Suggested Format for Writing Up Histories and Physical Exams

Your history-taking and physical examination reports are legal documents. As such, they must be legible, signed (including your legibly **printed** name), timed and dated. It is also recommended that you include your pager number here.

I. Admission Write Ups

1. Patient identification
2. Thoroughly defined chief complaint
3. History of presenting illness including relevant background medical history and relevant aspects of functional enquiry
4. History of past health, family history, social history
5. Medications, allergies, tobacco, alcohol, and other drug use
6. Remainder of functional enquiry
7. Physical examination by system
8. Summary of available laboratory and imaging results
9. Summary of problems
10. Impression and differential diagnosis
11. Plans with justification

POINTER

The interests of most of the people reading the chart will lie under points 9 to 11. However, it is extremely important that points 1 to 8 are accurately documented in order to help your colleagues understand the patient's problems.

POINTER

It is always desirable to include relevant background information early in the history even if this forces you away from your usual sequence (e.g., mention at the outset that the patient smokes if hemoptysis is presenting problem; mention at outset that the patient has known breast carcinoma if presenting problem is seizure). Similarly, it is desirable (and a sign of sophistication) to include relevant historical points in the history of presenting illness. Do not withhold that information until the functional enquiry (e.g., inpatient with cough mentions hemoptysis, sputum, chest pain, fever, dyspnea, etc. at outset).

II. Progress Notes

1. Be concise
2. Refer to problems and plans that had been identified in admission write-up
3. New developments and test results as appropriate
4. New plans as appropriate
5. Discharge plans

Consider the **SOAP** model:

Subjective (how patient feels/concerns)

Objective (what <u>you</u> find)
- exam
- lab and diagnostic tests

Action and **P**lan
- lab and diagnostic tests
- problem list **(prioritize!!!)**, include overall thoughts regarding discharge readiness at end. Each problem should include a differential / plan i.e.:

1. Anemia
   - HgB ↓ 120→95 g/L over 24 hours

   ddx
   - a) GI blood loss (denies) ☐ check occult blood
   - b) GU blood loss (denies) ☐ urine R & M
   - c) Other blood loss
   - d) Hemolysis
     - ☐ retics
     - ☐ LDH
     - ☐ T. Bili
     - ☐ Haptoglobin
   - e) bone marrow suppression – check meds

   Also in plan: repeat CBC at 1600h today. Note: Normal volume status, no chest pain, no need to transfuse now, but cross-match NOW for 2 units.