Chapter 3

Documentation Strategies

Functions of Documentation

Documentation is a critical step in the health assessment process. The healthcare provider can perform an excellent examination; however, the documentation that follows determines the worth of the examination. The documentation of the patient–provider encounter not only provides the background necessary for follow-up with the patient but it also serves as a legal account of the patient–provider interaction and subsequent interactions. If the documentation just indicates that the healthcare provider found "no problems," it is unclear to the next provider what areas were truly assessed and what questions were asked. For example, if a history of the respiratory system is taken but the documentation merely states "no problems," it is unclear to the next healthcare provider, or to a person performing a legal review of the chart, if the patient has been successfully queried about tuberculosis, chronic obstructive pulmonary disease, asthma, or sleep apnea. It also fails to provide sufficient data to justify the cost of any specific tests or treatments that require third-party reimbursement. From a more practical perspective, giving a more detailed list of the items or questions reviewed with the patient also provides documentation for the provider himself, and it facilitates management of the patient in future encounters (**Figure 3-1**). Once a provider has documented specifics about the past medical history, he does not need to repeat the same questions in future encounters. Instead, the provider is able to focus on any changes in the history since the last appointment. This facilitates continuity of care and helps the patient to feel that her past history is well known and her current needs are being met.

General Considerations

As a healthcare provider begins to document the history and physical examination, it is important to keep some simple strategies in mind. If a preprinted (check-off) form is being used, it is appropriate to fill out the form while interviewing or examining the patient. Be sure to record vital signs as you take them and do not rely on your memory. Also remember the basic rule: If the examiner forgets to assess anything in the history or physical, he or she can come back to it later in the process, but the examiner must only record data that he or she has truly obtained. If the provider is using an open format, or a nonprinted form, it is helpful to take detailed notes while assessing the patient and then combine and transfer the notes into formal written format as soon as possible (**Figure 3-2**). Again, if any assessment parameters

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FIGURE 3-1 The healthcare provider listens to a patient's history of present illness, documenting pertinent data.

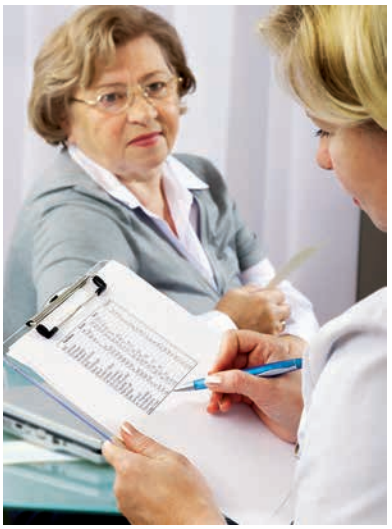

FIGURE 3-2 The healthcare provider takes brief notes during the interview.

have been omitted in either the history or the physical, it is appropriate to indicate "not assessed"; be sure not to fabricate any findings or data. Instead, make a note in the plan of care of additional areas that need to be covered during the next appointment. For example, if one forgets to assess the thyroid and the patient's chief complaint includes fatigue, then it would be appropriate to make a notation in the plan that the thyroid should be assessed and a thyroid-stimulating hormone (TSH) level drawn at the next encounter.

Although accuracy is foremost in each provider's mind when performing a history and physical examination, speed of documentation is also important. One strategy that ensures both accuracy and speed is the use of drawings. Frequently, healthcare providers use a stick figure to document pulses and deep tendon reflexes (**Figure 3-3**) and use an anatomical drawing of the body or a body part to document the size and location of skin lesions, rashes, or wounds. In many institutions both the stick figures and anatomical drawings of the body are already on the preprinted forms, whereas in other institutions, the provider must draw each item. The goal is to provide the best "picture" of the patient's condition, either in written format or with a drawing, in order to serve as a comparison for future assessments.

