

New York University School of Medicine

Format for Patient Write-Ups by Students in the Department of Medicine

Date and time:

Name of patient:

Source and reliability:

Chief complaint:¹

Mr. Jones is a 67-year old male who presented to the ER with “sharp pain in my chest” and night sweats for three days.

History of the present illness:²

Mr. Jones has smoked cigarettes continuously since age 17, for a total of 118 pack-years. At age 25, the patient began working in a shipyard and as a result had extensive asbestos exposure for the next 20 years. He was well until 10 years ago, when he developed a cough almost every morning, productive of about a teaspoon of greenish sputum, without any change over time, or any blood. The sputum production clears over the course of the morning, and in general is worst in the spring. When the patient takes antibiotics for any reason, on average, once a year, he notes that his sputum becomes clearer and decreases in volume.

Over the past six months, the patient lost 25-pounds without either trying to lose weight or a change in his appetite. Two months ago, the patient noted occasional flecks of blood in his sputum, but no change in his chronic cough. Over the past 2 weeks, sputum production has increased to 3 teaspoons per day, and includes the afternoons, and now is blood-streaked.

Three days prior to admission the patient noted a sharp pain in his right chest. The pain came on gradually, does not radiate, is worsened by taking a deep breath, and is not related to exercise or meals. He denies shortness of breath, dyspnea on exertion, and peripheral edema. He denies fever, but for the last three nights he soaked his sheets with sweat. This morning he saw his private doctor who told him his chest X-ray was abnormal. The doctor also reported that his white blood count was elevated, and recommended that he come to the ER, where he arrived at 1 pm. Because of his abnormal CXR, the ER admitted him directly to the medical service with no further evaluation or treatment.

He has no history of TB, previous hospitalization for pulmonary symptoms or pneumonia, abnormal CXR, asthma, international travel, or trauma to the chest. He is unaware of his PPD status. There is no history of cardiac illness or cancer.

Past Medical History³

1. Gout – 1975, 1996, brief episodes of pain and swelling in Right big toe, effectively treated with allopurinol.
2. Major Depression- 1980, following prolonged illness and death of father. Treated with oral medication (unknown) and psychotherapy for two years. No recurrences.
3. No other history of any major medical illnesses or hospitalizations since childhood. Specifically no history of hypertension, high cholesterol, cancer, STD, diabetes, liver or heart disease.

¹Include patient age/sex/ethnicity (if relevant), complaint(s) (preferably in patient’s own words), and duration.

The chief complaint should include a brief summary of the main reasons the patient is seeking medical care. Other symptoms may be included in the Present Illness; those not related to the present illness, should be enumerated in the ROS.

²Tell the patients history as a story, chronologically. Begin with the earliest antecedent event for the present illness and move in a strictly chronological manner to the present. Report only the evidence. **Do not interpret in the HPI.**

Writing an effective HPI will require understanding the differential diagnosis and listing findings that are important in discriminating among the most likely elements of the different diagnosis. The actual discussion of the diagnosis must wait until the assessment. However, consideration of the differential diagnosis will help guide you through asking the “best” questions and writing the history.

- a. For all relevant symptoms, describe them fully:
the **WIDOW** mnemonic helps:
 - W Where is symptom, which side, where radiating
 - I Intensity (mild, severe, sharp, dull)
 - D Duration (how long? How long is each episode? Interval?)
 - O Onset (gradual, sudden, progressing in intensity, diminishing)
 - W What makes it better (nitroglycerine, eating, rest, position, aspirin) or worse (exercise, etc.).

- b. Note that prior hospitalizations or medical encounters, and lab results related to this illness are part of the HPI, and should be included in their chronological sequence.
- c. Include a few of the most pertinent negatives.
- d. Certain symptoms are usually addressed in the “Review of Systems”, discussed below; however, if the symptom can be related to HPI it should be included there.

