

SCREENING HISTORY

I. IDENTIFYING DATA: NAME (or initials), GENDER, AGE, RACE/Ethnic Background if relevant

II. CHIEF COMPLAINT(S) WITH DURATION:

A one-line description of why the patient is here. Use the patients own words not medical jargon. Include patient's age, sex, occupation, problem, and duration. *E.g. MK is 55-year-old male truck driver with two weeks of "bad chest pains."*

III. HISTORY OF PRESENT ILLNESS (HPI) - PROBLEM-BY-PROBLEM

This is a narrative that should flow like a story in a logical and chronological order, from the onset of symptoms to present day. It describes the patient's sickness or disability from two perspectives:

A. THE BIOMEDICAL PERSPECTIVE (the "disease")

This is a chronological account of the onset and course of the patient's symptoms. Under this part of the HPI, two major problem groups are included: those identified by the chief complaint and any significant, active medical, surgical or psychiatric problems which the patient has and which may impact on the patient's chief complaint.

1. THOSE IDENTIFIED BY THE CHIEF COMPLAINT: The HPI should be a clear, chronological narrative of each problem identified. This "story" should be complete, beginning when the patient first experienced the problem.

- a. If the patient has more than one chief complaint and each is a separate, distinct problem, then each must be dealt with separately. If, however, the chief complaints are clearly symptoms of one pathologic process, then they can be listed under one problem.
- b. If the patient's chief complaint includes a symptom (example, pain) the symptom should be described in terms of: (a) location, (b) radiation, (c) quality, (d) severity-grade/intensity, (d) timing, (onset, duration, i.e.: sudden, gradual, acute, chronic), (f) frequency/pattern, (intermittent, continuous, progressive), (g) setting, (h) aggravating/exacerbating factors, (i) alleviating factors, (j) associated manifestations. This should be done for each and every major symptom being characterized in the HPI.
- c. If the problem has received prior treatment, the specifics of the treatment(s) and the response to the treatment(s) should be described. In addition, relevant data from the patient's past charts, (i.e., lab data, pathologic report, etc.) if pertinent to the problem, also belong in the HPI.
- d. Significant positive and negatives also belong in the HPI. Mention should be made of: (a) pertinent symptoms which the patient may or may not experience and which relate to the chief complaint - e.g., in a patient with a chief complaint of burning epigastric pain, it is important to know and to document whether the patient does (a pertinent positive) or does not (a pertinent

negative) have black stools, (b) pertinent aspects of the patient's past, social or family history which may or may not be present - as pertains to the differential diagnosis of the present problem - example, for a patient with the chief complaint of hemoptysis, smoking is a significant positive; for a patient with a chief complaint anterior neck enlargement, a negative history of head/neck radiation is a significant negative. When included in the History of Present Illness, significant positives or negatives need not be reiterated in a Past History or Review of Systems.

2. THOSE PROBLEMS WHICH INCLUDE ACTIVE, SIGNIFICANT ILLNESSES

- a. Significant, active medical, surgical or psychiatric problems that the patient has and which impact on the problems identified in the chief complaint should be included and described problem-by-problem in the HPI.
- b. Again, there should be a clear, chronologic narrative of each problem identified. It should include the onset of the problem, its manifestations and complications, prior treatment and response to treatment and impact on the patient's life.

B. THE PATIENT'S PERSPECTIVE (the "illness")

For each problem identified, a separate paragraph should be included, which documents; (1) the patient's understanding of the disease, symptoms or disability, (2) the impact of the disease, the disability or the needed medical care on the patient's life, work and relationships. (3) Patient's expectations and reason for the visit. Special attention should be given to the concept of suffering experienced by the patient. This should include a description of fears the patient's and concerns of what is happening to him/her. (4) If appropriate, information about the patient's preferences for end-of-life care and proxy decision-making.

IV. MEDICAL HISTORY

A. Adult Illnesses:

1. This should be a chronological listing of current and past medical illnesses. For each, note the date, place and name of physician, any important details regarding the outcome or subsequent complications. If the patient names a specific disease or uses medical terminology (e.g., myocardial infarction), attempt to have the patient identify the data utilized to make the specific diagnosis. This inquiry should be open-ended. Questions such as the following are helpful:
 - a. Are you now seeing a doctor for any reason?
 - b. Have you ever been hospitalized? If so, when and where? What was the reason? What was the outcome?
 - c. Have you in the past ever consulted or been treated by a physician for any significant or recurring problem?
2. Occasionally the patient will fail to mention a problem for which he/she has been treated in the past but will recall during the Review of Systems. If it truly

represents a problem for which he/she has been treated in the past and is not a current, active symptom, it should be recorded in the Past History.

