

# **The AOA Guide:**

## ***How to Succeed in the Third-Year Clerkships***

**Example Notes for the MSIII**

**2013**

## Preface

This guide was created as a way of assisting you as you start your clinical training. For the rest of your professional life you will write various notes, and although they eventually become second nature to you, it is often challenging at first to figure out what information is pertinent to a particular specialty/rotation. This book is designed to help you through that process.

In this book you will find samples of SOAP notes for each specialty and a complete History and Physical. Each of these notes represents very typical patients you will see on the rotation. Look at the way the notes are phrased and the information they contain. We have included an abbreviations page at the end of this book so that you can refer to it for the short-forms with which you are not yet familiar. Pretty soon you will be using these abbreviations without a problem! These notes can be used as a template from which you can adjust the information to apply to your patient. It is important to remember that these notes are not all inclusive, of course, and other physicians will give suggestions that you should heed. If you are having trouble, remember there is usually a fourth year medical student on the rotation somewhere, too. We are always willing to help!

## Table of Contents

Internal Medicine Progress Note (SOAP).....	3
Neurology Progress Note (SOAP).....	5
Surgery.....	7
Progress Note (SOAP).....	7
Pre-Operative Note.....	8
Operative Note.....	8
Post-Operative Orders.....	8
Post-Operative Note.....	9
Obstetrics and Gynecology.....	10
L&D H&P.....	10
Delivery Note.....	10
Post-Partum Note (SOAP).....	10
C-Section Operative Note.....	11
Post-Cesarean Section Note (SOAP).....	11
Pre-Operative, Operative, and Post Operative Notes for Gynecology (use the Surgery template for these).....	11
Psychiatry Progress Note (SOAP).....	12
Pediatrics.....	14
Outpatient Progress Note (SOAP).....	14
Inpatient Progress Note (use the Internal Medicine SOAP).....	14
History and Physical.....	15
Internal Medicine (complete H&P).....	15
Adaptations for all other rotations.....	20
Abbreviations used in this guide.....	22

## Internal Medicine

### Progress Note

7/15/12 (Date) 0630 (Time)

MS III Green 3 Progress Note

\*Note: for Internal Medicine at TJUH, write on the front side of the progress note printed off every morning. Your intern will write on the back.

**S:** Pt resting comfortably this morning. Overnight, pt c/o insomnia. Also c/o continued leg pain. Pt rates pain at 5/10. Pt received PRN Percocet x2 overnight. Denies CP/SOB/N/V/D/F/C. Tolerating PO well, had 2BM overnight.

*Anything subjective goes in this section, i.e. any pt complaints or problems.*

**O:** VS: Tc: 97.4 Tmax: 98.6 P: 80 RR: 20 BP: 120-130/70-90 SpO2: 99% on RA  
I 24 hrs: 3800 mL O 24hrs: 1500 mL Balance: +1800

*(The below exams are mandatory on every patient, but there will also be exams specific to your patient to do every day based on their diagnoses, i.e. a neuro exam if the patient had a stroke. Put that in this section, as well.)*

CV: RRR, +S1 +S2, Ø m/r/g

Lungs: CTAB Ø w/r/r/c

Abd: +BS, soft, NT/ND, no rebound, no guarding, no hepatosplenomegaly, no masses

Ext: no c/c/e

Labs/Studies: (Put a P with a circle around it to indicate labs; fill them in later when the results are available. Write all daily labs and trends in here (ex: Hgb 9.2 ↓ 10.3)). Most people use the “lab skeletons” to make it easier:



CT abdomen 7/14: shows splenic remnants consistent with splenic auto-infarction.

### A/P

*This has many formats, the main two are:*

- 1. Problem based (as below)*
- 2. Systems based (i.e. list ID, then under that heading have all current infections, their status and the treatment; second list CV, list all problems such as HTN or CAD that relate to that system, their status and the treatment, and so on for all systems)*

*Ask your attending which of the above systems they prefer, and follow that model.*

*The first sentence is critical as it is usually the first sentence in your presentation.*

The patient is a 28-year-old female with PMH of sickle cell disease, DM II, HTN, GERD, and anxiety who presents with left leg pain and increased reticulocyte count concerning for likely sickle cell crisis.

1. Sickle Crisis
  - Hemoglobin, reticulocyte count stable
  - Pain currently controlled on Dilaudid PCA and PO oxycontin
  - T/C switching to IV morphine today
2. DM
  - Controlled on metformin
  - Creatinine levels WNL, cont. metformin
  - Continue SSI (sliding scale insulin)
3. HTN
  - Controlled, continue on current meds
4. GERD
  - Controlled, continue on current meds
5. Anxiety
  - Controlled during the day, but patient continues with insomnia
  - T/C adding Ambien PRN
6. FEN (Food, electrolytes, nutrition)
  - Now with good PO intake, can decrease IV fluids to 100 mL/hr
  - T/C Diabetic diet given PMH
7. DVT Prophylaxis
  - SCDs (sequential compression devices)
8. Disposition
  - Full code
  - D/W (discuss with) team possible D/C (discharge) this week

Signature

Last Name MSIII

*A note: The addition of T/C (to consider) and the words “discuss with team” are great to use in front of what you want to do. You can also add question marks after things if you are unsure. People want to see what you are thinking, but also want others to know when they read this that these things are not definite yet (The MSIII at the top should do that, but people don’t always read that).*

#### **Extra Hints**

- Put what day of the antibiotic it is today. So if it is the 4th day in a total of 14 days then put “Day 4/14”
- Writing out medication names and doses is tedious, but sometimes very helpful to get you to remember what medication your patient is on and what dosing regimens are for the medication.
- Make a copy of your note in the morning after you write it. That way if someone asks you something you don’t remember (the vitals, the sodium today, etc.) you can just pull it out of your pocket and look at it. Depending on the service, you may wait until after rounds to place the note in the chart.

