

## *Sample Physical Exam Documentation*

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## **Sample Physical Exam Documentation**

Home / Education / Requirements/Grading / History and Physical Examination (H&P) Examples. 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 ...**

Obtain stool sample for occult blood (when indicated) Lymphatic (Palpation of Nodes in 2 or more areas) Neck Axillae Groin Other. Skin and Subcutaneous Tissue. Inspection (rashes, lesions, ulcers) ... DOCUMENTATION OF HISTORY AND PHYSICAL EXAM ...

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

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 Temperature: 37.5° C oral (list the site where the temperature was taken, i.e., oral, rectal,

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

Sample Detailed Normal Exam Documentation. If you are documenting a more in-depth neurological exam, your corresponding documentation for a normal exam should look something along the lines of the following: Mental Status: The patient is alert and oriented to person, place, and time with normal speech. Memory is normal and thought process is ...

### **Documenting a Neuro Exam, Decoded | MidlevelU**

A physical exam of the chest includes both the heart and lungs, which can each be quite complex in themselves. So, for our purposes, we'll break the exam and documentation of the chest down into its components. Continuing our MidlevelU series on documentation basics, today we'll look at how to document an exam of the respiratory system.

### **Documenting a Respiratory Exam - Just the Basics | 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**

The 1995 guidelines identify Body Areas and Organ Systems as a framework for documenting the physical exam, but do not say what to chart under either. The 1997 guidelines define mandatory physical exam elements and called them Bullets. A comprehensive exam requires all bulleted items to be examined, and at least 2 per system to be documented.

### **ED Charting and Coding: Physical Exam (PE) - ALiEM**

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 ...**

Male GU Exam A normal male genitourinary exam would be dictated as follows: The testicles are descended bilaterally. They are firm, non tender, and without masses or lesions. No penile lesions are noted and there is no discharge from the urethra. The scrotum is without induration, erythema, or edema. No hernias are palpated in the...

### **Genitourinary Exam | medicalscribe**

Nursing assessment is an important step of the whole nursing process. Assessment can be called

the “base or foundation” of the nursing process. With a weak or incorrect assessment, nurses can create an incorrect nursing diagnosis and plans therefore creating wrong interventions and evaluation. To prevent those kind of scenarios, we have created a cheat sheet that you can print and use to ...

### **Complete Head-to-Toe Physical Assessment Cheat Sheet ...**

NOTE: Documentation above describes an exam of the ENMT Organ System. Ears, Nose, Mouth and Throat all mentioned. Compare documentation to Sample Exam 1 documentation of HEENT: Some facial erythematic. Pupils are equal and reactive to light and accommodation. His extra ocular movements are full. Fundi are intact.

### **Documenting an Exam - Tulane University**

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**

You would think it would be a simple thing to find someones sample notes but apparently not so much. I appreciate that you took the time to post these! Thanks! Chelsey says: ... THANK YOU SO MUCH for posting assessment documentation examples. I've been looking for this type of info for a while now. grette says: March 27, 2013 at 4:56 pm ...

### **Assessment Documentation Examples | Student Nursing Study Blog**

Transcribed Medical Transcription Samples / Reports For MT Reference ... Normal Physical Examination Template Format For Medical Transcriptionists. ... Ophthalmology Eye Exam Chart Note Sample Reports. Ophthalmology Medical Transcription Operative Sample Reports For Medical Transcriptionists. Orthopedic (Ortho) Operative Procedure Medical ...

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

Normal Physical Exam Template Samples. Physical Exam Format 1: Subheadings in ALL CAPS and flush left to the margin. PHYSICAL EXAMINATION: GENERAL APPEARANCE: The patient is a [x]-year-old well-developed, well-nourished male/female in no acute distress. ... PE Sample 1. Physical Exam Format 2: Subheadings in ALL CAPS and transcribed in ...

### **Normal Physical Exam Template Samples - MT Sample Reports**

Sample Pediatric History and Physical Exam Date and Time of H&P: 9/6/16, 15:00 Historian: The history was obtained from both the patient's mother and grandmother, who are both considered to be reliable historians. Chief complaint: "The rash in his diaper area is getting worse." History of Present Illness: Cortez is a 21-day-old African American male infant who presented

### **Sample Pediatric History and Physical Exam**

FPM Toolbox Encounter Forms. Download encounter forms to help ensure accurate documentation for asthma, diabetes, hypertension, and other conditions common in primary care.

### **Encounter Forms -- FPM Toolbox - American Academy of ...**

FNotebook.com is a rapid access, point-of-care medical reference for primary care and emergency clinicians. Started in 1995, this collection now contains 6664 interlinked topic pages divided into a tree of 31 specialty books and 728 chapters.

### **Hip Exam - Family Practice Notebook**

1 THE HISTORY AND PHYSICAL (H & P) I. Chief Complaint Why the patient came to the hospital Should be written in the patient's own words II. History of Present Illness (HPI) a chronologic account of the major problem for which the patient is seeking medical care

## 1 THE HISTORY AND PHYSICAL (H & P)

GUIDELINES FOR WRITING SOAP NOTES and HISTORY AND PHYSICALS Lois E. Brenneman, M.S.N., C.S., A.N.P., F.N.P. Written documentation for clinical management of patients within health care settings usually include one or more of the following components. - Problem Statement (Chief Complaint) - Subjective (History) - Objective (Physical Exam ...

# Sample Physical Exam Documentation

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