

# GUIDELINES FOR WRITING

## SOAP NOTES and HISTORY AND PHYSICALS

by

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# GUIDELINES FOR WRITING SOAP NOTES and HISTORY AND PHYSICALS

**Lois E. Brenneman, M.S.N., C.S., A.N.P., F.N.P.**

Written documentation for clinical management of patients within health care settings usually include one or more of the following components.

- Problem Statement (Chief Complaint)
- Subjective (History)
- Objective (Physical Exam/Diagnostics)
- Assessment (Diagnoses)
- Plan (Orders)
- Rationale (Clinical Decision Making)

Expertise and quality in clinical write-ups is somewhat of an art-form which develops over time as the student/practitioner gains practice and professional experience. In general, students are encouraged to review patient charts, reading as many H/Ps, progress notes and consult reports, as possible. In so doing, one gains insight into a variety of writing styles and methods of conveying clinical information. Frequently, these documents written by persons with extensive clinical experience who have developed succinct and precise clinical writing styles. Ultimately, each individual will incorporate input from a variety of sources and synthesize a clinical writing style which is both professionally functional and unique to that person.

The following sections will address the specifics for obtaining information and writing each of these components. Numerous examples are given throughout. At the end of this discussion, an example of a SOAP note for a particular clinical problem is presented. For purposes of comparison, an example of a HISTORY AND PHYSICAL (H/P) for that same problem is also provided. Note that the SOAP contains only that information which is relevant to evaluate the problem at hand while the H/P is more a thorough data base and contains all information, whether or not it is relevant to the patients problem or chief complain (CC).

Whether the practitioner writes a SOAP note or a History and Physical will depend on the particular setting wherein the problem is being addressed. Usually, an H/P is done for an initial visit with a client at a particular out-patient health care facility or whenever the client is admitted to an in-patient facility. Frequently, an H/P is done annually at a given facility while any interim visits for particular health care problems are documented as SOAP notes.

Specifically for in-patient settings, after an admission H/P is done, SOAP notes detail the regular follow-up visits by various health care professionals. Often they comprise the format for the "Progress Notes" and address the status of particular problems for which the patient has been admitted.

A variety of different professionals practicing in a given institution might be writing SOAP notes on a patient. Each will address the problem(s) from a wide variety of professional perspectives. The dietician may address the patient's compliance or comprehension of an ADA diet and document the visit in the form of a SOAP note. The podiatrist may be charting on the same patient's diabetic foot ulcer. The cardiologist may be addressing the patient's status with respect to angina or S/P MI. The intern may be addressing the overall management of the patient on the particular unit. Each would likely write a SOAP note which documents his/her visit and summarizes the findings.

The frequency of visits and writing SOAP notes will be a function of how often the particular services in question are needed. The intern assigned to the floor or service may chart daily or more even more frequently if problems/complications arise. The podiatrist may make bi-weekly visits and chart accordingly. The dietician may see the patient only once if the hospital stay is short. In the case of the out patient, a SOAP note is generated for each contact with the health care facility.

## PROBLEM STATEMENT

**STATEMENT OF PROBLEM OR PURPOSE OF VISIT:** This statement details the purpose of the visit. It may or may not be the same as the Chief Complaint (CC). For example, the problem statement may be "Angina/R/O MI" but the patient's CC may have been "I feel dizzy and sweaty and I have pain running down my arm and in my jaw." In other cases, the problem statement and the CC will be identical. In the example presented at the end of this discussion, the problem statement is "Abdominal pain" and the CC is "I have abdominal pain and it is quite severe."

Often, but not always, particular problems have been previously assigned a number on a problem list which appears on the patient's office chart or hospital record. Any time someone charts on a particular problem in the Progress Notes, that person lists the problem to be addressed (and perhaps its number) just before writing the SOAP note. Examples of problem statements are as follows

- Chest pain
- Abdominal pain
- Hypertension
- College physical or annual Pap and Pelvic

**SUBJECTIVE OR HISTORY:** This portion of the SOAP note (or H/P) include a statement, preferably in the patient's own words regarding chief complaint (CC) which details why the patient has presented to the health care facility - i.e. why is he/she here?

- "I have abdominal pain"
- Pt here for routine f/u HTN
- Pt requests physical for high school soccer team

For SOAP notes, all other pertinent information reported by the patient (or significant others) should be included in this section. The information should detail what the patient has told the health care provider, and include the pertinent information to work up the particular complaint. It should include SYMPTOM ANALYSIS, PERTINENT POSITIVES, PERTINENT NEGATIVES AND ROS FOR THE PARTICULAR SYSTEM INVOLVED. If one is writing this subjective portion would follow the standard format for writing a patient history.

Relevant information which the patient (or family, etc.) reports should be included. Certain information may appear in either the subjective or objective portion of the SOAP or H/P depending on the source of the information. For example, if the patient tells interviewer that he had a cardiac cath at XYZ hospital and that it has revealed thus and so, then this information belongs under SUBJECTIVE.

Patient reports that he had a cardiac cath at NYU Medical Center in 1994 after which "they told me that 3 of my vessels were clogged."

If the health care provider has read the actual cath report or has spoken with the cardiologist/other professional staff, then what is essentially the same information would appear under the OBJECTIVE component of the note.

Cardiac Cath done in March of 94 at NYU Medical Center reveals 3 vessel disease with 80% occlusion of ..... etc.

In addition to the problem at hand, SOAP notes generally address important past medical history, relevant family history, social history, albeit briefly so. Important aspects of the medical history (e.g. diabetes,

HTN, s/p MI, s/p pacemaker, etc.) have implications for any and all subsequent health care problems and should be at least mentioned in the note. THERE IS NEVER AN EXCUSE TO NOT TO ASK AND DOCUMENT INFO RE: MEDICATIONS (RX/OTC), ALLERGIES, OR IMPORTANT MEDICAL CONDITIONS. The reference need not be detailed and can be brief but it should be included.

- "a known diabetic on oral hypoglycemics"
- "hypertension on Vasotec x 4 years; suboptimal control"
- "denies history of diabetes, HTN, asthma, or CA."

Even the most trivial complaints warrant documenting this type of information. Would you want to give the patient on Hytrin for BPH or a patient who has been treated for cataracts a seemingly harmless antihistamine/decongestant preparation for his cold? How about the person who reports an allergy to prednisone? Should you RX a Medrol Dosepak for his poison ivy? IF YOU DON'T ASK, YOU WON'T KNOW AND IN A COURT OF LAW, IF YOU DID NOT DOCUMENT IT, YOU DID NOT DO IT!

The following is an example of the SUBJECTIVE portion of a SOAP note. It includes only that information which is relevant to the problem at hand. Essentially the same information (up to PMH) would comprise the HPI in an H/P for this same problem.

### **PROBLEM #1: Abdominal Pain**

**SUBJECTIVE:** 24 year old female; was in her usual state of health until 3 days ago when she began to experience abdominal pain described as "severe" and sharp/knife-like. Localized to lower abdominal regions; more intense on the right side. Worsens w movement; somewhat relieved by Advil, but not markedly so. Pain gradual in onset; worsening over the last few days. Became quite severe last evening, keeping her awake most of the night. Uncertain re: fevers; reports chills last evening and sweats after taking Advil.