## Neurology

**S:** No acute events O/N (overnight). Pt. cont. to c/o (complain of) weakness in LLE, now improving.

**O:** VS: BP: 124/84 P: 82 T: 37.1 R: 22

**PE:**

**Gen:** NAD, resting comfortably in bed

**HEENT:** atraumatic, normocephalic; TM clear with visible landmarks; sclera and conjunctiva clear; no LAD, no neck masses or asymmetry, no carotid bruit

**CV:** RRR, normal S1 and S2, no S3, S4, murmurs, rubs, or gallops

**Lungs:** CTAB, no wheezes, rales, or rhonchi

**Abd:** soft, NT/ND, +BSx4 quadrants, no masses palpable, no organomegaly

**Skin:** no rashes, lesions, petechiae

**Ext:** 2+ pedal pulses bilaterally, no c/c/e

**Neuro:** (normal exam)

1.) Mental status AAOx3 (or lethargic/obtunded/etc) N/R/C intact WORLD ↔ DLROW Recall 3/3	Awake, Alert, Oriented to person, place, time Naming, repetition, comprehension intact Spells world backwards Recall 3 named objects (red, ball, pen) after 2 minutes
2.) CN PERRL, EOMI, V1-V3 intact, FS, palate elevates symmetric, TM, SCM 5/5	Pupils equal, round, and reactive to light Extraocular muscles intact Sensation in V1-V3 intact Face symmetric Palate elevates symmetric Tongue midline 5/5 strength in sternocleidomastoid
3.) Motor NI B+T 5/5 strength x4 No fix, no drift	Normal bulk and tone 5/5 strength in all 4 extremities No fix or drift
4.) Sensation Intact to LT/PP/Temp/Vib/Prop No agraph, no astereo	Intact to light touch, pin prick, temperature, vibration and proprioception No astereoagnosia No agraphesthesia
5.) Coordination FTN, RAM, and HTS intact	Finger-to-nose, rapid alternating movements, heal-to-shin intact
6.) Gait Narrow based, no ataxia, intact to tandem and heal-toe, negative Rhomberg	

<p>7.) Reflex</p>	<p>Arrow at feet: Babinski upgoing (+) or downgoing (-,nl)</p>
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**A:** 64 year old male with PMH atrial fibrillation presents with L-sided weakness and found to have R MCA ischemic stroke on CT. L-sided weakness continues to improve, with patient exhibiting increased strength. Patient maintained on warfarin with INRs now in therapeutic range.

**P:**

1. Neuro: Continue PT/OT for L sided weakness
2. CV: Cont. warfarin at current dose with daily INR
3. FEN/GI: Cardiac diet
4. Prophylaxis: SCDs (sequential compression devices), OOB with assistance as tolerated

## Surgery

### Progress Note

6/5/11 (Date) 0500 (Time)

Progress Note MSIII Surgery

**S:** 33 yo female admitted for appendicitis, hospital day #3, POD (post-op day) #2, s/p appendectomy. Abx – Flagyl day #1. Patient having some peri-incisional pain, however pain is well controlled with PCA (patient controlled analgesia pump). No drainage from incision site, (+) ambulation, (+) BM and flatus. Currently on clear liquid diet and is tolerating it well. Foley still in place. (-) N/V, (-) SOB, no overnight issues.

**O:** VS: Tmax 38.3, Tc 38.1, BP 120/80, P 75, RR 16, O2 99% on RA  
I/O: 1250/ 2000 x 24hrs, 1000/1200 since midnight, UO (Urine Output) 1100 cc in 24 hours, 46cc/hr, JP (Jackson-pratt drain) - 200cc in 12 hrs, 16 cc/hr, (if patient had NG (nasogastric) tube, or other drains you would record their 12hr output here also)

Gen: NAD, AAOx3

CV: RRR, (+) S1/S2, (-) m/r/g

Lungs: CTAB (-) w/r/r/c

Abd: (+) tenderness on palpation in RLQ (right lower quadrant), ND, (+) BS

Incision: C/D/I (clean, dry, intact), (-) erythema, staples intact, JP drain in place

Ext: (-) C/C/E, 2+ dorsalis pedis bilaterally, (-) calf tenderness, calf SCDs (sequential compression devices) in place.

