Case 1

Patient Name: Rita Rieno
Clinical Setting: Family Practice Office
CC: An 18 y/o female presents for "a runny nose."

Vital Signs
Blood pressure: 110/60
Respirations: 14 per minute
Temperature: 98.2°F
Pulse: 68 bpm
Weight: 168 lbs
Height: 5'11"

NOTES:

Subjective

Objective

Assessment

Plan

CC: An 18 y/o female presents for "a runny nose."

History			✓
	1 Introduces self and explains role of provider.		
	2 Properly washes hands before touching the patient (15-sec wash and turns off with towel).		
	3 Opening question: What brings you in today?	My nose won't quit running.	
Chronology/ Onset	4 **When** did this start?	It's been the last couple of years, but has gotten really bad the last month.	
	5 Did you ever have this **before**?	It never really goes away completely.	
Description	6 Could you **describe the nasal discharge?**	It's clear.	
Exacerbation	7 Does anything make it **worse**?	It's worse in the spring and fall.	
Remission	8 What makes it **better**?	Benadryl helps, but it makes me drowsy.	
	9 How **often** do you take Benadryl?	A couple times a week.	
	10 How **many milligrams**?	I take 2 tablets. I don't know milligrams.	
Symptoms associated	11 Do you have **itchy, watery eyes**?	Yes.	
	12 **Headache**?	No.	
	13 **Nasal congestion**?	Yes. Quite a bit.	
	14 **Ear pain**?	No.	
	15 **Fever**?	No.	
	16 **Sore throat**?	Just scratchy.	
	17 **Cough**?	No.	
Social Hx	18 Do you **smoke**?	A little.	
(FED TACOS)	19 **How much** is "a little"?	A pack lasts me 2 or 3 days.	
	20 **How long** have you been smoking?	About a year or two.	
	21 Do you drink **alcohol**?	No.	
	22 Do you use any **drugs**?	No.	
	23 What is your **occupation?**	I'm a senior in high school.	
Medical Hx	24 Do you have any medical conditions?	No.	
Allergies	25 Do you have any allergies?	Cats seem to bother me.	
	26 What happens when you are around cats?	My eyes itch and my throat gets scratchy.	
Surg Hx	27 Have you had any surgeries?	No.	
Hosp Hx	28 Have you ever been hospitalized?	No.	
Family Hx	29 Medical conditions that run in the family?	Yes.	
	30 Who?	My father. He has allergies.	
Menstrual Hx	31 When was the **FDLMP**?	About a week ago.	
Medications	32 Are you on any medications?	Just Benadryl when I need it.	

Physical Examination			✓
	33 Informs patient that the physical exam is to begin and asks permission.		
	34 Rewashes hand before touching patient if candidate has recontaminated them.		
Sinuses	35 Palpation	**Mild maxillary sinus tenderness**	
Eyes	36 Inspection	**Dark circles are noted under the eyes No periorbital edema noted**	
Ears	37 External inspection	**No exudate**	
	38 Otoscopic examination	**TM's gray b/l**	
	39 Inverted otoscope with finger distended		
	40 Proper ear position—Adult: up, back, out.		
Nose	41 Inspection with light source	**Boggy turbinates/clear nasal discharge**	
Throat	42 Inspection with light source and tongue blade	**Clear postnasal drip present**	
Lymphatics	43 Palpation of cervical nodes	**No cervical adenopathy**	
Respiratory	44 Auscultation performed on bare skin	**Clear to auscultation**	
	45 Through complete inspiration and expiration		
	46 Symmetrically		
	47 At least 2 anterior levels, 1 lateral, and 3 posterior		
Cardiac	48 Auscultation performed on bare skin	**RR without murmurs, rubs, or gallops**	
	49 Areas: aortic, pulmonic, tricuspid, and mitral		
Assessment	50 Presents patient with a proposed diagnosis (environmental allergies).		
Plan	51 MTHR: Antihistamine, allergy testing, holistic, smoking cessation, contact avoidance.		
(MOTHRR)	52 Explains and offers OMM.		
	53 Performs OMM appropriately (no HVLA).		
	54 Return plan: Devises and explains a follow-up plan with the patient.		
	55 Thanks the patient and asks if there are any questions.		

