We are including these so that you see the materials that are taught to first year students.

Notes about medical history that students will find helpful and should refer to frequently!

WHY DO PEOPLE GO TO THE DOCTOR?

There are many reasons why people go to the doctor. In addition to the traditional "sick" visit, people also seek their physician for follow-up of chronic problems, and health maintenance. These visit types differ based upon patient age and sex. It is important to understand the physician's responsibility for their patients' health besides providing care when they are sick.

The following charts are a guide to understand why people go to the doctor, while not meant to be comprehensive – they provide an outline for what you will see in your preceptor's office.

CHILDREN	**ADULTS**
1) Sick Visits	1) Chronic Problem
2) Health Maintenance/Screening (check-ups)	2) Sick Visits
3) Chronic Problems	3) Health Maintenance/Screen (check-ups)

Adults are seen more commonly for chronic problems - children more for sick visits and 'check-ups'.

'SICK' VISIT examples

CHILDREN	**ADULTS**
1) Fever	1) Upper Respiratory infection
2) Otitis media/upper respiratory infection	2) Musculoskeletal injuries
3) Gastrointestinal distress	3) Gastrointestinal distress
4) Injuries	

CHRONIC DISEASE FOLLOW-UP VISITS

CHILDREN	**ADULTS**
1) Asthma	1) Hypertension
2) Neurodevelopment problems	2) Diabetes
	3) Psychiatric Conditions
	4) Asthma/COPD(Chronic obstructive pulmonary disease)

HEALTH MAINTENANCE / DISEASE SCREENING VISITS

INFANTS/CHILDREN	**ADULTS**
1) Immunization	1) Cancer Screening
2) Growth and Development	2) Chronic Disease Screening, (Hypertension, Diabetes, Hypercholesterolemia)
3) Safety Issues	3) Substance Abuse
4) Substance Abuse (Adolescents/Teens)	

Outline of the Complete Medical History and Write-up

I. Chief Complaint (CC)

II. History of Present Illness (HPI)

A. 7 Cardinal Features of the presenting symptom (CC)

1. Quality
2. Location
3. Chronology
4. Setting and Onset
5. Severity
6. Modifying Factors
7. Associated Symptoms

Include Pertinent Positives - a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint ***which is present*** in the patient.
Include Pertinent Negatives - a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint which ***is absent*** in the patient.

III. Past Medical and Past Surgical History (PMSH)

A. Medical Illnesses/ Hospitalizations
B. Surgical History
C. Psychiatric History
D. Childhood Illnesses
D1. (Add Birth and Developmental History to a Pediatric History)
E. Injuries
F. Medications
G. Allergies
H. Transfusions
I. Pregnancies

IV. Social History/Habits and Risk Behavior

A. Birthplace
B. Education
C. Work and Work History including exposure to hazardous materials
D. Marital/Relationship Status
E. Quality/Quantity of Social Relationships
F. Diet
G. Exercise
H. Tobacco Use
I. Alcohol Use
J. Drug Use
K. Sexual Behaviors History
L. Domestic Violence
M. Injury Prevention (seat belts, bicycle helmets, etc.)

V. **Family History**

A. Significant **Illnesses** in 2-3 generations of family – Document -
   Ages and health status of **siblings**
   Ages and health status of **parents**
   Ages and health status of **grandparents**
   Ages and health status of **children**

B. Ask about Common **Diseases** with known genetic links
   1) familial incidence of arthritis, cancer, diabetes, hypertension, myocardial infarction, stroke, mental illness, alcoholism
   2) any other illness that **runs in the family**

VI. **Health Care Maintenance** (Prevention and Screening)

A. Cancer Screening
B. Immunizations
C. High Risk Population Screening (e.g. HIV testing for those with high-risk behavior)
D. Other (cholesterol, vision, hearing, dental, sun exposure)
E. Health Care Proxy