**Labs:** CBC, BMP, UA, etc.

**Imaging:** CXR negative, etc

**A/P:** 33 yo female, POD # 2, s/p appendectomy. Patient doing well.

1. Low grade temp – probably secondary to atelectasis
  - Continue incentive spirometry
  - Continue Flagyl antibiotics
  - T/C blood cultures if continued fever
  - Encourage ambulation
2. Pain is improving
  - T/C switching PCA to oral analgesic
3. Diet – tolerating clear liquids
  - Advance to house diet
4. Good urine output
  - D/C Foley
5. Prophylaxis
  - Continue incentive spirometry
  - Continue SCDs

**Pre-Operative Note: (Written the day before surgery)**

6/1/11 14:00 Pre-op note MSIII green surgery

Preop dx: appendicitis

Labs: CBC, BMP, PT/PTT results

CXR: clear

ECG: normal sinus rhythm, within normal limits

Blood: Typed and crossed x 2 units

Anesthesia: preop completed consent for anesthesia is signed and in the chart

Consent: signed and in the chart

Orders: 1gm cefoxitin OCTOR (on call to OR), NPO (nothing by mouth) after midnight

**Operative Note**

6/2/11 11:00 OP note MSIII green surgery

OP Note: Green surgery team

Preop dx: appendicitis

Postop dx: appendicitis

Procedure: Open Appendectomy

Surgeons: Write attendings, residents, med student present for the surgery

Anesthesia: General

Fluids: 1200 LR (lactated ringers)

Urine output: 500 cc

EBL (Estimated blood loss): 50 cc

Op findings: no perforation

Specimen: Appendix sent to pathology

Drain: JP drain

Complications: none

**Post Operative Orders: ADC VANDALISM**

6/2/11 Post OP orders MSIII green surgery

Admit: 3 west

Diagnosis: appendicitis s/p appendectomy

Condition: stable

Vitals: q (every) shift

Allergies: NKDA (no known drug allergies)

Nursing orders: strict I/Os, SCD (sequential compression devices), foley catheter to gravity, incentive spirometry

Diet: NPO

Activity: as tolerated

Labs: CBC, BMP in AM

IV fluids: D5 ½ NS (normal saline) + 20 KCL at rate of 100cc/hr

Studies: CXR

Meds: Abx: cefotaxime 1 g IV q 8hrs for 24 hours



Prophylaxis: heparin 5000 units SC

Analgesic: PCA (patient controlled analgesic) pump

Any preop medications the patient has been on and PRN meds

Call house office if HR > 100 or < 60, BP > 180/100 or < 90/60 temp > 39.5

**Post Operative Note (at least 6 hours after surgery)**

6/2/11 1800 post OP note Green Surgery MSIII

Status: s/p appendectomy, patient having mild discomfort

Neuro: AAOx3

VS: stable/afebrile

I/O: 1000ml LR (lactated ringers)

UO (urine output): 500cc x 6hours

Labs: CBC, BMP in am

Physical Exam:

CV: RRR, (+) S1/S2, (-) m/r/g

Lungs: CTA B/L

Abd: Soft RLQ (right lower quadrant) tenderness, (-) bowel sounds, dressing C/D/I (clean, dry, intact)

**A/P:** 33 yo female s/p appendectomy POD (post-op day) # 0 in stable condition

1. IV hydration
2. Pain management with PCA
3. 1 g cefotaxime IV q 8 hrs for 24 hours
4. DVT (Deep vein thrombosis) prophylaxis: SCDs (sequential compression devices), heparin 5000 units sc

## Obstetrics and Gynecology

### L&D History & Physical:

**CC:** (vaginal bleeding/contractions/loss of fluid, etc)

**HPI:** \_\_ yo G\_P\_\_\_\_ with IUP @ \_\_ wks by EDC of \_\_. EDC by LMP and c/w 1st tri U/S. Pt presents today c/o \_\_ +/- CTX (frequency, duration) +/- LOF +/- VB +/- FM. ?PIH (pregnancy-induced hypertension) ?PTL (pre-term labor) ?complications this pregnancy (GDM (gestational diabetes), Rh negative status, etc)

**Ob Hx:** year/EGA/type of deliv/gender/wt/complications

**Gyn Hx:** STDs/PID/abnl Paps

**PMHx:** standard questions + HTN/DM/MVP/asthma/thyroid/renal/VTE

**PE:** standard exam +fundal height/Leopold's/reflexes/cervical exam, evaluation for ROM (rupture of membranes) (i.e. nitrazine/ferning)

**Plan:** FHT reassuring/reactive, primary Ob Dx (active labor/PPROM/preeclampsia/postdates, etc) - plan for pit/abx/conservative mgmt/consult/US. Other OB DX (GBS/GHTN/GDM/SGA) - plan for abx/labs/etc. Medical Dx (asthma/MVP/thyroid/anemia) - plan

*Delivery Note:* See the Maxwell guide for a complete fill-in-the blank note that you can use. Dr. Wolf also provides a fill-in-the blank delivery note in her "Survival Guide."

