Sample H&P for Complicated Patient*

6/21/2002 Medical Student H&P
11:00

Note the date, time, and fact that this is a medical student note are clearly labeled.

CC: Mr. Jones is a 72yo white, retired farmer, who presented to the ER because "I fainted 3 times in the last 2 days."

CC is specific, gives key pt demographics, and duration of cc. If he'd had a h/o CAD or CVA, you could include that here.

HPI: Mr. Jones was in his usual state of health, which allows him to lead a fairly active life, until 2 days PTA when he was in the kitchen making a sandwich. At that time he felt "dizzy" and found himself on the floor. He described the dizziness as "feeling like he was going to pass out." He doesn't remember what happened but thinks he lost consciousness for only a few seconds to minutes. No one was home at the time to witness it. He had a headache after the episode, which he relates to hitting his head. (It has eased off with Tylenol.) Prior to losing consciousness, he did not experience a headache, chest pain, palpitations, or shortness of breath. He was not incontinent. Other than the headache, he felt fine and ate his sandwich once he "came to."

He had a very similar episode the next day while he was sitting down watching TV. He felt like he was going to faint and then became aware that he had missed part of his show. The 3rd fainting spell occurred this morning as he was getting out of bed. He fell back onto the bed so did not hurt himself. He told his wife what happened and she insisted that he come to the ER.

The chronology is very clear and descriptions are specific. The information is presented as a story. The question 'why seek help now' is clearly addressed. ('Usual state of health' alone can be misleading if a patient is usually in poor health. Notice the brief elaboration.)

He has not started any new medicines or engaged in any new activities lately. He has not been sick including no N/V/D. He has never had chest pains or been told he has heart disease. He has had vertigo in the past but that was very different from his current "dizziness". He has not had any change in vision, slurred speech, weakness, numbness, or tingling in the last week.

Pertinent positives and negatives are in a separate paragraph.

He still likes to ride his tractor and do light farming but is afraid to since these episodes started. He is also afraid to drive as it could happen then and cause an accident.

The effect of the problem on the patient's life is addressed.

PMH:

1. COPD- smoked 2 ppd for 40 years, quit 1987.
2. HTN- usually runs 130s/80s, per patient
3. Pneumonia- hospitalized for 3 days in 1996 (received pneumovax then)
4. Osteoarthritis of hips, knees, and hands
5. BCCA- multiple removed from arms and face
6. Gout
7. BPH
8. Diverticulitis 1988- last colonoscopy 2000 w/ 2 polyps
9. Appendectomy 1965
10. Right inguinal hernia repair 1982

Pertinent specifics about the conditions in the PMH are noted.

Operations can be listed separately under Past Surgical History (PSH)

Medications

1. lisinopril 20 mg po daily, for HTN
2. Hytrin 5 mg po at bedtime, for BPH
3. ASA 325 mg po daily, for cardioprotection
4. Allopurinol 300mg po daily, for gout prevention
5. Atrovent 2puffs 4 times a day, for COPD
6. Motrin 200mg po 2-3 times a day as needed for arthritis
7. Aleve 1-2 tabs po 2-3 times a day as needed for arthritis
8. Tylenol arthritis 1-2 tabs po 3-4 times a day as needed for arthritis
9. Saw palmetto 2 tabs po daily, for prostate

You are strongly encouraged to include the reason for each medication. It is also interesting to learn why patients think they are taking certain medications.

Allergies- sulfa (rash)
Adverse drug reactions- codeine (N/V)

Drug reactions are clearly separated from the true allergies.

FHx- Father killed in WWII
Mother-HTN and DM, died age 75 of heart attack
Sister- 75 and healthy
Brother – 70 with heart problems and emphysema
Brother- died at 68 of heart attack
Son- 47, healthy

The health of all 1st degree relatives is addressed.

SHx- Married 50 years this Oct; retired corn and tobacco farmer but still maintains about 3 acres of grazing pasture and a small vegetable garden himself; High School grad; served 1 year in Korea (Army). One son and 3 grandchildren who live nearby. He keeps 2 horses for them but doesn't ride himself anymore. Tobacco- as above, ETOH- 2 beers/day for about 20 years but now only an occasional beer every month; no other drugs; monogamous w/ wife.

The SHx provides a clear sense of what the patient's lifestyle is like, including activity level and support system. Habits are detailed but there is no redundancy, e.g. tobacco history was already addressed in the HPI.

ROS- Cough- chronic, mostly in the morning, productive of a small amount of white phlegm
low back pain- chronic and worse at the end of the day
nocturia- gets up 3-4 times a night, worse over past year

Only positives not pertinent to the HPI are included. Given your stage of training, many attendings may want you to include ***everything*** you ask in the ROS, including the negatives. This is perfectly acceptable. This guideline is meant to reflect what an experienced clinician does in practice, so you can apply it to all stages of your career.