In the documentation process, it is important to only use standard abbreviations. Institutions will have different policies about the use of abbreviations. One institution may severely restrict the use of abbreviations, especially if it has found that the abbreviations have led to medication or treatment errors. Therefore, each provider should check with her specific institution to determine which abbreviations are acceptable. As a reference, both commonly used abbreviations and symbols can be found in many medical dictionaries. Although abbreviations facilitate the speed of recording the history and physical examination, remember that the data and information need to be recorded in such a manner that others reading the write-up can clearly understand the information presented.

Although many methods of documentation are available, such as direct computer written reports, each new method provides potentially new concerns. As of April 2003, federal guidelines, called the Health Insurance Portability and Accountability Act (HIPAA), have been implemented to restrict the sharing of patient information, either direct or indirectly. Although data can easily be recorded directly into an institution's computer database, this process places an added responsibility upon the provider that computer screens are not left unattended, where patient data can be seen or reviewed by unauthorized individuals. The new guidelines also regulate with whom a provider can share patient information. In addition, HIPAA regulations require the patient to provide consent for his medication information to be disclosed to other individuals. The challenge for the provider is to write an appropriate record of the history and physical examination, using the latest technology available without violating the patient's right to confidentiality. The use of e-mail and faxes to share patient information poses an additional problem. Most institutions advise that a disclaimer be inserted at the bottom of any patient-related communication that indicates that the following information is confidential. For example, if information needs to be shared electronically, the following disclaimer may be used:

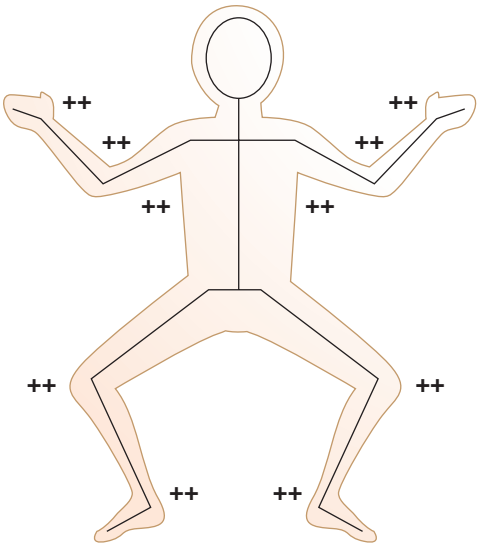

FIGURE 3-3 A stick figure can be used to document deep tendon reflexes. 0, no response; 1+, sluggish; 2+, expected response; 3+, slightly hyperactive; 4+, hyperactive.

> HIPAA Notice: The information transmitted within this email or in any attached documents is intended solely for the individual or entity to which it is addressed. That information may contain confidential and/or privileged material. If you believe you have received this email in error, please immediately contact the sender and delete the material from your system.

SOAP Approach

The most common approach for documenting a history and physical is the SOAP format. The SOAP format stands for Subjective data, Objective data, Assessment, and Plan. In documenting the history and physical examination, you should remember that the **Subjective** section includes any information or facts that the patient presents or that the chart provides. Standard sections within the Subjective section include chief complaint, history of present illness, past medical history, medications, allergies, last menstrual period for women, family history, social history, nutritional assessment, and the review of systems. The **Objective** section consists of data and information obtained by the examiner with his or her eyes, ears, and hands. If obtained at the time of the examination or immediately afterwards, laboratory findings and diagnostic test results are also recorded in the Objective section. Previous test results belong in either the history of present illness or in the review of systems. **Assessment** refers to the final assessment; it pulls together the findings presented in the subjective and objective sections to form a diagnosis. The **Plan** outlines the treatment plan related to the chief complaint, current comorbidities, and/or additional problems that have become evident during the examination. (For further explanation of subjective and objective data, see Box 1-1 in Chapter 1.)