**Pre-Op Dx:** IUP (intra-uterine pregnancy) @ \_\_ wks, admitting Dx. If C/S or operative delivery, document reason (NRFHT, maternal exhaustion, failure to dilate, arrest of labor)

**Post-Op Dx:** same, with delivery of viable M/F +/- episiotomy +/- laceration (type & degree)

**Procedure:** SVD/VAVD/FAVD

Surgeon, Assist: coverage

Anesthesia: spinal/epidural/general/NCB

EBL, IVF, drains (+/- foley, describe urine)

+/- placenta, cord gas, cord blood, etc

**Placenta:** spontaneously/manually extracted/intact/3V

**Complications, sponge & needle count**

**Disposition**

**Infant:** presentation, position, time of birth, sex, nuchal cord, appears (1,5) wt, measures for resusc (bulb suction, tactile stim), +/- neo present +/- blow by O2/intubation

**Postpartum Note**

06/21/08 0800 PPD#1 MSIII Note

(Day of delivery = PPD (post-partum day) 0)

**S:** c/o mild cramping, tolerating PO, ambulating without difficulty. +BM, +void. Denies N/V, denies CP/SOB/HA/dizziness/breast tenderness. Moderate lochia (postpartum vaginal bleeding: basically ask if it is lighter than, same as, or heavier than a period). She is breastfeeding the infant and is having some difficulty getting the child to latch. She would like to go home with oral contraception.

**O:** VS: Tc: 98.7 Tmax: 98.9 P: 100 RR: 14 BP: 120/80

I/O: PO/IV intake / urine/emesis/etc

CV: RRR, +S1+S2, no m/r/g

Pulm: CTAB, no w/r/r

Abd: soft, F (fundus) = U-1 (one fingerbreadth below the umbilicus), firm, NT (non-tender)

Ext: no LE edema

**Labs:** Mother A+, infant AB+, RPR neg, Rubella immune

CBC: (pre-delivery and post-delivery values)

**A:** \_\_ yo G\_P\_\_\_\_\_ PPD #1 SVD

**P:**

1. AF VSS, pt doing well
2. Check CBC
3. Other medical problems
4. Breastfeeding, contraception

### **Operative Note for C-Section:**

Use the format for the operative note under surgery. Under “Findings” write “Live male infant at weight 7lb 8oz with APGARs of 7 and 8. Clear amniotic fluid. No adhesions. Normal sized ovaries and tubes.”

### **Post-Operative Cesarean-Section Note:**

Take the format above, just call it POD #1. Usually the patients are on strict I&O for the first day (IV fluid, foley, etc). Also, comment on the incision site and say it is C/D/I (clean, dry, intact) and closed with staples/ suture.

**Pre-operative, Operative, and Post-Operative notes** for all Gynecology patients are the same as the surgery notes (see the surgery section in this guide).

## Psychiatry

As this note is different from the other notes, first is a breakdown of the Mental Status Exam (Psych's physical exam) and second there is an example of a SOAP note. It is important to note that the "subjective" section of the SOAP note often includes parts of the Mental Status Exam.

### Mental Status Exam (MSE)

#### Appearance and Behavior

Alertness and Consciousness: awake, alert, arousable, obtunded

Behavior: pleasant, irritable, agitated, distractible

Dress and grooming: well-groomed, disheveled, in hospital gown, etc

Posture and Gait: steady, ataxic, shuffling

Physical Characteristics: emaciated, obese, appears stated age, track marks, etc.

Eye Contact: poor, fair, good

Attitude toward interviewer: cooperative, hostile

Motor Activity: psychomotor agitation/retardation, tremor

Specific Mannerisms: tics, hand gestures, etc

**Speech:** Rate, volume, prosody, clarity, tone (pressured, quiet, slurred)

**Mood:** a quote from the patient that summarizes how they feel ("depressed," "sad," "no problems")

**Affect:** external expression in terms of range (flat, blunted, constricted, normal range), quality (labile vs. stable), and appropriateness (appropriate vs. inappropriate)

**Thought Process:** the way that the patient is expressing their ideas (goal-oriented, circumstantial, tangential, flight of ideas, loosening of associations, neologisms, clanging, perseverating)

**Thought Content:** the actual ideas the patient is expressing to you; describe these with direct quotes if possible; this includes:

- Hallucinations (auditory, visual, tactile)
- Delusions (religious, paranoid, referential, grandiose, bizarre, etc)
- Suicidal/Homicidal Ideation

**Cognition:** Mini-mental status exam (MMSE): x/30; the MMSE will assess the following and you can note where there are deficits (this Cognition portion is often not included in daily progress notes)

Orientation: to name, place, time (AAO x 1-3)

Concentration: WORLD ↔ DLROW

Memory/Recall: 3 words (e.g. ball, kite, love); immediately and after two minutes

Language

**Insight:** the patient's ability to recognize their problem and the impact of the problem

(good, fair, poor)

**Judgment:** the patient’s ability to make good decisions about everyday activities (for example: a patient who continues to stick finger in electrical socket shows poor judgment; a patient who knows not to stick finger in socket, but does not know to shower when dirty shows fair judgment; and a patient who knows not to stick finger in socket, and will shower when dirty shows good judgment)

**Psychiatry Progress Note** – Should include subjective information, an objective mental status exam, and A/P.

### Sample Note

6/21/08 0745

Psychiatry Progress Note MSIII

**S:** The patient states “they put a pickle in my brain and fried it,” when asked how she was feeling. She denies any problems sleeping indicating that she slept “9 million hours.” She indicates she has been eating her meals. The RN (nurse) notes indicate that the patient was seen interacting with others last night. She denies suicidality. She indicates she “may” wash her clothes today.