Past Surgical History³

1. Appendectomy- Age 19, uncomplicated
2. Fracture L Tibia- Age 26

Allergies

1. Allergic to tetracycline – caused rash on body about 20 years ago.
2. No other known drug or food allergies

Family History⁴

Father died aged 70, due to cancer of the colon Mother alive and well at 85. Daughter, age 39 A&W.
Two siblings, brother 59 A&W, sister 65, HTN on medication

There is no family history of TB, other cancers, premature heart disease, diabetes, alcoholism.

Social History

Patient retired five years ago after 40 years of work in shipyards and a shoe factory.⁵ He lives in Brooklyn with his wife and daughter who is divorced, both of whom accompanied him to the hospital. He is heterosexual with one partner, his wife. He drinks 5 cans of beer a week on average. Denies any illicit or recreational drug use. He receives social security and a pension.

Medications

Allopurinol 300 mg p.o. daily

Review of Systems⁶

General: Denies chills, or malaise.

HEENT: Denies head trauma, headaches, or dizziness. Has used eyeglasses for, past 35 years. Denies other problems with vision. Denies problems with hearing, tinnitus. Denies chronic sinus problems, but suffers from hay fever in the fall. Denies frequent sore throats or dental problems.

Pulmonary: See HPI

Cardiovascular: Denies h/o congenital heart disease, murmur, rheumatic fever, angina, hypertension, palpitations, MI, abnormal EKG, orthopnea, dyspnea on exertion, edema, heart surgery, PVD angiography, syncope.

GI: Denies history of ulcer disease, hepatitis, cholecystitis, upper or lower GI bleeding, or hemorrhoids. Denies nausea, vomiting, change in appetite, diarrhea, melena, constipation.

GU: Denies history of urinary infections, problems urinating, dysuria, hematuria. history of syphilis, gonorrhea, or prostate disease. Reports satisfactory sexual relations.

e. The HPI should include a **complete** review of the system(s) relevant to the C.C.

³The Past Medical and Surgical Histories are written in the format of a summary list in chronological order.

Problems should be included if they have led to medical attention or hospitalization.

Include pertinent negatives in your write-up for only a few of the most prevalent, serious diseases that you have asked about. For each problem addressed, note the duration of the problem, time of onset, whether it is currently active, and how it is being treated. If the patient was hospitalized, try to include the hospital name and location. It is also appropriate to list obstetrical history including prior pregnancies, miscarriages, abortions, cesarean section deliveries, and complications.

⁴In large families, a sketch of the family tree may be more useful in conveying the information. Family history of the illness being considered should be included in the HPI.

⁵Occupational history is almost always relevant to patient's illness or psychosocial situation.

⁶The ROS is also an opportunity to pick up past problems that the patient might not otherwise have the opportunity to tell you. Include time-frames. Body systems discussed in the HPI need not be repeated in the ROS, you may simply write "See HPI." Positive symptoms should be elaborated upon briefly.

Significant positive history should be moved into the HPI, PMH, or PSH, as appropriate. (Thus, if while conducting the ROS, you find something germane to the HPI, when you are writing or narrating the history, include it in the HPI; the ability to do such editing is a learned skill, and is a more advanced phase of development).

| | |
|------------------|--|
| Hematologic: | No known anemia, easy bleeding or bruising |
| Endocrinologic: | No polyuria, polydipsia, heat or cold intolerance. No hair changes or known thyroid trouble |
| Musculoskeletal: | See PMH, Denies other joint, bone, or muscle problems. |
| Neurologic: | Denies motor or sensory neurologic problems, difficulties in walking or balance, seizures, headaches, TIA, or CVA. |
| Psychiatric: | See PMH |
| Skin: | Denies rashes, lesions, or other skin problems. |

Physical Exam

General Appearance⁷

A cachectic male appearing older than his stated age, lying comfortably in bed, in no acute distress.

Vital Signs

BP 110/74 pulse 90/regular while lying
 BP 105/70 and pulse 96/regular while standing
 Respirations 24 and shallow, temperature 100.8°F orally

Skin⁸

Skin-a 2x1.5 cm brown, raised, crusted, rough patch on left upper back, non-tender, non-warm, with irregular borders.

