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| --- | --- | --- | --- | --- |
| **Name:** | | **Pt. Encounter Number:** | | |
| **Date:** | | **Age:** | | **Sex:** |
| **SUBJECTIVE** | | | | |
| **CC:**  *Reason given by the patient for seeking medical care “in quotes”* | | | | |
| **HPI:**  *Describe the course of the patient’s illness, including when it began, character of symptoms, location where the symptoms began, aggravating or alleviating factors, pertinent positives and negatives, other related diseases, past illnesses, and surgeries or past diagnostic testing related to the present illness.* | | | | |
| **Medications:** *(List with reason for med )* | | | | |
| **Allergies:** *(List with reaction)*    **Medication Intolerances:** | | | | |
| **Past Medical History:**    **Chronic Illnesses/Major traumas**    **Hospitalizations/Surgeries**    *“Have you ever been told that you have  diabetes, HTN, peptic ulcer disease, asthma, lung disease, heart disease, cancer, TB, thyroid problems, kidney problems, or psychiatric diagnosis?”* | | | | |
| **Family History**  *Does your mother, father, or siblings have any medical or psychiatric illnesses?  Is anyone diagnosed with: lung disease, heart disease, HTN, cancer, TB, DM, or kidney disease?* | | | | |
| **Social History**  *Education level, occupational history, current living situation/partner/marital status, substance use/abuse, ETOH, tobacco, and marijuana.  Safety status* | | | | |
| **ROS Student to ask each of these questions to the patient: “Have you had any…..”** | | | | |
| **General**  *Weight change, fatigue, fever, chills, night sweats,  and energy level* | | | **Cardiovascular**  *Chest pain, palpitations, PND, orthopnea, and edema* | |
| **Skin**  *Delayed healing, rashes, bruising, bleeding or skin discolorations, and any changes in lesions or moles* | | | **Respiratory**  *Cough, wheezing, hemoptysis, dyspnea, pneumonia hx, and TB* | |
| **Eyes**  *Corrective lenses, blurring, and visual changes of any kind* | | | **Gastrointestinal**  *Abdominal pain, N/V/D, constipation, hepatitis, hemorrhoids, eating disorders, ulcers, and black, tarry stools* | |
| **Ears**  *Ear pain, hearing loss, ringing in ears, and discharge* | | | **Genitourinary/Gynecological**  *Urgency, frequency burning, change in color of urine.*  *Contraception, sexual activity, STDs*  *Female: last pap, breast, mammo, menstrual complaints, vaginal discharge, pregnancy hx*  *Male: prostate, PSA, urinary complaints* | |
| **Nose/Mouth/Throat**  *Sinus problems, dysphagia, nose bleeds or discharge, dental disease, hoarseness, and throat pain* | | | **Musculoskeletal**  *Back pain, joint swelling, stiffness or pain, fracture hx, and osteoporosis* | |
| **Breast**  *SBE, lumps, bumps, or changes* | | | **Neurological**  *Syncope, seizures, transient paralysis, weakness, paresthesias, and black-out spells* | |
| **Heme/Lymph/Endo**  *HIV status, bruising, blood transfusion hx, night sweats, swollen glands, increase thirst, increase hunger, and cold or heat intolerance* | | | **Psychiatric**  *Depression, anxiety, sleeping difficulties, suicidal ideation/attempts, and previous dx* | |
| **OBJECTIVE** | | | | |
| **Weight         BMI** | **Temp** | | | **BP** |
| **Height** | **Pulse** | | | **Resp** |
| **General Appearance**  *Healthy-appearing adult female in no acute distress. Alert and oriented; answers questions appropriately. Slightly somber affect at first and then brighter later.* | | | | |
| **Skin**  *Skin is brown, warm, dry, clean, and intact. No rashes or lesions noted.* | | | | |
| **HEENT**  *Head is normocephalic, atraumatic, and without lesions; hair evenly distributed. Eyes:  PERRLA. EOMs intact. No conjunctival or scleral injection. Ears: Canals patent. Bilateral TMs pearly gray with positive light reflex; landmarks easily visualized. Nose: Nasal mucosa pink; normal turbinates. No septal deviation. Neck: Supple. Full ROM; no cervical lymphadenopathy; no occipital nodes. No thyromegaly or nodules. Oral mucosa, pink and moist. Pharynx is nonerythematous and without exudate. Teeth are in good repair*. | | | | |
| **Cardiovascular**  *S1, S2 with regular rate and rhythm. No extra sounds, clicks, rubs, or murmurs. Capillary refills two seconds. Pulses 3+ throughout. No edema.* | | | | |
| **Respiratory**  *Symmetric chest wall. Respirations regular and easy; lungs clear to auscultation bilaterally*. | | | | |
| **Gastrointestinal**  *Abdomen obese; BS active in all the four quadrants. Abdomen soft, nontender. No hepatosplenomegaly*. | | | | |
| **Breast**  *Breast is free from masses or tenderness, no discharge, no dimpling, wrinkling, or discoloration of the skin*. | | | | |
| **Genitourinary**  *Bladder is nondistended; no CVA tenderness. External genitalia reveals coarse pubic hair in normal distribution; skin color is consistent with general pigmentation. No vulvar lesions noted. Well estrogenized. A small speculum was inserted; vaginal walls are pink and well rugated; no lesions noted. Cervix is pink and nulliparous. Scant clear to cloudy drainage present. On bimanual exam, cervix is firm. No CMT. Uterus is antevert and positioned behind a slightly distended bladder; no fullness, masses, or tenderness.  No adnexal masses or tenderness. Ovaries are nonpalpable.*  *(Male:  Both testes are palpable, no masses or lesions, no hernia, and no urethral discharge.)*  *(Rectal as appropriate:  No evidence of hemorrhoids, fissures, bleeding, or masses—Males: Prostate is smooth, nontender, and free from nodules, is of normal size, and sphincter tone is firm).* | | | | |
| **Musculoskeletal**  *Full ROM seen in all four extremities as the patient moved about the exam room.* | | | | |
| **Neurological**  *Speech clear. Good tone. Posture erect. Balance stable; gait normal.* | | | | |
| **Psychiatric**  *Alert and oriented. Dressed in clean slacks, shirt, and coat. Maintains eye contact. Speech is soft, though clear and of normal rate and cadence; answers questions appropriately.* | | | | |
| **Lab Tests**  *Urinalysis—point of care test done today in the office- results positive for nitrites and blood, negative for leukocytes.*  *Urine culture collected in office—pending results, sent to lab*  *Wet prep collected in office—pending results, sent to lab* | | | | |
| **Assessment** | | | | |
| * + Include at least three differential diagnoses     - Provide rationale for each differential diagnosis   + Final diagnosis     - Pathophysiology of primary and rationale for choosing as final | | | | |
| **Plan** | | | | |
| * + Medications     - New orders     - Which should be continued     - Which should be discontinued   + Non-pharmacological recommendations   + Diagnostic tests   + Patient education for patient and/or family   + Cultural considerations suggested for this patient   + Health promotion and health maintenance   + Referrals   + Follow up     - Timeframe     - What will be addressed in next visit? | | | | |

**Additional criteria:**

Include a title page and references with all of your papers. There should be at least four references from textbooks, journal articles, CDC or NIH that are not older than 5 years. Please do not use Wikipedia, WebMD, dictionaries, or any websites that are not evidence based.