**O:** T: 98.6 P: 100 RR: 16 BP: 120/80

MSE (see previous page): The patient was dressed inappropriately in a dirty sweatshirt, hospital gown, and mismatched shoes. She was malodorous. She made appropriate eye-contact and cooperated with the exam. No abnormal movements; no psychomotor agitation/retardation. Her speech was of normal rate, volume, and prosody, though she mumbled. Her stated mood is “fine,” and her affect is congruent with her stated mood. She denies SI/HI (suicidal or homicidal ideation) and denies any VH/TH (visual, tactile hallucinations). She endorses AH (auditory hallucinations), stating that she hears “the president talking to my brain.” She indicates that the voice she hears simply tells her she is “doing a good job.” She denies thought insertion and thought broadcasting. Her insight is poor and her judgment is impaired.

CV: RRR, no m/r/g/S3/S4

Lungs: CTAB

Abd: soft NT, ND, + BS

**A/P:** The patient is a 63 yo F with disorganized schizophrenia who is slowly improving on medications.

- Willing to attempt ADLs (activities of daily living) today, an improvement since yesterday
- Continue risperidone at current dose
- Individual/group/milieu (*this is written for all patients in the inpatient setting, meaning that they are getting therapy by just being there*)
- Mental Health court tomorrow

**Psychiatry Consult and Liaison:** You will be writing a full History and Physical on each patient. Follow the guide on H&Ps in the back of the booklet and remember to use the 5 Axes for assessment. Remember to include the mental status exam as part of your physical exam.

## Pediatrics

### Pediatrics Outpatient SOAP Note

05/29/12 (Date) 0900 (Time)

**S:** 4 month old male presents for well baby visit

Concerns: No concerns since last visit

Diet: Several bottles of Similac with iron per day, no solids (ask about fluoride and vitamin supplementation)

Development: Normal Denver – babbles and coos, smiles, laughs, holds head up, rolls from front to back, raises body on hands, grasps rattle, recognizes parent's voice

Bowel/Bladder: BMs x 2 per day, soft, slightly formed stool, no straining, no blood, 6-8 wet diapers per day (toilet training after 21 months)

Sleep: Sleeps in crib in own room on his back, wakes once per night for bottle

Dental: No teeth. (if a child has a tooth it should be brushed, should see dentist at age 3)

Safety: Rear facing car seat in the back seat, sleeps on back, (+) smoke and carbon monoxide detectors (helmet use, gun safety, pet safety)

Immunizations: Up to date, needs DTaP (diphtheria, tetanus and acellular pertussis), Hib (haemophilus influenzae type B), IPV (inactivated poliovirus), PCV (pneumococcal)

For adolescents: Drugs/alcohol/tobacco, sexual activity, after-school activities, hours of screen time (TV and computer), school, depression/self-esteem

**O:** Length: 25in, Weight: 14lbs 8oz, Head Circumference: 16.5in, Pulse: 130

Gen: Awake, alert, no acute distress, smiling

HEENT: Anterior fontanelle open, flat and soft (AFOFS), normal cephalic atraumatic (NCAT), (+) red reflexes bilaterally, follows past midline, (-) strabismus, pupils equal round and reactive to light (PERRL), normal tympanic membranes B/L, inferior turbinates slightly pale and boggy, throat clear

Neck: Supple, (-) lymphadenopathy (LAD)

Skin: (-) rashes, (-) mongolian spots

CV: regular rate and rhythm, (+) S1S2, (-) murmurs, equal radial and femoral pulses

Resp: CTA B/L, (-) wheezes/rhonchi/rales

Abd: Soft, (+) bowel sounds, NT, ND, (-) masses, (-) hepatosplenomegaly

Ext: normal range of motion (ROM), (-) Ortolani, (-) Barlow

Neuro: (+) Moro reflex, (+) grasping reflex, (+) stepping reflex

**A/P:** 4 month old male presents for well baby visit. No new complaints.

1. Diet: add cereal and then pureed fruits/veggies, only add one new food per week to gauge tolerance
2. Safety: discussed 'child proofing' the house (hot liquids, sharp objects, outlets, cords, etc.) as baby is becoming more mobile
3. Immunizations: Received DTaP, IPV, Hib, PVC today
4. Return in 2 months

*Inpatient Note:* Use the Internal Medicine note as a guide but remember to add in a sentence about how the child is eating, sleeping, urinating, and defecating. Also, give I's and O's in ml/kg/hour.

## Sample History and Physical

Below is an example of a thorough History and Physical. It can be used as a guide for an H&P you will do on all admissions and consults throughout the year regardless of the rotation. After the example, there are suggestions of ways to change the H&P for that rotation.