Humanistic Evaluation	Y/N
Did the candidate present in a self-caring manner (e.g., hair control, clothing, cleanliness, aroma, etc.)?	
Did the candidate make periodic eye contact?	
Was the candidate's language clear and EASY to understand?	
Did the candidate have any substance in his or her mouth during the session?	
Did the candidate exhibit body language that would make you feel the candidate was communicating with you?	
Was the candidate enthusiastic?	
Did the candidate exhibit pride in his or her efforts?	
Did the candidate make any comment regarding your lifestyle (e.g., your work, family, activities, etc.)?	
Did the candidate express any humanistic statement recognizing your concerns?	
Did the candidate explain the medical problem and offer you a possible diagnosis?	
Did the candidate suggest a treatment plan that you could understand?	
Did the candidate inquire whether you might want to consult with family members or others about your visit?	
Did the candidate present as if he or she were a competent interviewer?	
Did the candidate ask you if you had any questions?	
Did the candidate thank you?	

Sample SOAP Note Provided for Case 1

Subjective 8/11/2009 0930

CC: Runny Nose

Miss Rieno, an 18 y/o Caucasian female presents with a clear, continuous runny nose that has occurred for the last several years, but that has worsened over the last month. She states the discharge is worse in the spring and fall, but "really never goes away." She has attempted relief with Benadryl a couple times a week, taking two tablets of unknown milligrams with some relief, but admits associated drowsiness. She admits itchy, watery eyes; nasal congestion; and a scratchy throat. She denies cephalgia, ear pain, fever, or cough.

Social History: Tobacco: - 1/2 ppd × 2–3 years
Alcohol: denies
Drugs: denies
Occupation: student

Family History: Father with history of allergies

FDLMP - 1 week ago

Medications: Benadryl prn as above

Medical history: None

Allergies: environmental—cats

Surgeries: none

Hospitalizations: none

Objective

Vitals: BP 110/60, Resp 14, Pulse 68 bpm, Temp 98.2, Wt 168 lb, Ht 5' 11"

General: WDWN in NAD

HEENT: Sinuses: mild maxillary tenderness b/l
Eyes: infraorbital venous pooling. No periorbital edema
Ears: TM's gray b/l with good light reflex
Nose: mucosa pale with boggy turbinates and clear exudate
Throat: mild clear postnasal drainage

Neck: No lymphadenopathy

Lungs: Clear to auscultation

Heart: Reg rhythm without murmur, rub, or gallop

Assessment

1) Allergic rhinitis
2) Doubt viral rhinosinusitis
3) Doubt bacterial rhinosinusitis
4) Tobacco use disorder exacerbating rhinitis

Plan

1) Histamine antagonist—Cetirizine 5 mg PO daily
2) OMM—sinus drainage technique applied
3) Consider allergy testing. Contact avoidance counseling
4) Provided smoking cessation counseling and offered cessation assistance
5) Return to office in 2 weeks

Lyncean Ung OMS-IV

Case 2

Patient Name: Harmon Hertz
Clinical Setting: Family Practice Office
CC: A 45 y/o male presents for "shoulder pain."

Vital Signs
Blood pressure: 118/75
Respirations: 14 per minute
Temperature: 98°F
Pulse: 88 bpm
Weight: 175 lbs
Height: 5'11"

NOTES:

Subjective

Objective

Assessment

Plan

CC: A 45 y/o male presents for "shoulder pain."