Two broad subclassifications of the SOAP format are a comprehensive health history and physical examination and a focused, or episodic, health history and physical examination. Both a comprehensive and focused history and physical use the same format, but the extent of the information obtained varies. (See Chapter 1 for a detailed description of the components of each type of history.) The reason for the patient's visit and the extent of the illness dictate which approach is used. If a patient is presenting to the healthcare provider for a specific problem, such as a sore throat, then a focused history and physical is completed. If a patient presents for an annual physical examination or is a new patient, then the provider should use a comprehensive format, which explores all the systems. Part of the role of the healthcare provider is to determine which SOAP format is to be used, what questions are pertinent to explore, and how the data can be integrated into an appropriate list of diagnoses, differential diagnoses, and problems. This organization of data presents the stepping stone for the next phase, the development of the treatment plan or plan of care.

Documentation Tips

Each component of the health history contains information that is important for making diagnosis and treatment decisions (for more information, see Chapter 1). Just as the right questions must be asked, the right data must be documented. This section provides tips for ensuring proper documentation. There are a number of different formats that can be used for documentation, including a preprinted form that requires checking off the correct box and an open format in which no preprinted information appears. Both systems have advantages and disadvantages. The preprinted formats are easy and quick to use. They help to ensure that all the desired areas are assessed, and they eliminate the struggle over wording. However, the preprinted forms frequently limit the amount of extra information that can be added, so in some cases when positive findings are obtained, it is difficult to individualize the form to accurately document the data. On the other hand, the open format is similar to a blank page, where no headings or prompts are included. With the open format, the provider can include as much information as she or he wishes; however, a provider may fail to include all the necessary data because prompts or choices were not provided. In addition, the open format is more time consuming because each provider must individually write each finding in the history and physical examination, and word selection may become an issue.

Whether you are using a "check-off" format or an open format, it is important that each system is covered completely and the data accurately reflect both what the patient stated and the provider's physical findings. Note that frequently the patient will provide additional information scattered throughout the examination process. It is important for the documentation process that the subjective information, the information the patient tells you, is properly recorded in the subjective component of the write-up, and that any physical findings that the provider finds are documented in the objective

component. It is also important to accurately listen to the information the patient is providing, and then document the information in the most accurate medical terminology possible. Usually only the chief complaint is provided as a direct patient quote. For example the patient may state that she or he had a "heart attack," but the provider's documentation should indicate the patient had a myocardial infarction. Also with respect to the physical examination, it is important to realize that the examination itself is performed region by region, or area of the body by area of the body, but the data are documented according to systems. For example, when examining the neck, assess the thyroid and the carotid arteries. However, documentation of the thyroid occurs under the system heading "endocrine," and carotid artery findings are documented under "cardiac" or "cardiovascular."

Subjective Data

Patient Identifiers and Chief Complaint

The provider should first document patient identifiers, including the patient's name, date of birth, and the date and time of examination. This is followed by the "chief complaint." The chief complaint must be expressed in the patient's own words and is written in quotation marks. For example, if a patient presents to a clinic with a chief complaint of abdominal pain and expresses it as "my stomach is killing me," then the phrase "my stomach is killing me" is documented in the chief complaint. Documenting the patient's chief complaint in his or her own words serves to highlight the patient's reason for presenting to the healthcare facility.

History of Present Illness

Along with the chief complaint, the history of present illness is documented. The history of present illness (HPI) is a concise description of the patient's recent history. The opening sentence should contain key pertinent data that both the provider and any other healthcare professional should know, including age, gender, and significant comorbidities. For example, if the patient presents with a chief complaint of a "lump in her breast" and is 10 weeks' pregnant, the opening sentence of the history of present illness should state "a 26-year-old female who is 10 weeks pregnant presents with a recent history of a lump in the upper outer quadrant of her left breast." This information alerts the provider and all other healthcare workers that the patient is pregnant, a key factor that must be considered when developing the patient's treatment plan. If in fact this patient has breast cancer, then the typical treatment guidelines for breast cancer will need to be altered. The patient will not be a candidate for any treatment or medication that would be harmful to the fetus. Failure to document this information would have significant legal implications.

