

Unlocking the Past: History Physical Exam And Patient Note

Shelter Name: _____ Date: _____ Intake Date: _____ Species: _____ Patient Name: _____		MISSISSIPPI STATE UNIVERSITY™ COLLEGE OF VETERINARY MEDICINE
Presenting Complaint: _____		
Signalment/History: Breed: _____ Appetite: N A _____ Urination: N A _____ Heartworm Status: _____ Color: _____ Water Intake: N A _____ Vomiting: No Yes _____ Unkn Neg Pos N/A Age: _____ Attitude: N A _____ Coughing: No Yes _____ FIV/FELV Status: _____ M <input type="checkbox"/> F <input type="checkbox"/> Altered <input type="checkbox"/> Feces: N A _____ Sneezing: No Yes _____ Unkn Neg Pos N/A Known Pre-Existing Diseases and Current Medications: _____		
Physical Exam: Temp (f): _____ Pulse Rate: _____ Respiratory Rate: _____ Weight (lb): _____ BCS (1-9): _____ Fecal Score (1-7): _____ General Appearance: N A _____ Eyes: N A Ocular Discharge <input type="checkbox"/> _____ Ears: N A Otic Inflammation <input type="checkbox"/> Ear Mites <input type="checkbox"/> _____ Respiratory: N A Nasal Discharge <input type="checkbox"/> Abnormal Lung Sounds <input type="checkbox"/> _____ Oral Exam: N A Periodontal Disease (Grade 1 2 3 4) <input type="checkbox"/> Oral Ulcers <input type="checkbox"/> Stomatitis <input type="checkbox"/> _____ Lymph Nodes: N A _____ Cardiovascular: N A Murmur (Grade 1 2 3 4 5 6) <input type="checkbox"/> _____ Abdomen: N A Distended <input type="checkbox"/> _____ Genitourinary: N A _____ Skin: N A Alopecia <input type="checkbox"/> Pruritus <input type="checkbox"/> Scales/Crusts/Collarettes <input type="checkbox"/> _____ Musculoskeletal: N A _____ Neurological: N A _____ Other Exam Findings: Fleas <input type="checkbox"/> Ticks <input type="checkbox"/> Tapeworms <input type="checkbox"/> _____		
Examination/Diagnostic Tests/Doctor's Notes: Fecal Flotation: _____		
Treatment Plan: _____		
Student: _____ Faculty: _____		<div style="border: 1px solid black; padding: 5px;"> Your Newly Adopted Pet Needs: _____ _____ _____ _____ By: ____/____/____ With Your Regular Veterinarian </div>

When a patient visits a healthcare professional, one of the first steps in diagnosing their condition is to collect a thorough medical history and perform a physical examination. These two components, known as the History Physical Exam (HPE) and patient note, respectively, play a crucial role in understanding a

patient's condition and formulating an accurate treatment plan. In this comprehensive guide, we will delve into the importance, process, and key components of the History Physical Exam and patient note, taking you on a journey through medical history.

The Importance of the History Physical Exam:

The History Physical Exam is like a window into a patient's past. It allows the healthcare professional to gather essential information about the patient's medical background, past illnesses, medications, family history, and other pertinent details. By analyzing this data, healthcare professionals can gain insights into the patient's present condition, identify potential risk factors, and establish a baseline for future comparisons.



Target USMLE Step 2 Clinical Skills Handbook : Clinical Skills: History, Physical Exam and Patient Note by Dr. Mary June (1st Edition, Kindle Edition)

★★★★☆ 4.4 out of 5

Language : English
File size : 1890 KB
Text-to-Speech : Enabled
Screen Reader : Supported
Enhanced typesetting : Enabled
Print length : 120 pages



The Process of Performing History Physical Exam:

The process of conducting a History Physical Exam involves a series of steps that healthcare professionals follow to ensure a comprehensive evaluation of the

patient's medical history and current symptoms. Here's a breakdown of the process:

1. **Collecting Patient Demographics:** This step involves obtaining basic information about the patient such as their name, age, sex, address, and contact information.
2. **Chief Complaint:** Healthcare professionals ask patients about the primary reason for their visit and document their chief complaint.
3. **Past Medical History:** The next crucial step is to gather information about the patient's past medical history, including any previous illnesses, surgeries, or significant medical events.
4. **Family History:** Understanding a patient's family medical history is vital in identifying genetic predispositions and potential diseases that may be hereditary.
5. **Social History:** Healthcare professionals inquire about the patient's lifestyle, habits, social support, occupation, and any relevant environmental or social factors that may contribute to their health condition.
6. **Medication History:** It is crucial to document all the medications the patient is currently taking, including prescribed drugs, over-the-counter medications, and supplements.
7. **Allergies:** Gathering information about any allergies the patient may have is essential to prevent adverse reactions during the treatment process.
8. **Review of Systems:** Healthcare professionals assess and document the patient's symptoms and complaints related to various body systems.
9. **Physical Examination:** A detailed physical examination is performed, during which healthcare professionals assess the patient's vital signs, body

systems, perform palpation, percussion, and listen to various bodily sounds using specialized medical devices.