- B. Health Screening (e.g., Pap test, cholesterol, PSA, tuberculin tests, mammograms, stools for occult blood or colonoscopy, dental and eye exams): Include results and dates last performed.
- C. Immunizations - tetanus, pertussis, diphtheria, polio, measles, rubella, mumps, influenza, Hepatitis A, Hepatitis B, Pneumococcal vaccine, meningococcal vaccine, varicella, Human Papillomavirus (HPV), Rotavirus.
- D. Obstetric & Gynecologic History
Obstetric History: Number of pregnancies, number of live births (vaginal or Caesarean), number of abortions (spontaneous or induced), any complications during pregnancy.
Gynecologic history – last menstrual period, regularity of menses, history of STIs, infertility, abnormal pap test
- E. Psychiatric Illnesses or Hospitalizations: Depression/Anxiety, ADHD, bipolar disorder...
- F. Significant Childhood and Developmental Illnesses:
- G. Injuries and Accidents: Give details as to place, date, treatment and sequelae.

V. SURGICAL HISTORY

Operations: Give details as to reason for surgery, type of surgery, place, date, and any complications.

VI. THERAPIES

- A. Medications: Give GENERIC names and doses, reasons for starting, dates, compliance, side effects. Be certain to ask for frequently overlooked medications, including Over-the-counter (OTC) meds. (Be careful not to use any unapproved abbreviations.)
- B. Complementary, Alternative Medicines/Therapies
“A lot of people are using complementary or alternative approaches such as herbs, vitamin supplements, acupuncture and massage therapy. Are you currently using any of these?”

VII. ALLERGIES:

- A. Drug Reactions: Inquire about any allergies and about allergies or reactions to any medication, topical, oral or IV dye - be sure to include name, date, and nature of reaction

- B. Food, Environmental, Topical (chemical) allergic reactions

VIII. PSYCHOSOCIAL HISTORY

- A. Marital Status and relationship(s) satisfaction
- B. Living Conditions: including who lives at home and home safety (intimate partner violence)
- C. Employment: (including employment of spouse and past employment, if applicable) Pay special attention to occupational exposures and occupational health risks, job satisfaction, military service, (when and where, jobs/tasks, how has it affected you?)
- D. Gender Identity and Sexual History: gender identity/preferred pronouns, number of current partners, sexual concerns, sexual behaviors, use of contraception/STI protection, history of sexually transmitted diseases
- E. Significant Life Events and stressors: deaths, divorce, unemployment, financial hardships, alcoholism, relocation, physical or sexual abuse
- F. Diet, Sleep, Exercise - Dietary restrictions, patterns or supplements? Document sleep pattern including normal time patient goes to sleep and awakens. Naps during the day? Problems with sleep? Amount/type of exercise.
- G. Habits:
 - 1. Tobacco - type, how much, how long – quit date
 - 2. Alcohol - type, how much, how long – quit date
 - 3. Drugs - especially recreational - type, how much, how long, how often – quit date

IX. FAMILY HISTORY:

	<u>Age</u>	<u>Cause of Death/Age at Death</u>	<u>Illness During Life</u>
Mother			
Father			
Each sibling			
Each child			

- A. Ask for specific named disease(s): cancer, tuberculosis, heart disease, hypertension, stroke, kidney disease, diabetes mellitus, anemia, seizures, or symptoms like those of the patient.
- B. If a particular illness is represented in more than one family member, a branching diagram should be constructed.

X. REVIEW OF SYSTEMS (Not intended to be definitive or all inclusive.)

Constitutional:	appetite; recent weight change; fevers/night sweats; fatigue
Skin:	rashes; changes in size/color of a mole
Eyes/Ears/Nose/Mouth/ Throat:	discomfort/pain in eye(s); changes in vision; hearing loss; dizziness/spinning; drainage from ear(s); stuffiness; drainage from nose; pain/ulcers in mouth; changes in voice/hoarseness
Breasts:	lumps; pain; nipple discharge; rashes/skin changes
Respiratory:	cough; coughing-up blood; wheezing; snoring/daytime tiredness
Cardiac:	shortness of breath at rest/with exercise/lying flat; chest pain; palpitations; lightheadedness/fainting; leg/ankle swelling
Gastrointestinal:	abdominal pain/discomfort; change in bowel habits; trouble swallowing; vomiting blood; rectal bleeding/black stools; yellowing of skin/eyes
Genitourinary:	problems passing/holding urine; blood in urine
Male:	discharge from/sores on penis; testicular lumps/pain
Female:	spotting between cycles; vaginal discharge; hot flashes; vaginal bleeding for post-menopausal patients
Musculoskeletal:	joint/muscle pain; limitation of normal activity from neck or back pain
Neurological:	onset of weakness/numbness/loss of feeling in face, arm(s) or leg(s); problems speaking; problems walking like unsteadiness or shaking; headaches
Psychiatric:	feeling sad or depressed; feeling any risk of harming yourself, harming others or being harmed by others; lost interest in doing pleasurable activities
Endocrine:	increased thirst/ urination; fractures of bones; heat/cold intolerance
Hematologic/Lymphatic	prolonged bleeding or increased bruising; new/tender lumps or glands