

3. Head.

Eyes: vision, movement, gross visual fields, conjunctivae and sclerae; pupils-size, reaction, equality; appearance of fundi; corneal sensitivity.

Ears: hearing; air and bone conduction; discharge; appearance of tympanic membranes; movement of membranes; topht; coronary crease.

Nose: obstruction to breathing; septal deviation and/or perforation; discharge.

Mouth: sores; dental status; appearance and palpation of mucosa, tongue, gums, floor of mouth; appearance of tonsils, pharynx; appearance and movement of uvula, palate; gag reflex.

4. Neck.

Palpable masses; thyroid; location of trachea; venous engorgement; bruits; flexibility.

5. Lymph Nodes.

Enlargement, consistency and/or tenderness of cervical, axillary, epitrochlear, popliteal and inguinal glands.

6. Chest.

Appearance and function of chest wall.

Breasts: appearance, asymmetry, tenderness, masses, nipple discharge.

Lungs: type of respiration, percussion note, diaphragm movements, character of breath sounds; presence of rales, rhonchi, wheezes or rurs; post-tussive rales.

7. Heart.

Apex location, precordial movements

Palpation & percussion: location of cardiac borders, thrills, shocks, heaves, palpable sounds, carotid and jugular pulse wave characteristics.

Auscultation: heart sounds; S₁, S₂, S₃, S₄; presence of murmurs, clicks, rub, split sounds; effect of respiration, change in position & maneuvers on murmurs & sounds; radiation of murmurs.

Pulses: carotids, brachials, radials, femorals, dorsalis pedis, posterior tibials.

8. Spine.

Mobility, tenderness, curvature.

9. Abdomen.

Appearance (distended, flat, scaphoid), abnormal movements, dilated veins, striae, scars.

Auscultation: bowel sounds, bruits, rurs.

Percussion: distension, organ size (liver, spleen, bladder), shifting dullness, measure liver size in MCL in cm.

Palpation: resistance, tenderness, rebound, organs (liver, spleen, kidney), masses, epigastric or incisional hernia.

10. Extremities.

Skin color, temperature, texture, varicosities, clubbing, edema, joint motions, muscular abnormalities, circumference.

11. Neurological.

Mental status, cranial nerves, cerebellar function, muscle strength, reflexes, gait and station, rapid sensory exam including vibratory.

12. Genitalia.

Discharge, sores, or scars, hydrocele, varicocele, testicular masses; inguinal and femoral herniae.

Pelvic examination - inspection and palpation of vulva and perineum, evaluation of perineal and vaginal supports, preparation of Papanicolaou smear, visualization of vaginal walls and cervix, bimanual palpation of uterus and adnexa.

13. Rectal.

Hemorrhoids, sphincter tone, prostate, masses, gross blood or Hematest. Note color of stool.

Laboratory Data.

Record in red, CBC & differential, ESR, urinalysis, chest X-ray, ECG, and others when appropriate (e.g. arterial blood gases, amylase, prothrombin time, SMAC, cultures).

Formulation.

This should be a one-paragraph summary of major positive and pertinent negative findings from the history and physical examination. Significant laboratory data should also be noted. The possible interrelationships of these findings and the nature of the disordered pathophysiology should be summarized. Briefly indicate any social or psychological problems which may present a major and immediate obstacle to treatment or recovery. This is the foundation upon which the diagnostic possibilities and therapeutic plans will be based.

Impressions.

List the major diagnostic possibilities considered likely explanations for the abnormal findings and provide supporting data for and against each diagnosis.

Where there are several significant problems, these should be listed sequentially and each discussed similarly.

Plan.

A statement or outline of initial plans for evaluation and treatment of each diagnostic impression should be detailed.

Signature _____ (CC3, CC4, M.D.)

Date _____

COLUMBIA UNIVERSITY

Department of Medicine

OUTLINE FOR MEDICAL HISTORIES

Introductory Note

Most physicians agree that an accurate and comprehensive history is the most rewarding of all the techniques utilized to resolve clinical problems. To accomplish this, a good history should be so precise and quantitative that its essential features could be charted on graph paper with a time coordinate; a good history should be so comprehensive that succeeding physicians need not interrogate further; a good history should "tell a story".

All data must be accurate and specific. There is no place for generalities. The mere mention of pain is of little assistance unless its character is fully described. Although conciseness is essential, no details should be omitted when describing positive points. When the patient mentions a previous illness by name, put it in quotation marks and follow it by a description of the symptoms so that a correct diagnosis may be deduced from the facts thus presented. It should be emphasized that every fact must be dated as carefully as the patient's memory permits, either by the actual date or by the age of the patient at the time. Appropriate data from previous records should be incorporated into the narrative.

The first step in taking a history is having the patient describe the presenting illness in his or her own words. By further questioning an orderly and interpretive chronicle written in graceful and concise English should be constructed. In general, at the beginning of the interview, principally open-ended questions are asked to enable the patient to express the range of his complaints and concerns. Later during the interview, closed-ended questions predominate in order to nail down specifics.

The History

Identify Informant

Reliability of Informant

Chief Complaint.

This is a statement in the informant's own words of the symptoms which brought him/her to medical attention. These data, their duration, as well as occupation and marital status should be included in an opening sentence as follows:

"This is the first admission of this 60 y.o. female married lawyer with the chief complaint: 'I have had a pain in my chest and difficulty breathing for two weeks'".

A pre-existing ailment may, when pertinent, be included in the opening sentence as follows:

"This is the third admission of this 60 y.o. female juvenile-onset diabetic lawyer who now enters with the complaints of chest pain and shortness of breath for the past two weeks".

Occasionally patients are hospitalized for evaluation of a specific physical or laboratory finding rather than because of a chief complaint. In these instances the record should state the findings as the basis for admission to the hospital.