Sexually active, new partner beginning 4 months ago. He told her the relationship is monogamous; she "hopes it is." Previous sexual partner over 1 year ago. New partner irregularly uses condoms; "He gets mad when I ask him to and says I don't trust him." Did not press the issue because "I am afraid of losing him." No other contraception; LMP 19 days ago.

Vaginal discharge which was "a little yellowish" approx 10 or 12 days ago; assumed it was yeast and self-medicated w OTC Gyn-Lotrimin. Discharge persisted but was ignored because it was "only a little." Denies burning, pain, pruritus or swelling/redness to the vulva. Denies dysuria, frequency or urgency. No previous STDs; Heterosexual w 4 previous sexual partners; never tested for HIV. New partner heterosexual w number of previous partners unknown.

G1PO, 1 elective AB 4 years ago. Menarche age 13, cycles q 28-30, flow: 5-6 days. Mild dysmenorrhea; responds to Advil. Denies excessive bleed, clots or unusual discharge prior to this episode; no frequent yeast infections. Last PAP 2 years ago and normal. No SBE; is "not sure how."

**PMH:** overall unremarkable; occasional colds/flu, usual childhood illnesses. Had 2nd MMR on entering college; ? tetanus booster. Never initiated hepatitis series. Denies diabetes, HTN, cancer or asthma. Denies any depression or counseling. Surgeries: 1 TOP; otherwise non-contributory. Previous injuries, accidents and hospitalizations: non-contributory.

**FH:** 1 sister w ectopic and question of STD; cousin w endometriosis; otherwise non-contributory.

**SH:** college student; lives in dorm. Active in school and extra-curricular activities; works part-time at deli. Sexually active as per HPI. Non-smoker, ocas ETOH on w/e, no hx drug abuse. Family life stable and unremarkable.

**ALLERGIES:** NKDA

**MEDS:** occasional Advil, takes vitamins

## OBJECTIVE

**OBJECTIVE OR PHYSICAL ASSESSMENT:** This section should include information obtained via physical exam, laboratory analysis, XRAYs, professional consults, etc. IT SHOULD NOT INCLUDE ANY INFORMATION WHICH THE PATIENT HAS TOLD YOU. That information belongs in the SUBJECTIVE. It may, however, include observations that you have made while interviewing the patient.

"The patient was tearful and somewhat reticent to give information during the interview."

For a HISTORY AND PHYSICAL, the OBJECTIVE would be the complete physical exam. It would be written following standard format and would include any additional information available (lab reports, XRAYs, etc). For a SOAP note, the OBJECTIVE would include all of the information necessary to evaluate the particular problem in question. AS A GENERAL RULE, THE PHYSICAL EXAM FINDINGS INCLUDED IN THIS SECTION WOULD BE THE VITAL SIGNS, HEIGHT/WT, GENERAL SURVEY, HEART, LUNGS AND WHATEVER ADDITIONAL SYSTEMS ARE RELEVANT TO THE PROBLEM. PERTINENT LABORATORY DATA, XRAYs, CONSULT REPORTS, ETC. would be included. For the previously described patient with abdominal pain, the OBJECTIVE would be as follows:

VS: 100/68, 102.5, 110, 26, WT 110, HT 5'2"

Gen: AOX3, WDWN female who appears moderately ill looking at this time. Repositions on table with obvious discomfort. Tearful, and somewhat reticent to give information during the interview.

Heart: S1>S2 at apex, RRR without murmurs, clicks or gallops, pulses 2+/equal bilaterally

Chest: A/P not inc; lungs: resonant/clear

Abdomen: Flat w RLQ scar noted; otherwise unremarkable to inspection w normoactive bowel sounds heard in all 4 quadrants. Tympanic percussion note throughout. Liver span: 9 cm RMCL, 5 cm RMSL w no splenic dullness noted at 10 ICS-LAAL. Diffusely tender to palpation w marked tenderness to RLQ. Abdomen is without organomegaly or abdominal masses noted. No lateral pulsation to aortic region; no CVA tenderness.

Pelvic exam: external genitalia WNL/without lesions, speculum exam reveals a yellow purulent discharge from the cervical os; bimanual exam elicits cervical motion tenderness and a right adnexal mass. The region is exquisitely tender to palpation. Left adnexal region overall unremarkable: non-tender; no structures palpated. Uterus is retroflexed and of normal size and consistency. Rectal confirms vaginal, stool guaiac negative.

Diagnostics: wet mount show numerous polys to the cervical discharge; urine dip is negative; white count 13.6 w prominent shift to left; HCG neg.

While not an absolute rule, SOAP notes usually include at least brief mention of the heart and lungs, along with the other relevant systems. Excluding the heart/lungs would be the exception and not the rule, and, in general, is not a good practice.

One could make an argument that a visit for poison ivy on a 15 year old who has had many previous visits would not mandate a heart or lung exam. Had that same 15 year old been a smoker who "forgot" to

mention that he had a dry cough for the last 4 weeks and subsequently was found to have mycoplasma pneumonia, giving him a Medrol Dosepak (which could exacerbate bacterial infections), would be less than desirable treatment his self-limiting dermatitis. A 30 second auscultation of the lungs might well have revealed crackles, a strong clue to the diagnosis.

Even worse, what if this previously health 15 year old, "nice kid" has a new onset murmur secondary to SBE which he contracted via secretly using IV heroin. He thought he was "safe" because he "only shares needles with people I know." Three days later, he is admitted to the ICU with a septic pulmonary embolism. Would you like to explain to the lawyer hired by the parents why you saw the patient in the office 3 days earlier, charged the parents \$54 for an office visit, and never noticed that he had a new 3/6 systolic murmur; a murmur which would have taken 15 seconds to find?

Regarding, the example of the patient with abdominal pain, if the chief complaint had been, instead, chest pain or SOB, the exam of the cardiac and pulmonary system would have been a great deal more detailed and the pelvic exam would not likely be relevant. Obviously, the diagnostics would be much different, as well. Similarly, had the patient been a known COPD, the pulmonary exam would be a great deal more detailed EVEN IF the complaint were still for abdominal pain. Moreover, if the log were an H/P, every system would be examined in detail, whether or not it was relevant to the chief complaint.

As much as possible use medical terminology when describing objective findings. The patient does not "appear to have a red rash to his forearm." Rather, he has a "a 4 x 6 cm, irregularly shaped lesion comprised of scaly oval plaques on an erythematous base, over the ulnar aspect of the forearm." Instead of noting simply that the patient "appears to be depressed," describe his behavior: "He has flat affect during the history and averts his eyes, rarely looking at the interviewer."