PE- Thin, alert, elderly white man with a purple-red nodule above the left eye who is sitting up on the stretcher breathing comfortably and appears neither acutely nor chronically ill.

General description is *specific.*

Vitals- T 97.8 BP 105/40, supine, 100/40; standing P 56, regular, supine; 52 standing R 22, unlabored, O2 sat- 93% (RA)

Pertinent details of the vitals are included.

Head- 3cm, tender, round, purple-red nodule above left eyebrow, skin intact, no surrounding erythema; Eyes- PERRL; fundi- limited exam secondary to hazy, brown opacities obscuring retina
Ears- both ear canals impacted w/cerumen
Nose- nares patent w/o edema or D/C
Mouth/throat- edentulous, moist mucosa w/o lesions

This section can be combined as HEENT, depending on personal preference.

Neck- supple, thyroid nonpalpable, no LAD
Back- spine straight w/o point tenderness, lumbar paraspinal muscles tight w/ diffuse tenderness
Lungs- hyperresonant, diminished BS throughout, I:E ratio 1:3, no wheezes or crackles
CV- carotids 2+ w/o bruits, JVP 5 cm, heart bradycardic, regular S1, S2 w/ II/VI holosystolic murmur at apex radiates to axilla; rad pulses 2+, fem pulses 1+w/ rt bruit, DP 1+ left, nonpalp right
Abd- scaphoid, normoactive bowel sounds, soft, NT; liver 7 cm by percussion, spleen nonpalp, no masses or bruits
Rectal- normal sphincter tone, brown heme neg stool, large, firm prostate w/o nodules or asymmetry (per ER resident)

Sometimes certain parts of the exam that are sensitive like GU and pelvic have already been performed by the time you see the patient and the patient declines to have them repeated. In this situation, you still include any findings but note that you did not personally perform that portion of the exam. You should still ALWAYS try to perform these parts of the exam yourself with a chaperone. Remember you are required to fulfill certain procedural requirements related to this.

Ext- clubbing, no edema, hair loss on feet to mid calf but warm w/o cyanosis, Heberden's nodes on 2nd-5th digits of both hands, knees enlarged w/o effusion, warmth, or erythema but crepitations bilaterally, hips NT w/ FROM
Neuro- MMSE 29/30 (forgot one object), CN 2-12 intact except diminished hearing to finger rub bilaterally, BC>AC on Rinne test, sensation intact to pinprick, vibration, and light touch in all 4 ext, strength 5/5 bilaterally delts, biceps, triceps, wrist ext, hand grip, hand intr, psoas, quads, tib ant, EHL, gastroc; muscle bulk and tone normal; no pronator drift, fine motor normal, Romberg absent; coordination: FTN and HTS normal, gait slightly broad based but steady; DTRs 2+ bicep, tricep, brachrad and 1+ patella, Achilles absent; Babinski absent;
Skin- leathery w/ marked wrinkles on face and neck, multiple brown papules ½-1 cm w/ regular boarders that appear "stuck on" scattered on back, scaly erythematous macules scattered on forearms, dorsum of hands, and one on right temple and one behind left ear

Descriptions in the PE are consistently specific, vague terms are avoided. You know exactly what the examiner did and did not perform.

Lab data

Hgb- 12.5 (13.5 in 1999)
WBC- 5.0 (P50%, L40%, M10%)

Plts- 425,000
MCV- 70

136 112 20 glc- 168
4.0 32 1.4
(creat 1.0 in 1999, CO2 32 in 1999)

Ca- 8.2, Mg 2.0, PO4 3.2

U/A- trace glucose and protein, no RBC's or WBC's, nit. neg.

Pertinent old lab data is included.

CXR- hyperinflated lung fields with rounded opacity in RUL, decreased alveolar markings apices> bases, no cardiomegaly (formal radiology report pending).

ECG- sinus bradycardia, rate 56 w/ RBBB pattern, rt and left atrial abnormality, one ectopic beat, and 3mm Q's in III and aVF

Student provides own interpretation.

Problem list

1. Syncope
2. Head trauma
3. Possible lung mass
4. ECG w/ RBBB, ectopy , and evidence of likely old IMI
5. COPD
6. Microcytic anemia
7. Hyperglycemia
8. Renal insufficiency
9. HTN
10. Nocturia, recently increased w/ trace glucose and protein on U/A
11. PVD
12. LBP
13. OA
14. BPH
15. Elevated CO2, chronic and likely secondary to CO2 retention from #5
16. Polypharmacy
17. Solar keratosis and h/o BCCA
18. Sulfa allergy

The problem list is complete, prioritized, and specific w/o being redundant or too detailed. There is subjectivity to the specific prioritization, but the most urgent issues are at the beginning starting with the cc and the least urgent issues are at the end.

Assessment/Plan:

Mr. Jones is a 72yo man w/ 2d h/o syncope that is acute in onset, not positional, and is in the setting of an abnormal ECG, all of which is concerning for an arrhythmia.