Mastering the Patient Note:

One of the most critical aspects of the History Physical Exam is recording the patient's information accurately and efficiently. The patient note serves as a comprehensive, organized summary of the patient's medical history, symptoms, and physical examination findings. It is a vital communication tool that allows healthcare professionals to easily retrieve and review patient information, collaborate with colleagues, and make informed decisions regarding the treatment plan.

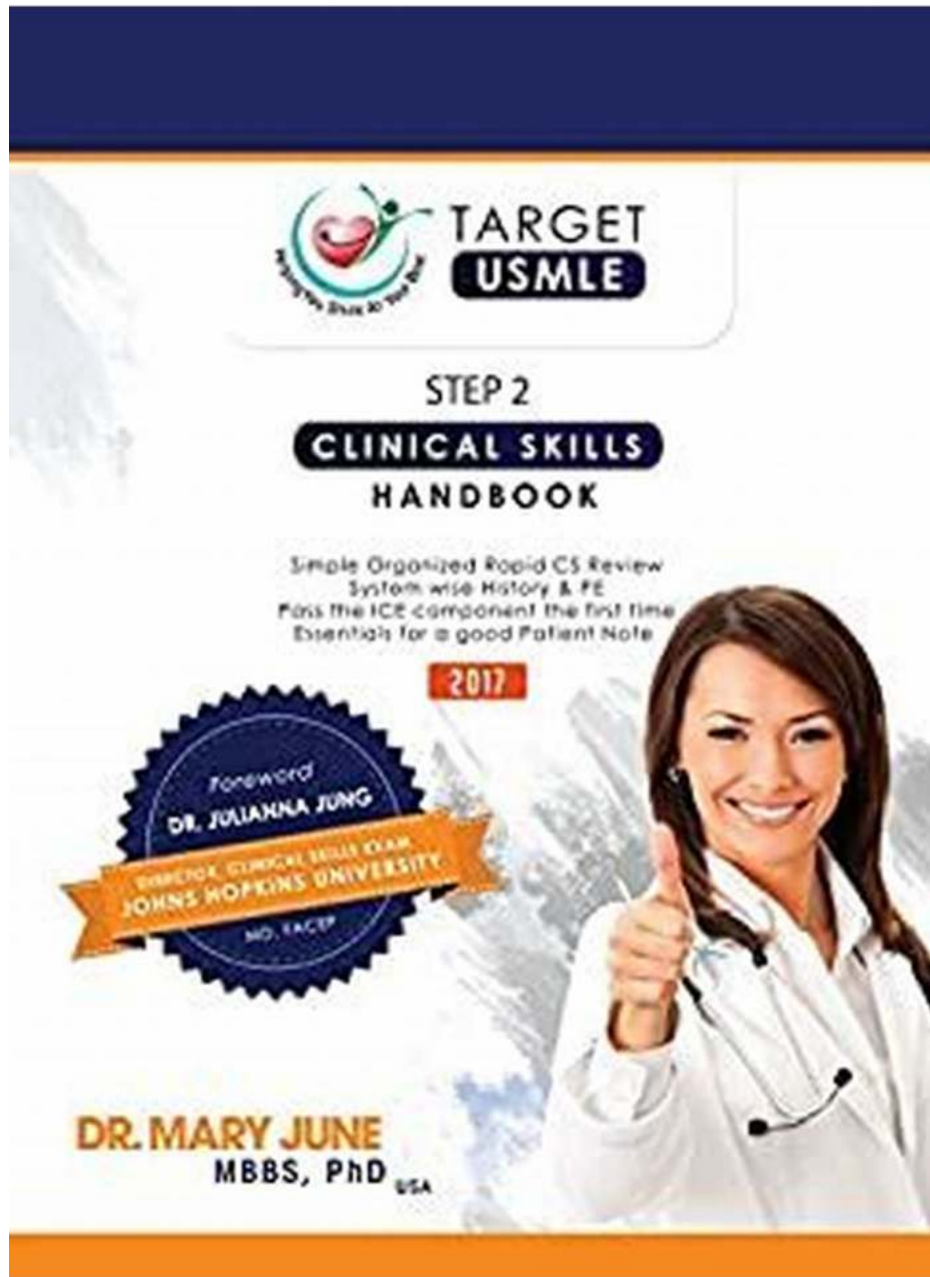
Typically, the patient note consists of the following sections:

- **Chief Complaint:** A concise description of the patient's primary reason for the visit.
- **History of Present Illness (HPI):** A detailed account of the patient's symptoms, including the onset, duration, quality, severity, alleviating/aggravating factors, and associated symptoms.
- **Review of Systems (ROS):** A complete review of the patient's symptoms and complaints related to each body system.
- **Past Medical History (PMH):** An overview of the patient's previous medical conditions, surgeries, allergies, and medications.
- **Family and Social History (FMH/SH):** Information about the patient's family medical history, as well as any relevant social and occupational details.
- **Physical Examination Findings:** A comprehensive summary of the physical examination findings, including vital signs, auscultation sounds, palpation

findings, and any abnormalities.

