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 having chest pains for the last week.	Define the reason for the patient's visit as who has been specifically as possible.
History of Present Illness	
This is the first admission for this 56 year old woman, who states she was in her usual state of good health until one week prior to admission. At that time she noticed the abrupt onset (over a few seconds to a minute) of chest pain which she describes as dull and aching in character. The pain began in the left para-sternal area and radiated up to her neck. The first episode of pain one week ago occurred when she was working in her garden in the middle of the 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 no sweating, nausea, or vomiting. The pain lasted approximately 5 to 10 minutes and resolved when she went inside and rested in a cool area.	Convey the acute or chronic nature of the problem and establish a chronology. onset character location radiation circumstances; exacerbating factors associated symptoms duration resolution; alleviating factors
Since that initial pain one week ago she has had 2 additional episodes of pain, similar in quality and location to the first episode. Three days ago she had a 15 minute episode of pain while walking her dog, which resolved with rest. This evening she had an episode of pain awaken her from sleep, lasting 30 minutes, which prompted her visit to the Emergency Department. At no time has she attempted any 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 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 chest pains before, does not have claudication. She was diagnosed with HTN 3 years ago,	Describe the natural history of her problem since its onset Change or new circumstances to the problem New duration Reason she come in for visit What has patient tried for relief Relevant positive and negative ROS for this complaint Review of systems for the relevant organ system
She does not smoke nor does she have diabetes. 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.	Relevant risk factor/environmental conditions
Past Medical History	
Surgical – **1994:** Total abdominal hysterectomy and bilateral oophorectomy for uterine fibroids. **1998:** Bunionectomy	This highly relevant, although it may seem like a trivial detail at first

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 describes no history of cancer, lung disease or previous heart disease.

Always use generic names

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 wine once a week with dinner.

Quantity

Tobacco use: None.

Medications: No prescription or illegal drug use. Occasional OTC ibuprofen (Advil) for headache (QOD).

Include over-the-counter drugs

Family History

Mother: 79, alive and well.

Father: 54, deceased, heart attack. No brothers or sisters. There is a positive family history of hypertension, but no diabetes, or cancer.

Comment specifically on the presence or absence of diseases relevant to the chief complaint

Review of Systems

HEENT:
No complaints of headache change in vision, nose or ear problems, or sore throat.

Separate each ROS section for easy identification

Cadiovascular:
See HPI

OK to refer to HPI if adequately covered there

Gastrointestinal:
No complaints of dysphagia, nausea, vomiting, or change in stool pattern, consistency, or color. She complains of epigastric pain, burning in quality, approximately twice a month, which she notices primarily at night.

List positive and negative findings in brief, concise phrases or sentences

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.