Time abbreviations

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- Number of days = number of days/7 – (e.g. 3/7 = 3 days)
- Number of weeks = number of weeks/52 – (e.g. 4/52 = 4 weeks)
- Number of hours = X<sup>o</sup> – (e.g. 8<sup>o</sup> = 8 hours)

## Medication abbreviations

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### Common abbreviations used for medications










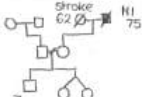
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- OD = Once daily
- BD = Twice daily
- TDS = Three times daily

- QDS = Four times daily
- PRN = As required
- SC = Subcutaneous
- IM = Intramuscular
- IV = Intravenous

## Family tree symbols

Symbols commonly used when drawing a family tree are shown below.

<b>Male</b>	
<b>Female</b>	
<b>Your patient (female)</b>	
<b>Affected by disease</b>	
<b>Married</b>	
<b>Divorced</b>	
<b>Child</b>	
<b>Twins</b>	
<b>Deceased</b>	
<b>Example:</b> Joe has had a heart attack. He has twin sisters and his parents are divorced. His maternal grandparents died from a heart attack at 75 and a stroke at 62. His paternal grandparents are alive and well.	

Family tree symbols

## Documenting the clinical examination

### On examination (O/E)

Start by documenting your general inspection (e.g. *"Patient was laid on the bed and appeared in significant discomfort"*).

### Observations (Obs/Vitals)

This is where you document the patient's current observations/vital signs (e.g. *BP/Pulse/RR/Oxygen saturation/Temperature*)

### Fluid balance

If the patient's fluid balance is being monitored write down the input (*drinking/IV/NG*) and output (*urine/stools/drains*) that has been measured.

### Focused clinical examination findings

Here you can document the focused system examinations you have performed, with the associated findings.

Examples of focused system examinations include:

- Cardiovascular examination (CVS)
- Respiratory examination (Resp)
- Gastrointestinal examination (G.I.)
- Neurological examination (Neuro)

## Examination abbreviations

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Some common abbreviations used when documenting clinical examination include:

- O/E = On examination
- BP = Blood pressure
- RR = Respiratory rate
- Sats = Oxygen saturation
- RA = Room air (when placed next to oxygen saturation)
- I + II + 0 = Heart sounds 1 and 2 heard, with no added sounds
- II + II + I = Heart sounds 1 and 2 heard, with an additional sound (e.g. murmur)
- BS = Bowel sounds
- RUL/LUL = Right upper limb / Left upper limb
- RLL/LLL = Right lower limb / Left lower limb
- CN = Cranial nerve (usually followed by a number e.g. CN 1)

## Examination diagrams

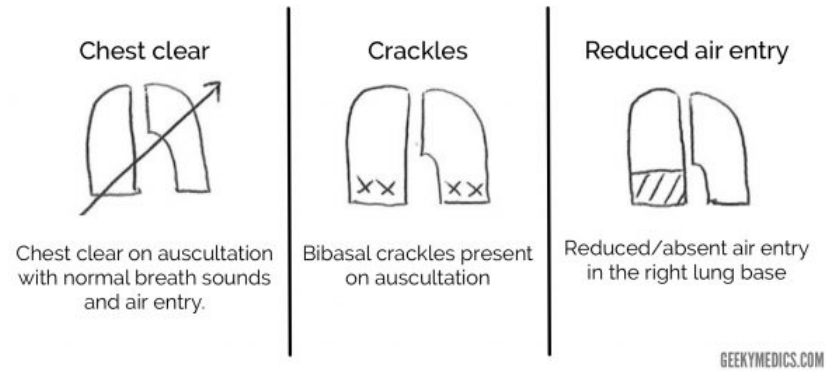
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Below are some common diagrams used when documenting clinical examination. You should avoid relying purely on diagrams to document your findings as these can be sometimes misinterpreted. Ideally, you should write out your findings beside a diagram to avoid misinterpretation. If you can't draw something, then don't, it's much better to describe what you see in writing if this is the case.

### Chest diagrams

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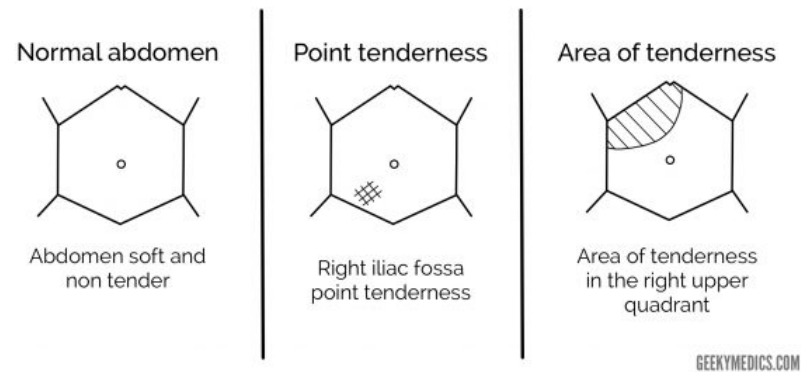
## Chest diagrams



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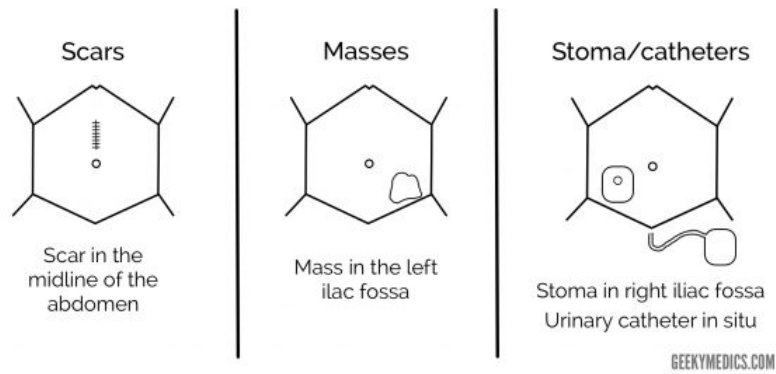
## Abdominal diagrams

## Abdominal diagrams



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## Other diagrams



## Documenting the diagnosis/differential diagnosis

In this section of the clerking, you need to document a diagnosis or suggest a differential diagnosis.

Most of the time when you clerk a patient you won't have a confirmed diagnosis and therefore you would write down some possible differentials.

The symbol for a **diagnosis** is a **singular triangle**.

The symbol for **differential diagnosis** is **two triangles** next to each other.

Differential diagnosis	△ △
Diagnosis	△



## Documenting the management plan

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In this section, you need to document your plan in the form of a list.

This makes it clear to others reading the notes what investigations are underway and what interventions are planned.

### *Plan*

- 1) *Urgent medical registrar review*
- 2) *Critical care outreach review*
- 3) *Switch to 60% Venturi mask and monitor O2 saturations*

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## Completing the entry in the notes

**At the end of your entry to need to include the following:**

- Your full name
- Your grade/role (e.g. Medical student/F2/Respiratory registrar)
- Your signature
- Your professional registration number (e.g. GMC number)
- Your contact number (e.g. phone/bleep)

*Plan*

- 1) Urgent medical registrar review
- 2) Critical care outreach review
- 3) Switch to 60% Venturi mask and monitor O2 saturations

*Dr Raymond Elliott**F2**RElliott**Bleep 542742**GMC number 37588*

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## References

If you would like to have a more in-depth look at the recommended standards for medical documentation then check out: <https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards>

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