History				✓
	1	Introduces self and explains role of provider.		
	2	Properly washes hands before touching the patient (15-sec wash and turns off with towel).		
	3	Opening question: What brings you in today?	My left shoulder really hurts.	
Chronology/ Onset	4	**When** did this start?	About 2 months ago.	
	5	Did you ever have this **before**?	No.	
	6	What are you **doing** when it happens?	It started after I painted my house.	
	7	Did it come on **suddenly or gradually**?	Gradually.	
Description	8	Could you **describe it**?	It's achy and stiff.	
	9	**Where** is it located?	On the outside of my left shoulder.	
	10	Does it **radiate/go** anywhere?	No.	
Duration	11	**Does it come and go** or is it **continuous**?	It hurts all the time.	
Intensity	12	How severe is it, on a scale from **1 to 10**?	A 6.	
Exacerbation	13	Does anything make it **worse**?	When I try to raise my arm, it's worse.	
Remission	14	What makes it **better**?	Keeping still and aspirin.	
	15	**How much** aspirin do you take?	650 milligrams	
	16	**How often** do you take it?	Two or three times a day.	
Symptoms associated	17	**Fever or chills**?	No.	
	18	**Other joint pain**?	No.	
	19	**Weakness**?	I just can't lift it because of the pain.	
	20	**Numbness or tingling**?	No.	
	21	**Chest pain**?	No.	
	22	**Shortness of breath**?	No.	
	23	**Cough**?	No.	
Social Hx	24	What does your **diet** look like?	I watch the sweets.	
(FED TACOS)	25	Do you **exercise** using your arm?	Not really. Just with my job.	
	26	Do you use any **drugs**?	No.	
	27	Do you use **tobacco**?	No.	
	28	Do you drink **alcohol**?	Yes.	
	29	**How much** a day?	Just a couple beers a week.	
	30	Do you drink **caffeine**?	Two cups of coffee in the morning.	
	31	What is your **occupation**?	I deliver newspapers.	
Medical Hx	32	Do you have any medical conditions?	A touch of diabetes.	
Allergies	33	Do you have any allergies?	No.	
Surg Hx	34	Have you had any surgeries?	No.	
Hosp Hx	35	Have you ever been hospitalized?	No.	
Family Hx	36	Medical conditions that run in the family?	Diabetes runs in the family.	
Medications	37	Are you on any medications?	No. My diabetes is controlled by diet.	

Physical Examination ✓

	38 Informs patient that the physical exam is to begin and asks permission.		
	39 Rewashes hands before touching patient if candidate has recontaminated them.		
Neck	40 Inspection	**Symmetrical**	
	41 Active range of motion	**Full AROM**	
	42 Palpation	**Nontender to palpation**	
Respiratory	43 Auscultation performed on bare skin	**Clear to auscultation**	
	44 Through complete inspiration and expiration		
	45 Symmetrically		
	46 At least 2 anterior levels, 1 lateral, and 3 posterior		
Cardiac	47 Auscultation performed on bare skin	**RR without murmurs, rubs, gallops**	
	48 Areas: aortic, pulmonic, tricuspid, and mitral		
MS	49 Inspection of bilateral shoulders	**No erythema, ecchymosis, deformity**	
	50 Active ROM b/l shoulders, elbows	**L shoulder limited to 90 degrees abd**	
	51 Passive range of motion for limited R shoulder	**L shoulder is limited to 90 degrees**	
	52 Palpation of bilateral shoulders	**No point tenderness**	
Vascular	53 Brachial and radial pulses compared bilaterally	**2/4 b/l**	
Neurologic	54 Motor: Strength testing with b/l comparison	**Patient hesitant secondary to pain**	
	55 Sensory to sharp/dull, light touch	**Intact**	
	56 Reflexes—b/l upper extremity	**2/4 bicep, triceps, brachioradialis**	
Special Testing	57 Arm drop test	**Negative**	
Assessment	58 Presents patient with a proposed diagnosis.	**Adhesive capsulitis, r/o rotator cuff inj**	
Plan	59 MTHR: Pain control, shoulder X-ray, holistic (RICE), referral		
(MOTHRR)	60 Explains and offers OMM.		
	61 Performs OMM appropriately (no HVLA).		
	62 Return plan: Devises and explains a follow-up plan with the patient.		
	63 Thanks the patient and asks if there are any questions.		