## ASSESSMENT

**ASSESSMENT:** Assessments are DIAGNOSES, whether that diagnosis is a medical or nursing diagnosis. In general, the former are preferred and expected. The student should write, for example

1. Bronchitis with underlying history of COPD (or AECB)
2. Dehydration secondary to protracted vomiting
4. Diuretic therapy R/O hypokalemia
3. Unstable angina

DO NOT use "nursing diagnoses" which have been designed to address medical conditions but which have been worded carefully so as to "not make a medical diagnosis." WHERE A MEDICAL DIAGNOSIS IS CALLED FOR, USE ONE. Do not, for example, use "Alteration in fluid and electrolyte imbalance related to decreased fluid intake" when diagnosing a patient who is dehydrated. "Dehydration secondary to ....." (whatever is the reason) is the appropriate way to diagnose that patient. Similarly, do not write "Alteration in comfort related to ....." when what you mean is that the patient has pain. If the student's preceptor is a physician he/she may regard the student who presents such a diagnosis as having just landed in from Mars, or at least, somewhere out in the ozone layer. If one's preceptor is a nurse practitioner, he/she may need Maalox to deal with the unpleasant flashback from nursing school.

If the patient has post-op pain or pain secondary to whatever cause, simply state it as such. As a nurse practitioners it is perfectly acceptable and, in fact, expected that we use "medical" diagnoses. Recall, when the student graduates from the program, he/she will be expected to function as a nurse practitioner with a relatively high level of function. If the employer/agency wanted an R.N., he/she/it would have hired one.

Certain nursing diagnoses are quite useful, acceptable and may certainly be included, where applicable. "Nursing" diagnoses are particularly useful for many psycho-social situations e.g. "Alteration in coping secondary dysfunctional family dynamics" or "Grieving" or "self care deficit" etc. and should be included where applicable.

When writing the objective findings, avoid ambiguity or terms like "seems to," "appears to have," etc. The patient does not "seem to have scabies" or "appear to have angina." If the patient has angina (or scabies), definitively diagnosis it and write a plan which reflects the proper treatment. Where the diagnosis is unclear, use the terminology "rule out" e.g. "R/O angina." In this case, the plan addresses whatever is necessary to establish the diagnosis and initiate the proper treatment.

Avoid the term "related to." The preferred term is "secondary to." Also, avoid the term "suffers from." What exactly is "suffering" and how exactly does one "suffer from" i.e. angina, a UTI, COPD. It is preferable to write that "he has been previously diagnosed with angina" or simply write that "the patient has angina."

Where the exact nature of the problem is unclear, use R/O diagnoses or "E.U." where it refers to "etiology unknown" i.e. "vesicular lesions E.U.; R/O contact dermatitis." One may also use the term "cannot rule out" i.e. "Migraine cannot rule out aneurysm" or "Cough cannot rule out pneumonia."

EXAMPLE: returning to our previous patient with the abdominal pain, the assessment (diagnoses) might include the following:

1. PID probable gonorrhea r/o tuboovarian abscess
2. Knowledge deficit: SBE/sexual practice/GYN care
3. R/O other STD

Any rationale for making particular diagnoses or choosing particular treatment plans will be included under a separate section labeled RATIONALE.

A common area of confusion for nurse practitioner students when they are writing the "assessment" for soap notes is that they often include information which they had been previously taught to include as a part of their "nursing assessment." For purposes of SOAP notes, information previously gathered as part of a "nursing assessment - subjective and objective data - now belongs in the respective subjective and objective sections of the SOAP note. The assessment section is strictly limited to diagnoses.

## PLAN

**PLAN:** The plan can be thought of as the steps necessary to address, solve or treat the problem. Sometimes the plan is synonymous with the orders. It need not be so. The plan is just that: a proposed course of action. Not infrequently the plan includes rationale for the particular course of action which has been chosen. This rationale can be included in a separate section or it can be integrated with the plan. Usually the former approach tends to be somewhat easier, especially for the student. Specific details and examples concerning writing rationale will be addressed in the following section.

Writing the Plan is usually quite straight forward. Continuing with the example of the patient with the abdominal pain the PLAN would be as follows:

### PLAN

1. Admit to Dr. Brown's person's service
2. VS: q 8h
3. NPO
4. ACTIVITY: BRP
5. IV: D545NS at 125/hr
6. Cervical culture: routine c/s, GC, chlamydia: DONE in office
7. CBC, SMAC drawn in office; U/A, HCG done in office



8. Blood work A.M.: VDRL, Hepatitis B profile, HIV w consent
9. MEDS:
  - Clindamycin 600 mg IVSS q 6h
  - Gentamycin 80 mg IVSS q 8h
  - Augmentin 500 mg IVSS q 8h
10. Pelvic u/s: STAT
11. GYN consult: STAT
12. Anticipate counseling/teaching on discharge
  - SBE
  - Safe sex
  - Contraception
  - Yeast infections/OTC tx

Clearly the plan directs the approach to care of the patient or treating the problem at hand. The plan should address the "whole picture" i.e. include what is anticipated to be done as well as that which will be done immediately. FOR OUTPATIENTS, IT SHOULD ALWAYS SPECIFY A TIME WHEN THE PATIENT WILL BE FOLLOWED UP.

**Example:** Return to clinic in 3 weeks for reevaluation. To call sooner if there are problems in the interim.

**Example:** Will f/u HTN q 3-4 months; patient to schedule appointment. Notify sooner for problems.

## RATIONALE

**RATIONALE:** The plan and rationale would tend to go "hand and hand." The PLAN specifies proposed treatments for particular diagnoses while the RATIONALE details the "justification" for the particular approach chosen. For example, the rationale might explain why the practitioner believes the headache for a given patient might be caused by an aneurysm and warrants a CAT scan to rule out aneurysm. As another example, the rationale would address why the practitioner believes the cough could be pneumonia and is ordering a CXR. Obviously not every headache warrants a CAT and not every cough needs a radiograph. The rationale would address why it is so for a particular case.

FOR PURPOSES OF THIS COURSE, RATIONALE SHOULD BE INCLUDED IN ALL CLINICAL LOGS AND SHOULD INCLUDE AT LEAST ONE REFERENCE. The RATIONALE should address the various components of the treatment plan. In actual practice, the rationale is often not included and when included it may not be labeled as such. It may be as "Comment" or is sometimes called "Critical Decision Making." Often, it is not included at all. The latter is particularly true if the plan is self-evident from the diagnoses (e.g. amoxicillin 250 tid x 10 days where the diagnosis the assessment is strep pharyngitis).

When writing rationale, some element of judgement is appropriate. It is probably not necessary to include the rationale for that which is clearly self evident. For example when ordering CBC to work up a diagnosis of "fatigue R/O anemia," it is probably not necessary to justify ordering the CBC. Instead, the rationale could address the fact that anemia along with depression and whatever else is the part of the differential diagnosis for fatigue (according to XYZ reference) and should be considered for this particular patient in question.

If a particular diagnosis is not being considered for a patient, i.e. it has been already ruled out, the rationale should indicate why that is so. For example, rationale might discuss the reason why the practitioner has chosen the diagnosis of bacterial vaginosis and initiated treatment with Flagyl versus a diagnosis of candidiasis vulvovaginitis in which case, the appropriate treatment would be PO Diflucan or vaginal Terazol 7 cream.