VII. **Review of Systems (ROS)**

A.	Constitutional	B.	Skin
C.	Head	D.	Eyes
E.	Ears	F.	Nose
G.	Mouth	H.	Throat
I.	Breasts	J.	Respiratory
K.	Cardiovascular	L.	Gastrointestinal
M.	Urinary	N.	Genital
O.	Menstrual-Reproductive	P.	Endocrine
Q.	Musculoskeletal	R.	Hematological
S.	Nervous System	T.	Psychiatric

COMPONENTS OF THE MEDICAL HISTORY DESCRIBED

I. Chief Complaint (CC): The patient's stated reason for the medical encounter

II. History Present Illness (HPI): Characterize the chief complaint according to the principles of interviewing that you learned in the Physician Patient and Society course. This includes the 7 cardinal features of the symptom (quality, location, chronology, associated symptoms, modifying factors, setting and onset, and severity) as well as asking all questions in the past medical history (PMH), family history (FH), social history (SH) and review of systems (ROS) that directly relate to the chief complaint. Therefore, if a patient is experiencing shortness of breath, you should characterize the complaint and then include any pertinent PMH, FH, SH, and cardiorespiratory review of systems in your HPI since most causes of SOB can be traced to these two systems. Therefore, at the end of the HPI, it is worthwhile to ask yourself: "*have I characterized the chief complaint and asked the relevant questions from the appropriate past medical history, family history, social history and review of systems"?*

The HPI is the most demanding part of history. It details completely and concisely all of the features of the illness or symptom complex that brought the patient to the hospital or the physician's office. It should be detailed in chronological order and in literate fashion so that details and time sequence are understandable to the reader. This is a task of potentially extraordinary complexity. It requires that you get the full details as outlined above, as well as the care that the patient has sought for the symptoms, diagnostic tests performed, physician's and patient's impressions of the symptoms and the plan that has been outlined thus far.

While not expected for this course work, keep in mind during the time that you are doing clinical rotations, you will also be asked to review previous medical records to supplement the information that the patient has given you and confirm the details of the tests that the patient has had leading up to the hospitalization. While this list of questions and issues that need to be addressed seem to be daunting, they can all be seen as a part of the time course of the illness for which the patient presents.

Events should be related temporally but attention should be paid to the avoidance of skipping back and forth between the details of symptoms in different organ systems. If a patient has an illness that has multiple symptoms from different organ systems, it is often helpful to detail the symptoms separately followed by their time course, features, pertinent positives and negatives. In addition, if the patient has had multiple episodes of a symptom complex or multiple exacerbations of one disease, it is often helpful to get the full details of a typical episode, record the frequency of episodes and record how the current episode may differ from a typical episode if it does.

There clearly is judgment involved in deciding whether an item belongs in the HPI. A rule of thumb is to include all the symptoms from the Review of Systems in which the patient's chief complaint falls as well as any diseases that relate to that system. As you take the history and form ideas or hypotheses about what disease entities that the symptoms might represent, be careful to then include questions from the systems that these diseases involve. This requires that you begin to integrate the knowledge that you have gained in the Pathophysiology course with the symptoms that the patient reports to you. You should not include the details of illnesses that are not related to the HPI here as this information belongs to the PMH.

III. Past Medical History (PMH): In this section, you should detail the patient's previous medical and surgical problems. To be included in this section, it should be a clear diagnosis, not only a symptom or symptom complex. In addition, if a patient tells you that they have had a certain disease; you should typically ask about the presenting symptoms, diagnostic tests used to arrive at the diagnosis, and subsequent course of the disease. This information allows you to include only clearly established diagnoses. The more varied that the disease presentation can be, the more critical it is that you record the details completely. You can use a shorthand method of recording the PMH/PSH by listing the diagnosis followed by the date that the diagnosis was made and the details that you have collected. An example is given below.

a. Essential Hypertension - 1986, diagnosed on routine PE, without complications, treated with ACE Inhibitor, Vasotec
b. Systemic Lupus Erythematous - 1989, presenting with diffuse arthralgia and arthritis as well as skin rash, diagnosed clinically and treated with Naprosyn for his/her joint pain