Once the opening sentence is developed, the clinician then documents the patient's presenting signs and symptoms. For each sign or symptom, the clinician should fully explore each topic by asking pertinent questions using the mnemonic PQRST or CLIENT OUTCOMES, as discussed in Chapter 1. These are important factors that guide this patient's plan of care and help to identify future teaching needs.

If a patient describes more than one sign or symptom, each one should be explored. For example, if the patient states that she has a severe headache as well as nausea and vomiting, each component needs to be described or explored in depth. The clinician never wants to make the assumption that the signs and symptoms are related. The headache may be a long-term problem that the patient always has, but the nausea and vomiting may be a new onset.

For situations in which the patient has an extensive recent history, such as a trauma patient admitted into the hospital, the key pertinent data are summarized in the history of present illness, so all healthcare providers who are involved in the patient's care understand what has happened to the patient, and what treatment modalities have already been implemented. In addition, all recent diagnostic tests, along with the outcome of any intervention taken during this recent hospitalization should be summarized. For example, if a patient is intubated in the emergency room, the practitioner should record whether the initial intubation effort was successful, what size tube was inserted, where

the ET tube markings are in relationship to the patient's lips, and what was suctioned from the lungs. If it was a traumatic intubation, this should be documented in an effort to alert other healthcare workers that the patient may have bloody oral secretions as well as hemoptysis. It also alerts others that the patient may develop laryngeal edema upon extubation.

The history of present illness should include any pertinent recent test results and test dates. For example, if a patient presents with chest pain but indicates that he had a negative stress test 2 weeks ago, these data should be incorporated into the history of present illness, as they have a direct bearing on the patient's chief complaint. However, if the same patient presents for evaluation of hematuria, then a recent stress test result should be incorporated into the past medical history. Test results should be summarized, providing other healthcare workers, physicians, nurses, and other practitioners with an overview of results and indications. The history of present illness should not be a repetition of the formal diagnostic reports. Dates also help other healthcare workers understand previous occurrences, but it is important to summarize the information in the history of present illness and not just list the dates in a bulleted format. Thus, the history of present illness should be a concisely written paragraph (or paragraphs) that describes the patient's signs and symptoms and the course of events up until the present encounter. A guiding rule of thumb is to consider the record to cost "a dollar a word"; hence it is important to be concise, but also to be accurate and document all pertinent data. The key for the novice provider is to determine what is pertinent information and what is superficial information.

Past Medical History

Once the history of present illness is concisely documented, describe the patient's past medical history. The past medical history should include significant information about previous or current illnesses, hospitalizations, surgeries, injuries, immunizations, medications, and allergies (for a complete list, see Chapter 1). Also, document information about transfusions and any transfusion reactions, immunizations, and results of any screening examinations. When recording this information, it is important that dates, or approximate dates, are included in order to provide an accurate perspective of the patient's past history. For females, last menstrual period (LMP) should be documented. Although the history of present illness is written in paragraph form, the past medical history is typically presented as bulleted information with appropriate dates included. If a preprinted form is being used, it is important to add the appropriate dates and outcomes in addition to the finding itself. For example, if the patient has a history of hypertension (HTN), and the preprinted form has a selection for HTN, not only should HTN be checked, but it should indicate either the year it was diagnosed, or the number of years the patient has had the condition, and if the hypertension is well controlled. If the patient does not have allergies or if she or he is not taking any medications, it is important that the word "none" is listed beside the heading. This eliminates a question as to whether the clinician forgot to ask about allergies or medications.

Family History

Following the past medical history, the family history is documented. The family history should include pertinent negatives, as well as positive findings. Broad categories that are usually explored in this section include a family history of cancer, diabetes, cerebrovascular accidents, myocardial infarctions, and genetic defects. Within each of these categories it is appropriate to further explore positive findings. For example if a patient has a family history of cancer, the clinician should document the type of cancer and which family member. For cardiovascular diseases it is also appropriate to document the family member's age at the time of the event. For example, it makes a difference in terms of cardiovascular risk factors if a patient's father had a myocardial infarction at the age of 54 and died from it or whether the father had a myocardial infarction at the age of 84.