The following is an example of a PLAN and RATIONALE for 26 year old, otherwise healthy male with repeat BP 140/110 who has been diagnosed with hypertension r/o secondary etiology.

#### PLAN

1. SMAC
2. Random urine: U/A
3. 24 hour urine: Total protein, creatinine clearance, VMA, norepinephrine. If elevated will consider nephrology consult.
4. Renal Doppler.
5. Lotensin 20 mg q d # 7 samples given
6. Collection container and written instructions given. Initiate teaching re: HTN with specifics addressed and handouts given at this time.
7. RTC in 1 week for recheck BP; will titrate medication accordingly. To notify sooner if any untoward effects in the interim.

**RATIONALE:** secondary HTN would need to be ruled out due to client's young age where the incidence of essential hypertension is low and the likelihood of secondary etiology is significant. In particular, would like to r/o renal or endocrine based pathophysiology. Serum Na, K, creatinine and urine for protein ordered for assessment of renal function. If elevated, consider sonogram for evidence of anatomic abnormalities and consultation with nephrology. ACE inhibitor therapy good choice for this age group due to low side effect profile and beneficial effect for HTN secondary to renal artery stenosis which would rank high in the differential diagnosis/etiology for a 26 year old.

For the above example, one would include a reference (APA format) which indicates wherein the student got that information i.e. Kelly, Harrison's, etc. It is not necessary to include rationale for that which is obvious i.e. why he was offered HTN teaching or handouts, etc. Such rationale is reasonably self-evident.

Recalling the example of the 24 year old with abdominal pain, she was diagnosed with tubo-ovarian abscess and admitted on IV antibiotics. The rationale would address why the diagnosis was made, why she was admitted and why the particular antibiotics were chosen. It also addresses the issue of hepatitis.

**RATIONALE:** The elevated temp, white count and numerous polys in the discharge, in combination with the pelvic findings of cervical motion tenderness, clearly point to the diagnosis of PID (Rivlin, M. and R Martin, 1994). Moreover, the right adnexal mass and exquisite tenderness to this area would support a high index of suspicion for tubo-ovarian cyst, in which case we would anticipate surgical intervention with GYN consult ASAP. Antimicrobial therapy chosen, in accordance with standard practice, so as to provide adequate coverage for most of

the polymicrobial flora encountered in these types of pelvic infections (Clark-Pearson and Yusoff Dawood, 1990). Clearly this patient has profound knowledge deficits which need to be addressed prior to her discharge or on f/u office visit so as to avoid reoccurrence and/or other problems.

Clark-Pearson and Yusoff Dawood (1990). Green's gynecology: Essentials of clinical practice, 4th ed. Boston: Little, Brown and Co.

Rivlin, M. and Rick Martin (1994) Manual of clinical problems in obstetrics and gynecology, 4<sup>th</sup> ed. Waltham, Ma.: Little, Brown and Company.

## EXAMPLE OF SOAP NOTE

### PROBLEM #1: Abdominal Pain

**SUBJECTIVE:** 24 year old female; was in her usual state of health until 3 days ago when she began to experience abdominal pain described as "severe" and sharp/knife-like. Localized to lower abdominal regions; more intense on the right side. Worsens w movement; somewhat relieved by Advil, but not markedly so. Pain gradual in onset; worsening over the last few days. Became quite severe last evening, keeping her awake most of the night. Uncertain re: fevers; reports chills last evening and sweats after taking Advil.

Sexually active, new partner beginning 4 months ago. He told her the relationship is monogamous; she "hopes it is." Previous sexual partner over 1 year ago. New partner irregularly uses condoms; "He gets mad when I ask him to and says I don't trust him." Did not press the issue because "I am afraid of losing him." No other contraception; LMP 19 days ago.

Vaginal discharge which was "a little yellowish" approx 10 or 12 days ago; assumed it was yeast and self-medicated w OTC Gyn-Lotrimin. Discharge persisted but was ignored because it was "only a little." Denies burning, pain, pruritus or swelling/redness to the vulva. Denies dysuria, frequency or urgency. No previous STDs; Heterosexual w 4 previous sexual partners; never tested for HIV. New partner heterosexual w number of previous partners unknown.

G1PO, 1 elective AB 4 years ago. Menarche age 13, cycles q 28-30, flow: 5-6 days. Mild dysmenorrhea; responds to Advil. Denies excessive bleed, clots or unusual discharge prior to this episode; no frequent yeast infections. Last PAP 2 years ago and normal. No SBE; is "not sure how."

Past Medical History: overall unremarkable; occasional colds/flu, usual childhood illnesses. Had 2nd MMR on entering college; ? tetanus booster. Never initiated hepatitis series. Denies diabetes, HTN, cancer or asthma. Denies any depression or counseling. Surgeries: 1 TOP; otherwise non-contributory. Previous injuries, accidents and hospitalizations: non-contributory.

Family History: 1 sister w ectopic and question of STD; cousin w endometriosis; otherwise non-contributory.

Social History: college student; lives in dorm. Active in school and extra-curricular activities; works part-time at deli. Sexually active as per HPI. Non-smoker, ocas ETOH on w/e, no hx drug abuse. Family life stable and unremarkable.

ALLERGIES: NKDA

MEDS: occasional Advil, takes vitamins

## OBJECTIVE

VS: 100/68, 102.5, 110, 26, WT 110, HT 5'2"

Gen: AOX3, WDWN female who appears moderately ill looking at this time. Repositions on table with obvious discomfort. Tearful, and somewhat reticent to give information during the interview.

Heart: S1>S2 at apex, RRR without murmurs, clicks or gallops, pulses 2+/equal bilaterally

Chest: A/P not inc; lungs: resonant/clear

Abdomen: Flat w RLQ scar noted; otherwise unremarkable to inspection w normoactive bowel sounds heard in all 4 quadrants. Tympanic percussion note throughout. Liver span: 9 cm RMCL, 5 cm RMSL w no splenic dullness noted at 10 ICS-LAAL. Diffusely tender to palpation w marked tenderness to RLQ. Abdomen is without organomegaly or abdominal masses noted. No lateral pulsation to aortic region; no CVA tenderness.

Pelvic exam: external genitalia WNL/without lesions, speculum exam reveals a yellow purulent discharge from the cervical os; bimanual exam elicits cervical motion tenderness and a right adnexal mass. The region is exquisitely tender to palpation. Left adnexal region overall unremarkable: non-tender; no structures palpated. Uterus is retroflexed and of normal size and consistency. Rectal confirms vaginal, stool guaiac negative.

Diagnostics: wet mount show numerous polys to the cervical discharge; urine dip is negative; white count 13.6 w prominent shift to left; HCG neg.