### History and Physical

Chief Complaint: “I was driving home and my heart started racing”

**HPI:** The patient is a 39-year-old pregnant female who had a sudden onset of palpitations and dizziness while driving home on the day of admission. The patient describes the palpitations as though her baby was kicking in her chest (she is 27 weeks pregnant) and she felt as though her heart was racing. While there was associated dizziness, the patient did not lose consciousness nor did she experience any diaphoresis, nausea, or chest pain. She did become short of breath, but attributes this to feeling anxious about what was happening to her. She completed her drive home and then laid on the floor and finally a couch to see if she would feel better. The palpitations and dizziness continued and nothing made either better or worse. The patient thought her blood sugar may be low and so she took her blood sugar by Accucheck and it was 91. She also took her blood pressure and pulse and noted that her blood pressure was 90/ “something” and that her pulse was 126. She repeated her pulse two more times and found it to be 129 and then 131 even after trying to “calm down”. She had never experienced anything like this in the past and so she called her Ob/Gyn thinking something may be wrong with the fetus. Her Ob/Gyn suggested she go to the emergency room and so a friend of hers drove her to Christiana ER late yesterday evening, which was the day of admission.

### PMH

- Gestational diabetes with her 1st child which resolved at birth
- Genital herpes
- Mild seasonal allergies.

### PSH

- Tonsillectomy
- Wisdom tooth extraction
- Episiotomy
- She also had some “extra skin” removed from her episiotomy site by an Ob/Gyn in 2001 since she had an “overzealous” scar formation.

### Medications

Currently: Prenatal vitamins.

Prior to becoming pregnant: Orthovera patch, herbs, megavitamins, lysine PRN

### Allergies

Codeine and sulfa drug; reactions to both not known.

### Family History

Patient is adopted and has no information on her biological parents. She has one living child who is healthy.

## Social History

The patient is currently married and lives at home with her husband and her child. She was married from 1991-1993 and she divorced then remarried the man who is her current husband in 1998. She has never used tobacco and denies the use of any illegal drugs including misuse of prescription drugs. She used to drink a glass of wine once a week prior to becoming pregnant. The patient has never used any IV drugs or needles for any purpose. She has no tattoos and has nothing except her ears pierced. She has been treated for genital herpes and she prefers to take lysine supplements now instead of anti-viral medication. She indicates she will start acyclovir about two months prior to giving birth. She received the genital herpes from her ex-husband. She has never paid for or received money for sexual relations and in the last ten years she has only had one sexual partner. The patient is the Director of Admissions at a private school. She does feel safe at home. She wears a seatbelt and has firearms at home though they are safely stored and locked. She also has a cat.

## Review of Systems:

**General:** Recent weight gain with pregnancy, she is always fatigued, no fevers or chills.

**Skin:** No changes, no itching

**Head:** No recent headaches or trauma. Dizziness as above in HPI.

**Eyes:** No recent changes in vision. The patient does not need glasses or contacts.

**Ears:** No hearing loss, tinnitus, vertigo, discharge, or pain.

**Nose:** No rhinorrhea, epistaxis, or changes in her sense of smell or taste.

**Mouth/Throat/Neck:** No sore throat, dysphagia, odynophagia, or change in her sense of taste. No recent bleeding. She has not noticed any new neck masses.

**Breast:** No changes noted except for an increase in size due to pregnancy

**Respiratory:** Some shortness of breath (as in HPI), no cough or wheeze.

**Cardiovascular:** No chest pain. Palpitations as in HPI, no edema.

**GI:** No nausea, vomiting, or abdominal pain. The patient is constipated which she describes as normal and her stools are hard and brown. There has been no change in color or consistency and there has been no visible blood.

**Urinary:** No dysuria. She has noted frequency but as expected with her pregnancy. No incontinence.

**Genital:** Gravida 2. Para: 1001 (full term deliveries/pre-term deliveries/TAB or SAB/living children). Patient is due on 11/24/05. She had had preterm contractions in July and was given Indocin and the contractions resolved. She has had no other complications with either this pregnancy or her last (except for the gestational diabetes as noted above).

**Musculoskeletal:** Patient complains of some bilateral hip pain (from her pregnancy). She has no problems with range of motion or joint pain. She did stub her toe last week and felt it “crack”. She splinted the toe herself and did not seek medical care.



**Neurologic:** no loss of consciousness. Dizziness as above. Patient also complains of some hand weakness.

**Hematologic:** No known anemia or easy bruising.

**Endocrine:** No expressed heat/cold intolerance. No diaphoresis. Patient notes that she could not perform an oral glucose tolerance test during this pregnancy because of adverse reactions to the test during her first pregnancy. There is an assumed diagnosis of gestational diabetes for this pregnancy.

**Psychiatric:** Patient is happy with no recent changes in mood. No anxiety or depression.

### **Physical Exam**

**Vitals:** Temp 37.1° C by mouth. Pulse 106/min. Respirations 16/min. Blood pressure 106/84 supine

**General:** Patient is in no apparent distress and appears to be in a good state of health with appropriate affect and bearing for her age and current state.

**Skin:** Some spider veins noted on her upper thighs bilaterally. Finger and toenails were painted.

**Head:** Normocephalic, atraumatic

**Eyes:** Pupils equal, round, and reactive to light-3mm. Extraocular eye muscles intact. Anicteric, non-injected. Sharp margins to optic cup and vessels within normal limits.