In some cases, a genogram may be included. The genogram provides a rapid way to condense the data and indicates whether immediate relatives are alive or have died, and what type of comorbidities each individual has or had. Symbols are used to represent family members when developing the genogram. An open circle refers to female relatives, an open square represents male relatives;

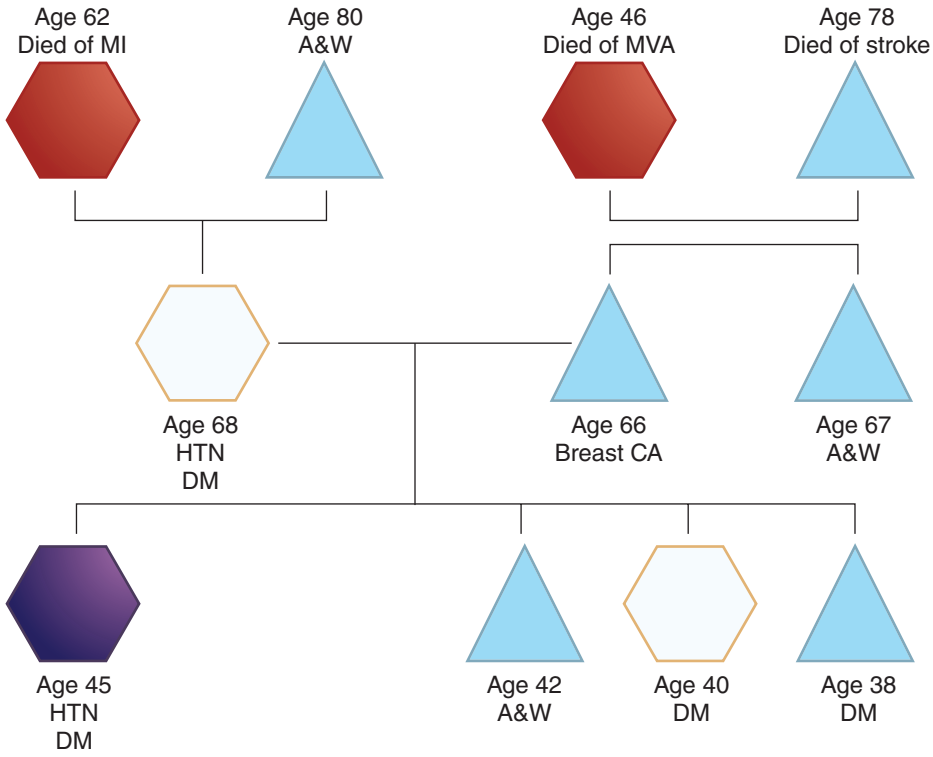

FIGURE 3-4 Genogram. This patient is a 45-year-old man who has hypertension (HTN) and diabetes mellitus (DM). He has three siblings: two sisters and a brother. One sister and his brother have DM. The patient's parents are alive. His father has HTN and DM and is 68 years old. His mother is 66 years old and has had breast cancer (CA). His aunt is age 67 and alive and well (A&W). Maternal grandparents are both dead. His grandfather died in a motor vehicle accident (MVA) at age 46, and his maternal grandmother died of a stroke at age 78. Paternal grandparents were divorced. His paternal grandfather died of a myocardial infarction (MI) at the age of 62, and his paternal grandmother is A&W.

if either the circle or square is colored in, it indicates that the individual is deceased. Lines are used to indicate both marriages and children, and a broken line indicates a divorce. In developing a genogram, it is important to indicate the patient's position within the genogram with an arrow. **Figure 3-4** depicts a genogram.