Present Illness.

No matter what the illness, its story should be told in a logical sequence beginning with the first symptom or sign that can reasonably be ascribed to the present problem. Each major symptom should then be described, giving its time of onset, course of development and present status. Any symptoms that the clinical picture suggests and that are not present should be denied in detail. Medications and other treatments employed during the present illness should be identified.

If there are two or more unrelated problems that are part of the presenting illness, each should be described separately in appropriate chronological sequence.

Current Regimen.

Special diets and all medications with dosages that the patient is currently taking should be clearly detailed in this separate section.

Past Health.

1. General Health: How does the patient view his own past health? Date and describe recent examinations by physicians, insurance companies or employers. When available, the names, addresses and telephone numbers of physicians should be entered.
2. Acute Infectious Disease: rheumatic fever, chorea, measles, mumps, tropical illnesses.
3. Immunizations: where appropriate.
4. Allergies: toxic reactions to drugs, foods, allergens, hay fever.
5. Transfusions: dates, reactions.
6. Hospitalizations, Operations or Injuries: List all major surgical procedures with dates, indications and diagnoses. List all major trauma with level of function following treatment.

Systems Review.

Include past and present symptoms unrelated to the Present Illness. Distinguish clearly as to whether complaints were or are present.

1. Constitutional: fevers, "energy" level.
2. HEENT:
Headache: frequency, duration, response to treatment.
Eyes: vision, glasses, date of last examination, diplopia, inflammation, pain.
Ears: hearing, tinnitus.
Nose: epistaxis, obstruction.
Infections: tonsils, pharynx, teeth and gums.
3. Respiratory: pleurisy, cough, sputum (description), wheezing, asthma, hemoptysis, pulmonary emboli, pneumonia, tuberculosis or exposure to it; tuberculin skin test (PPD), date, and results; latest chest X-ray, date and results.
4. Cardiac: any known heart disease, chest pain, angina, dyspnea or orthopnea, paroxysmal nocturnal dyspnea, palpitations, peripheral edema; date last electrocardiogram and results. Risk factors for arteriosclerotic cardiovascular disease (i.e., hypertension, diabetes mellitus, family Hx, cigarette smoking, hyperlipidemia).
5. Vascular Disease: claudication, gangrene, cold feet, skin changes in feet, deep vein thromboses, dissecting aortic aneurysm.
6. Gastro-intestinal: appetite, digestion, heartburn, nausea, vomiting, hematemesis, change in bowel habits, color of stool, diarrhea, blood in stool, abdominal pain; history of peptic ulcer, gall bladder disease, liver disease, hepatitis, jaundice; abdominal X-rays, dates and results.
7. Genito-urinary: dysuria, nocturia, hematuria, polyuria, frequency, trouble passing urine. History of urinary infection, nephritis, renal stones, sexually transmitted diseases, treatment.
Menstrual Hx: regularity and duration of periods, date of onset, date of last period, menopause, dysmenorrhea, extent of bleeding, bleeding between periods. Birth control medication.
Pregnancies: number, complications, abortions.
Sexual Function: any change in sexual interest or drive, concern about sexual function or ability; number of partners, oral and/or anogenital sex.
Breasts: pain, lumps, discharge.
8. Neuro-muscular: dizziness, vertigo, tremors, syncope, loss of coordination, weakness, strokes, memory changes, arthritis, joint pains, bone disease.
9. Emotional: any recognized emotional problems; are you considered very nervous or easily upset? any symptoms of depression, sadness, sleep disturbance, crying spells, anorexia, loss of interest in usual activities, suicidal thoughts, any treatment for emotional problems.
10. Hematological: any red blood cell, white blood cell, platelet, coagulation disorders.

11. Skeletal, Rheumatic, and Connective Tissue: gout, rheumatoid arthritis, systemic lupus erythematosus, dermatomyositis, scleroderma, polyarteritis nodosa.
12. Endocrine: diabetes mellitus; thyroid; polyuria, polyphagia, polydipsia; heat tolerance; change in hat and glove size.
13. Dermatological: rashes, pruritus, petechiae.

Personal History.

1. Marital Status: health of spouse, children.
2. Occupation: trade, exposure.
3. Habits: tobacco, alcohol, diet, non-prescribed drugs (heroin, methadone, marijuana, LSD, cocaine and other addicting or habituating agents) exercise habits.
4. Birth: place, date, travel history including areas of the U.S. that have special types of contagion.
5. Present Environment: living conditions, number in household, stairs required, pets.
6. Weight: average, maximum with date, present weight, reason for loss or gain.
7. Financial: general, medical and hospital insurance.
8. Psychosocial: Does the patient know what's wrong with him? Unless it is obvious, why does the patient present now? Have there been any recent major changes in his/her life? How has the illness affected or how will it affect his/her life? How has the patient previously coped with illness, hospitalizations, and doctors? What are the patient's expectations from treatment? Is the patient currently using defense mechanisms which may interfere with treatment or recovery?

Family History.

List parents and siblings with age, state of health or age at death. Inquire about illnesses relating to patient's problem. Illnesses with known familial tendencies can sometimes best be diagrammed.

Conclude the history with an open-ended question such as: "Is there anything else in your past or present medical history we should talk about?"

OUTLINE FOR PHYSICAL EXAMINATION

1. Vital Signs.

Temperature, Pulse, Respiration, Blood Pressure (arm, R or L; position).

2. General Appearance.

This consists of a general survey of the patient without reference to any particular system and includes sex; apparent period of life; apparent state of health, nutrition and development; stature; gross deformities; posture; gait; color of skin and mucous membranes; dyspnea; orthopnea; edema; facies; mental condition, affect. The skin should be described noting texture, rashes, pigmentation and hair distribution.