Head

Bi-temporal wasting, normocephalic, atraumatic

Eyes

conjunctiva pink, sclerae anicteric, pupils 3mm equally round and reactive to light and accommodation (PERRLA), fundi demonstrate flat discs, normal vessels, without hemorrhages or exudates

Ears

external auditory canals (EAC) normal, tympanic membranes intact, hearing grossly intact

Nose

mucosa pink, no discharge or polyps

Mouth

moist membranes, partial upper dentures, otherwise dentition normal for age, no oral lesions.

Throat

Non-injected

Neck

supple, full range of motion (FROM), trachea midline, no a pulse thyromegaly, carotids 2/2 without bruits, no JVD or HJR or abnormal pulses or bruits

Nodes⁹

No cervical, submandibular, supraclavicular, axillary, or inguinal lymphadenopathy

Breasts

Normal male, no masses, discharge, or tenderness

Lungs¹⁰

I: barrel-chest, unable to take a deep breath due to guarding in right chest

P: No tenderness; tactile fremitus increased right base

P: hyperresonance bilaterally, dull to percussion at right base

A: rales, bronchial breathing, and egophany at right base, otherwise breath sounds diminished throughout

⁷Always begin with the appearance, which is your first impression when you enter the room, and begin to examine the patient. Even as you are taking the history, you are observing the patient.

⁸When there is a positive finding, describe as completely as possible. Strive to use standard, objective **quantitative** terms and avoid subjective terms such as small, mild, etc.

⁹List each area examined separately.

Heart

- I:** No apical heave or parasternal (RV) lift
P: PMI in 4th intercostal space in the mid-clavicular line;
No palpable heave, lift or thrill
A: S1, S2 normal; no splitting or loud P2; I/VI low-pitched
early systolic murmur best heard at the lower left sternal
border; no rubs, or gallops

Abdomen

- I:** Abdomen flat, no scars, striae or dilated veins
A: Bowel sounds normal; no bruits (aorta, iliofemoral or renal)
P: Soft, nontender; no guarding or rebound; liver palpable 4cm
below the right midclavicular line; spleen not palpable; no
masses.
P: Liver span 10 cm by percussion in right midclavicular line

Back

no spinal or CVA tenderness

Genitalia

normal male, circumcised. Testes descended b/l, no masses., skin
no skin lesions.

Rectal

good sphincter tone, no masses or tenderness. prostate smooth,
1+ enlarged, no masses. stool guaiac negative

Extremities

no clubbing, cyanosis, or edema; no tenderness, joints have full
range of motion; no subcutaneous nodules, no abnormalities of
big toe, no tophi.

Pulses:

| | <u>Brach</u> | <u>Rad</u> | <u>Fem</u> | <u>Pop</u> | <u>PT</u> | <u>DP</u> |
|---|--------------|------------|------------|------------|-----------|-----------|
| R | +2 | +2 | +2 | +2 | +2 | +2 |
| L | +2 | +2 | +2 | +2 | +2 | +2 |

no bruits

Neuro:

MS: awake, alert, fully responsive, oriented to person,
place, and time. Normal affect.

CN: I not tested
II visual acuity (corrected 20/20),
full visual fields
III, IV, VI extraocular movements intact
V nl sensation on face, jaw clench
VII no weakness
VIII hearing intact
IX, X gag reflex present bilaterally
XI symmetric trapezius, SCM
strength
XII tongue midline

motor: RUE 5/5 RLE 5/5
LUE 5/5 LLE 5/5

sensory: intact to pinprick, light touch,
position and vibration

cerebellar: no dysdiadochokinesis, gait
normal, Romberg's sign absent

reflexes: biceps 2+
triceps 2+
patellar 2+
achilles 2+
plantar downward
no snout or glabellar reflexes

Laboratory

Hematocrit 27, MCV 79, White blood cell count 12.8 with 79
polys, 4 bands, 13 lymphs, 4 monos.

Electrolytes, liver function tests and urinalysis all normal.

