DATA BASE: SAMPLE HISTORY

IDENTIFYING DATA (Use patient's initials, not full name)

CM is a 45-year-old, widowed, white saleswoman, born in the U.S.

CHIEF COMPLAINT

"Bad headaches"

HISTORY OF PRESENT ILLNESS (HPI, Problem by problem)

For about 3 months Mrs. M. has been increasingly troubled by headaches that are right-sided, usually throbbing, and can range from mild to moderately severe. Typically her headaches are rated at 4 over 10. She recently had a severe headache that she rated 8 over 10 and missed work because of this headache. This was associated with nausea and vomiting. Headaches have increased in frequency and now average once a wk. The headaches usually last from 2 to 4 hours. However, the most recent headache, which was the most severe, lasted almost 8 hours. During a headache bright lights bother her and she just wants to lie down in a dark quiet room and fall asleep. Aspirin provides little relief. She has not noticed any association with food or drink. She has no other related symptoms, such as fever, dental pain, weakness, numbness or loss of vision. There is no history of head injury or trauma. She remembers having a similar kind of headache with nausea and vomiting that began at age 15, recurred through her mid-20s, then diminished to one every 2 or 3 months and disappeared.

Patient Perspective

She thinks her headaches may be like those in the past. However, she now has high blood pressure and is concerned because her mother had high blood pressure and died of a stroke. She is also concerned that they make her irritable with her family.

PAST MEDICAL HISTORY

Significant Childhood Illnesses

Only measles and chickenpox

Immunizations

Last tetanus 1998
Flu vaccine last November

Adult Illnesses/Hospitalizations

- Kidney infection 1982 treated with ampicillin and developed a generalized rash.
- Hypertension x 7 years, well controlled with home BPs normally 120-130/low 80s

Psychiatric Illnesses/Hospitalizations

None

Operations

Tonsillectomy, age 6,
Appendectomy, age 13

Injuries/Accidents

1998 foot laceration, 4 stitches

Obstetric History

G3, P3, 3 living children. Menarche age 12. Last menses 2 weeks ago.

Transfusions

None

CURRENT HEALTH STATUS

Medications

Aspirin for headaches
Multivitamin 1 per day
Hydrochlorothiazide 25 mg per day (x 7 years)
No herbs or supplements

Allergies/Drug Reactions

Ampicillin causes rash

Health Screening

- **Last pap smear 2000, normal.**
- **Normal mammogram in 2000.**
- **Does breast self-exams monthly**
- **Cholesterol = 220 (in 2000)**

Diet, Sleep, Exercise

- Diet – **Low in calcium with little milk or cheese. She frequently eats mid-morning and evening snacks that are high in fat. She does follow a low salt diet**.
- Sleep – **Generally good, average 7 hr**
- Exercise – **"No time"**

Habits

- Tobacco – **1 pack cigs per day from age 18**
- Alcohol – **Rare drink (wine) only, no history of abuse**
- Drugs – **Never tried illegal drugs**

Alternative Therapies

None

PSYCHOSOCIAL HISTORY

- **4 yr ago her husband died suddenly of heart attack, leaving little savings and no insurance.**
- **Lives alone, recently moved to a small apartment to be near daughter**
- **Cosmetic saleswoman for 15 years at Sears. Likes her job but feels stressed by demands from the new manager**
- **Not sexually active since the death of her husband who was her only partner**
- **Denies depression**
- **Feels safe at work and home**

FAMILY HISTORY

- **Mother died, 67, stroke; had varicose veins, headaches, hypertension**
- **Father died, 43, train accident**
- **One brother, 56, has high blood pressure, otherwise well**
- **One brother, 51, apparently well except for mild arthritis**
- **Daughter, 23, "migraine headaches," otherwise well**
- **Son, 21, well**
- **Son, 20, well**

REVIEW OF SYSTEMS:

General: **Has gained about 10 lb in the past 4 yr, no fatigue**

Skin: **No rashes or other changes**

Head: **See present illness.**

Eyes: **Reading glasses for 5 yr, last checked 1 yr ago. No double or blurry vision**

Ears: **Hearing good. No tinnitus, vertigo, infections**

Nose, Sinuses: **occasional mild cold. No hay fever, sinus trouble**

Mouth and Throat: **Last to dentist 2 yr ago. Occasional canker sore**

Neck: **No lumps, goiter, pain**

Breasts: **No lumps, pain, discharge.**

Respiratory: **No cough, wheezing, shortness of breath, pneumonia, tuberculosis.**

Cardiac: **No known heart disease. No orthopnea, chest pain, palpitations.**

Gastrointestinal: **Appetite good; no reflux. Bowel movement about once daily though sometimes has hard stools for 2-3 d when especially tense; no diarrhea or bleeding. No pain, jaundice, gallbladder or liver trouble**

Urinary: **No frequency, dysuria, hematuria or flank pain**

Genitoreproductive: **Regular menstrual periods. No vaginal discharge or itch**

Musculoskeletal: **Mild aching low back pain often after a long day's work; no radiation down legs; used to do back exercises, but not now. No other joint pain**

Peripheral Vascular: **Varicose veins appeared in both legs during first pregnancy. Has had swollen ankles after prolonged standing for 10 yr; no history of phlebitis or leg pain**

Neurological: **No fainting, seizures, tremors, weakness, or tingling. Memory good**

Psychiatric: **No anxiety or nervousness or depression**

Endocrine: **No known thyroid trouble, temperature intolerance. Sweating average. No symptoms or history of diabetes**

Hematologic: **No easy bleeding. No anemia**

Adapted from Bates' Guide to Physical Examination and History Taking, Chapter 21, *The Patient's Record*, pp. 722-726