Also included in this section are numerous subheadings that pertain to previous problems or health history. These include:

a. Past Illness (examples above)
b. Past Surgeries
c. Childhood Illnesses
d Injuries
e. Immunizations
f. Allergies (include a description of the reaction)
g. Transfusions
h. Pregnancies
i. Medications - include doses and frequency

IV. Family History (FH): Diseases that can be inherited are a critical part of history. You should record the health status and health problems, concentrating on those that are known to have genetic links, of the patient's grandparents, parents, siblings and children. If any of these persons are deceased, record the cause of death and the age at which that occurred. While the history of the grandparents may be hard to obtain, it is important to attempt to get information for at least two generations of the family that have lived long enough to get heritable diseases. This can be recorded in long hand or in family tree format being sure to identify which one is the patient if a family tree is used. In addition to whatever format is being utilized, you should also ask about the major disease categories that are known to have genetic links such as Diabetes Mellitus, Hypertension, Myocardial Infarction, Stroke, Arthritis, Asthma and Cancer.

V. Social History (SH): This section should attempt to detail prominent features in the life of the person that you are examining. It should include a comment on where the person was born, when and how they came to be in their current community, their marital status, current work, some comment on the quality and quantity of their social relationships and their means of emotional support. By convention, this is the section of the write-up where the history of smoking, alcohol, sexual history, and drug use history are recorded.

VI. Review of Systems (ROS): This is a systematic, comprehensive review of multiple symptoms that the patient may have experienced. The areas that you have to question can be conveniently grouped according to the pathophysiological system in which they fall. A list of systems follows this section. There are several critical items that need to be mentioned with regard to the recording of the ROS in the writeup. If a patient tells you that they have experienced a certain symptom, pursue that positive answer to determine whether it is a current problem, an acute problem that will need attention during this visit, or a fleeting or past problem that does not require attention at all. Do not simply record that symptom as "positive." Conversely, it does not suffice to describe the whole- system as negative while not recording the items that you asked the patient. This is the case because recording the system as negative does not adequately characterize what items you asked the patient about. This is generally referred to as “pertinent positive” and “pertinent negative” review of system as applied to the chief complaint.

A NOTE ABOUT TIMING - ROS questions are asked in many situations. It is important to be clear why you are asking them, and what time period you want the patient to consider in answering the question. <u>If the patient is an outpatient who you will follow over time</u>, you are really asking whether a patient has had significant symptoms recently (and in some circumstances like hemoptysis or sudden asymmetric weakness or loss of consciousness, ever), and then pursuing enough detail to determine

whether you might be able to make a diagnosis or need to do some tests, or be aware of these symptoms for a later visit. If the patient is an inpatient who you will follow during the hospitalization, your question really has to do with whether the patient has experienced symptoms in ROS recently, and significantly enough that you need to focus on it (either testing or treatment) during this hospitalization. You are not asking whether a patient has ever had a rash, or ever had epistaxis (bloody nose) or heartburn

What follows is a list of questions from various organ systems that should be addressed in the ROS.

1. **CONSTITUTIONAL SYMPTOMS:** Fever, night sweats, chills, fatigue, anorexia, insomnia, weight change, weakness, irritability.

2. **SKIN:** Change in moisture, temperature, color or texture, lesions, rashes, itching, bruising, bleeding disorders, changes in hair or nails.

3. **HEAD:** Change in head size, headache, trauma.

4. **EYES: Vision** changes, glasses, blurring, eye pain, diplopia (double vision), scotomata (blind spots), flashes of lights, injury, irritation, discharge, photophobia, excessive tearing.

5. **EARS: Hearing** loss, pain, infections, discharge, tinnitus, vertigo.

6. **NOSE: Dryness**, bleeding, pain, discharge, coryza, epistaxis, obstruction, sinus pain, change in smell.

7. **MOUTH: Condition** of teeth, pain in mouth or tongue, bleeding gums, lesions in mouth, tongue or lips.

8. **THROAT: Soreness**, hoarseness, dysphagia.

9. **BREASTS:** (both sexes) Pain, swelling, discharge, masses.