¹⁰For the lung, heart and abdomen
examinations, it is particularly useful
to describe the results of:

Inspection
Palpation
Percussion
Auscultation

This may also be used for other parts
of the physical such as the neck
exam.

Percussion is not usually a part of the
heart exam.

Auscultation of the abdomen should
precede palpation and percussion.

Chest X-ray - Flattening of the diaphragm, and hyperlucency throughout. A 1x2 cm mass in right hilum with dense right lower lobe alveolar consolidation and blunting of right costophrenic angle.

EKG: NSR Rate 90, NDEA, Low voltage diffusely, No STTW changes.

Summary¹¹

67 yo white male smoker, shipyard worker, with history indicative of COPD and chronic productive cough, gout, and depression presents with 6 month history of 25 lb. weight loss, 2 months of hemoptysis and increased sputum production and nightsweats, and 3 days of pleuritic pain in the right chest. The physical is remarkable for pulse of 96, Temp 100.8, barrel chest with guarding on the right, clinical signs of consolidation at the right base. There is a single skin lesion on the left upper back. Labs show microcytic anemia, elevated white count with a normal differential, CXR reveals an infiltrate in the right lower lobe and pleural effusion and right hilar mass. The current problems can be summarized as follows:

Problem List

1. Acute pulmonary process
2. Right hilar mass
3. Chronic cough
4. Weight loss
5. Anemia
6. Skin lesion
7. Health Maintenance ***

Assessment¹²

1. Acute pulmonary process

Pneumonia is the most likely explanation for the acute process. This is supported by acute onset of change in sputum, hemoptysis, night sweats, fever, pleuritic chest pain, signs of consolidation, CXR showing lobar infiltrate and pleural effusion, and leucocytosis. This probably represents community-acquired pneumonia, most likely due to pneumococcus, but could be due to H. influenzae, S. aureus, B. catarrhalis, L. pneumophila. An alternative diagnosis causing pleuritic chest pain, hemoptysis and fever is pulmonary embolism with infarction. Against this diagnosis is the patient's change in sputum production, and the pulmonary consolidation that is not wedge-shaped. Another alternative diagnosis is a chronic pulmonary infection, such as tuberculosis, which can cause fever, weight loss, increased sputum, hemoptysis, and infiltrate. Against tuberculosis is the acute time frame, and the location of the infiltrate. The acute time frame is against other chronic pulmonary infections. Thus, for the acute process, I favor community-acquired pneumonia (95% chance), or tuberculosis (5% chance).

¹¹Summarize the most positive and negative findings of the case including symptoms, signs and lab findings.

List the problems you will address in the assessment in order of clinical importance at presentation.

***Required on all Ambulatory Care write-ups and suggested on others.

¹²This is where you present your diagnostic reasoning and therapeutic plan. You are expected to commit to a diagnosis at the end. Use the data you have assembled to expand on your problem list, create a differential diagnosis for each problem, consider the pros and cons of each diagnosis, and establish a final differential diagnosis in order of likelihood.

Try to estimate and quantitate the probability of each of the most important diagnoses you have considered in your differential for this specific patient.

Always try to synthesize and consolidate historical, physical exam and laboratory data into a coherent diagnosis.

For each problem, provide an assessment first. This is a written formulation, in whole sentences, of your reasoning. Then suggest a plan of action based on the considerations in your assessment. This should be divided into diagnostic and therapeutic possibilities and presented as lists.