- **Assessment and Plan:** This section outlines the healthcare professional's assessment of the patient's condition and a detailed plan for further investigations, treatment, and follow-up.

The Evolution of History Physical Exam:



The History Physical Exam has come a long way since the inception of medicine. In ancient times, healthcare providers relied heavily on observations and basic physical examinations to diagnose patients. Over the centuries, as medical knowledge expanded and technological advancements were made, the physical examination techniques became more refined and specialized.

Today, healthcare professionals utilize various tools and devices, such as stethoscopes, blood pressure monitors, and otoscopes, to conduct a thorough physical examination. They also have access to a vast range of medical tests and imaging modalities that aid in accurately diagnosing and treating patients.

Incorporating Technology into the History Physical Exam:

With the rapid advancement of technology, the History Physical Exam is embracing digital solutions to enhance efficiency, accuracy, and accessibility. Electronic health records (EHRs) have revolutionized the patient note, allowing healthcare professionals to quickly retrieve and update patient information, share records securely, and streamline the overall workflow. Telemedicine platforms have made it possible for patients to receive remote medical consultations, expanding access to care for individuals in rural or underserved areas.

Additionally, the integration of artificial intelligence (AI) and machine learning (ML) algorithms has the potential to assist healthcare professionals in analyzing vast amounts of patient data, comparing symptoms, predicting outcomes, and suggesting personalized treatment options.

In :

"The past informs the present, and the patient note holds the key to unlocking the mysteries of a patient's health."

- Dr. John Doe

The History Physical Exam and patient note are fundamental components of modern medicine. They allow healthcare professionals to delve into a patient's past, identify potential risk factors, and craft personalized treatment plans. By embracing technology, healthcare professionals can streamline the process, enhance accuracy, and revolutionize the patient experience. As we continue to uncover the mysteries of medicine, the History Physical Exam and patient note serve as guiding tools, ensuring that each patient receives the best possible care.

So, the next time you visit a healthcare professional, remember the invaluable role played by the History Physical Exam and patient note in unlocking the secrets of your health journey.

Article by: Your Name



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A well organized, clear and concise rapid revision guide to prepare for the USMLE Step 2 Clinical Skills exam. The book is useful for the 3 and 4th year

medical students (IMGs & AMGs) during their clinical rotations. The different components of the exam are dealt with in detail: ICE (Data gathering in History, Physical exam check list including special tests and a good Patient note guidelines), CIS (Communication interpersonal skills, tackling challenging situations) and tips for SEP (Spoken English proficiency for non-native English speakers. The e-book has interactive hyperlinks to the popular 'Online Video Tutorial' (www.targetusmle.com) – which is a complete coaching program for CS prep from the comfort of your home. It is the first of its kind designed by Dr. Mary June for which the CS handbook is an essential companion guide. Flip through the pages to see how easy Step 2 CS prep can be! Do it once. Do it right. Pass Step 2 CS exam the first time!

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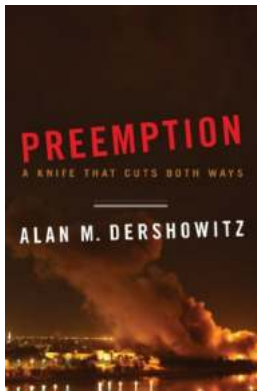
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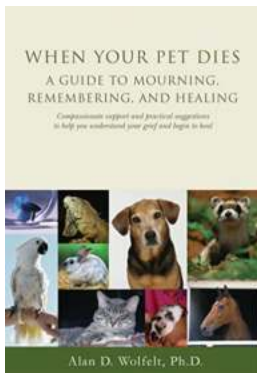
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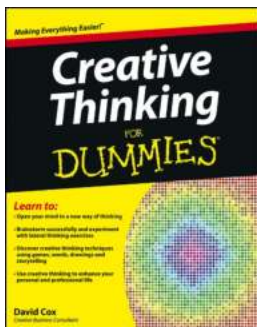
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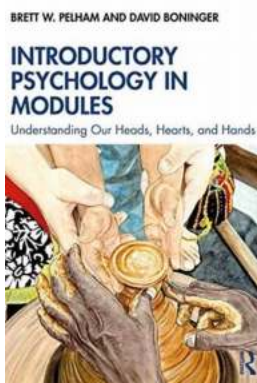
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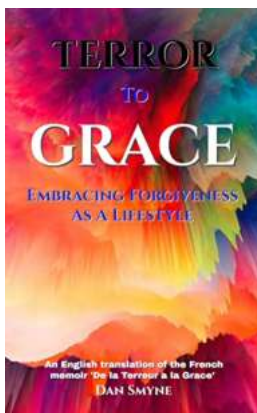
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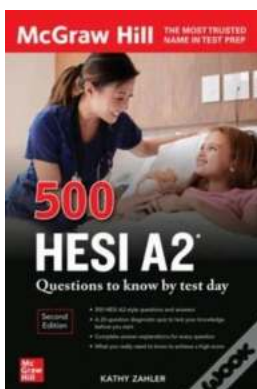
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