10. **RESPIRATORY:** Cough (acute or chronic), sputum production, hemoptysis, dyspnea, wheezing, chest pain, pleurisy, orthopnea.

11. **CARDIOVASCULAR SYSTEM:** Chest pain, exertional dyspnea (shortness of breath), paroxysmal nocturnal dyspnea, orthopnea, palpitations, syncope, peripheral edema, cyanosis, murmur, intermittent claudication, Raynaud's phenomenon, varicose veins, phlebitis.

12. **GASTRO-INTESTINAL TRACT:** Dysphagia, odynophagia, appetite, heart burn (acid indigestion), eructation (belching), regurgitation, bloating, abdominal pain or discomfort, fullness, distention, pain, nausea, vomiting, hematemesis, jaundice, bowel habit change, rectal pain, hemorrhoids, hernia, hematochezia, melena, diarrhea, constipation.

13. **URINARY SYSTEMS:** Dysuria, frequency, urgency, polyuria, nocturia, incontinence, flank pain, hematuria, retention, dribbling, hesitancy, poor stream, back or costovertebral angle (CVA) tenderness.

14. **GENITAL SYSTEM:**
    a. Gynecological: discharge, itching, genital lesions
    b. Male Genitalia: pain, lumps, urethral discharge, testicular pain or swelling
    c. Sexual Problems: dissatisfaction, dyspareunia, potency, recent change in pattern.

15. **MENSTRUAL-REPRODUCTIVE HISTORY:** Dysmenorrhea, intermenstrual bleeding, changes in cycle, amenorrhea, menorrhagia, metrorrhagia. Peri-menopausal symptoms like hot flashes, sweating, post-menopausal bleeding. Emotional reaction to menarche and menopause.

16. **ENDOCRINE SYSTEM:** General (weight change, easy fatigue, behavioral changes), thyroid disease (goiter, heat or cold intolerance, sweating, exophthalmos, tremor, skin and hair changes), diabetes (polyuria, polydipsia, vaginal discharge and itching, skin infections), pituitary disease (change of facial features, hands, feet). Secondary sex characteristics, habitus, hair distribution. Impotence, libido, sterility.

17. **MUSCULO-SKELETAL SYSTEM:** Bone pain, tenderness, swelling, stiffness, limitation of movement of neck, trunk, extremities. Weakness. Trauma, fracture. Swelling backache and leg cramps.

18. **HEMATOLOGICAL: Lymph** node enlargement, pain, bleeding, bruising.

19. **NERVOUS SYSTEM:** Syncope (faint), dizziness, convulsions, vertigo, difficulty with speech or swallowing, localized or generalized symptoms, tremor, weakness, pain, numbness, paresthesia, incoordination, difficulty with bladder or bowel control.
    a. Cranial nerve symptoms: change in smell, Diplopia, change in vision, blind spots, difficulty with speech, swallowing, or chewing, facial numbness or drooping, change in hearing, tinnitus
    b. Motor system: paralysis, atrophy, involuntary movements, seizures, gait, incoordination
    c. Sensory system: pain, paresthesia, hyperesthesia, anesthesia
    d. Mentation: orientation, memory. Reading and writing. Loss of consciousness.

20. **PSYCHIATRIC:** Rapid changes in mood, memory loss, phobias, hallucinations, sleep disturbances, problems with coping, suicide, (attempts or thoughts), anhedonia, frequent crying

Review of Systems - Lay terms

GENERAL: Any problems with your sleep? energy level? appetite? Any recent change in your weight? Any fever, chills? Any problem with excess thirst? Does the heat or cold bother you more than it bothers most people?

SKIN: Any problem with your skin…itching, bruising, growths? changes in moles or a freckle? Any problem with skin moisture…too dry, too oily?

HEAD: Any problem with headaches, dizziness, blackouts?

EYES: Do you have any trouble with your vision? blurred vision? double vision? Do you ever see spots or flashes? Any problem with discharge, redness, itchiness, or tearing?)
Do bright lights bother your eyes?