**Ears:** Auricles intact bilaterally. No discharge. Tympanic membranes pale bilaterally.

**Nose:** No polyps or discharge. Nares are symmetrical. No tenderness.

**Mouth/Throat:** Adequate dentition with some plaque noted on teeth. Moist mucous membranes. No exudates or erythema. No ulcers or lesions. Palate movement is equal bilaterally.

**Neck:** Normal range of motion. Trachea is midline. Thyroid exam within normal limits.

**Heart:** Tachycardic with an irregularly irregular rhythm. Audible S1 and S2. No murmurs, rubs, gallops, S3, nor S4. PMI in 4th interspace in the mid clavicular line. The central venous pressure was estimated at 6mmHg with the head at 45 degrees.

**Lungs:** Clear to auscultation bilaterally. Resonant to percussion. Equal chest excursion. Normal vocal fremitus.

**Abdomen:** Linea nigra of pregnancy noted on abdomen. No tenderness on palpation. No rebound. Fundal height 27cm (consistent with dates). Normoactive bowel sounds. Tympanic on percussion. Liver span estimated at 9cm in the mid clavicular line. No splenomegaly. No costovertebral angle tenderness.

**GU:** Patient refused

**Rectal:** Patient refused

**Musculoskeletal:** No muscular atrophy. Full range of motion.

**Vascular:** No carotid bruits

Vessel	Right	Left
Carotid	2/4	2/4
Radial	2/4	2/4
Femoral	2/4	2/4
Popliteal	Unable to appreciate	Unable to appreciate
Posterior Tibial	2/4	2/4
Dorsalis Pedis	2/4	2/4

**Lymphatic:** No lymphadenopathy (preauricular, posterior auricular, occipital, anterior cervical, posterior cervical, submandibular, submental, supraclavicular, femoral, inguinal)

**Neurologic** (also see Neurology Exam, pp. 5-6): Cranial nerve 1 intact to coffee grounds. CN 2 intact to print 2cm in height held 12 inches from face. CN 3,4,6 intact to tracking a finger. CN 5 intact to bilateral bite on tongue blades. CN 7 intact to puffing cheeks, smiles, growls, closing eyelids, and wrinkling brow. CN 8 intact to normal volume of speech. CN 9,10 intact with equal elevation of palate bilaterally. CN 11 intact to shoulder shrug. CN 12 intact with no tongue deviation on protrusion. Power 5/5 throughout (deltoids, biceps, triceps, wrist extensors, wrist flexors, hip extensors, hip flexors, quadriceps, plantarflexors, dorsiflexors). Sensation was grossly intact when tested with a safety pin. Cerebellar exam was within normal limits with finger-nose-finger and rapid alternating movements. Reflexes: 2+ upper (biceps and triceps) and lower (patellar and Achilles) bilaterally.

**Labs/Studies:**

8/24 (day of admission):

Sodium 137		TSH: 3.22	
Potassium 3.8			
Chloride 106		WBC 13.1	
CO2/bicarb 20		Hemoglobin 11.8	
BUN 10		Hematocrit 33.9	
Creatinine 0.5		Platelets 246	
Glucose 86			
Magnesium 1.8			
	Set 1	Set 2	Set 3
TroponinT	< .01	< .01	< .01
CK	< 25	< 20	< 20
CKMB	1.4	1.3	1.1

**Urinalysis**

Specific gravity 1.008

Clear, yellow

15 mg/dL ketones

pH 7.0

neg for blood, heme, leukocyte esterase, nitrites, urobilinogen, and protein

**EKG:** (see attached) irregularly irregular with some fibrillation waves present

**Assessment:** Patient is a 39 year old female with a history of gestational diabetes and genital herpes, who presents with new onset palpitations and dizziness.

**Differential Diagnosis:**

1. Cardiovascular
  - a. Atrial fibrillation
    - i. Hyperthyroid
    - ii. Structural disease
      1. Valvular
      2. Myocardial infarction
      3. Atrial enlargement
  - b. Ventricular tachyarrhythmia (unlikely)
  - c. Pregnancy-induced hypotension from compression of the inferior vena-cava with increased heart rate as compensation
2. Renal
  - a. Hypovolemia
    - i. Dehydration
    - ii. Hemorrhage
3. Metabolic
  - a. Hypoglycemia
  - b. Hyperthyroid
4. Psychiatric
  - a. Panic attack

**Plan**

1. CV:
  - a. EKG, echocardiogram, cardiac enzymes
  - b. Perhaps start diltiazam, or a beta blocker to rate control
2. Labs:
  - a. Chem 7, orthostatics, CBC
  - b. Blood sugar, TSH level
3. Monitor. Consider PRN benzodiazepines
4. Fluid/Electrolytes/Nutrition: no issues
5. Prophylaxis: SCDs
6. Disposition: Awaiting studies to determine if the event is cardiac in nature

## The History and Physical for Each Rotation

**Internal Medicine:** The more information, the better typically. Anything at all relevant or not relevant can go into the History and Physical. You will likely not be typing the History and Physical out, but will instead be trying to write it on a blank slip of paper or some pre-approved form at your rotating hospital. Your preceptors and attending physicians will want to see typical medical student H&Ps which are long, drawn-out and include a lot of information that might never be asked by a physician again. You will need at least an hour to try and get that kind of information especially at first. Typically however; you will be with an intern who needs to get the information in 15 minutes down in the ER so they can write orders and admit the patient. A good suggestion is to try and get your team to send you down first to interview the patient, and then page them when you are ready (this may not work for them so just go with the flow). Also, if you have to write your H&P on a blank paper, get in the habit of leaving room for the HPI and then labeling all of the other things you will ask on the page like a template...then you can fill them in directly on the sheet instead of transferring notes later. Then all you will have to do is write the HPI and fill in your labs and A/P sections.