## ASSESSMENT

1. PID probable gonorrhea r/o tuboovarian abscess
2. Knowledge deficit: SBE/sexual practice/GYN care
3. High risk sexual practice w no Hepatitis B immunization

## PLAN

1. Admit to Dr. Brown's service
2. VS: q 8h
3. NPO
4. ACTIVITY: BRP
5. IV: D545NS at 125/hr
6. Cervical culture: routine c/s, GC, chlamydia: DONE in office
7. CBC, SMAC drawn in office; U/A, HCG done in office
8. Blood work A.M.: VDRL, Hepatitis B profile, HIV w consent
9. MEDS:
  - Clindamycin 600 mg IVSS q 6h
  - Gentamycin 80 mg IVSS q 8h
  - Augmentin 500 mg IVSS q 8h
10. Pelvic u/s: STAT
11. GYN consult: STAT
12. Anticipate counseling/teaching on discharge
  - SBE
  - Safe sex
  - Contraception
  - Yeast infections/OTC tx

**RATIONALE:** The elevated temp, white count and numerous polys in the discharge, in combination with the pelvic findings of cervical motion tenderness, clearly point to the diagnosis of PID (Rivlin, M. and R Martin, 1994). Moreover, the right adnexal mass and exquisite tenderness to this area would support a high index of suspicion for tubo-ovarian cyst, in which case we would anticipate surgical intervention with GYN consult ASAP. Antimicrobial therapy chosen, in accordance with standard practice, so as to provide adequate coverage for most of the polymicrobial flora encountered in these types of pelvic infections (Clark-Pearson and Yusoff Dawood, 1990). Clearly this patient has profound knowledge deficits which need to be addressed prior to her discharge or on f/u office visit so as to avoid reoccurrence and/or other problems.

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Rivlin, M. and Rick Martin (1994) Manual of Clinical Problems in Obstetrics and Gynecology, 4<sup>th</sup> ed. Waltham, Ma.: Little, Brown and Company.

### EXAMPLE OF HISTORY AND PHYSICAL

For comparison purposes, the patient and CC are the same as the SOAP note presented in the preceding example. The H/P includes considerable more detail and information versus the SOAP note which provides only that information which is relevant to addresses the problem.

**CC:** "I have abdominal pain and it is very bad"

**HPI:** 24 year old female; was in her usual state of health until 3 days ago when she began to experience abdominal pain described as "severe" and sharp/knife-like. Localized to lower abdominal regions; more intense on the right side. Worsens w movement; somewhat relieved by Advil, but not markedly so. Pain gradual in onset; worsening over the last few days. Became quite severe last evening, keeping her awake most of the night. Uncertain re: fevers; reports chills last evening and sweats after taking Advil.

Sexually active, new partner beginning 4 months ago. He told her the relationship is monogamous; she "hopes it is." Previous sexual partner over 1 year ago. New partner irregularly uses condoms; "He gets mad when I ask him to and says I don't trust him." Did not press the issue because "I am afraid of losing him." No other contraception; LMP 19 days ago.

Vaginal discharge which was "a little yellowish" approx 10 or 12 days ago; assumed it was yeast and self-medicated w OTC Gyn-Lotrimin. Discharge persisted but was ignored because it was "only a little." Denies burning, pain, pruritus or swelling/redness to the vulva. Denies dysuria, frequency or urgency. No previous STDs; Heterosexual w 4 previous sexual partners; never tested for HIV. New partner heterosexual w number of previous partners unknown.

G1PO, 1 elective AB 4 years ago. Menarche age 13, cycles q 28-30, flow: 5-6 days. Mild dysmenorrhea; responds to Advil. Denies excessive bleed, clots or unusual discharge prior to this episode; no frequent yeast infections. Last PAP 2 years ago and normal. No SBE; is "not sure how."

**PAST MEDICAL HISTORY:** overall unremarkable. Occasional colds/flu. Denies hx of diabetes, HTN, cancer or asthma. Denies hx of depression or counseling.

**CHILDHOOD ILLNESSES AND IMMUNIZATIONS:** usual childhood illnesses. Completed OPV/DTP series. Has had 2nd MMR on entering college; uncertain re last tetanus booster. Has never initiated hepatitis series.

**ACCIDENTS/INJURIES:** fell out of tree as child and fractured collarbone. MVA 5 years ago with broken wrist and whip-lash injury; no residue deficits. Injured knee with surgical repair to ACL 3 years ago secondary to skiing accident.

**SURGICAL HISTORY:**

- AP at age 14
- wisdom teeth extracted age 19
- 1 elective TOP 2 years ago
- ACL repair as per above

**HOSPITALIZATIONS:** for surgeries as described above. One admission for bronchitis/pneumonia as a child.

**PSYCHIATRIC/SUBSTANCE ABUSE ADMISSIONS:** none

**FAMILY HISTORY:**

- Father (†58): HTN and angina
- Mother: (†57): NIDDM, overweight
- 1 Sister (†28): well
- 1 Brother (†22): depression on SSRI

**CANCER:**

- Pat grandfather (colon)
- Maternal aunt (breast)
- Maternal uncle (lung)

Denies: cervical, ovarian, uterine

**CARDIAC/HTN:**

- Mat grandfather MI age 58, CVA age 70
- Mat uncle: MI age 62, HTN
- 2 pat uncles: HTN

**DIABETES:**

- Mat grandmother, 1 mat uncle

**ASTHMA:** none

**GYN:**

- Mother: hysterectomy (52): DUB
- Sister: ectopic, adhesions, ?PID
- Cousin: endometriosis

**SOCIAL HISTORY:** College senior (art major); active in school and extra-curricular activities to include theater group and year book. Lives in dorm; works part-time in deli. Heterosexual and sexually active with perceived monogamous boyfriend, as per HPI. Leisure activities include skiing, music, "hanging out with friends" and shopping. Life outlook normally positive. Goals: to secure employment as a curator of an art museum "in the city," and to "get married and have children." Non-smoker, ocas ETOH on w/e; no hx drug abuse. Caffeine intake: 2-3 c/day, exercises at college health facility 2-3 times per week. Family life stable and unremarkable. Financially secure; support by parents.

**NUTRITIONAL HISTORY:** eats "a lot of junk food" but also tries to watch her weight. Brings home food from the deli and dines mostly at college cafeteria. "Pigs out" frequently at Burger King, or local ice cream establishment. No history of dysfunctional eating patterns.

**ALLERGIES:** NKDA; seasonal rhinitis, "might be" allergic to family cat who causes her to sneeze.

**MEDS:** occasional Advil, takes vitamins.

## REVIEW OF SYSTEMS

**GENERAL:** recent fever/chills as per HPI; denies recent wt changes, fatigue, weakness, night sweats, bleeding tendencies, easy bruising, anemia, transfusions, sickle cell, HIV testing

**SKIN:** denies rashes, hives, eczema, lumps, sores, itching, dryness, color change, changes in moles/nevi, warts, changes in hair/nails, use of hair dye.

**HEAD:** denies lumps, vertigo, H/A, pain, fainting, trauma

**EYES:** last eye exam 2 years ago, wears contacts; seasonal allergy w itching/red eyes. Otherwise denies visual changes, pain, redness, excessive tearing, discharge, infections, double vision, glaucoma, cataracts, photophobia.