Plan¹³

Diagnostic:

1. sputum for gram and AFB stains, and cultures
2. blood cultures
3. PPD skin test
4. Therapeutic trial of antibiotics
5. Consider V/Q scan if no response to antimicrobial agents within 24 hours

Therapeutic:

1. IV hydration
2. empiric broad spectrum antibiotics
 - a) vancomycin because of concern for resistant pneumococci, while awaiting stain and culture results
 - b) erythromycin for atypical organisms
 - c) duration of course and nature of antibiotics will await evaluation of response to therapy and results of diagnostic tests

¹³The Plan is based on the assessment. The diagnostic component should include the tests that will differentiate among the major items in the differential diagnosis. The therapeutic component should include non-specific elements that should be done regardless of the specific cause (e.g. blood pressure support for a hypotensive patient) as well as specific measures addressed to the most likely etiologies

2. Right hilar mass

Right lung mass could be a tumor or a hilar node from a chronic infection such as tuberculosis. Given the intensive exposure to tobacco and asbestos and the history consistent with chronic bronchitis it is possible that there is a bronchogenic carcinoma that partially obstructs a bronchus impairing clearance of secretions causing pneumonia. In favor of a neoplasm is the weight loss, anemia, and exposure history. There are no findings against this. Thus, for the lung mass I favor bronchogenic carcinoma (70% chance), tuberculosis (10% chance), other granulomatous disease (10% chance), or lung abscess (10% chance).

Plan

Diagnostic:

1. CT scan of the chest
2. Sputum cytologies
3. May need bronchoscopy for tissue Dx.

Therapeutic:

Will be based on the specific etiology

3. Chronic cough

Chronic cough, in an 118 pack year smoker with purulent sputum that clears with antibiotics suggests chronic bronchitis. The barrel chest, hyperresonance, and flattened diaphragm also suggest COPD, (emphysema). Thus patient likely has mixed picture (typical of COPD with both bronchitis and emphysema). All other possibilities are remote. The cause of the right hilar mass may be contributing to this process of late (hemoptysis for 2 months).

Plan

Diagnostic:

1. PFT's to confirm diagnosis, assess extent of disease and predict response to bronchodilators.
2. ABG when acute illness resolves to assess prognosis and potential therapeutic response to continuing oxygen therapy.

Therapeutic:

Will depend on results of diagnostic tests.

4. Weight loss

Weight loss, with cachexia and wasting, is indicative of a chronic process. Consider neoplasm or infection. With right hilar mass, strong history of exposures, consider bronchogenic carcinoma (80% chance). Other neoplasms much less likely based on normal exam (10% chance). Also consider tuberculosis (10% chance), but no past history, apices are normal, and TB usually does not present as a mass.

Plan

Diagnostic:

1. Cytologies
2. Bronchoscopy
3. Sputum for AFB

Therapeutic:

Pending

5. Anemia
etc., for all issues on problem list
6. Skin Lesion
etc., for all issues on problem list
7. Health maintenance***

Diagnoses¹⁴

1. Right lower lobe pneumonia, possibly secondary to 2 or 3.
2. COPD
3. Probable occult lung neoplasm with weight loss, anemia.
4. skin lesion, probable seborrheic keratosis
5. history of gout, on medication
6. history of depression
7. allergy to tetracycline

Proposed Pathogenesis¹⁶

Discussion¹⁵

***Required on all Ambulatory Care write-ups and suggested on others. Include all screening, immunization, and prevention and counseling appropriate for this patient

¹⁴This is your diagnostic impression **at this point in time** (admission or whenever you did the H & P and may have some initial labs). This is not a paragraph, but a list that includes all of the patient's problems and diagnoses. **It should not be a differential diagnosis of one problem** since you have already done this in your assessment. If you are not sure of a diagnosis, **commit yourself** to the most likely and those very few you still want to rule out. **Try to consolidate problems you have considered in your assessment into unifying diagnoses if possible.**

¹⁶ Create a diagram that ties together as many as possible of the patient's main symptoms, physical findings, and labs with your understanding of the disease processes involved and their pathogeneses. **See attached example.**

¹⁵Elaborate on an aspect of the leading problem, and review either pathophysiology, etiology, prognosis or therapy. **Be sure to bring the discussion back to your patient.** This would be an ideal time to discuss the hospital course, if applicable. Often, specific parts of the course, such as a complication or a particular test result can help highlight relevant points of pathophysiology, etiology, prognosis, or therapy. Do not write more than 1 or 2 pages. References are suggested.

Proposed Pathogenesis of this Patient's Illness

