SAMPLE H&P

Chief Complaint (CC): chest pain *(patients' presenting complaint(s) in his own words)*

History of Present Illness (HPI): *(details of patients' presenting complaints)*
This is the first Hospital admission for this 52 year old lawyer with a past history of hypertension. Mr. A noted the abrupt onset *(timing)* of a dull aching pain *(describe pain completely*) in the retrosternal area *(location*) while delivering a summation in court *(in what context).* The pain radiated into his left arm and upper jaw, was associated with a feeling of queasiness and sweating and lasted 10 minutes. He sat down and let his associate finish the summation and the pain went away spontaneously after 5 minutes. Later that afternoon, while playing squash, he had the onset of similar but more severe aching pain, in the same distribution, associated with queasiness, sweating and weakness. An ambulance brought him to Hahnemann's Emergency Department. This pain lasted about 30 minutes and was relieved when he was given NTG. He says he has "borderline cholesterol." His father died of a myocardial infarction at age 54; one brother age 47 has heart disease. He has never smoked. He denied any shortness of breath, palpitations, previous similar pain, diabetes or known cardiac disease.

Past Medical History (PMH): *(describe when started, how treated, and how controlled)*
Mild asthma as child-now completely resolved
Chickenpox – age 7;
Eczema—still has mild and infrequent
Hypertension, first noted at age 47- does not know if it is controlled with meds

Past Surgical History
Tonsillectomy – age 5
Appendectomy – age 18
Vasectomy – age 42

Injuries
Fractured tibia while skiing – age 38

Immunizations
Normal childhood immunizations
Last tetanus shot – age 38 when had the tibial fracture

Medications (*no abbreviations, look up all medicines to learn their side effects, ask about over the counter and herbal supplements)*
Norvasc 5 milligrams daily po
Multivitamin over the counter

Allergies *(describe what happens during the allergy and when it was first noted*)
Penicillin – severe hives but no pulmonary symptoms when first exposed to it as a child. He's never taken PCN since.
Cats & tree pollen cause mild itching – not bothersome

Health Maintenance Screening
Last eye exam 1 year ago- reportedly normal
Hemoccult check for blood in stool – 6 mos. Ago –negative per pt
Prostate exam – 6 mos. Ago- normal per pt

Family History
Father – died at age 54 -MI, was hypertensive
Mother – 76, alive and well

2 siblings: Brother - 47 – S/P MI
Sister – 49 breast cancer
3 children: Son – 28, healthy
Son – 25- asthma, hay fever
Daughter – 22 healthy

Social History
Attended University of Pennsylvania and Villanova Law School. Works as partner in law firm. His job is extremely stressful. He is currently separated from his wife, and lives with his girlfriend. He is only sexually active with her and has no problems. Does not use condoms. They have a turtle. He has three children with whom he has a close relationship and feels he has a good support system. ETOH: a glass of wine with dinner. Denies drug use. Does not exercise regularly except for playing occasional squash. No blood transfusions. No chemical exposure or recent foreign travel. No history of abuse.

Review of Systems
General: gained 20 pounds gradually over past yr; no fever, chills, sweats, fatigue.
Skin: no rashes, photosensitivity.
Head: "sinus headache", no history of head injury
Eyes: wears reading glasses, no history of eye pain, red or pink eye, decreased tearing or eye discharge. Saw ophthalmologist last year
Ears: denies difficulty hearing, ear infection, discharge or dizziness
Nose: recurrent seasonal rhinitis (tree pollen in the spring), no epistaxis. Has had recurrent sinusitis, ENT doc tells him he has polyps
Mouth and Throat: recurrent cold sores, no recent sore throat
Respiratory: denies shortness of breath, cough, hemoptysis, positive TB test or exposure. No recent wheezing; no orthopnea, PND.
Cardiac: see HPI
Gastrointestinal:. No nausea, vomiting, diarrhea, constipation, or bleeding per rectum. Takes Metamucil for irregularity at times.
Genito-urinary: No hematuria,dysuria or urinary hesitancy. No penile discharge.
Endocrine: no change in skin or hair, no polyuria or polydipsia, no hoarseness, dysphagia, intolerance to temperatures
Vascular: No claudication or ulcers. No varicose veins.
Musculoskeletal: Tennis elbow right arm, intermittently, uses a splint when he plays squash. No gout, arthritis, back pain
Neurological: no history seizure, no sensory loss, no motor weakness, no migraines, no paresthesias
Psychiatric: seeing a therapist regarding the separation from his wife

Physical Exam *(do a thorough exam but make sure the most thorough part is on the systems where patient has a complaint)*

General: Mr. A is a slightly obese man who looks his stated age of 52. He was in no distress at the time of this exam; he was sitting in bed, relaxed and easily communicating.