Social History

Following family history, the provider should document the patient's social history (SH), including the nutritional history. Social history should include the patient's marital status, highest level of education, and use of alcohol, tobacco, and recreational drugs (see Chapter 1 for a more inclusive list). Other items can be included such as sleep habits, exercise habits, and religious preference. In obtaining this information it is important to be concise and summarize the pertinent points in order to individualize the patient's plan of care. Hence, although a patient may exercise daily and do a number of different types of sports or exercises, a brief summary of the patient's exercise pattern is all that is needed. For example unless the patient is presenting for a sports-related injury, it is sufficient to state, "Patient exercises for 45 minutes three times per week." On the other hand, if the patient's history indicates that he has a limited income, poor housing, and no running water, these details belong in the written social history because they may have a direct impact on the patient's plan of care. Nutritional history can be documented as a summary statement, and does not need to include a 24-hour recall unless nutritional status is a pertinent problem for the patient. For example, if a patient is homeless and has an open wound that has been healing poorly, then a more complete

documentation of that patient's dietary intake may be appropriate in order to document her or his need for further assistance or social services.

Review of Systems

The next broad category under the subjective findings is the review of systems. Within each system, the clinician should document the data that were sought, including pertinent negatives. The term "no significant findings" or "negative" should be avoided. Such forms of documentation fail to provide any specific information as to what was asked or not asked. Also fully describe any positive findings. For example if the patient's chief complaint is a "cold," but the review of systems reveals he or she has a history of asthma, the clinician should determine how many years the patient has had asthma, what seems to trigger the asthma, how the attacks present themselves, what makes it better, what makes it worse, and when the last attack was. Subsequent chapters discuss the specific questions related to each system that need to be explored in further detail. Chapter 1 lists the broad categories. Which systems are explored is determined by the patient's chief complaint, list of comorbidities, and whether the examination is a comprehensive history and physical or a focused history and physical. For a comprehensive examination, all the systems should be appropriately explored in the review of systems, and for the focused examination only those systems pertinent to the history of present illness and past medical history are explored.

Determining which systems are explored in the review of systems is an important clinical decision that guides the remainder of the physical examination and the documentation process. The review of systems represents the end of the subjective component of the SOAP.

Objective Data

Physical Examination

The objective component begins with the physical examination; the review of systems and physical examination should match each other (i.e., if all systems are evaluated in the review of systems, then all systems should be evaluated in the physical examination). If a focused examination is being done, and if only the general, respiratory, and cardiac systems are explored in the review of systems, then the physical examination should focus on these same three components. Conversely, if the physical examination included general, respiratory, cardiovascular, and gastrointestinal, then these same four systems should have been explored in the review of systems. Concise accurate documentation of all findings is imperative in the physical examination. Correct terminology, accurate descriptions, appropriate legends, and completeness are vital components within the physical examination. Legally, the standard rule is: If it is not documented, it either was not assessed or not done. Hence, omissions can be critical. If the clinician fails to document that all lobes of the lung are clear to auscultation, then one cannot assume that all lobes were assessed. Also, if in the documentation of the cardiac assessment, the provider does not comment about rate, rhythm, or pulse deficit, then one cannot derive that these aspects were evaluated or assessed.

Diagnostic Tests

The last component of the objective section is diagnostic tests (laboratory findings). In some institutions, the laboratory findings are integrated into the appropriate system. For example arterial blood gases and the most current chest x-ray may be documented in the respiratory section. In other institutions, laboratory findings, such as a basic or complete metabolic panel, are listed separately. Again abbreviations and symbols may be used, if approved by the institution or facility.

