The Medical History – Written Example

Please refer to this written example when you write-up all of your future medical histories in PCM-1.

Chief Concern: Chest pain for 1 month

HPI: Mr. PH is a 52 y/o accountant with hypercholesterolemia and polycythemia vera who has been in relatively good health (except for problem #2 below) until one month ago when he noticed chest tightness with exertion. The patient decided to lose weight through exercising and began to run. When running greater than six to seven blocks, the patient developed a tight feeling in his chest that subsided in approximately five minutes after he stopped running. Initially, the feeling was mild, occurred only with the running and was associated with no other symptoms. It did not radiate. On the night prior to admission, while watching TV, he had the same pain, except this time it was of increased intensity (10/10), lasted 20 minutes, and was associated with shortness of breath and a brief period of profuse diaphoresis. Regarding risk factors for coronary artery disease, the patient does not smoke, has no high blood pressure or diabetes, has borderline high cholesterol, and patient's father died suddenly at age 40 from a presumed heart attack.
The patient is concerned that he has the same problem that his father had and that he has the same potential to "drop dead". He normally has sexual intercourse with his wife one to two times per week, but because of the fear of having the pain during intercourse the patient has avoided any intimate contact with his wife.

Problem #2 Polycythemia Vera: three years ago, during a routine physical for work, the patient was found to have elevated hemoglobin and was worked-up at LUMC by Dr. Smith. His red blood cell mass was high and the patient was found to have primary Polycythemia Vera. Initially he was treated with monthly phlebotomies, but for the last year has received a phlebotomy only once every six months. He has no symptoms of this illness.
The patient is aware of the possible complications of this illness. Initially, he worried about them, but for the last year, since he has felt well; he accepts the illness and sees his Hematologist on a regular basis.

MEDICAL HISTORY

1. Adult Illnesses:
    a. Polycythemia Vera – diagnosed incidentally three years ago. Currently asymptomatic and treated every 6 months with phlebotomy.
    b. Hypercholesterolemia – diagnosed by screening two years ago. Treated with ‘statin’ medication.
2. Health Screening: colonoscopy at LUMC 2009, no polyps
3. Immunizations – tetanus booster in 2016
4. Obstetric & Gynecologic History – N/A
5. Psychiatric Illnesses or Hospitalizations - none
6. Significant Childhood Illnesses - none

7. Injuries and Accidents: MVA in 1996; hospitalized for observation overnight.

SURGICAL HISTORY

Operations: appendectomy at age 12

THERAPIES

1. Medications: Simvastatin 40mg daily
2. Complementary, Alternative Medicines/Therapies - none

ALLERGIES:

1. Drug Reactions: was told that he was allergic to penicillin as a child, but knows no further details
2. Food, Environmental, Topical (chemical) allergies - none

PSYCHOSOCIAL HISTORY

1. Marital Status and relationship(s) satisfaction – married and satisfied with relationship; one child in college at U of I
2. Living Conditions: lives with wife, no one else in house
3. Employment: works as a sales rep for a company that sells MRI units to healthcare systems.
4. Sexual History: one current partner (wife), does not use contraception as wife is post-menopausal
5. Significant Life Events and stressors: concerned with college tuition finances
6. Spiritual History/Sources of Support: considers themselves a spiritual person. Does not identify with a particular religion. Main source of support is his wife
7. Diet, Sleep, Exercise – eats varied diet, not much fat; gets 7-8h of sleep at night, some exercise in past year, none recently due to fears of chest pain.
8. Habits:
    a. Tobacco – 1ppd smoker for 10y
    b. Alcohol – 3 beers weekly; no more than one daily
    c. Drugs – no history of illicit drug use

FAMILY HISTORY:

	Age	Cause of Death/Age at Death	Illness During Life
Mother	79		HTN, osteoarthritis
Father		Presumed MI at 40	None known
Each sibling			
Each child	19		Alive and well

REVIEW OF SYSTEMS

1. Constitutional - normal appetite and has no recent weight change or fatigue
2. Skin - no rashes
3. Eyes - vision is normal - wears glasses only for reading for the last year - last eye exam was one year ago
4. Ears/Nose/Mouth/Throat - no changes in hearing, tinnitus, sore throat, nasal congestion
5. Breast – Not applicable
6. Respiratory – no cough, sputum, hemoptysis or wheezing
7. Cardiovascular - see HPI
8. Gastrointestinal - denies any trouble swallowing, heartburn, nausea, vomiting, indigestion, change in bowel habits, rectal bleeding or black stools
9. Genitourinary - has noticed mild hesitancy when initiating urination - denies any discharge from his penis or testicular pain; no dysuria or frequency.
10. Musculoskeletal - denies any joint pain, redness, stiffness
11. Neurologic - denies syncope, seizures, weakness, numbness, tingling or changes in his memory
12. Psychiatric – no feelings of depression, anxiety
13. Endocrine - denies heat or cold intolerance, excessive seating, history of diabetes, excessive thirst
14. Hematologic - see HPI