**EARS:** denies hearing impairment, use of hearing aid, tinnitus, vertigo, earaches, infection, discharge.

**NOSE/SINUS:** seasonal allergy/rhinitis w nasal congestion. Otherwise denies frequent URI, nasal congestion/stuffiness, obstruction, discharge, itching, hay fever, nosebleeds, sinus infection, trauma

**MOUTH/THROAT:** last dental exam 8 months ago; 1 permanent bridge. Denies abscess, caries, gingivitis, bleeding, pus, or dentures. Denies sore tongue, frequent sore throat, hoarseness, voice changes, postnasal drip, oral thrush.

**NECK/NODES:** "swollen glands" last year w episode of strep pharyngitis, denies goiter, pain or tenderness on movement, stiffness/limited ROM of neck.

**RESPIRATORY:** denies cough, pain, dyspnea, sputum production. Denies hemoptysis, wheezing, asthma, bronchitis, emphysema, pneumonia, pleurisy, TB. Last PPD (neg) on entering college 3 years ago, never had CXR.

**BREAST:** no SBE; denies known lumps, pain, tenderness, discharge or other changes. Never had mammogram.

**CARDIAC:** denies disease/surgery, chest pain/discomfort, HTN, MI, palpitations, mummings, arrhythmias, rheumatic fever, dyspnea, DOE, orthopnea, PND, edema. Never had EKG, stress test or other cardiac testing.

**GI-UPPER:** now anorexic since last evening; normally good appetite. Denies gastritis, pain, ulcer, dysphagia, infections, heartburn, food intolerance, nausea, vomiting, regurgitation, hemoptysis, indigestion, excessive belching.

**GI-LOWER:** See HPI; normally w/o abdominal pain. Denies infections, frequent bowel movements, change in bowel habits, rectal bleeding, black tarry stools, hemorrhoids, constipation diarrhea, or excessive flatus. Stools normally formed, brown and q daily. Denies "pencil" stools," infections, jaundice, liver/gallbladder/spleen, hepatitis, IBS, Crohn's.

**VASCULAR:** denies pain in legs, calves/thighs/hips while walking. Denies leg cramps, ulcers, varicose veins, thrombophlebitis, clots in veins, swelling of legs, coolness/dyscoloration of extremity, loss of hair on legs, Raynaud's phenomenon/disease.

**URINARY:** 2 recent UTIs treated at college health center; Otherwise denies frequency, urgency, polyuria, nocturia, burning/pain on urination, hematuria. Denies hesitancy, decreased force of stream, incontinence, stones, flank pain, retention, color, unusual odor to urine.

**MUSCULO-SKELETAL:** sprained ankle twice last year. One episode of back pain 6 months ago from "carrying heavy books." Otherwise denies muscle or joint pains/tenderness. Denies stiffness of muscles/joints, muscle cramps, arthritis, deformities, gout, backache, weakness, limitation to ROM, prosthesis.

**NEUROLOGICAL:** denies LOC, CVA, epilepsy, fainting, blackouts, seizures, weakness, paralysis, numbness, tingling, tremors, involuntary movements, tics, loss of memory, disorientation, speech disorders, unsteady gait, loss of taste/smell.

**ENDO:** denies thyroid disorders, heat/cold intolerance, excessive sweating, diabetes, excessive thirst/hunger, polyuria

**PSYCHIATRIC:** denies mood changes, nervousness, depression, therapy/counseling, psychiatric disorders, hallucinations, psychiatric admissions.

**GEN/GYN:** see HPI

### PHYSICAL EXAM

VS: 100/68, 102.5, 110, 26; WT 110, HT 5'2"

General: AOX3, WDN female who appears moderately ill looking at this time. Repositions on table with obvious discomfort. Tearful, and somewhat reticent to give information during the interview. Hygiene is good.

Skin/structure: Overall fair without significant lesions noted; turgor good, somewhat flushed with increased temp, dry to touch. Hair distribution, texture and quantity overall unremarkable. Nail beds pink with good capillary refill.

Head: AT/NC; without tenderness, lesions or lumps. Facial features symmetrical and overall unremarkable; no weakness noted.

Eyes: wears contacts. Vision 20/25 w hand-held eye chart; no presbyopia. PERRLA, EOMI, VFI. Structures without lesions noted: sclera white, cornea clear/regular, conjunctiva pink and without excess vascularity. No discharge, excessive tearing or photophobia. Fundi: background clear w sharp disc margins; no arteriolar narrowing, hemorrhages, cotton wool patches or AV nicking noted.

Ears: No lesions noted to external structures; no tenderness on retraction of pinnae or pressure to tragus. TMs bilaterally pearly gray with light reflex and bony landmarks intact. Canals clear and without excess cerumen or exudates. Forced whisper perceived accurately at 5 feet. Rinne: AC > BC. Weber: midline; no lateralization.

Nose/Sinus: Symmetrical without evidence of septal deviation or trauma. Nares patent; turbinates intact. Mucosa is pink and without evidence of discharge, exudates, swelling or congestion. Olfactory testing is deferred. No paranasal tenderness; sinuses transilluminate equally bilaterally.

Mouth: Mucosa pink and moist without lesions to the buccal cavity. Dentition in good repair; gingivae pink without swelling, redness or lesions noted. Tongue is midline; without fasciculation. No coating or lesion noted. No odor present.

Throat: oropharynx without erythema, exudates or increased lymphoid tissue noted. Tonsils are present and otherwise unremarkable. Uvula is midline and rises symmetrically; gag reflex intact. Phonation without hoarseness and otherwise unremarkable.

Neck: supple w full ROM. Symmetrical; trachea midline. Thyroid is not enlarged and is without nodularity.



Nodes: without cervical, axillary, epitrochlear or inguinal adenopathy.

Breasts: examined seated and supine. Medium in size, symmetrical w regular contours; no retractions or dimpling noted. Soft, non-tender to palpation without masses noted. There is some tissue thickening to the upper outer quadrants bilaterally but no dominant mass.

Chest: Respirations unlabored and even/without distress; rate slightly elevated. AP diameter not enlarged; respiratory excursion is symmetrical with tactile fremitus of normal intensity and equal bilaterally. Diaphragmatic excursion: 4 cm. Percussion tone is resonant to all fields posteriorly. Vesicular breath sounds heard throughout w no adventitious sounds noted. No egophony, whispered pectoriloquy or bronchophony is noted.

Cardiac: examined seated and supine. No abnormal pulsations, lifts or heaves noted. No thrills; PMI in 5ICS-MCL. S1 louder at apex; S2 louder at base. RRR w no murmurs, clicks or gallops heard. Physiologic split of S2 noted on inspiration.

Vascular: No JVD. All pulses 2+ and equal bilaterally in upper and lower extremities. No bruits heard.

Abdomen: Flat w RLQ scar noted; otherwise unremarkable to inspection w normoactive bowel sounds heard in all 4 quadrants. Tympanic percussion note throughout. Liver span: 9 cm RMCL, 5 cm RMSL w no splenic dullness noted at 10 ICS-LAAL. Diffusely tender to palpation w marked tenderness to RLQ. Abdomen is without organomegaly or abdominal masses noted. No lateral pulsation to aortic region; no CVA tenderness.