Assessment

Once the subjective and objective data are completed, the clinician then organizes the findings into an appropriate section called assessment, or final assessment findings. The final assessment findings

BOX 3-1 SAMPLE PROBLEM LIST FOR A PATIENT IN HEART FAILURE

Atrial fibrillation
Hypokalemia
Potential hyperkalemia (secondary to the use of a potassium-sparing diuretic)
Fluid overload
Shortness of breath
Skin breakdown
Anxiety (secondary to shortness of breath)
Potential for deep venous thrombosis (secondary to inactivity)
Potential for respiratory failure
Potential for cardiogenic shock

can be divided into three categories: (1) all new diagnoses, as well as any preexisting diagnoses; (2) differential diagnoses, or those diagnoses that require further testing in order to confirm them; and (3) a problem list. When this approach is used, the final assessment findings include any additional findings that may or may not be directly related to the history of present illness. For example, if the patient has a history of smoking, cigarette abuse should be listed. If the patient is a type 2 diabetic, then type 2 diabetes should be listed, in addition to any diagnoses related to the patient's chief complaint. Many times, however, the diagnosis is not firmly established; in this case possible diagnoses are listed as "differential diagnoses." Some individuals may label these as "rule outs." For example, consider a 54-year-old man who presents with a 2-hour history of chest pain that is epigastric in nature, does not radiate, and is relieved by antacids. These symptoms may lead the novice practitioner to think about gastro-esophageal reflux disease (GERD), but another more significant differential is acute coronary syndrome, which needs to be "ruled out" before the diagnosis of GERD can be focused upon.

A third component of the assessment section is called the problem list. Not all patients will have a problem list, but for many hospitalized patients, the problem list includes other issues that are not true diagnoses, but issues that need to be addressed as the result of either the diagnosis or the plan of care. For example, if a patient is hospitalized for heart failure and her basic metabolic panel indicates that she is hypokalemic, then the diagnosis is "heart failure," and hypokalemia would appear in the problem list. Typically, items in the problem list are conditions that can be treated and, it is hoped, resolved. For example, with heart failure, the heart failure will be treated, but not cured. However, with appropriate potassium replacement, the hypokalemia can be eliminated as a problem. It may need to be continually reassessed; hence developing a problem list helps to guide further treatment and care. It documents in a readily retrievable format other issues that need to be potentially re-evaluated. **Box 3-1** provides a sample problem list.

Plan

The last component of the findings is the plan. There are five components of the plan. These are non-pharmacological interventions, pharmacological interventions, educational needs for both the patient and his family, follow-up, and referrals. Which components are included in the plan are determined by both the data obtained in the subjective and objective components of the write-up as well as the diagnosis and differentials. Not every patient will have a non-pharmacological section to the treatment plan. This component is frequently reserved for hospitalized patients, and it represents the "orders" for the staff nurses to follow. Also depending upon the patient's diagnosis, medications may not be ordered. Under "education," it is critical to document any instructions that have been given to the patient and/or family. This includes any instructions in terms of when to seek additional medical attention. One common legal problem that frequently surfaces is the patient or family's comment "we were not told." In order to avoid these situations, the clinician should document (1) what was taught or explained, (2) to whom it was told, (3) if the patient or family stated that he/she or they understood the information presented, (4) and what was the format. For example, were they given written instructions as well as verbal instructions?

Summary

Documentation of the patient's health history and physical examination is vital in order to guide the care and treatment of the patient, to provide ongoing feedback to other healthcare providers, and to provide a sound basis for legal review. The provider must complete documentation that is accurate, concise, and confidential. It is an important aspect of assessment that should not be overlooked. **Figure 3-5** demonstrates documentation of a sample case. This format is used to demonstrate cases throughout the rest of the text.