Humanistic Evaluation Y/N

Did the candidate present in a self-caring manner (e.g., hair control, clothing, cleanliness, aroma, etc.)?	
Did the candidate make periodic eye contact?	
Was the candidate's language clear and EASY to understand?	
Did the candidate have any substance in his or her mouth during the session?	
Did the candidate exhibit body language that would make you feel the candidate was communicating with you?	
Was the candidate enthusiastic?	
Did the candidate exhibit pride in his or her efforts?	
Did the candidate make any comment regarding your lifestyle (e.g., your work, family, activities, etc.)?	
Did the candidate express any humanistic statement recognizing your concerns?	
Did the candidate explain the medical problem and offer you a possible diagnosis?	
Did the candidate suggest a treatment plan that you could understand?	
Did the candidate inquire whether you might want to consult with family members or others about your visit?	
Did the candidate present as if he or she were a competent interviewer?	
Did the candidate ask you if you had any questions?	
Did the candidate thank you?	

Sample SOAP Note Provided for Case 2

Subjective 8/22/2009 1450

CC: Left shoulder pain × 2 months

Mr. Hurtz, a 45 y/o male, presents with left should pain that began 2 months ago shortly after painting his house. No prior episodes of the same. Pain began gradually and is described as "achy and stiff." Patient locates pain on the outside of the left shoulder without radiation. It is continuous and is scaled at 6/10. Attempting to raise his arm makes the pain worse. He gets some relief with keeping the arm still and aspirin 650 mg 2 or 3 times a day. He denies fever, chills, weakness, numbness, tingling, chest pain, shortness of breath, or cough.

Social History:	**Diet: avoids sweets**	**Med history: diabetes—dietary control**
	Exercise: no regular routine	**Allergies: none**
	Drugs: denies	**Surgeries: none**
	Tobacco: denies	**Hospitalizations: none**
	Alcohol: 2–3 beers per week	**Family History: Diabetes**
	Caffeine: 2 cups of coffee a day	**Medications: Aspirin as above**
	Occupation: newspaper delivery	

Objective

Vitals: BP 118/75, Resp 14, Pulse 88 bpm, Temp 98, Wt 175 lb, Ht 5' 11"
General: WDWN in NAD

Neck:	**Symmetrical, full active range of motion, nontender to palpation**
Lungs:	**Clear to auscultation**
Heart:	**Reg rhythm without murmur, rub, or gallop**
MS:	**Bilateral shoulders without erythema, ecchymosis, or deformity. Right shoulder active and passive abduction limited to 90 degrees. Palpation without point tenderness. Arm drop test negative**
Vascular:	**Brachial and radial pulses 2/4 bilaterally**
Neuro:	**Patient unable to perform left shoulder strength testing because of apprehension** **Bilateral upper extremities sensory intact to sharp/dull and light touch** **Reflexes 2/4 brachial, radial and brachioradialis bilaterally**

Assessment

1) Adhesive capsulitis
2) Somatic dysfunction
3) Rule out arthritis
4) Doubt rotator cuff injury
5) Doubt ACS but with risk factors
6) Diabetes

Plan

1) Ibuprofen 600 mg three times a day with food × 5 days
2) OMM—Spencer technique performed
3) Left shoulder X-ray, EKG, CBC, Bun/creat, Hgb A1c
4) Instructed on ROM exercises. Offered work excuse; patient declined
5) Return to office in 5 days for follow-up and results

Jennifer Lin OMS-IV

Case 3

Patient Name: Ida Kno
Clinical Setting: Primary Care Outpatient Office Visit
CC: A 76 y/o female is brought into your office by her daughter for forgetfulness.

