Sample Written History and Physical Examination   
History and Physical Examination   
   
   
   
   
Comments   
   
Patient Name:   
Rogers, Pamela   
Date:   
6/2/04   
   
Referral Source:   
Emergency Department   
   
Data Source:   
Patient   
   
Chief Complaint & ID: Ms. Rogers is a 56 y/o WF   
   
   
Define the reason for the patient’s visit as who has been   
having chest pains for the last week.   
   
   
   
   
specifically as possible.   
   
   
   
   
   
History of Present Illness   
   
This is the first admission for this 56 year old woman,   
   
   
Convey the acute or chronic nature of the problem and   
who states she was in her usual state of good health until   
   
establish a chronology.   
one week prior to admission. At that time she noticed the   
abrupt onset (over a few seconds to a minute) of chest pain   
   
onset   
which she describes as dull and aching in character. The   
   
character   
pain began in the left para-sternal area and radiated up to   
   
location   
her neck. The first episode of pain one week ago occurred   
   
radiation   
when she was working in her garden in the middle of the   
   
circumstances; exacerbating factors   
day. She states she had been working for approximately 45   
minutes and began to feel tired before the onset of the pain.   
Her discomfort was accompanied by shortness of breath, but   
   
associated symptoms   
no sweating, nausea, or vomiting. The pain lasted   
approximately 5 to 10 minutes and resolved when she went   
   
duration   
inside and rested in a cool area.   
   
   
   
   
resolution; alleviating factors   
   
Since that initial pain one week ago she has had 2 additional   
   
Describe the natural history of her problem since its   
episodes of pain, similar in quality and location to the first   
   
onset   
episode. Three days ago she had a 15 minute episode of   
pain while walking her dog, which resolved with rest. This   
   
Change or new circumstances to the problem   
evening she had an episode of pain awaken her from sleep,   
   
New duration   
lasting 30 minutes, which prompted her visit to the   
   
   
Reason she come in for visit   
Emergency Department. At no time has she attempted any   
   
What has patient tried for relief   
specific measures to relieve her pain, other than rest. She   
describes no other associated symptoms during these   
episodes of pain, including dizziness, or palpitations. She   
becomes short of breath during these   
   
   
   
   
Relevant positive and negative ROS for this complaint   
episodes but describes no other exertional dyspnea,   
orthopnea, or paroxysmal nocturnal dyspnea. No change in the pain   
with movement, no association with food, no GERD sx, no palpable pain.   
She has never been told she has heart problems, never had any   
   
Review of systems for the relevant organ system   
chest pains before, does not have claudication. She was diagnosed with   
HTN 3 years ago,   
   
She does not smoke nor does she have diabetes.   
   
   
   
Relevant risk factor/environmental conditions   
She was diagnosed with hypertension 3 years ago and had a   
TAH with BSO 6 years ago. She is not on hormone replacement   
therapy. There is a family history of premature CAD.   
She does not know her cholesterol level.   
   
Past Medical History   
   
Surgical –   
1994:   
Total abdominal hysterectomy and bilateral   
   
This highly relevant, although it may seem like a   
   
   
oophorectomy for uterine fibroids.   
   
   
   
trivial detail at first   
1998:   
Bunionectomy

Medical History –   
1998:   
Diagnosed with hypertension and began on   
   
   
unknown medication. Stopped after 6 months   
   
   
because of drowsiness.   
1990:   
Diagnosed with peptic ulcer disease, which   
   
   
resolved after three months on cimetidine. She   
   
Always use generic names   
   
   
describes no history of cancer, lung disease   
or previous heart disease.   
   
Allergy:   
Penicillin; experienced rash and hives in 1985.   
   
Always list the type of reported reaction   
   
Social History –   
Alcohol use:   
1 or 2 beers each weekend; 1 glass of   
   
Quantity   
   
   
   
wine once a week with dinner.   
Tobacco use:   
None.   
Medications:   
No prescription or illegal drug use.   
   
   
   
Occasional OTC ibuprofen (Advil) for   
   
Include over-the-counter drugs   
   
   
   
headache (QOD).   
   
Family History   
   
Mother:   
   
79, alive and well.   
   
   
   
   
Comment specifically on the presence or absence of   
Father:   
   
54, deceased, heart attack. No brothers   
   
diseases relevant to the chief complaint   
   
   
   
or sisters. There is a positive family history of   
   
   
   
hypertension, but no diabetes, or cancer.   
   
Review of Systems   
   
HEENT:   
No complaints of headache change in vision, nose or ear   
   
Separate each ROS section for easy identification   
problems, or sore throat.   
   
Cadiovascular:   
See HPI   
   
   
   
   
   
   
   
OK to refer to HPI if adequately covered there   
   
   
Gastrointestinal:   
No complaints of dysphagia, nausea, vomiting, or change in   
   
List positive and negative findings in brief, concise   
stool pattern, consistency, or color. She complains of   
   
   
phrases or sentences   
epigastric pain, burning in quality, approximately twice a   
month, which she notices primarily at night.   
   
