

Sample Written History and Physical Examination

History and Physical Examination

Comments

Patient Name: Rogers, Pamela
Date: 8/20/04

Referral Source: Emergency Department

Data Source: Patient

Chief Complaint & Hx: Ms. Rogers is a 58-yr. W/F
having chest pain for the last week.

Define the reason for the patient's visit as she has been
specifically as possible.

History of Present Illness

This is the first admission for this 58-year-old woman,
who states she was in her usual state of good health until
one week prior to admission. At that time she noticed the
strangest onset (pain is her words) to a sensation of chest pain
which she describes as dull and aching in character. The
pain began in the left para-sternal area and radiated up to
her neck. The first episode of pain one week ago occurred
when she was working in her garden in the middle of the
day. She states she had been working for approximately 45
minutes and began to feel tired before the onset of the pain.
Her discomfort was accompanied by shortness of breath, but
no sweating, nausea, or vomiting. The pain lasted
approximately 5 to 10 minutes and resolved when she went
inside and rested in a cool area.

Convey the acute or chronic nature of the problem and
establish a chronology.

onset
character
location
radiation
circumstances; exacerbating factors

associated symptoms

duration
resolution; alleviating factors

Since that initial pain one week ago she has had 2 additional
episodes of pain, similar in quality and location to the first
episode. Three days ago she had a 10-minute episode of
pain while walking her dog, which resolved with rest. This
evening she had an episode of pain awaken her from sleep,
lasting 30 minutes, which prompted her visit to the
Emergency Department. At no time has she attempted any
specific measures to relieve her pain, other than rest. She
describes no other associated symptoms during these
episodes of pain, including dizziness, or palpitations. She
became short of breath during these
episodes but attributes to other exertional dyspnea,
asthma, or postprandial nocturnal dyspnea. No change in the pain
with movement, no association with food, no DREPS-ur, no palpable pain.
She has never been told she has heart problems, never had any
chest pains before, does not have claustrophobia. She was diagnosed with
HIV 2 years ago.

Describe the natural history of her problem since its
onset

Changes or new circumstances to the problem
New duration
Reason she came in for visit
What her patient tried for relief

Relevant positive and negative Hx for this complaint

Review of systems for the relevant organ system

She does not smoke nor does she have diabetes.
She was diagnosed with hypertension 5 years ago and had a
TAM with BSO 6 years ago. She is not on hormone replacement
therapy. There is a family history of premature CAD.
She does not know her cholesterol level.

Relevant risk factors/environmental conditions

Past Medical History

Surgical --
1994: Total abdominal hysterectomy and bilateral
oophorectomy for uterine fibroids.
1998: Bariatric surgery

This highly relevant, although it may seem like a
trivial detail at first

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G Orfield



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