The Comprehensive Health History and Physical Examination: a Lifespan Approach

Rodney W. Hicks, Ph.D., RN, FNP-BC, FAANP, FAAN
Innovator of eLOGS

and

Diane C. Seibert, Ph.D., CRNP, NAP, FAANP*
Uniformed Services University of the Health Sciences

Published by Advanced Practice Education Associates, Inc.
Lafayette, Louisiana

All rights reserved. This book is protected by copyright. No part of this book may be reproduced or transmitted in any form or by any means including mechanical, electronic, photocopying, recording, or by information storage or retrieval systems except by expressed, written permission of the authors and the publishers.

Copyright © 2020

ISBN: 978-1-892418-17-3

Printed in the United States

elogs.org

*"The views expressed are those of the authors and do not reflect the official policy or position of the Uniformed Services University of the Health Sciences, the Department of the Defense, or the United States government".

TABLE OF CONTENTS

Adult Medical History
- Subjective....1
- Objective....14

Pediatric Medical History
- Subjective....52
- Objective....67

Preconception Visit....106

New OB Assessment
- Subjective....107
- Objective....110

Sample Notes....120

Evaluation & Management (E & M) Codes
- Established patients....122
- New patients....124

DISCLAIMER

The purpose of this book is to provide the practitioner with a frame of reference for activities associated with obtaining the medical history and performing a physical examination. It is NOT the intent of this book to provide detailed explanation of the findings or the importance of the various elements, or define terms. Such material is well covered in other physical examination books. Every effort has been made to ensure that the information within this book is accurate, but no guarantee is made to that effect. The ultimate responsibility for the history and physical lies with the practitioner.

Suggested updates, additions, or modifications may be submitted to APEA, the publisher, for consideration by the authors.

If you cannot agree to this disclaimer, please notify APEA and refrain from using this book.

1. PATIENT IDENTIFICATION

(Document two patient identifiers, state source of information, state reliability of information)

A. First name, middle initial, last name
B. Medical record number
C. Date of birth
D. Place of birth (City, State)
E. Marital status (Single/Married/Divorced/Partnered)
F. Occupation
G. Current living arrangements
H. Source of referral (if applicable)
I. Ethnicity
J. Primary language spoken
K. Insurance identifying information (if known)

2. REASON FOR VISIT (CHIEF COMPLAINT)

A. State reason for health care encounter
B. Use patient's own words

3. MEDICATIONS

A. Prescriptions (by Whom, for What; taken as directed? Adequate supply?)
B. Over-the-counter products (Supplement/Herbals/Nutrients)
C. Medication reconciliation
  I. Patient has list?
  II. Pharmacy of record
D. Vaccine history
  I. Hepatitis A, Hepatitis B
  II. Herpes zoster (shingles vaccine)
  III. Human papillomavirus virus (HPV)
  IV. Influenza, seasonal (annual re-vaccination)
  V. Meningococcal
  VI. Measles, mumps and rubella vaccine (MMR)
  VII. Pneumococcal
  VIII. Tetanus, diphtheria, pertussis (Td, Tdap)
  IX. Varicella

Follow CDC's Recommended Immunization Schedule

4. ALLERGY/ADVERSE REACTIONS

A. Medication (hives, anaphylaxis, sensitivity)
B. Food
C. Latex
D. Seasonal/environmental

5. HISTORY OF PRESENT ILLNESS (HPI)

(OLD CARTS) Mnemonic
A. **O**nset - When did it start?
B. **L**ocation/Radiation - Where did it start?
C. **D**uration - How long has this gone on?
D. **C**haracteristics - What does it feel like?
E. **A**ggravating or alleviating factors - What makes it worse?
F. **R**elieving Factors - What makes it better?
G. **T**iming - Is it constant, cyclic or does it come and go?
H. **S**everity - Scale from 0-10?

6. PAST MEDICAL HISTORY (PMH)

A. General state of health (in patient's own terms)
B. Past medical illnesses, past mental health disorders
C. Childhood illnesses
D. Communicable diseases
E. Medical hospitalizations (date/location/reason/outcome)
F. Previous surgeries, anesthesia reactions
G. OB/maternity history
H. Accidents (date/type/outcome)
I. Prior blood product recipient?
J. Recent travel out of region?

