# Normal Exam Documentation

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#### **Normal Exam Documentation**

Documentation of a basic, normal neuro exam should look something along the lines of the following: The patient is alert and oriented to person, place, and time with normal speech. No motor deficits are noted, with muscle strength 5/5 bilaterally. Sensation is intact bilaterally. Reflexes are 2+ bilaterally.

### Documenting a Neuro Exam, Decoded | MidlevelU

F:\2012-13\FORMS\Normal\_PE\_Sample\_write-up.doc 1 of 5 Revised 1/28/13 DATA BASE SAMPLE: PHYSICAL EXAMINATION WITH ALL NORMAL FINDINGS GENERAL APPEARANCE: (include general mental status) 45 y/o female who is awake and alert and who appears healthy and looks her stated age VITALS

#### DATA BASE SAMPLE: PHYSICAL EXAMINATION WITH ALL NORMAL ...

Mental Status Exam Medical Transcription Samples for Medical Transcriptionists. ... Normal Physical Examination Template Format For Medical Transcriptionists. This page has moved and can be found at the link below, Normal Physical Exam Template format for Medical Transcriptionists.

### Normal Physical Examination Template Format For Medical ...

Bald head with slight dryness on scalp. Otherwise, normal exam. Eyes. Lids and conjunctivae (discharge, icterus, ptosis, edema) No significant findings. Pupils and irises (reaction to light and accommodation, size, symmetry, extraocular movements, visual fields, visual acuity) Vision corrected to normal with bifocal lenses.

#### **DOCUMENTATION OF HISTORY AND PHYSICAL EXAM**

Genitourinary Exam. A normal female exam includes evaluation of the perineum (the space between the vagina and anus), the external genitalia, the vagina, uterus and adnexa (ovaries) The external genitalia is without lesions. Introitus is normal, vaginal walls pink and moist without lesions or evidence of trauma. There is no cervical motion...

# **Genitourinary Exam | medicalscribe**

Documentation of the Ocular Exam Nicholas Testa, MD . Associate Medical Director LAC+USC Medical Center ., Assistant Clinical Professor of Emergency Medicine . testa((ousc.edu . Documenting an ocular exam is a unique art that if done in a consistent fashion can guide the

#### Documentation of the Ocular Exam - ophthal.nyuem.org

Normal Eye Exam Documentation. The documentation process is not only used for the abnormal eye but also the normal eye. This eye exam is guided by a health institution. The institution can perform an audit to see the proper documentation. The audit has several criteria. Normal eyes are not always in good health.

#### Normal Eye Exam Documentation | Perrla Eyes

The testicular exam is done as part of a routine physical exam or for evaluation of testicular/penile complications (e.g. pain, swelling, etc.). We describe the proper technique here.

#### Male Genitalia Exam: Physical Exam - EBM Consult

28. Pelvic & Pap Smear A pelvic examination and pap smear should be performed every 2 years between ages 21-29 and every 3 years between ages 30-64 after 3 conscective normal pap tests. Stop screening between ages 65-70, if no abnormal pap tests in 10 years. 30. Mammogram A mammogram should be obtained every 1-2yrs for women 50 & older 31.

#### **OB/GYN MEDICAL RECORD DOCUMENTATION GUIDELINES - cfhp.com**

History and Physical Examination (H&P) Examples The links below are to actual H&Ps written by UNC students during their inpatient clerkship rotations. The students have granted permission to have these H&Ps posted on the website as examples.

# History and Physical Examination (H&P) Examples | Medicine ...

Exam of the affected eye will reveal decreased acuity, an abnormal optic disc in 1/3 of patients and often an RAPD. Retinal artery occlusion: This can occur as a result of local thrombosis (associated with typical atherosclerotic risk factors), an embolic event (e.g. from carotid stenosis or atrial fibrillation) or carotid dissection (often associated with flexion extension injury to the neck).

#### **UCSD's Practical Guide to Clinical Medicine**

Sample Write-Ups Sample Neurological H&P CC: The patient is a 50-year-old right-handed woman with a history of chronic headaches who complains of acute onset of double vision and right eyelid droopiness three days ago.

## Sample Write-Ups - Department of Neurology Home

Adson's Test Ankle Anterior Drawer Test Ankle Exam Ankle External Rotation Test Anterior Slide Test Apley's Compression Test Apley's Scratch Test Ballottable Patella Sign Barlow's Test Brief Musculoskeletal Exam Canadian C-Spine Rule Carpal Compression Test Clawhand Deformity Costoclavicular Maneuver Crossed-Leg Test Drop Arm Test Elbow Exam ...

#### Shoulder Exam - FPnotebook.com

Assessment of the gynecologic history and the pelvic examination is part of the assessment of female patients in many clinical contexts. Clinician familiarity with the gynecologic evaluation can help reduce anxiety for both patients and health care professionals. The gynecologic history and physical examination in adult women are reviewed here.

## **UpToDate**

I disagree. Most first and second year "learn the physical exam" type courses want you to write a freaking book for your H&Ps. Our physical exams would be like half a page - you definitely would get in trouble for using abbreviations, etc, like that. Now third and fourth year, I think that exam would be fine for everything but IM.

#### Physical exam documentation | Student Doctor Network

Further documentation of colposcopic (and naked eye findings) on the pelvic exam diagram is encouraged: e.g., location, extent, detailed ... Pelvic exam is normal, without lesions. You do not see the erythema. y. On colposcopic exam, the vulva is normal. y. This is the image of the cervix. SCENARIO 3.

#### Pelvic Exams and Evaluations - mtnstopshiv.org

Sample Normal Exam Documentation. Documenting a normal exam of the head, eyes, ears, nose and throat should look something along the lines of the following: Head - The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring. Hair is of normal texture and evenly distributed.

# The 411 on Documenting a HEENT Exam | MidlevelU

Example of a Complete History and Physical Write-up Patient Name: Unit No: Location: Informant: patient, who is reliable, and old CPMC chart. Chief Complaint: This is the 3rd CPMC admission for this 83 year old woman with a long history of hypertension who presented with the chief complaint of substernal "toothache like" chest pain of 12 hours

# **Example of a Complete History and Physical Write-up**

CHARTING EXAMPLES FOR PHYSICAL ASSESSMENT SKIN, HAIR AND NAILS Skin pink, warm, dry and elastic. No lesions or excoriations noted. Old appendectomy scar right lower abdomen 4 inches long, thin, and white. Sprinkling of freckles noted across cheeks and nose. Hair brown, shoulder length, clean, shiny. Normal distribution of hair on scalp and perineum.

# CHARTING EXAMPLES FOR PHYSICAL ASSESSMENT | The Other Side ...

The otoscopic exam is performed by gently pulling the auricle upward and backward. In children,

the auricle should be pulled downward and backward. This process will move the acoustic meatus in line with the canal. Hold the otoscope like a pen/pencil and use the little finger area as a fulcrum. This prevents injury should the patient turn suddenly.

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