EARS: Do you have any difficulty with your hearing or ringing in your ears? pain in your ears? itching? drainage? Do you have any difficulty with dizziness? a sensation that the room is spinning around you?

NOSE/THROAT/MOUTH: Any mouth or throat problems…hoarseness, difficulty swallowing, pain, or swelling? Any problems with your teeth or gums?

BREASTS: Any problems with pain, swelling in your breast? Any discharge? lumps?

RESPIRATORY: Do you get short of breath or have pain with breathing? Do you get short of breath with activity? Do you ever wheeze? Do you ever wake up at night short of breath? (Can you go up one/two flights of stairs without stopping? Would you have to stop to catch your breath at the top?) Do you cough up phlegm or blood?

CARDIOVASCULAR: Do you ever have chest pain? Do you ever wake up in the middle of the night short of breath? Have you increased the number of pillows that you sleep on to help you breath at night? Do you have skipped or rapid beating of your heart? Have you ever passed out? Do you have a problem with swelling or cramping in your legs? Have you ever noticed a color change in your fingers or toes when exposed to cold temperatures? Do you have varicose veins

GI: Do you ever have trouble swallowing or painful swallowing? Any problems with heartburn? Have you been sick to your stomach? Have you vomited? ever vomited blood? Do you have belly pain, cramps or bloating? Any problems with bowel movements? (Diarrhea? Constipation? Noticed any blood in your stools or black or tarry stools.

GU: Do you have any problems with urination? (Any burning when you pass your urine? Are you passing urine more frequently? When you feel the urge to urinate, do you feel like you have to go right away? Is the force of your urine stream as strong as it always was? Do you have incontinence…trouble controlling your urine?) Do you have or have you had blood in your urine?

GENITAL SYSTEM:

a. Gynecological - Do you have any vaginal discharge, itching, growths or lumps?

b. Male Genitalia - Do you have any discharge from your penis? pain, lumps, or growths? testicular pain or swelling?
c. Sexual Problems - Are you satisfied with your sexual function? What difficulties do you have, if any? Has your desire for sexual activity changed recently? Do you have pain with intercourse?

MENSTRUAL-REPRODUCTIVE HISTORY: Do you have any difficulties with your periods? pain? bleeding between periods? irregular cycles? intervals without periods? heavy bleeding? prolonged periods? Have your periods stopped? Are you having any hot flashes or sweating as your periods are changing? bleeding after menopause completed? Do you have any emotional reactions to beginning (menarche(or ending your periods (menopause)?

ENDOCRINE SYSTEM: Do you have any change in weight? energy level? unexplained changes in behavior? Any neck growths? feelings of warmth or cold when others are not? excessive sweating? eye bulging? shaking of your hands that is not voluntary? loss or thinning of hair? Any excessive thirst? frequency of urination? Any change in facial features/appearance? size of hands or feet? Any loss of pubic hair? hair growth in locations you haven't had it before?

MUSCULO-SKELETAL SYSTEM: Do you have any bony pain? tenderness? joint pain? swelling? or stiffness? Do you have limited movement of any joint or in neck/back that seems greater than others? Do you have any weakness? back pain?

HEMATOLOGICAL: Do you have any lumps in your neck? under your arms? or in your groin? History of bleeding or bruising?

NERVOUS SYSTEM: Do you have any fainting, dizziness, convulsions/seizures or "fits"? difficulty with or change in speech? swallowing? hand or head shaking that isn't voluntary? localized weakness, pain, numbness or tingling? difficulty with balance? bladder or bowel control?

a. Cranial nerve symptoms - Do you have any change in smell? vision (double vision, blurry vision?) speech, swallowing, chewing? Any drooping of the face or eyes? change in hearing? ringing or buzzing in your ears?
b. b. Motor system - Any paralyzed part of the body? loss of muscle bulk? involuntary movements? difficulty with walking? coordination?
c. Sensory system - Any pain, numbness, tingling, or increased sensitivity of a body part?
d. Mentation - Any change in your thinking? sense of where you are? your memory? reading or writing ability?