7. SOCIAL HISTORY AND HABITS (SH)

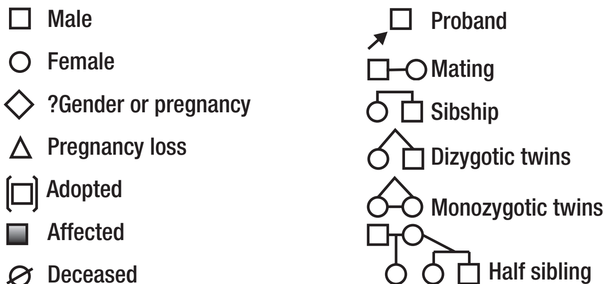
A. Birthplace (City, State, Country)
B. Living conditions/arrangements
C. Substances
   I. Tobacco-cigarettes (pack year history)
   II. Tobacco-cigars, oral (chewing), vaping
   III. Illicit drugs (type, frequency)
   IV. Alcohol (type, frequency)
D. Educational level achieved

E. Occupation history (dates/types)
   F. Occupational exposure (carcinogens, noise)
   G. Sexual history
      I. Sexual orientation
      II. Number lifetime partners
      III. Age of first encounter
   H. Dietary preferences/recall
   I. Sleep patterns (**BEARS**)
      I. **B**edtime problems
      II. **E**xcessive daytime sleepiness
      III. **A**wakening at night
      IV. **R**egularity/duration of sleep
      V. **S**noring
   J. Sleep aids (white noise, medications)
   K. Military service (if applicable)
   L. Exercise patterns
   M. Hobbies
   N. Religious observations

8. FAMILY HISTORY (FH)

Construct pedigree to reflect medical conditions in direct family members.

A. Standard pedigree symbols



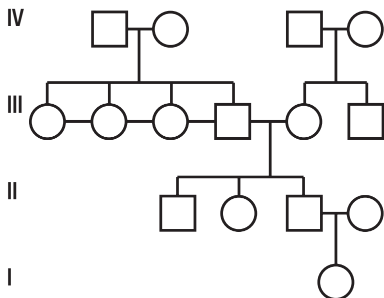
B. Generations

Generation IV
- Grandparents

Generation III
- Parents
- Parents' siblings

Generation II
- Siblings
- Partner/spouse

Generation I
- Children

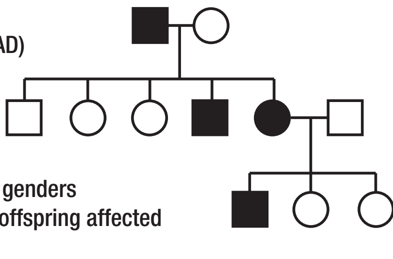


C. Autosomal disorders

I. Autosomal Dominant (AD)

- Affected person in every generation
- Every affected person has affected parent
- Occurs equally in both genders
- Approximately 50% of offspring affected

■ = Affected

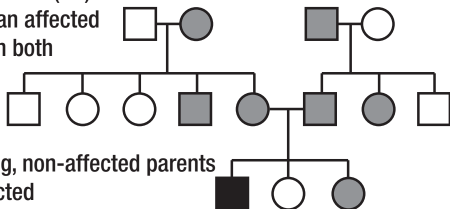


Note 1: Clinical features of AD disorders can vary from mild to severe depending on disease penetrance and expressivity.
Note 2: Some AD disorders (i.e. Neurofibromatosis) develop "denovo" in an embryo with the classic AD inheritance pattern descending from that affected individual.

II. Autosomal Recessive (AR)

- More carriers than affected
- Occurs equally in both sexes
- Consanguinity increases risk
- Affected offspring, non-affected parents
- ¼ offspring affected

■ = Affected, ● = Trait, ○ = Normal



D. Genetic family history

I. Important elements of family (genetic) history

- Date of birth or current age
- Ethnicity
- Maternal and paternal
- Other branches of family as indicated
- Pregnancy losses
- Monozygotic or dizygotic twins
- All marriages/relationships
- Children adopted in or out
- Consanguinity
- Health status of each individual
- Age of diagnosis
- Primary site for any cancer diagnosis
- Record date or age at death
- Record cause of death

II. Red flags from family (genetic) history

- Multiple affected family members
- Multiple affected generations
- Early age of disease onset (e.g., breast cancer age < 36)
- Disease in the less-often-affected sex
- Multi-focal, multi-system, bilateral disease
- Unexplained infertility
- > 3 pregnancy losses
- Dysmorphic features with or without co-morbid medical conditions or developmental delay
- Learning disabilities or behavioral problems
- Movement disorders (hypotonia, ataxia)
- Congenital or juvenile deafness, blindness, or cataracts

III. Common familial conditions

a. Arthritis
b. Asthma
c. Bleeding disorder/tendency
d. Breast cancer
e. Cerebral vascular accident
f. Coronary heart disease
g. Colon cancer/polyps
h. Depression
i. Diabetes (Type, age onset)
j. Hypertension
k. Hyperlipidemia