Pelvic exam: external genitalia WNL/without lesions, speculum exam reveals a yellow purulent discharge from the cervical os; bimanual exam elicits cervical motion tenderness and a right adnexal mass. The region is exquisitely tender to palpation. Left adnexal region overall unremarkable: non-tender; no structures palpated. Uterus is retroflexed and of normal size and consistency. Rectal confirms vaginal, stool guaiac negative.

Extremities: without clubbing cyanosis or edema. Anatomical alignment noted.

Musculoskeletal: Gait WNL. Muscle strength 5/5 to all groups. Joints w full ROM to all planes and w/o deformities noted. Spine w full ROM and curvature WNL; no paravertebral tenderness.

Neurological: AOX3 w no mental status deficits noted. CN: 2-12 intact. DTR 2+ to upper and lower extremities; Babinski negative. Sensory intact to proprioception, sharp-dull discrimination, vibration and stereognosis. No motor deficits noted. Cerebellar function intact to finger to nose pointing and rapid alternating movements. Romberg negative

Diagnostics: wet mount show numerous polys to the cervical discharge; urine dip is negative; white count 13.6 w prominent shift to left; HCG neg.

## **ASSESSMENT**

1. PID probable gonorrhea r/o tuboovarian abscess
2. Knowledge deficit: SBE/sexual practice/GYN care
3. R/O other STD

## PLAN

1. Admit to Dr. Brown's service
2. VS: q 8h
3. NPO
4. ACTIVITY: BRP
5. IV: D545NS at 125/hr
6. Cervical culture: routine c/s, GC, chlamydia: DONE in office
7. CBC, SMAC drawn in office; U/A, HCG done in office
8. Blood work A.M.: VDRL, Hepatitis B profile, HIV w consent
9. MEDS:
  - Clindamycin 600 mg IVSS q 6h
  - Gentamycin 80 mg IVSS q 8h
  - Augmentin 500 mg IVSS q 8h
11. Pelvic u/s: STAT
12. GYN consult: STAT
13. Anticipate counseling/teaching on discharge
  - SBE
  - Safe sex
  - Contraception
  - Yeast infections/OTC Treatments

**RATIONALE:** The elevated temp, white count and numerous polys in the discharge, in combination with the pelvic findings of cervical motion tenderness, clearly point to the diagnosis of PID (Rivlin, M. and R Martin, 1994). Moreover, the right adnexal mass and exquisite tenderness to this area would support a high index of suspicion for tubo-ovarian cyst, in which case we would anticipate surgical intervention with GYN consult ASAP. Antimicrobial therapy chosen, in accordance with standard practice, so as to provide adequate coverage for most of the polymicrobial flora encountered in these types of pelvic infections (Clark-Pearson and Yusoff Dawood, 1990). Clearly this patient has profound knowledge deficits which need to be addressed prior to her discharge or on f/u office visit so as to avoid reoccurrence and/or other problems.

Clark-Pearson and Yusoff Dawood (1990). Green's Gynecology: Essentials of Clinical Practice, 4th ed. Boston: Little, Brown and Co.

Rivlin, M. and Rick Martin (1994) Manual of Clinical Problems in Obstetrics and Gynecology, 4<sup>th</sup> ed. Waltham, Ma.: Little, Brown and Company.

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## PHYSICAL EXAM POCKET CARDS

THE FOLLOWING PAGES CAN BE PHOTOSTATED AND CUT ALONG THE LINES TO MOUNT ON 5X8 INDEX CARDS SO AS TO CREATE A POCKET GUIDE TO THE PHYSICAL EXAM.

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PHYSICAL EXAM - Card 1

1. GENERAL SURVEY:
  - State of development
  - State of nutrition
  - Apparent state of health
  - Signs of distress
  - Facial expression
  - Mood
  - Speech
    - Gait
    - Dress, grooming, hygiene
2. OBTAIN HEIGHT AND WEIGHT
3. OBSERVE WALKING/GAIT
  - Normal walking
  - Heel to toe walking
  - Heel walking
  - Toe walking
4. PERFORM SNELLEN EXAM
5. PERFORM ROMBERG EXAM
6. INSPECT AND PALPATE SPINE
7. ROM OF SPINE

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PHYSICAL EXAM - Card 2

CLIENT SITS ON EXAM TABLE

8. OBTAIN TPR\BP (both arms)
9. OBSERVE SKIN
  - Temperature, moistness
  - Texture, thickness, mobility
  - Lesions: type, color, location, size, arrangement
10. INSPECT/PALPATE: HEAD, SCALP, FACE
  - Skull: size, contour, masses
  - Hair: color, distribution, texture, loss pattern, parasites
  - Face: symmetry, movement, expression
11. INSPECT/PALPATE: EYEBROWS, LIDS, LASHES
  - Eyebrows: quantity, distribution
  - Eyelids/lashes: position, color, surface, direction of lashes

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PHYSICAL EXAM - Card 3

12. INSPECT: SCLERA, CONJUNCTIVA, CORNEA, IRIS
  - Sclera: color
  - Cornea: clarity, surface (use oblique lighting)
  - Iris: color, shape, clarity, symmetry
  - Conjunctiva: color, surface
13. TEST EXTRAOCULAR MOVEMENTS
14. INSPECT PUPILS
  - Size, shape, symmetry equality
15. TEST PUPILS
  - Reaction to light
  - Accommodation
  - Convergence
16. TEST VISUAL FIELDS

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PHYSICAL EXAM - Card 4

17. FUNDUSCOPIC EXAM

- Red reflex
- Disc margin characteristics
- Background/physiologic cup
  - Venules/arteries: appear, ratio
  - Copper wiring
- Nicking
- White patches

18. INSPECT EXTERNAL AUDITORY CANAL and TYMPANIC MEMBRANE (OTOSCOPE)

- Canal: patency, discharge, cerumen
- Tympanic membrane: color, light reflex landmarks

19. CHECK HEARING: Whisper, Weber, Rinne

20. INSPECT EXTERNAL AND INTERNAL NOSE

- Nostril: test patency of each
- Mucosa: color, integrity
- Septum: position
- Turbinates: characteristics

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PHYSICAL EXAM - Card 5

21: INSPECT AND PALPATE FRONTAL AND MAXILLARY SINUS

- Tap sinus for tenderness
- Transilluminate P.R.N.

22. INSPECT MOUTH AND PHARYNX

- Lips: appearance, cracks, fissures
- Mucosa: color, integrity
- Gingiva: appearance
- Teeth: condition, alignment, missing
- Tongue: coating, symmetry, movement, midline, undersurface, palpate for masses (gauze), resistance (blade)
- Hard and soft palate
- Uvula: midline, rises with "AH"
- Tonsils: presence, swelling, redness
- Gag reflex

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PHYSICAL EXAM - Card 6

23. INSPECT/PALPATE NECK AND NODES

- Neck: symmetry, position of trachea, ROM in 6 positions, muscle strength (shrug against resistance, push against hand on each side of face)
- Nodes: preauricular, postauricular, tonsillar, submaxillary, superficial cervical, posterior cervical, deep cervical, supraclavicular

24. INSPECT/PALPATE THYROID

- Observe size, shape position with/wo swallowing (uniform rise isthmus)
- Palpate each lobe (bend head forward, tilt toward side, displace thyroid toward tilt, palpate w and w/o swallow.