Vital Signs
Blood pressure: 158/88
Respirations: 12 per minute
Temperature: 98.8°F
Pulse: 72 bpm
Weight: 112 lbs
Height: 5'4"

NOTES:

Subjective

Objective

Assessment

Plan

CC: A 76 y/o female is brought into your office by her daughter for forgetfulness.
Daughter answered the majority of the questions (mother's answers are in bold type)

History			✓
	1 Introduces self and explains role of provider.		
	2 Properly washes hands before touching the patient (15-sec wash and turns off with towel).		
	3 Opening question: What brings you in today?	**My daughter**. (Daughter answers, "Mom's getting forgetful.")	
Chronology/ Onset	4 When did this **start**?	At least a year or more ago.	
	5 How has it **changed**?	It's getting worse.	
Description	6 **Describe** or give an **example** of the forgetfulness.	She can never find things.	
Intensity	7 How has it affected her **activities of daily living**?	I have to take her everywhere.	
Exacerbations	8 Does anything make this **worse**?	Not that I've noticed.	
Remissions	9 Does anything make this **better**?	She seems better in the mornings.	
Symptoms associated	10 **Slurred speech, facial droop**?	She can't find the right words.	
	11 **Numbness/tingling/weakness**?	No.	
	12 **Fever or chills**?	No.	
	13 Has she **fallen** or **hurt** herself?	No.	
	14 **Anxiety**?	Yes, she's so restless.	
	15 **Depression**?	She seems down all the time.	
	16 **Sleeping**?	She's up a lot throughout the night.	
Social Hx	17 **Appetite**?	We have to remind her to eat.	
	18 Do you **smoke**?	**No**.	
	19 Do you drink **alcohol**?	**No**.	
	20 **Caffeine**?	**I like tea**.	
	21 What is her **occupation**?	She stayed at home and raised us.	
Medical Hx	22 Does she have any medical conditions?	She has arthritis.	
Allergies	23 Does she have any allergies?	No.	
Surgical Hx	24 Has she had any surgeries?	No.	
Hosp Hx	25 Has she ever been hospitalized?	No.	
Family Hx	26 Medical conditions that run in the family?	Her mother didn't know us in the end.	
Medications	27 Is she on any medications?	She takes arthritis medicine.	
	28 Do you know the name?	No, I don't.	

Physical Examination			✓
	29 Informs patient that the physical exam is to begin and asks permission.		
	30 Rewashes hand before touching patient if candidate has recontaminated them.		
Vitals	31 Repeats BP with correct technique.	**BP 150/68**	
	32 Appropriate size cuff		
	33 Applied correctly placing cuff on bare arm		
General	34 General assessment	**Alert, no apparent distress, thin**	
Neurologic	35 Cranial nerves	**CN II–XII intact**	
	36 Muscle strength: B/l upper and lower extremities	**5/5 throughout**	
	37 Sensation: Sharp/dull b/l upper/lower extremities	**Intact throughout**	
	38 Reflexes: bilateral upper and lower extremities	**3/4 R arm/leg and 2/4 L arm/leg**	
	39 Babinski's	**Up going right, down going left**	
	40 Cerebellar function: Romberg, Finger/nose, RAM	**Intact**	
Neck	41 Auscultation for bruits	**Left carotid bruit**	
	42 Palpation of thyroid	**No thyromegaly**	
Respiratory	43 Auscultation performed on bare skin	**Clear to auscultation**	
	44 Through complete inspiration and expiration		
	45 Symmetrically		
	46 At least 2 anterior levels, 1 lateral, and 3 posterior		
Cardiac	47 Auscultation performed on bare skin	**RR without murmurs, rubs, gallops**	
	48 Areas: aortic, pulmonic, tricuspid, and mitral		
Mental Status	49 Assesses orientation.	**Oriented to person only**	
Assessment	50 Presents patient/family with a proposed diagnosis.	**Dementia**	
Plan	51 MTHR: Testing (CT scan, carotid ultrasound, labs), holistic (agency resources), MMSE		
(MOTHRR)	52 Return plan: Devises and explains a follow-up plan with the patient and family.		
	53 Thanks the patient and asks if there are any questions.		