PSYCHIATRIC: Any change in mood? new fears/phobias? Do you ever see or hear things that aren't there? Do you have any difficulty sleeping? coping with life stresses? feelings about ending your life? plans to end your life? Do you cry frequently and for no reason? Do you no longer get pleasure from things that used to give you pleasure?

GUIDELINES FOR ORAL PRESENTATIONS (for case-type presentation) for ECL

Chief Complaint/Opening Line/Orienting Statement , includes identifying information and the chief complaint

HPI-should reflect the chief complaint, its features (7 cardinal features)
You should at least detail:

1. The seven cardinal features of the presenting symptom.
2. PMH that could be related to diseases that present with the chief complaint
3. FH that could be related to the chief complaint
4. SH that could be related to the chief complaint
5. Summary statement
    a. Must start with pt demographics (Gender, Age) and end summary sentence with as much of a "commitment" your proposed diagnosis as you are able to give at your level of training.

Chief Complaint/Opening Line/Orienting Statement , includes identifying information and the chief complaint (see opening line notes below, which chiefly pertain to DCS2)
Your opening line will vary depending on the audience, the situation, and the purpose of the presentation. It should orient the listener to key elements of the chief complaint and how it relates to the broader case. Consider the following situations.

1. In a new patient who presents with symptoms of cough, you should make sure that the chief complaint is in the first sentence of your presentation. "This is a 32-year-old man who presents to the hospital with shortness of breath and cough."
2. You do not need to present all the details of the Past Medical History in the first line of the presentation, but you should consider whether some aspects of the medical history would influence the listener's thinking and is **so** important that you should include it in the first sentence. For example, one would think differently if the opening line of the presentation above were: "This is a 32-year-old man with a 12-year history of HIV infection and progression to AIDS who now presents with shortness of breath and cough."

HPI-should reflect the chief complaint, its features (7 cardinal features)
You should at least detail:

- The seven cardinal features of the presenting symptom.
- Pertinent Review of Systems (ROS questions from the system(s) in which chief complaint may fall)
- PMH that could be related to diseases that present with the chief complaint
- FH that could be related to the chief complaint
- SH that could be related to the chief complaint
- Condition specific data- detailed (disease based) information about specific conditions that don't fit into above categories (nausea in patient with headache is something that you likely need to think of migraine or elevated intracranial pressure which then makes you ask and then report on nausea.)

NOTE: Risk factors for disorders that could present with the chief complaint is a broad term that includes items from many of the above categories (something from the PMH, FH, SH, or medications that makes a particular diagnosis more likely, i.e. heavy drinking from SH or aspirin from medications are risk factors for a bleeding ulcer. FH of MI or PMH of HTN are risk factors for MI).

NOTE: Collectively, the information beyond the 7 cardinal features represents **pertinent positive**s (pertinent positive is a symptom, risk factor or risk behavior associated with pathological conditions

presenting with such a chief complaint that is present in the patient) and **pertinent negative**s (pertinent negative is a symptom, risk factor, or risk behavior associated with pathological conditions presenting with such a chief complaint that is absent in the patient). The pertinent positives and negatives depend on your knowledge of pathophysiology.

Medications*-list the medication and doses that the patient is taking.
Allergies*-list agent and type of reaction.
By the end of the HPI presentation, the listener should have some idea of the diagnostic possibilities that you are considering.
*Some advocate for presenting Meds/allergies in all patients to encourage you to think about whether meds or allergies could be related to HPI

Summary statement

- Must start with pt demographics (Gender, Age)
- Most pertinent PMH, FH, SH, i.e. if is immediately related to the chief complaint
- End summary sentence with as much of a "commitment" to your proposed diagnosis as you are able to give at your level of training. For instance, in the case above, you may say "32-year-old male with a 12-year history of AIDS who now presents with fever and cough (will add physical exam and labs as you perform more complete exams), suspicious for PCP pneumonia". You may only be able to narrow down your most likely diagnosis after the history and physical (you will likely be doing more, i.e. labs, XRAYs, to further clarify). For instance, "18-month-old full term male with 2 days of cough and wheeze, and now 1 day of increased work of breathing, consistent with either asthma or bronchiolitis"
- Do not have your summary statement be a rehashing of the HPI!