25. INSPECT, PALPATE, AUSCULTATE CAROTIDS

- Inspect: JVD
- Auscultate: bruits (bell)
- Palpation: character, qual, symmetry, amplitude

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PHYSICAL EXAM - Card 7

26. INSPECT POSTERIOR THORAX

- Shape, masses, contour, AP-transverse ratio, deformities, respiratory movements (ease, symmetry, use of accessory muscles)

27. PALPATE POSTERIOR THORAX

- Palpate: tenderness, masses
- Vocal fremitus
- Thoracic expansion

28. PERCUSS POSTERIOR THORAX

- Posterior percussion sites: Intensity, pitch, duration, quality of note
- Level of diaphragmatic excursion

29. AUSCULTATE POSTERIOR THORAX

- Breath sounds: timing, pitch, intensity and quality (vesicular)
- Adventitious sounds: presence/absence

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PHYSICAL EXAM - Card 8

30. INSPECT/PALPATE FINGERS/HANDS/WRIST

- Nails: color, shape, capillary fill, lesions
- Palpate: Distal and proximal interphalangeal joints, metacarpal joints, carpal joints
- Wrist: ROM (up, down, fist open, fist closed w fingers in front, hand side to side, fingers spread/closed)

31. CHECK HANDGRIPS

32. CHECK CEREBELLAR FUNCTION:

- Finger to nose pointing, rapid, alternating movement

33. CHECK SENSORY FUNCTION:

- Vibration, proprioception, 2 pt discrimination, sharp dull discrimination, stereognosis, graphesthesia, cold/hot discrimination. Start distally, move proximally PRN if deficits.

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PHYSICAL EXAM - Card 9

34: INSPECT/PALPATE ARMS, STRENGTH ARMS, ROM ELBOW

- Elbows: ROM (flex/extend arms at elbows, rotate palms up/down)
- Arms: Inspect/palpate, test muscle strength (forearm: push arm down/up against resistance, upper arm: push hand vertically against resistance)

35: TEST MUSCLE STRENGTH TO MAJOR MUSCLE GROUPS:

- Push/pull against resistance

36: TEST REFLEXES:

- Triceps, biceps, brachioradialis (supinator), patellar, achilles, plantar

37: INSPECT/PALPATE SHOULDERS, ROM OF ARMS/ SHOULDERS (Note: may combine with #35)

- Inspect/palpate shoulders
- ROM arms/shoulders: arms at side, overhead, behind neck behind back

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PHYSICAL EXAM - Card 10

38. INSPECT BREASTS

- Shape, symmetry, contour, dimpling in four positions (arms at side, arms overhead, hands on hips, bending forward)

39. PALPATE BREASTS

- Breasts: masses, tenderness
- Nipples: pull up, observe discharge

40. INSPECT/PALPATE AXILLA

- Axillary nodes: (central, pectoral, subscapular, lateral)

41. INSPECT/PALPATE ANTERIOR THORAX

- Inspect: Shape, masses, contour, deformities, pulsations, respiratory movements (symmetry, ease, use of accessory muscles, lifts, heaves, retractions)
- Palpate: tenderness, masses
- Vocal fremitus
- Thoracic expansion

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PHYSICAL EXAM - Card 11

42. PALPATE PMI

- Location, diameter, amplitude, duration

43. AUSCULTATE ANTERIOR THORAX

- Breath sounds at auscultation sites

44. AUSCULTATE HEART AT BASE

- Use diaphragm, client may lean forward
- S2 loudest, S4, aortic murmurs

CLIENT NOW LIES DOWN ON EXAM TABLE

45. INSPECT/PALPATE BREASTS

- Hand behind head
- Inspect: masses, size, shape, symmetry, contour, nipple characteristics
- Palpate: masses, tenderness, discharge

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PHYSICAL EXAM - Card 12

46. PERCUSS ANTERIOR THORAX

- Anterior percussion sites: intensity, pitch, duration, quality of percussion note

47. AUSCULTATION OF HEART SEQUENCE

- Diaphragm (high pitched)
- Bell (low pitched)
- Note: Apical rate, rhythm, composition of S1/S2, presence or absence of extra sounds with effect of position
- Physiologic split S2: more pronounced during inspiration; abnormal with expiration; best at pulmonic area with expiration; best at pulmonic area
  
- Cardiac Auscultatory Points:
  - Aortic (2nd ICS R: S2 loud, S4)
  - Pulmonic (2nd ICS L: S2 loud)
  - Erbs Point: (3 ICS L: equal)
  - Tricuspid: (4 ICS LLSB)
  - Mitral: (5ICS L: S1 loud, S3)

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PHYSICAL EXAM - Card 13

48. AUSCULTATION OF MITRAL AREA (APEX)

- Client can turn to left
- Use diaphragm then bell
- PMI to axilla

49. INSPECT ABDOMEN

- Contour, symmetry, bulges, pulsations, scars, striae

50. AUSCULTATE ABDOMEN

- Bowel sounds, bruits
- Auscultation over 4 quadrants, plus Aortic arteries, Renal arteries, Iliac arteries, Femoral arteries

51. PERCUSS ABDOMEN

- 4 quadrants
- Suprapubic area
- Percuss/measure liver dullness
  - MCL: 6-12 cm
  - MSL: 4-8 cm
- Percuss spleen: AAL left
- CVA/Liver tenderness (with blow)

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PHYSICAL EXAM - Card 14

52. PALPATE ABDOMEN: LIGHT/DEEP

- 4 quadrants: hernia, masses, tenderness, organomegaly
- Liver, spleen, kidneys
- Aortic artery, Renal, iliac artery

53. PALPATE INGUINAL AREA

- Femoral pulse: character, quality, symmetry, amplitude
- Femoral nodes: horizontal group, vertical group

54: INSPECT/PALPATE UPPER LEG

- Note: redness, abnormalities,
- Test muscle strength

55: INSPECT/PALPATE KNEE/CALF/LOWER LEG

- Note: varicosities, redness, tenderness, abnormalities
- Knee: contours (hollows present), presence/absence of fluid
- Palpate for pretibial edema

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PHYSICAL EXAM - Card 15

56. ROM KNEE/HIP

- Knee: bring to chest
- Hip: place heel to opposite patella then do internal and external rotation

57. INSPECT/PALPATE/ROM FEET

- Dorsalis pedis pulse
- Inspect dorsal and plantar surface
- ROM: feet up, down, internal/external rotation

58. PLACE FEMALE PATIENT IN LITHOTOMY POSITION AND PROCEED WITH PELVIC, IF INDICATED. FOR MALE PATIENT, MAY DO RECTAL AT THIS POINT VIA PATIENT PLACING FOREARMS ON EXAM TABLE AND BENDING OVER OR ALTERNATIVELY MAY DO WITH PATIENT IN LATERAL POSITION AFTER PALPATING THE ABDOMEN

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