**Surgery:** A difficult H&P to write because you are expected to only write the relevant information, but it can be difficult to know what is relevant to the surgeon. In general, worry less about the social history/sexual history/family history unless it is very pertinent to the disease process that you are being asked to treat. Get a good prior surgical history on your patient including which side the operation was on and how long ago, as well as any complications. Many surgeons like little drawings of the abdomen on the sheet with scars, pain, masses, etc. marked on the drawing.

**Ob/Gyn:** These are somewhere between a medicine and surgery H&P. The important thing to include is the Ob and Gyn histories, as well as the pelvic exam. Also, always start the HPI with the gravidity and parity of the patient (for example “the patient is a 24 year old G2P1001 who...”).

A sample of a good Ob/Gyn history for a patient would be:

- OB: Patient is G2P1001. She delivered a VMI (viable male infant) via SVD (spontaneous vaginal delivery) in 2000 with a complication of pre-gestational HTN. The HTN has since resolved with no further treatment.
- GYN: 12/28-30/5 (This means the patient began menarche at age 12, has regular cycles every 28-30 days, and bleeds for 5 days typically). She denies metrorrhagia (heavy bleeding during the period), menorrhagia (bleeding in between periods), and dysmenorrhea (very painful menses). She has never had an abnormal PAP smear, and has been treated for HSV2. She is currently on Acyclovir for suppression. No other STD history. The patient was on OCP (oral contraceptive pills) for 6 years prior to becoming pregnant, and stopped 6 months prior to becoming pregnant.

**Psychiatry:** While a long H&P on psychiatry is not unusual, be careful about rambling. You want to capture a “snapshot” of the patient, not record a 6 hour video documentary. Psychiatric patients are difficult because they usually talk too much, or very little. You will need to get only the relevant information and record that in the HPI. The physical exam includes the Mental Status Exam as well as usually a section for heart, lungs, and abdomen. Your assessment section is easier than in other H&Ps because you will write it in an “axis” system. The plan typically includes medications and some kind of monitoring.

An example of an axis assessment is:

- Axis I (major psychiatric diagnosis): schizophrenia, paranoid type
- Axis II (personality disorders and mental retardation): Deferred (usually you will not diagnose a personality disorder in an inpatient facility even if it is glaring)
- Axis III (Medical history): HTN, DM
- Axis IV (stressors): homelessness, no family
- Axis V (Global Assessment of Function Score): 30 (look this up on a chart)

**Pediatrics:** The H&P is essentially the same as for Internal Medicine. Make sure you include whether the child is urinating, defecating, feeding, sleeping, or irritable in the HPI. Also, you will want to include a birth history and developmental history in the social section. Something like: The patient was born at 7lbs 6oz via SVD (spontaneous vaginal delivery) with no complications during pregnancy or delivery. He has reached all current developmental milestones.

**Family Medicine:** You will probably never write an H&P for family medicine. If so, just follow the Internal Medicine sample.

## Abbreviations Used in this Guide

AAOx3	Awake, alert and oriented x 3 (person, place and time)
BM	Bowel movement
BMP	Basic metabolic panel
+BS	Positive bowel sounds
Ø c/c/e	No clubbing, cyanosis, nor edema
C/D/I	Clean, dry, intact
c/o	Complained of
CBC	Complete blood count
CP	Chest pain
CTAB	Clear to auscultation bilaterally
D/C	Discharge or discontinue (depending on context)
D/W	Discuss with
EBL	Estimated blood loss
F/C	Fevers/ chills
HD	Hospital day
I&Os	Ins and Outs (should specify time period)
JP	Jackson-Pratt drain
m/r/g	Murmurs, rubs, gallops
N/V	Nausea/vomiting
NAD	No acute distress
NKDA	No known drug allergies
NPO	Nothing by mouth
NT/ND	Nontender, non-distended
PCA	Patient controlled analgesia pump
PCB or SCD	Pneumatic compression boots or sequential compression devices
PMH	Past Medical History
PO	Oral intake
POD	Post-op day
RA	Room air
RR	Respiratory rate
RRR	Regular rate and rhythm
s/p	Status post
+S1,+S2	Audible first and second heart sound
SOB	Shortness of breath
SpO2	Oxygen saturation
SSI	Sliding Scale Insulin
t/c	To consider
Tc	Current temperature

Tmax	Max temp in past 24 hours
TTP	Tender to palpation
UA	Urinalysis
UO	Urine output
VS	Vital signs
w/t/r/c	Wheeze, rales, rhonchi, crackles
WNL	Within normal limits