Humanistic Evaluation	Y/N
Did the candidate present in a self-caring manner (e.g., hair control, clothing, cleanliness, aroma, etc.)?	
Did the candidate make periodic eye contact?	
Was the candidate's language clear and EASY to understand?	
Did the candidate have any substance in his or her mouth during the session?	
Did the candidate exhibit body language that would make you feel the candidate was communicating with you?	
Was the candidate enthusiastic?	
Did the candidate exhibit pride in his or her efforts?	
Did the candidate make any comment regarding your lifestyle (e.g., your work, family, activities, etc.)?	
Did the candidate express any humanistic statement recognizing your concerns?	
Did the candidate explain the medical problem and offer you a possible diagnosis?	
Did the candidate suggest a treatment plan that you could understand?	
Did the candidate inquire whether you might want to consult with family members or others about your visit?	
Did the candidate present as if he or she were a competent interviewer?	
Did the candidate ask you if you had any questions?	
Did the candidate thank you?	

Case 4

Patient Name: Ness Tinter
Clinical Setting: Primary Care Outpatient Office Visit
CC: A 26 y/o female presents c/o foot pain.

Vital Signs
Blood pressure: 112/58
Respirations: 12 per minute
Temperature: 98.8°F
Pulse: 72 bpm
Weight: 124 lbs
Height: 5'4"

NOTES:

Subjective

Objective

Assessment

Plan

CC: A 26 y/o female presents c/o foot pain.

History			✓
	1 Introduces self and explains role of provider.		
	2 Properly washes hands before touching the patient (15-sec wash and turns off with towel).		
	3 Opening question: What brings you in today?	I hurt my ankle.	
Onset	4 **When** did it happen?	Yesterday.	
	5 **How/what** were you **doing** at the time?	I stepped off a curb and twisted it.	
Chronology	6 Has this ever happened **before**?	Yes. This is probably the third time.	
	7 **When**?	I twisted it the first time 6 years ago.	
	8 **How was it treated**?	My doctor tells me to take ibuprofen. They usually wrap it. I've also been to physical therapy twice.	
Description/ Duration	9 **Where** is the pain?	The outside of my right ankle.	
	10 **Describe** the pain.	It's sharp.	
Intensity	11 How severe is it, on a scale from **1 to 10**?	About a 5.	
Exacerbation	12 What makes it **worse**?	Trying to walk on it.	
Remission	13 What makes it **better**?	Ibuprofen helps.	
	14 **How much** did you take?	600 mg.	
	15 How **often** are you taking it?	Every 3 hours.	
Symptoms associated	16 Any **bruising**?	Yes.	
	17 Any **swelling**?	It was swollen last night.	
	18 **Numbness or tingling**?	Maybe a little along the side.	
Social Hx	19 Do you **smoke or use tobacco**?	Yes.	
(FED TACOS)	20 **How much** a day?	About 5 cigarettes a day.	
	21 For **how long**?	About 5 years.	
	22 Do you drink **alcohol**?	No.	
	23 What is your **occupation**?	I'm in grad school and waitress at night.	
	24 **FDLMP**?	About a week ago.	
Medical Hx	25 Do you have any medical conditions?	I have reflux.	
Allergies	26 Do you have any allergies?	No.	
Surgical Hx	27 Have you had any surgeries?	No.	
Hosp Hx	28 Have you ever been hospitalized?	No.	
Family Hx	29 Medical conditions that run in the family?	High cholesterol.	
Medications	30 Are you on any medications?	Zantac.	
	31 How much?	Once a day	
	32 How many milligrams?	I'm not sure.	

