Date:
Time:

(Name) is a (age/DOB) year-old (sex) patient of (PCP).

Information obtained from (patient/family/chart). Statement addressing reliability.

CC:

One sentence description of the patient and the reason prompting their evaluation. Should give an overview of the patient, age, sex, reason for visit, and the duration of the complaint. If the patient has a history of a major medical problem that bears strongly on the understanding of this present illness, include it.

HPI:

Presented in both problem based and chronological fashion. The dominant problem serves as the centerpiece of the history. Focus on identifying and conveying information associated with a single, major theme. Characterize the chief complain – quality, severity, location, duration, progression, include pertinent negatives. Items from the review of systems that are unrelated to the present problem may be mentioned in passing. If the historian is poor, confused, or simply unaware of the details – state this and move on. Always note the source of your information.

PMH:

List any chronic medical problems, and discuss this during presentation if it bears directly on the current medical problem. Always have the information available to respond to questions.

Birth and Development History:

Discuss if it bears directly on current medical problem. Older children do not need documentation of their birth history unless it relates to their current medical problems, such as CP and HIE. Again have it documented for questions.

Allergies, Medications, and Immunization Status:

Present known information, particularly note any deficiencies.

Diet History:

Summarize diet.

Social History:

Home environment, school or daycare status, sexual history if relevant, and substance abuse. Know whom the patient lives with, water source, and pets in the house.

Family History:

Note history of genetically based diseases, sibling's health. State relevant history when presenting, but have information available for questions.

Review of systems:

There should be documentation on your H&P of questions asked, not just "negative" or "unremarkable." This is not an all inclusive past medical history, it is a recent ROS. Most of these should be incorporated at the end of the oral presentation; these questions are designed to uncover illnesses that might "travel with" the main problem. The listener needs this information to put the remainder of the history in appropriate perspective. If it is completely negative, it is acceptable to say so.

Physical Exam:

Always begin with a one sentence description of the patient's appearance along with vital signs. Document growth percentiles. Perform a full physical exam, including Tanner staghing and document all aspects of your exam. When presenting include all significant abnormal findings and any normal findings that contribute to the diagnosis.

Labs/Radiology/EKGs/etc:

Document all available data. Should be mentioned in the presentation.

Assessment and Plan:

Summarize the important aspects of the history, PE, and supporting lab tests. Formulate a differential diagnosis as well as a plan of action that addresses both the diagnostic and therapeutic approach to the patient's problem.

Medical Student, M3