1.1.12 History and Physical (V3)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2015-08-01 (open)]`

Table 39: History and Physical (V3) Contexts

Contained By:	Contains:
	Assessment Section (optional) Review of Systems Section (required) Chief Complaint Section (optional) Reason for Visit Section (optional) Chief Complaint and Reason for Visit Section (optional) History of Present Illness Section (optional) General Status Section (required) Medications Section (entries optional) (V2) (required) Plan of Treatment Section (V2) (optional) Procedures Section (entries optional) (V2) (optional) Assessment and Plan Section (V2) (optional) Instructions Section (V2) (optional) US Realm Date and Time (DT.US.FIELDED) (required) Immunizations Section (entries optional) (V3) (optional) Results Section (entries optional) (V3) (required) Past Medical History (V3) (required) Vital Signs Section (entries optional) (V3) (required) Problem Section (entries optional) (V3) (optional) Physical Exam Section (V3) (required) Social History Section (V3) (required) Family History Section (V3) (required) Allergies and Intolerances Section (entries optional) (V3) (required)

A History and Physical (H&P) note is a medical report that documents the current and past conditions of the patient. It contains essential information that helps determine an individual's health status. The first portion of the report is a current collection of organized information unique to an individual. This is typically supplied by the patient or the caregiver, concerning the current medical problem or the reason for the patient encounter. This information is followed by a description of any past or ongoing medical issues, including current medications and allergies. Information is also obtained about the patient's lifestyle, habits, and diseases among family members.

The next portion of the report contains information obtained by physically examining the patient and gathering diagnostic information in the form of laboratory tests, imaging, or other diagnostic procedures.

The report ends with the clinician's assessment of the patient's situation and the intended plan to address those issues.

A History and Physical Examination is required upon hospital admission as well as before operative procedures. An initial evaluation in an ambulatory setting is often documented in the form of an H&P note.

Table 40: History and Physical (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2015-08-01)					
templateId	1..1	SHALL		1198-8283	
@root	1..1	SHALL		1198-10046	2.16.840.1.113883.10.20.22.1.3
@extension	1..1	SHALL		1198-32518	2015-08-01
code	1..1	SHALL		1198-17185	
@code	1..1	SHALL		1198-17186	urn:oid:2.16.840.1.113883.1.11.20.22 (HPDocumentType)
informationRecipient	0..*	MAY		1198-32482	
intendedRecipient	1..1	SHALL		1198-32483	
participant	0..*	MAY		1198-8286	
inFulfillmentOf	0..*	MAY		1198-8336	
componentOf	1..1	SHALL		1198-8338	
encompassingEncounter	1..1	SHALL		1198-8339	
id	1..*	SHALL		1198-8340	
effectiveTime	1..1	SHALL		1198-8341	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
responsibleParty	0..1	MAY		1198-8345	
encounterParticipant	0..*	MAY		1198-8342	
location	0..1	MAY		1198-8344	
component	1..1	SHALL		1198-8349	
structuredBody	1..1	SHALL		1198-30570	
component	1..1	SHALL		1198-30571	
section	1..1	SHALL		1198-30572	Allergies and Intolerances Section (entries optional) (V3) (identifier:

XPath	Card.	Verb	Data Type	CONF#	Value
					urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2015-08-01
component	0..1	MAY		1198-30573	
section	1..1	SHALL		1198-30574	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1198-30575	
section	1..1	SHALL		1198-30576	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1198-30577	
section	1..1	SHALL		1198-30578	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1198-30579	
section	1..1	SHALL		1198-30580	Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
component	0..1	MAY		1198-30581	
section	1..1	SHALL		1198-30582	Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13
component	1..1	SHALL		1198-30583	
section	1..1	SHALL		1198-30584	Family History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01
component	1..1	SHALL		1198-30585	
section	1..1	SHALL		1198-30586	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5
component	1..1	SHALL		1198-30587	
section	1..1	SHALL		1198-30588	Past Medical History (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1

XPath	Card.	Verb	Data Type	CONF#	Value
					0.20.22.2.20:2015-08-01
component	0..1	SHOULD		1198-30589	
section	1..1	SHALL		1198-30590	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
component	0..1	MAY		1198-30591	
section	1..1	SHALL		1198-30592	Immunizations Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2015-08-01
component	0..1	MAY		1198-30593	
section	1..1	SHALL		1198-31385	Instructions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09
component	1..1	SHALL		1198-30595	
section	1..1	SHALL		1198-30596	Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09
component	1..1	SHALL		1198-30597	
section	1..1	SHALL		1198-30598	Physical Exam Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2015-08-01
component	0..1	MAY		1198-30599	
section	1..1	SHALL		1198-30600	Problem Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2015-08-01
component	0..1	MAY		1198-30601	
section	1..1	SHALL		1198-30602	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	MAY		1198-30603	
section	1..1	SHALL		1198-30604	Reason for Visit Section (identifier:

XPath	Card.	Verb	Data Type	CONF#	Value
					urn:oid:2.16.840.1.113883.10.20.22.2.12
component	1..1	SHALL		1198-30605	
section	1..1	SHALL		1198-30606	Results Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2015-08-01
component	1..1	SHALL		1198-30607	
section	1..1	SHALL		1198-30608	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	1..1	SHALL		1198-30609	
section	1..1	SHALL		1198-30610	Social History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01
component	1..1	SHALL		1198-30611	
section	1..1	SHALL		1198-30612	Vital Signs Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2015-08-01

1.1.13 Properties

1. Conforms to **US Realm Header (V3)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2015-08-01).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1198-8283) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.3" (CONF:1198-10046).
    b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32518).
    c. When asserting this templateId, all C-CDA 2.1 section and entry templates that had a previous version in C-CDA R1.1 **SHALL** include both the C-CDA 2.1 templateId and the C-CDA R1.1 templateId root without an extension. See C-CDA R2.1 Volume 1 - Design Considerations for additional detail (CONF:1198-32939).

The H&P Note recommends use of a single document type code, 34117-2 "History and physical note", with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type.

3. **SHALL** contain exactly one [1..1] **code** (CONF:1198-17185).

a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **HPDocumentType** urn:oid:2.16.840.1.113883.1.11.20.22 **DYNAMIC** (CONF:1198-17186).

4. **MAY** contain zero or more [0..*] **informationRecipient** (CONF:1198-32482).
    a. The informationRecipient, if present, **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1198-32483).

1.1.13.1 participant

The participant element in the H&P header follows the General Header Constraints for participants. H&P Note does not specify any use for functionCode for participants. Local policies will determine how this element should be used in implementations.

5. **MAY** contain zero or more [0..*] **participant** (CONF:1198-8286).

A special class of participant is the supporting person or organization: an individual or an organization that has a relationship to the patient, including parents, relatives, caregivers, insurance policyholders, and guarantors. In the case of a supporting person who is also an emergency contact or next-of-kin, a participant element should be present for each role recorded.

a. When participant/@typeCode is IND, associatedEntity/@classCode **SHALL** be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes **DYNAMIC** (CONF:1198-8333).

1.1.13.2 inFulfillmentOf

inFulfillmentOf elements describe the prior orders that are fulfilled (in whole or part) by the service events described in this document. For example, the prior order might be a referral and the H&P Note may be in partial fulfillment of that referral.

6. **MAY** contain zero or more [0..*] **inFulfillmentOf** (CONF:1198-8336).

1.1.13.3 componentOf

The H&P Note is always associated with an encounter.

7. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1198-8338).
    a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1198-8339).
        i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1198-8340).

The effectiveTime represents the time interval or point in time in which the encounter took place.

ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1198-8341).

The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care.

iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1198-8345).

1. The responsibleParty element, if present, **SHALL** contain an assignedEntity element, which **SHALL** contain an assignedPerson element, a representedOrganization element, or both (CONF:1198-8348).

The encounterParticipant elements represent only those participants in the encounter, not necessarily the entire episode of care.

iv. This encompassingEncounter **MAY** contain zero or more [0..*] **encounterParticipant** (CONF:1198-8342).

1. An encounterParticipant element, if present, **SHALL** contain an assignedEntity element, which **SHALL** contain an assignedPerson element, a representedOrganization element, or both (CONF:1198-8343).

v. This encompassingEncounter **MAY** contain zero or one [0..1] **location** (CONF:1198-8344).

1.1.13.4 component

8. **SHALL** contain exactly one [1..1] **component** (CONF:1198-8349).

In this template (templateId 2.16.840.1.113883.10.20.22.1.3.2), coded entries are optional.

a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-30570).

i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30571) such that it

1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2015-08-01) (CONF:1198-30572).

ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30573) such that it

1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1198-30574).

iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30575) such that it

1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1198-30576).

iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30577) such that it

1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier:

urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1198-30578).

v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30579) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1198-30580).

vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30581) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint and Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1198-30582).

vii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30583) such that it
    1. **SHALL** contain exactly one [1..1] **Family History Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01) (CONF:1198-30584).

viii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30585) such that it
    1. **SHALL** contain exactly one [1..1] **General Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1198-30586).

ix. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30587) such that it
    1. **SHALL** contain exactly one [1..1] **Past Medical History (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2015-08-01) (CONF:1198-30588).

x. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-30589) such that it
    1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1198-30590).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30591) such that it
    1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2015-08-01) (CONF:1198-30592).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30593) such that it
    1. **SHALL** contain exactly one [1..1] **Instructions Section (V2)** (identifier:

urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09) (CONF:1198-31385).

xiii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30595) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1198-30596).

xiv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30597) such that it

1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2015-08-01) (CONF:1198-30598).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30599) such that it

1. **SHALL** contain exactly one [1..1] **Problem Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2015-08-01) (CONF:1198-30600).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30601) such that it

1. **SHALL** contain exactly one [1..1] **Procedures Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1198-30602).

xvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30603) such that it

1. **SHALL** contain exactly one [1..1] **Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1198-30604).

xviii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30605) such that it

1. **SHALL** contain exactly one [1..1] **Results Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2015-08-01) (CONF:1198-30606).

xix. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30607) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1198-30608).

xx. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30609) such that it

1. **SHALL** contain exactly one [1..1] **Social History Section (V3)** (identifier:

urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01) (CONF:1198-30610).

xxi. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30611) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2015-08-01) (CONF:1198-30612).

xxii. This structuredBody **SHALL** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) or a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) (CONF:1198-30613).

xxiii. This structuredBody **SHALL** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1198-30614).

xxiv. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1198-30615).

xxv. This structuredBody **SHALL NOT** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1198-30616).

Table 41: HPDocumentType

Value Set: HPDocumentType urn:oid:2.16.840.1.113883.1.11.20.22

(Clinical Focus: Subclassification of history & physical document by setting, author role, and author specialty),(Data Element Scope: ClinicalDocument.code@code in H&P Document template in C-CDA R2.1),(Inclusion Criteria: Some selected LOINC codes for information that uses H&P Document template to represent the information in CDA),(Exclusion Criteria:)

This value set was imported on 6/25/2019 with a version of 20190517.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.1.11.20.22/expansion

Code	Code System	Code System OID	Print Name
11492-6	LOINC	urn:oid:2.16.840.1.113883.6.1	Provider-unspecifed, History and physical note
28626-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Physician History and physical note
34094-3	LOINC	urn:oid:2.16.840.1.113883.6.1	Cardiology Hospital Admission history and physical note
34095-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Comprehensive history and physical note
34096-8	LOINC	urn:oid:2.16.840.1.113883.6.1	Nursing facility Comprehensive history and physical note
34115-6	LOINC	urn:oid:2.16.840.1.113883.6.1	Medical student Hospital History and physical note
34116-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Physician Nursing facility History and physical note
34117-2	LOINC	urn:oid:2.16.840.1.113883.6.1	History and physical note
34138-8	LOINC	urn:oid:2.16.840.1.113883.6.1	Targeted history and physical note
34763-3	LOINC	urn:oid:2.16.840.1.113883.6.1	General medicine Admission history and physical note
…			

Figure 30: H&P encompassingEncounter Example

```
<componentOf>
    <encompassingEncounter>
        <id extension="9937012" root="2.16.840.1.113883.19" />
        <code codeSystem="2.16.840.1.113883.6.12" codeSystemName="CPT"
               code="99213" displayName="Evaluation and Management" />
        <effectiveTime>
            <low value="20090227130000+0500" />
            <high value="20090227130000+0500" />
        </effectiveTime>
        <location>
            <healthCareFacility>
                <id root="2.16.540.1.113883.19.2" />
            </healthCareFacility>
        </location>
    </encompassingEncounter>
</componentOf>
```

1.1.14 Operative Note (V3)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.7:2015-08-01 (open)]

Table 42: Operative Note (V3) Contexts

Contained By:	Contains:
	Operative Note Fluids Section (optional) Operative Note Surgical Procedure Section (optional) Surgical Drains Section (optional) Procedure Description Section (required) Procedure Disposition Section (optional) Procedure Estimated Blood Loss Section (required) Procedure Specimens Taken Section (required) Postoperative Diagnosis Section (required) Procedure Implants Section (optional) Plan of Treatment Section (V2) (optional) Anesthesia Section (V2) (required) Procedure Indications Section (V2) (optional) Planned Procedure Section (V2) (optional) US Realm Date and Time (DT.US.FIELDED) (required) Complications Section (V3) (required) Procedure Findings Section (V3) (required) Preoperative Diagnosis Section (V3) (required)

The Operative Note is a frequently used type of procedure note with specific requirements set forth by regulatory agencies.

The Operative Note is created immediately following a surgical or other high-risk procedure. It records the pre- and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the