

MINIMUM DATA REQUIRED FOR ALL WRITE-UPS

A. Patient Identification

This includes the patient's age, gender, ethnicity, medical record number, telephone number of nearest relative in case of emergency, and referral source if any.

B. Source and reliability of information

State the source and reliability of the data, noting any concerns you might have. This signals the quality of the data to the reader.

C. Chief Complaint (List as a separate heading)

State the patient's most bothersome symptom (chief complaint) using patient's own words, if possible.

D. History of Present Illness (HPI) (List as a separate heading)

This is the most important part of the history and should be written in the narrative form. Do not list stable problems or other PMH in this section unless they are pertinent to the patient's active complaint.

1. Begin with an overview of the chief complaint and other symptoms mentioned by the patient that fit together to best describe the most likely underlying disease process. Indicate when each symptom began and provide the following cardinal features where applicable:
 - a. location
 - b. quality
 - c. quantity/severity
 - d. timing (duration, frequency)
 - e. setting in which they occur
 - f. provocative factors
 - g. palliative factors
 - h. associated symptoms.
2. Next, record the relevant positive and negative non-symptom data such as data about previous doctors and healthcare facilities, diagnostic tests and results, treatments and results, specific habits, and occupation that are important for understanding the etiology (cause), pathogenesis (mechanism) and prognosis of the patient's problem
3. Provide the personal and emotional context of the patient's major problems. This section should display your understanding of how the patient's personal and emotional dimensions are linked with their physical problem.

NB: Data that is presented in the HPI do not need to be repeated in other parts of the write-up

E. Other current active problems

This section can be appended to the HPI. As with the HPI, these problems should be described with the appropriate symptoms and non-symptom data.

The following sections can be recorded in outline form or a combination of narrative and outline form:

F. Past Medical History (List as a separate heading)

1. List all relevant past medical events. Must include date or patient's age. Include examples of relevant past medical history:
 - a. illnesses (medical and psychiatric)
 - b. operations
 - c. injuries
 - d. pregnancies: gravidity, parity

G. Medication (List as a separate heading)

- Include prescription and over-the-counter medicines.
- a. name
 - b. dose
 - c. frequency
 - d. duration of use

H. Allergies (List as a separate heading)

- a. allergen such as food, drug or environmental
- b. nature of allergic response

I. Health Maintenance (List as separate heading)

- a. screening test
- b. exposures
- c. safety measures
- d. exercise
- e. sleep
- f. diet
- g. immunization

J. Social History (List as separate heading)

- a. current setting: relationships of other household members and significant others (marital status)
- b. education/occupation
- c. sexual history (if appropriate)
- d. tobacco
- e. substance use/abuse (alcohol: CAGE to be administered for all patients using alcohol)
- f. economic or other barrier to care

K. Family History (List as a separate heading)

Should contain screen for inheritable/familial diseases (age or birth date and health status of parents, siblings, and children)

L. Review of System (List as separate heading)

- a. Constitutional: General health, energy, appetite, fevers, chills, night sweats, weight changes.
- b. Skin: Pruritus, sores, bruising, hair, nails, mole changes
- c. Head/Neck: Trauma, pain
- d. Eyes: Visual problems, e.g. blurring, inflammation, spots, flashes.
- e. Ears: Hearing problems, otalgia, tinnitus.
- f. Nose: Rhinitis, epistaxis, sinusitis.
- g. Mouth/Throat: Dental problems, sores, hoarseness, dysphagia.
- h. Lymph Nodes: Swelling.
- i. Respiratory: Wheezing, cough, sputum, hemoptysis, dyspnea.
- j. Cardiovascular: Palpitation, pain, orthopnea, PND, exercise tolerance.
- k. GI Tract: Pain, indigestion, heartburn, nausea, vomiting, diarrhea, constipation, change in bowel, melena, rectal problems, bleeding, jaundice.