Vital signs:

Blood pressure: 175/95 both arms supine 170/90 right arm sitting

Pulse 100 regular with occasional irregularrity

Respirations: 16 and regular, Temperature 98.9

Weight 205 lbs.

Skin: pale, male pattern baldness, 1x1 cm nevus on back with well defined margins and uniform pigment

Head: normocephalic, atraumatic

Eyes: Visual Acuity with reading glasses tested: OD 20/30, OS 20/40

Visual fields full to confrontation, extra ocular movements (EOMs) intact, pupils are equal, round and reactive to light and accommodation (PERRLA), conjunctiva pink, no injection, sclerae not icteric, Fundus exam: discs sharp, arteriolar narrowing present bilaterally, no hemorrhages or exudates

Ears: Pinna normal, external canals normal.Tympanic membranes normal with good light reflex. Rinne test – (AC > BC) bilaterally. Weber test does not lateralize.

Nose: Mucosa pink, watery clear nasal discharge noted inferior turbinates appear normal

Sinuses – nontender over maxillary and frontal sinuses bilaterally

Throat: lips, buccal mucosa normal. Good dentition, no obvious caries, no gingival bleeding, tongue midline, uvula midline, gag reflex intact, tonsils absent

Neck: supple, no JVD, carotids 2+ without bruit, full range of motion, trachea midline and mobile, thyroid not enlarged or nodular, no lymphadenopathy

Chest: normal AP diameter, symmetrical expansion, normal tactile fremitus bilaterally, clear on percussion and auscultation. No wheezes, rales or rhonchi heard.

Breasts: normal male, no masses, gynecomastia or discharge

Cardiovascular: PMI located in the fifth intercostal space 2 cm lateral to midclavicular line. No RV heave. No thrill. S1 and S2 normal, physiologic splitting, a loud S4 is present at the cardiac apex, no murmurs or rubs

Abdomen: well healed appendectomy scar in right lower quadrant, abdomen obese but not distended, normoactive bowel sounds, liver span 8cm MCL, no masses, tenderness, guarding or rebound, no abdominal bruit

Rectal: anal sphincter normal, no hemorrhoids present, prostate normal size , no prostatic masses felt, no stool present in ampulla

Genitalia: normal circumcised male, testes normal consistency without masses, no penile discharge

Lymphadenopathy: No cervical, occipital, pre or post auricular, supraclavicular, axillary, epitrochlear nodes noted. No inguinal lymphadenopathy.

Pulses: femorals 2+, no bruit, Brachial, radial, dorsalis pedis 2+ bilaterally

Musculoskeletal: Normal range of motion of neck, shoulders, elbows, wrists. Good grip strength, Normal motion of hips, knees, ankles, feet. Tender over right lateral epicondyle. Range of motion of spine not tested

Neurologic: Oriented x3.Cranial nerves II to XII intact (I not tested), reflexes symmetric, 2+ biceps, triceps, brachioradialis; knees, ankles 1+. Sensation to pin and light touch normal. Cerebellar function-normal. Gait *not tested*.

Assessment and Plan: *(include education/counseling, psychosocial issues, and screening. Have a plan for each issue not just the patients' main presenting complaint)*

1. Chest pain: most likely cardiac origin with risk factors of HTN and positive FMH as well as "borderline cholesterol". Also, the onset of pain with stress/exertion and relief of pain with rest and NTG suggests a cardiac etiology. Less likely to be musculoskeletal, pulmonary or GI etiologies though possible.
    a. check serial EKG's
    b. check cardiac enzymes
    c. check fasting lipid profile
    d .telemetry monitoring to watch for arrhythmia
    e. control BP better
    f. discuss stress management
2. Poorly controlled hypertension with signs of end organ damage – arteriolar narrowing, displaced PMI, and S4-needs better control
    a. Could titrate Norvasc or consider change to ACE inhibitor or beta blocker
3. Possible history of hyperlipdemia-
    a. Check fasting lipids
    b. Educate re: low fat diet and exercise
    c. If necessary, start lipid lowering agent
4. Obesity—discuss weight loss options and educate as to why this is important
5. Stress- from separation & work. Discuss ways to reduce stress including therapy or exercise
6. Lateral right epicondylitis- mild; continue to use splint and discuss stretching exercises
7. Recurrent sinus infections/seasonal allergies-stable. No new plans
8. Screening: seems up to date but obtain permission to speak to primary doc to review events of this hospitalization and obtain records.