There is a summary statement that reiterates the cc and key related features, followed by a definite commitment to an impression.

1. Syncope from probable arrhythmia- cardiac etiology such as sick sinus syndrome or VT is compatible with history. Although he hasn't had CP, he has many cardiac risk factors (age, sex, FHx, tobacco, and possible diabetes) and could have had an MI to precipitate this. More likely an MI would be old, given the lack of symptoms but an acute coronary syndrome (ACS) can't be ruled out at this point. A neurologic process like vertebro-basilar insufficiency could cause syncope and he has evidence of vascular disease on exam. However, the lack of focal neurological signs or symptoms makes this less likely. He lacks incontinence or post-ictal confusion to suggest seizure. Finally the possible lung mass and significant tobacco history raise the possibility of lung cancer and possible CNS met. But again, lack of focal symptoms or headache preceding the fall makes this less likely. Orthostasis is a common cause of syncope in the elderly but his history and PE aren't compatible, despite being on Hytrin.

Notice how the differential diagnosis is woven into the discussion of the assessment. Critical features of the history, PE, and lab data are noted. The amount of space devoted to the explanation of the various differentials is proportional to their relative likelihood. Unlikely diagnoses are only mentioned. Very rare possibilities are not addressed.

Check troponin, admit to tele bed, consult cardiology for possible EP study, ECHO to assess for LV dysfunction and wall motion abnormalities to suggest prior infarct (and nidus for arrhythmia), fasting lipids in AM for risk factor modification

> The plan is listed immediately after each problem. But, it is equally correct to list all your assessments in one section and then have a separate section devoted entirely to the plan. It is a matter of personal choice.

2. Head trauma – risk of subdural but no focal findings or headache now, consider CT or MRI if change in neuro status or cardiac w/u for syncope unrevealing
3. Possible lung mass concerning for malignancy given the extensive smoking history and clubbing. Consider CT scan.

> Often you will be unsure of the plan but you still should try to come up with a plan. In these cases, use the word 'consider'. This allows you to demonstrate your thought processes without having something potentially erroneous or misleading in the medical record.

4. Microcytic anemia w/ thrombocytosis suggestive of Fe deficiency anemia. Stool heme neg but GI bleed would still be most likely source particularly given multiple NSAIDS. Check Fe panel, hemocult stools, monitor Hgb, and avoid NSAIDS. If stable can w/u as outpatient. If Hgb decreases, consider EGD to eval for PUD
5. Hyperglycemia- concerning for diabetes given recent increase in nocturia, monitor glucose, and add insulin if needed for glucose control, consider checking HgbA1c if persistently elevated glucose
6. Renal insufficiency- unclear chronicity but new since 1999; likely multifactorial given HTN, possible diabetes and NSAIDS. Once patient weighed will calculate estimate of creat cl and renally dose drugs, maintain good BP control and cont. ACEI but will d/c NSAIDS as above
7. COPD- clinically stable, continue Atrovent MDI
8. HTN- well-controlled, cont. lisinopril and Hytrin
9. Nocturia- likely secondary to BPH and may be exacerbated by hyperglycemia. Prostatitis possible but no tenderness on exam. No symptoms to suggest UTI. Will check U/A for glucose and signs of infection. Check postvoid residual. Cont. Hytrin for now as has tolerated in past (also may be helping maintain good BP control)
10. BPH- possibly worsening, will make sure no urinary retention, cont. meds (except saw palmetto as nonformulary)
11. Chronic CO2 elevation- likely compensatory secondary to chronic CO2 retention and respiratory acidosis from COPD, not acute problem but will be careful giving high levels of O2 if hypoxia develops and consider ABG.
12. Polypharmacy- will educate about OTC's and redundancies of NSAIDS

> Notice how this is not a literary work of art. Common abbreviations and incomplete sentences are used. However, the assessments and plans are clearly stated. This is not a thesis and you should not spend hours proofreading and making it pretty. Spend that time caring for patients.

13. DVT risk- he's on bedrest so will prophylax w/ heparin 5000U SQ bid
14. F/E/N- (fluids/electrolytes/nutrition)- he appears euvolemic so no IVF and low fat diet, consider diabetic diet if fasting glucose elevated.

#13 and 14 are commonly included in A/P for completeness sake and so these important issues are not overlooked. Sometimes 'status' (DNR vs. full code) is added to the problem list. This can be misleading and look as though it is factoring into your care of the patient in a way you probably don't intend. It should generally be avoided unless code status really is an active issue.

Note is signed on each page and name printed as signature is illegible. Student status noted by 'MS3'

*** This H&P was purposefully meant to illustrate a very complicated patient. Most of your patients won't have quite this many problems. However, I know you already have been given examples of more straight-forward cases. I wanted you to have an idea how to handle even the most difficult patient history.**

Guidelines and case developed by Dr. Heather Harrell for the University of Florida Medicine Clerkship.