Genitourinary:   
No complaints of dysuria, nocturia, polyuria, hematuria, or   
vaginal bleeding.   
   
Musculoskeletal:   
She complains of lower back pain, aching in quality,   
approximately once every week after working in her garden.   
This pain is usually relieved with Tylenol. She complains of   
no other arthralgias, muscle aches, or pains.   
   
Neurological:   
She complains of no weakness, numbness, or incoordination.

Physical Examination   
Vital Signs:   
Blood Pressure 168/98, Pulse 90, Respirations 20,   
   
   
Always list vital signs. Check for orthostatic BP/P   
Temperature 37 degrees.   
   
   
   
   
   
changes if it is relevant to the patient’s complaint   
   
General:   
Ms. Rogers appears alert, oriented and cooperative.   
   
   
Description may give very important clues as to the   
   
   
   
   
   
   
   
   
   
nature or severity of the patient’s problem   
Skin:   
Normal in appearance, texture, and temperature   
   
   
Comment on all organ systems   
   
HEENT:   
Scalp normal.   
   
   
   
   
   
   
List specific normal or pathological findings when   
   
   
   
   
   
   
   
   
   
relevant to the patient’s complaint   
Pupils equally round, 4 mm, reactive to light and   
accommodation, sclera and conjunctiva normal.   
Fundoscopic examination reveals normal vessels without   
hemorrhage.   
   
Tympanic membranes and external auditory canals normal.   
   
Nasal mucosa normal.   
   
Oral pharynx is normal without erythema or exudate. Tongue   
and gums are normal.   
   
Neck:   
Easily moveable without resistance, no abnormal adenopathy   
in the cervical or supraclavicular areas. Trachea is midline   
and thyroid gland is normal without masses. Carotid artery   
upstroke is normal bilaterally without bruits. Jugular venous   
pressure is measured as 8 cm with patient at 45 degrees.   
   
Chest:   
Lungs are clear to auscultation and percussion bilaterally   
   
This patient needs a detailed cardiac examination   
except for crackles heard in the lung bases bilaterally. PMI   
is in the 5th inter-costal space at the mid clavicular line. A   
grade 2/6 systolic decrescendo murmur is heard best at the   
second right inter-costal space which radiates to the neck.   
A third heard sound is heard at the apex. No fourth heart   
sound or rub are heard. Cystic changes are noted in the   
breasts bilaterally but no masses or nipple discharge is   
Seen.   
   
Abdomen:   
The abdomen is symmetrical without distention; bowel   
sounds are normal in quality and intensity in all areas; a   
bruit is heard in the right paraumbilical area. No masses or   
splenomegaly are noted; liver span is 8 cm by percussion.   
   
More precise than saying “no hepatomegaly”   
   
Extremities:   
No cyanosis, clubbing, or edema are noted. Peripheral   
pulses in the femoral, popliteal, anterior tibial, dorsalis pedis,   
brachial, and radial areas are normal.   
   
Nodes:   
No palpable nodes in the cervical, supraclavicular, axillary   
or inguinal areas.   
   
Genital/Rectal:   
Normal rectal sphincter tone; no rectal masses or   
   
   
Always include these exams, or comment specifically   
tenderness. Stool is brown and guaiac negative. Pelvic   
   
   
why they were omitted

exmaination reveals normal external genitalia, and normal   
vagina and cervix on speculum examination. Bimanual   
examination reveals no palpable uterus, ovaries, or masses.   
   
Neurological:   
Cranial nerves II-XII are normal. Motor and sensory   
examination of the upper and lower extremities is normal.   
Gait and cerebellar function are also normal. Reflexes are   
normal and symmetrical bilaterally in both extremities.   
   
   
   
   
Initial Problem List   
   
1.   
Chest Pain   
   
   
   
   
   
Although you can omit this initial problem list from your   
2.   
Dyspnea   
   
   
   
   
   
   
final written H&P, (and just list a final problem list   
3.   
History of HTN (4 years)   
   
   
   
   
shown below), it is useful to make an initial list simply   
4.   
History of TAH/BSO   
   
   
   
   
to keep track of all problems uncovered in the interview   
5.   
History of peptic ulcer disease   
   
   
   
(#1-9 in this list) and exam (#10-13)   
6.   
Penicillin allergy   
7.   
FH of early ASCVD   
8.   
Epigastric pain   
9.   
Low back pain   
10.   
Hypertension   
11.   
Systolic murmur   
12.   
Cystic changes of breasts   
13.   
Abdominal bruit   
   
Revised Problem List   
   
1.   
Chest pain   
   
   
   
   
   
This list regroups related problems (or those you   
2.   
FH of early ASCVD   
   
   
   
   
suspect are related) into a more logical sequence   
3.   
Early surgical menopause   
4.   
Dyspnea   
5.   
Recent onset HTN   
6.   
Abdominal bruit   
7.   
Systolic ejection murmur   
8.   
Epigastric pain   
9.   
History of peptic ulcer disease   
10.   
Lumbosacral back pain   
11.   
OTC non-steroidal analgesic use   
12.   
Cystic changes of breasts   
13.   
Penicillin allergy