Adaptations for the Complete Presentation

If oral presentation is a complete presentation of a full History and Physical (like you will perform in DCS2 Hospital sessions and in the clinical years), you will present full details of PMH, Meds/All, FH, SH, ROS in more complete fashion, but with less detail than information from these categories that are related to the HPI
Review of systems-for the presentation; you should only give those positive symptoms that will need to be addressed during the admission or at the end of the outpatient visit. Physical Examination-patient's general appearance (uncomfortable appearing woman in respiratory distress), a complete set of vitals, all parts of the exam that could have abnormalities produced by diseases that are on your differential.

PROBLEM LIST, ASSESSMENT AND PLAN

After you have written up a complete history, ROS, physical exam, and labs, the problem list, assessment and plan is what comes next.

Below is a description and examples for each component.

Problem List

Those issues which the patient and/or you identify as concerns. These may be physical, psychological or social. There may be several at each visit.

Example:

1. Chest pain

2. Weight gain

3. Tobacco Abuse

Assessment

This is what you think is causing the problem (i.e. the diagnosis) or a list of multiple possible causes (i.e. the differential diagnosis).

Example:

1. Chest pain - atypical in nature, heartburn-like, occurring only supine easily relieved with antacids. Differential diagnosis includes: GI - probably GERD, most likely because of previous mentioned characteristics, musculoskeletal - still most likely GI but given chest wall tender to palpation on exam suggests component of costochondritis (inflammation of joint spaces between sternum and ribs) as well, cardiac - but less likely because no significant risk factors and atypical pain, pulmonary - very unlikely, no symptoms referable to this system.

2. Weight gain - the patient does not watch diet or exercise regularly. (note - not a diagnosis but a description of the cause)

3. Tobacco abuse - long-time smoker, does not want to quit. (note - not a diagnosis but a description of the pattern)

Plan

This is what you are going to do about each problem. This includes diagnostic test, if indicated, and treatment.

Example:

1. Chest pain
   -start H2 blocker
   -call in 2 weeks to report progress
   -will hold NSAIDS for now for costochondritis till reflux improved
   -follow-up as indicated, may need UGI if no significant improvement with H2 blocker

2. Weight gain
   -patient interested in starting weight watchers, encouraged to do so
   -patient agrees to daily walking program of twenty minutes
   -return visit 3 months

3. Tobacco abuse
   -long discussion with patient regarding importance of quitting, patient unwilling to quit at this time,
   will discuss at future appointments

Put it all together and it looks like this:

1. Chest pain - atypical in nature, heartburn-like, occurring only supine, easily relieved with antacids. Differential diagnosis includes: GI - probably GERD, most likely because of previous mentioned characteristics, musculoskeletal - still most likely GI but given chest wall tender to palpation on exam suggests component of costochondritis (inflammation of joint spaces between sternum and ribs) as well, cardiac - but less likely because no significant risk factors and atypical pain, pulmonary - very unlikely, no symptoms referable to this system
   -start H2 blocker
   -call in 2 weeks to report progress
   -will hold NSAIDS for now for costochondritis till reflux improved
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2. Weight gain - patient does not watch diet or exercise regularly
   -patient interested in started weight watchers, encouraged to do so
   -patient agrees to daily walking program of twenty minutes
   -return visit 3 months

3. Tobacco abuse - long-time smoker, does not want to quit
   -long discussion with patient regarding importance of quitting, patient unwilling to quit at this time, will discuss at future appointments

H2 Blockers – acid blocking medications such as ranitidine (Zantac)
GI - gastrointestinal
UGI – upper gastrointestinal series – x-ray study to rule out ulcers or gastritis
GERD – Gastroesophageal reflux disease

NSAIDs – non-steroidal anti-inflammatory drugs – such as ibuprofen (Motrin, Advil).