Physical Examination ✓

	33 Informs patient that the physical exam is to begin and asks permission.		
	34 Rewashes hand before touching patient if candidate has recontaminated them.		
MS	35 Covers patient with a sheet from waist down.		
	36 Raises sheet to expose bilateral lower extremities.		
	37 Inspection of right ankle	**Ecchymosis inferior lateral malleolus**	
	38 Comparison to left ankle		
	39 Active range of motion right ankle	**Limited inversion**	
	40 Passive range of motion	**Limited inversion due to pain**.	
	41 Palpation	**Tenderness R lat ligament complex**	
Neurologic	42 Sensory exam light touch or sharp vs. dull	**Intact**	
Vascular	43 Peripheral pulses	**Intact**	
Position change	44 Helps patient with position change to standing.		
	45 Assess gait.	**Patient walks with limp on right**.	
Assessment	46 Presents patient with a proposed diagnosis.	**Achilles injury, sprain, or rupture**	
Plan	47 MTHR: Pain control (reduce ibuprofen), testing, holistic (RICE), referral		
(MOTHRR)	48 Explains and offers OMM.		
	49 Performs OMM appropriately (no HVLA).		
	50 Return plan: Devises and explains a follow-up plan with the patient.		
	51 Thanks the patient and asks the patient if she has any questions.		

Humanistic Evaluation Y/N

Did the candidate present in a self-caring manner (e.g., hair control, clothing, cleanliness, aroma, etc.)?	
Did the candidate make periodic eye contact?	
Was the candidate's language clear and EASY to understand?	
Did the candidate have any substance in his or her mouth during the session?	
Did the candidate exhibit body language that would make you feel the candidate was communicating with you?	
Was the candidate enthusiastic?	
Did the candidate exhibit pride in his or her efforts?	
Did the candidate make any comment regarding your lifestyle (e.g., your work, family, activities, etc.)?	
Did the candidate express any humanistic statement recognizing your concerns?	
Did the candidate explain the medical problem and offer you a possible diagnosis?	
Did the candidate suggest a treatment plan that you could understand?	
Did the candidate inquire whether you might want to consult with family members or others about your visit?	
Did the candidate present as if he or she were a competent interviewer?	
Did the candidate ask you if you had any questions?	
Did the candidate thank you?	

Case 5

Patient Name: Chester Paine
Clinical Setting: Emergency Room
CC: A 62 y/o Caucasian male presents with chest pain.

Vital Signs
Blood pressure: 180/104
Respirations: 20 per minute
Temperature: 97.9°F
Pulse: 88 bpm
Weight: 230 lbs
Height: 6'1"

NOTES:

Subjective

Objective

Assessment

Plan

CC: A 62 y/o Caucasian male presents with chest pain.

History			✓
	1 Introduces self and explains role of provider.		
	2 Properly washes hands before touching the patient (15-sec wash and turns off with towel).		
	3 Opening question: What brings you in today?	I was having chest pain.	
Chronology/ Onset	4 When did it **start**?	An hour ago.	
	5 Was the onset **sudden** or **gradual**?	Sudden.	
	6 What were you **doing when it started**?	Walking around the block.	
Duration	7 How **long** did the pain **last**?	Twenty minutes.	
	8 Did you ever have this **before**?	Yes.	
	9 When?	All last year . . . whenever I walk my dog.	
	10 How long does the pain **usually last**?	Three to 4 minutes.	
	11 Has it **changed in any way**?	I can't even walk a block anymore.	
Description	12 **Describe** the pain.	Sharp, aching, deep.	
	13 **Where** is the pain?	*Points just above the xiphoid process*	
	14 Does it **radiate/go** anywhere?	No.	
Intensity	15 How severe is it, on a scale from **1 to 10**?	It was a 7 or 8.	
Exacerbation	16 What makes it **worse**?	Well, anytime I overexert myself really.	
	17 Have you ever had this pain **at rest**?	Just in the past month or so.	
Remission	18 What makes it **better**?	Resting for a few minutes usually works.	
Symptoms associated	19 **Sweating**?	Sometimes, but just on my face.	
	20 **Nausea or vomiting**?	No.	
	21 **Shortness of breath**?	Only a little. Just when I get the pain.	
	22 **Dyspepsia**?	No.	
	23 **Cough**?	No.	
Social Hx	24 What does your **diet** look like?	I eat whatever I want.	
(FED TACOS)	25 Do you **exercise**?	Just walking the dog.	
	26 Do you **smoke**?	Yes.	
	27 **How much** do you smoke a day?	Two packs a day.	
	28 **How long** have you been smoking?	Twenty-five years.	
	29 Do you drink **alcohol**?	Yes.	
	30 How many drinks a day?	Two to 3 beers a day.	
	31 Do you use any **drugs**?	Ah, come on, Doc.	
	32 What is your **occupation**?	I'm an architect.	
Medical Hx	33 Do you have any medical conditions?	My blood pressure and cholesterol are high.	
Allergies	34 Do you have any allergies?	No.	
Surg Hx	35 Have you had any surgeries?	No.	
Hosp Hx	36 Have you ever been hospitalized?	No.	
Family Hx	37 Medical conditions that run in the family?	My parents had heart attacks in their 50s.	
Medications	38 Are you on any medications?	Hydrochlorothiazide and lovastatin.	
	39 Do you know the doses?	No.	
	40 How many times a day do you take each?	I just take one of each once a day.	