Assessment and Differential Diagnosis   
   
1.   
Chest pain with features of angina pectoris   
   
This patient’s description of dull, aching, exertion   
related substernal chest pain is suggestive of ischemic cardiac   
origin. Her findings of a FH of early ASCVD, hypertension, and   
early surgical menopause are pertinent risk factors for development   
of coronary artery disease. Therefore, the combination of this   
patient’s presentation, and the multiple risk factors make angina   
pectoris the most likely diagnosis. The pain symptoms appear to   
be increasing, and the occurrence of pain at rest suggests this   
fits the presentation of unstable angina, and hospitalization is   
indicated.   
   
   
   
Other processes may explain her chest pain, but   
are less likely. Gastro-esophageal reflux disease (GERD) may   
occur at night with recumbency, but usually is not associated with   
exertion. The pain of GERD is usually burning, and the patient   
describes no associated gastrointestinal symptoms such as   
nausea, vomiting or abdominal pain which might suggest peptic   
ulcer disease. The presence of dyspnea might suggest a   
pulmonary component to this patient’s disease process, but   
the absence of fever, cough or abnormal pulmonary examination   
findings make a pulmonary infection less likely, and the   
association of the dyspnea with the chest pain supports the   
theory that both symptoms may be from ischemic heart disease.   
   
2.   
Dyspnea   
   
Her dyspnea may correlate with findings on physical   
exam of a third heart sound and pulmonary crackles,   
suggesting left ventricular dysfunction. In that case, she may   
be manifesting symptoms and findings of congestive heart   
failure from myocardial ischemia.   
   
3.   
Recent onset hypertension and abdominal bruit   
   
This combination raises the possibility of a   
secondary cause of hypertension, specifically ASCVD of the   
renal artery leading to renovascular hypertension. The lack   
of hypertensive retinopathy and left ventricular hypertrophy   
on physical examination further support a recent onset of her   
BP elevation.   
   
4.   
Systolic murmur   
   
The possibility of important valvular heart disease   
is raised by the murmur, specifically, aortic stenosis. The   
murmur radiates to the neck as an aortic valvular murmur   
often does, but a normal carotid upstroke may mean this   
murmur is not significant.   
   
5.   
Epigastric discomfort, NSAID use with a history   
of peptic ulcer disease.   
   
6.   
Lumbo-sacral back pain   
   
7.   
Fibrocystic breast disease   
   
8.   
Penicillin allergy   
   
   
   
   
   
   
In the assessment you take each of the patient’s major   
problems and draw conclusions, in this case that the chest   
pain is more likely due to ischemic heart disease instead   
of other possibilities. You tie in several of the other   
problems as risk factors for ischemic heart disease, and   
not merely as random unrelated problems. You should list   
and extensive justification for your most likely diagnosis.   
You should also explain why you are less suspicious of   
alternative diagnoses, such as esophageal reflux disease,   
pulmonary or musculoskeletal pain.   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
As in the previous problem, you should explain, in more   
detail than is shown in this example, why you felt the dyspnea   
is more likely to be from ischemic heart disease, and not   
asthma, bronchitis, or other possibilities. Follow this pattern   
for all subsequent problems.

Plan:   
   
1.   
Carefully monitor the patient for any increased chest pain that   
might be indicative of impending myocardial infarction by admitting   
the patient to the telemetry floor.   
   
2.   
Start platelet inhibitors, such as aspirin to decrease the risk of   
myocardial infarction; start nitrates to decrease the risk of occlusion   
and to treat her symptoms of pain. For prolonged pain un-   
responsive to nitrates, she may need an analgesic such as   
morphine. The nitrates will also help to lower her BP.   
   
3.   
Patient should have her cholesterol monitored and when   
discharged she should be started on an appropriate exercise and   
weight loss program, including a low-fat diet. If her cholesterol   
is elevated, she may need cholesterol-lowering medication such   
as HMG Co-reductases.   
   
4.   
Schedule a cardiac catheterization since non-invasive   
tests have a high pretest probability for being positive and regard-   
less of the result, negative or positive, she will need a cath   
   
5.   
Begin diuretics for her dyspnea which is most likely secondary   
to volume overload – this will treat her high BP as well. She should   
have a ventriculogram with the cath that will assess cardiac size   
and presence of wall motion abnormalities.   
   
6.   
Appropriate lab work would include BUN/Creatinine   
to assess kidney function, electrolytes and baseline EKG.   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
   
You should develop a diagnostic and therapeutic plan   
for the patient. Your plan should incorporate acute and   
long-term care of the patient’s most likely problem. You   
should consider pharmacologic and non-pharmacologic   
measures and be cognizant of the fact that you need to   
treat the symptoms (i.e. make the patient comfortable) as   
much as treating the disease when possible. You are   
expected to know the usual classes of medications used   
to treat these illnesses.