Name JS	Date 1/19/13	Time 0845
	DOB 1/16/48	Sex M
HISTORY		
CC "I have chest pain."		
HPI 57-year-old Caucasian male in acute distress presents with a 2-hour history of chest pain. Mr. S woke up and felt a new "heaviness" in his chest. He took two Tums, which did not relieve the pain. Pain has gotten worse and is radiating down his left arm. He rates the pain an 8 (out of 10). He states he feels nauseated and slightly short of breath.		
Medications Vasodec: 10 mg qd for HTN. Last dose 1/18/13. ASA: 81 mg qd for "blood thinner." Last dose 1/18/13.		
Allergies NKA		
PMI Illnesses No history of angina or MI. History of hypertension for 5 years. History of GERD, self-treats with Tums.		
Hospitalizations/Surgeries No history of hospitalizations or surgeries.		
FH Father died of MI at age 52. No history of cancer or diabetes mellitus.		
SH Mr. S is married (for 25 years) and has two grown children living in the area. Mr. S is self-employed as a consultant and has insurance. He exercises 1–2 times per month. Mr. S tried to follow a low-fat diet. He smokes 2 packs per day (for 25 years).		
ROS		
General No history of recent weight change or dietary changes.	Cardiovascular History of HTN. Chest pain, radiating to left arm (see HPI).	
Skin Denies history of scars, eczema, psoriasis, or cancer.	Respiratory Smokes 2 ppd (≈ 25 years); slight SOB.	
Eyes Nearsighted and wears glasses. No history of glaucoma.	Gastrointestinal Nausea started with chest pain. History of GERD, well controlled with PPI.	
Ears Denies hearing problems.	Genitourinary/Gynecological Difficulty starting stream for past year. Has noctura » 2 nightly. 6 months ago, diagnosed with benign prostate hypertrophy.	
Nose/Mouth/Throat Denies oral problems; wears dentures, upper and lower.	Musculoskeletal Denies history of fractures, arthritis, or trauma.	

FIGURE 3-5 Sample documentation.

(*continues*)

Breast Denies problems.	Neurological Denies history of seizures, strokes, or syncope. No history of Parkinson's, tremors, paralysis, headaches, falls, or vertigo. Denies depression, memory impairment, dementia, or speech impairment.	
PHYSICAL EXAMINATION		
Weight 195 lb	Temp 98.0	BP 92/78
Height 6'	Pulse 118	Resp 24 and labored
Skin Cool and pale; turgor, brisk recoil.		
HEENT Eyes: No erythema of the sclera; pink conjunctiva, no discharge; EOMs intact w/o lid lag or nystagmus; fundoscopic exam revealed no AV nicking or cotton wool patches. Ears: Tympanic membrane pearly gray with no discharge. Mouth: Buccal mucosa pink, without lesions.		
Cardiovascular S1 and S2 heard with no splitting or murmurs. S3 audible predominantly at apex. PMI 5th ICS midclavicular line. No JVD noted. Carotids equal bilaterally with no bruits. No bruits over aorta, renal, iliac, or femoral arteries. Capillary refill brisk. Pretibial edema +1 bilaterally.		
Respiratory Respirations labored. Clear to auscultation in all lobes.		
Gastrointestinal Bowel sounds active in all quadrants. Abdomen soft and without tenderness. No hepatomegaly or splenomegaly noted.		
Genitourinary Not examined.		
Musculoskeletal Muscle strength 5/5 in upper and lower extremities bilaterally. Full ROM in all joints. No atrophy noted. No crepitus over joints noted. Gait deferred.		
Neurological Awake, alert, and orient ≈ 3. Moderately anxious. PERRLA. Speech clear. CN II–XII intact. All DTRs bilaterally 2+.		
Other		
Lab Tests Tropin I, CK-MB, basic metabolic panel, PT, PTT drawn but not back from lab.		
Special Tests 12 lead ECG indicates ST segment elevation in leads II, III, and AVF. No Q wave present; good progression of R wave leads V_1–V_3. Chest x-ray clear.		
Final Assessment Findings 1. Acute coronary syndrome 2. HTN 3. Cigarette abuse		

FIGURE 3-5 Sample documentation (*continued*).

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Additional Resource

HIPAA Regulations

http://www.hhs.gov/ocr/privacy/hipaa/understanding/
This website gives national standards about maintaining patient privacy.