

BASIC SCREENING HISTORY

(Details)

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

- II. **CHIEF COMPLAINT(S) WITH DURATION:**
A one-liner describing 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) quality, (c) quantity or severity-grade on a scale of 1-10, (d) timing (i.e., onset, duration, frequency), (e) setting, (f) aggravating and/or alleviating factors, (g) 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 significant positive) or does not (a significant 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. 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. 3) If appropriate, information about the patient's preferences for end-of-life care and proxy decision-making.

IV. **PAST MEDICAL HISTORY**

- A. Significant Childhood Illnesses - measles, German measles, mumps, whooping cough, chicken pox, rheumatic fever, scarlet fever, polio.
- B. Immunizations - tetanus, pertussis, diphtheria, polio, measles, German measles, mumps, flu vaccine, Hepatitis B, Pneumococcal vaccine, meningococcal vaccine.

C. Adult Illnesses:

1. This should be a chronological listing of 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 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.

D. Psychiatric Illnesses or Hospitalizations

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

F. Injuries and Accidents: Give details as to place, date, treatment and sequelae.

G. Obstetric History: Number of pregnancies, number of live births (vaginal or Caesarean), number of abortions (spontaneous or induced), any complications during pregnancy.

H. Transfusions: Include date, reasons for, and reactions.

V. **CURRENT HEALTH STATUS**

A. Medications: Give names and doses, reasons for starting, dates, compliance, side effects. Be certain to ask for frequently overlooked medications, including analgesics, antihistamines, antacids, sedatives, laxatives, vitamins, oral contraceptives, etc. (Be careful not to use any unapproved abbreviations.)

B. Allergies and Drug Reactions: Inquire about any allergies and about allergies or reactions to any medication - be sure to include name, date, and nature of reaction.

C. Health Screening (e.g., Pap test, cholesterol, rectal/prostate exam, tuberculin tests, mammograms, stools for occult blood or colonoscopy, breast self-examination or testicular self-exam): Include results and dates last performed.

D. Diet, Sleep, Exercise - attempt to estimate total calorie intake by inquiring about intake for each meal and any snacks. Dietary restrictions or supplements? Document sleep pattern including normal time patient goes to sleep and awakens. Naps during the day? Problems with sleep? Document amount of exercise.

E. Habits:

1. Tobacco - type, how much, how long – quit date
2. Alcohol - type, how much, how long – quit date

- 3. Drugs - especially illegal - type, how much, how long, how often – quit date
- F. Complementary and 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?”

VI. PSYCHOSOCIAL HISTORY

- A. Marital Status
- B. Living Conditions including who lives at home
- C. Employment: (including employment of spouse and past employment, if applicable) especially as concerns occupational exposure, job satisfaction.
- D. Sexual History: history of sexually transmitted diseases, frequency of intercourse, number of partners, sexual difficulties, sexual habits, use of contraception.
- E. Significant Life Events: deaths, divorce, unemployment, financial hardships, alcoholism, relocation, physical or sexual abuse
- F. Mental Status: mood changes, anxiety/stress, memory/cognitive changes, depression

VII. 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.

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

General:	General state of health (i.e., Do you consider yourself healthy or would you say that you have a lot of illness?) Usual weight, appetite, recent weight change, weakness, fatigue, fever, chills, sweats..
Skin:	Rashes: lumps, itching, dryness, color change, changes in hair or nails.
Head:	Headaches.
Eyes:	Vision, contact lenses or glasses, last eye examination, pain, redness, excessive tearing, double vision, transient loss or impairment of vision.
Ears:	Hearing changes, sensation of spinning, earaches, infection, discharge, ringing.
Nose and Sinuses:	Frequent colds, nasal stuffiness, Hay fever, nose bleeds.
Mouth and Throat:	Condition of teeth and gums, bleeding gums, last dental examination, sore tongue, frequent sore throats, hoarseness, bad breath, change in voice, loss of or peculiar taste.
Neck:	Lumps in neck, "swollen glands, pain or stiffness in neck.
Breasts:	Lumps, pain, nipple discharge, rash.
Respiratory:	Cough, sputum (color, quantity), coughing blood, wheezing, asthma, bronchitis, emphysema, pneumonia, pleurisy.
Cardiac:	Shortness of breath: at rest, with exertion, or with lying down, or that awakens one after a period of sleep. Chest pain, rapid or skipped heartbeats, swelling, syncope.
Gastrointestinal:	Trouble swallowing, heartburn, nausea, vomiting, vomiting of blood, indigestion, changes in bowel habits, rectal bleeding or black tarry stools, constipation, diarrhea, abdominal pain, food intolerance, excessive belching, or passing of gas, hemorrhoids, liver or gall bladder trouble, hepatitis, jaundice.
Urinary:	Increased frequency of urination, increased volume of urine, urination during usual sleeping hours, immediate need to urinate, problem in initiating urination, involuntary loss of urine, blood in urine, history of urinary stones.
GENITOREPRODUCTIVE	
Male:	Discharge from or sores on penis, testicular pain.
Female Menstruation:	Age at onset of menses, regularity, frequency, duration of periods, bleeding between periods or after intercourse, last menstrual period, excessive pain during menstrual flow, age at cessation of menstrual period, menopausal symptoms, post-menopausal bleeding, vaginal discharge or itching, birth control methods.
Musculoskeletal:	Joint pains or stiffness, arthritis, gout, backache; muscle pains or cramps.

Peripheral Vascular:	Leg cramps with walking, varicose veins, thrombophlebitis.
Neurological:	Fainting (syncope), seizures, paralysis, local weakness, numbness, tingling, tremors, memory.
Psychiatric:	Nervousness, tension, mood, depression.
Endocrine:	Thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst, eating or urination.
Hematologic:	Anemia, easy bruising or bleeding.