- l. Urinary Tract: Dysuria, polyuria, nocturia, hematuria, urgency, incontinence.
 - m. Female Genitalia: Sores, vaginal discharge/bleeding, sexual dysfunction.
 - n. Breast: Mass, tenderness, discharge.
 - o. Male Genitalia: Sores, discharge, scrotal pain, hernia, sexual dysfunction.
 - p. Joints/Extremities: Cramps, varicosities, pain, edema, arthralgias, low back pain.
 - q. Endocrine: Heat or cold intolerance.
 - r. CNS: Paralysis, paresthesias, balance, gait, seizures, syncope, dizziness, nervousness, depression.
 - s. Any exposure to fumes, dusts, chemicals, loud noise, radiation?
- List and describe all positives before listing negatives
 - Use the appropriate medical terminology

(NB: A of list pertinent positives and negatives with a statement that a 10-point review of systems was performed and was otherwise negative is adequate for billing)

M. Physical Exam (List as a separate heading)

The phrases "normal," "within normal limits," and "negative" are not acceptable

Vital Signs

- Temperature: _____ + route
- Pulse: _____ + regular/irregular
- Respiration: _____ + describe pattern, character
- Blood pressure: _____ (with orthostatic blood pressure and pulse readings where indicated)

General Appearance

Communicate a sense of what this person looks like with a brief description of:

- a. Body habitus
- b. Apparent age
- c. Distress
- d. Cooperation

Integument

Screen for skin lesions.

Eyes: Describe the patient's:

- a. Conjunctivae
- b. Sclerae (color)
- c. Pupils (size, reaction to light/accommodations, symmetry)
- d. Extraocular muscles
- e. Cornea/lens
- f. Fundus
- g. Visual fields

Ears: Describe the patient's:

- a. Hearing: acuity (describe method)
- b. Canals
- c. Tympanic membrane

Nose: Describe the patient's:

- a. Mucous membrane: color, patency of passages, discharge
- b. Septum: position

Mouth and Throat: Describe the patient's:

- a. Oral cavity: include tongue, teeth, gums, and mucous membrane
- b. Posterior pharynx

Neck: Describe the:

- a. Range of motion
- b. Thyroid

Lymph Nodes: Describe the findings on inspection and palpation of the:

- a. Neck
- b. Supraclavicular nodes
- c. Axillary nodes
- d. Inguinal nodes
- e. Femoral nodes

Thorax and Back: Describe the findings on inspection, palpation and percussion

Lungs: Describe findings on inspection, palpation, percussion and auscultation.

Cardiovascular: Describe

- a. The peripheral pulses: carotid radial, femoral, dorsalis pedis and posterior tibial
- b. Precordium
- c. Findings on inspection, palpation and auscultation of the heart

- Pulses and bruits may be reported in the respective anatomical regions or under the corresponding organ system

Breasts: Record findings of inspection and palpation

Musculoskeletal: Describe the patient's

- a. Spine
- b. Extremities
- c. Joints
- d. Muscles

Neurologic: Describe the patient's

- a. Cranial nerves
- b. Sensory exam
- c. Motor exam
- d. Coordination, gait and station
- e. Reflexes

Genital/Rectal: Description is required if it is relevant; otherwise indicate, "not done"

N. Imaging and Laboratory Data (List as separate heading)

Record and interpret relevant data

O. Assessment (List as separate heading)

1. Identify active problems
 2. Discuss, for each active problem:
 - a. Most likely diagnosis
 - b. Most likely alternatives and supporting data
 - c. For chronic problems, indicate underlying etiology, precipitating factors and complications
- Important psychosocial complications of the patient's illness should be discussed.

P. Assessment of Plan (May list as separate heading or include a plan for each problem in the Assessment)

For each major problem, write a plan with the following components where appropriate:

1. Diagnostic plan
2. Treatment plan
3. Prognosis/follow-up
4. Patient education
5. Economic/resource referrals

Q. Evaluation

Discuss and reconcile differences with senior resident before dictating your note.