Physical Examination			✓
	41 Informs patient that the physical exam is to begin and asks permission.		
	42 Rewashes hand before touching patient if candidate has recontaminated them.		
Vitals	43 Repeats BP with correct technique.	**BP 176/96**	
	44 Appropriate size cuff		
	45 Applied correctly placing cuff on bare arm		
General	46 Assess for **distress**.	**No apparent distress**	
Neck	47 Assess for **JVD**.	**No JVD**	
	48 Auscultation for carotid bruit.	**No bruit**	
Cardiac	49 Inspection: properly exposes the chest	**No heave or visible PMI**	
	50 Auscultation performed on bare skin	**Reg rhythm w/o murmur, rub, or gallop**	
	51 Areas: aortic, pulmonic, tricuspid, and mitral		
	52 Palpation for PMI	**Anterior axillary line 5th ICS**	
Respiratory	53 Auscultation performed on bare skin	**Clear to auscultation**	
	54 Through complete inspiration and expiration		
	55 Symmetrically		
	56 At least 2 anterior levels, 1 lateral, and 3 posterior		
Abdominal	57 Helps patient with position changes.		
	58 Covers lower extremities with a sheet during the exam.		
	59 Inspection: properly exposes the abdomen	**No masses**	
	60 Auscultation prior to palpation	**NABS without bruit**	
	61 Palpation of size of abdominal aorta	**No pulsitile masses**	
Assessment	62 Presents patient with a proposed diagnosis.	**Angina**	
Plan	63 MTHR: Aspirin, beta blocker, X-ray, ECG, labs, referral		
(MOTHRR)	64 Advises admission and cardiac evaluation.		
	65 Thanks the patient and asks if there are any questions.		

Humanistic Evaluation	Y/N
Did the candidate present in a self-caring manner (e.g., hair control, clothing, cleanliness, aroma, etc.)?	
Did the candidate make periodic eye contact?	
Was the candidate's language clear and EASY to understand?	
Did the candidate have any substance in his or her mouth during the session?	
Did the candidate exhibit body language that would make you feel the candidate was communicating with you?	
Was the candidate enthusiastic?	
Did the candidate exhibit pride in his or her efforts?	
Did the candidate make any comment regarding your lifestyle (e.g., your work, family, activities, etc.)?	
Did the candidate express any humanistic statement recognizing your concerns?	
Did the candidate explain the medical problem and offer you a possible diagnosis?	
Did the candidate suggest a treatment plan that you could understand?	
Did the candidate inquire whether you might want to consult with family members or others about your visit?	
Did the candidate present as if he or she were a competent interviewer?	
Did the candidate ask you if you had any questions?	
Did the candidate thank you?	