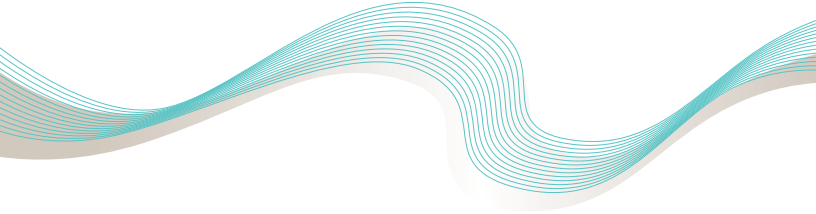
The AOA Guide:

How to Succeed in the Third-Year Clerkships

Example Notes for the MSIII

2016



Preface

This guide was created as a way of assisting you as you start your clinical training. For the rest of your professional life, you will write various notes. Although they will eventually become second nature to you, it is often challenging at first to figure out what information is pertinent to a particular specialty/rotation. This book is designed to help you through that process. In this book you will find samples of SOAP notes for each specialty and a complete History and Physical. Each of these notes represents very typical patients you will see on the rotation. Look at the way the notes are phrased and the information they contain. We have included an abbreviations page at the end of this book so that you can refer to it for the short-forms with which you are not yet familiar. Pretty soon you will be using these abbreviations without a problem! These notes can be used as a template from which you can adjust the information to apply to your patient. It is important to remember that these notes are not all inclusive, of course, and other physicians will give suggestions that you should heed. If you are having trouble, remember there is usually a fourth year medical student on the rotation somewhere, too. We are always willing to help!

Table of Contents

Internal Medicine Progress Note (SOAP) 3
Neurology Progress Note (SOAP) 6
Surgery 8
- Progress Note (SOAP) 8
- Pre-Operative Note 9
- Operative Note 9
- Post-Operative Orders 9
- Post-Operative Note 10

Obstetrics and Gynecology 11
- L&D H&P 11
- Delivery Note 11
- Post-Partum Note (SOAP) 11
- C-Section Operative Note 12
- Post-Cesarean Section Note (SOAP) 13
- Mag Note 13

Psychiatry Progress Note (SOAP) 14
Pediatrics 17
- Outpatient Progress Note (SOAP) 17
- Inpatient Progress Note (use the Internal Medicine SOAP) 18

History and Physical 19
- Internal Medicine (complete H&P) 19
- Adaptations for all other rotations 23

Abbreviations used in this guide 25

Internal Medicine

****Notes on internal medicine are generally longer than notes on other services. As the "primary team," you are responsible for addressing all of the patient's issues, and inpatients are often complex. When writing IM notes, be sure to address each problem a patient has in your assessment and plan**.

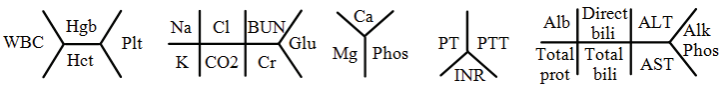
Progress Note
5/15/16 (Date) 0630 (Time) MS III Green 3 Progress Note
*For Internal Medicine at TJUH, write on the front side of the progress note printed off every morning. Your intern will write on the back. If you are on a Green IM team at TJUH, your notes will be entered electronically through JeffChart.

S: Subjective is what the patient tells you (i.e. "I'm having pain")
(On inpatient services, overnight issues are typically documented first in the note)
Pt resting comfortably this morning. Overnight, pt c/o insomnia. Also c/o continued leg pain. Pt rates pain at 5/10 and received PRN Percocet x2 overnight, which improved pain. Denies F/C/CP/SOB/N/V/D/abd pain. Tolerating PO well, had 2BM overnight, voiding on own.

O: Objective includes any vitals, physical exam, labs, and imaging (in this order).
Vital Signs
(Reporting ranges of vital signs is more important than individual values)
Tc: 97.4 Tmax: 98.6 P: 80 BP: 120-130/70-90 RR: 20 SpO2: 99% on RA
I 24 hrs: 3300 mL O 24hrs: 1500 mL (if pt has foley, note that) Balance: +1800

Physical Exam
(The below exams are mandatory on every patient, but there will also be exams specific to your patient to do every day based on their diagnoses, i.e. a neuro exam if the patient had a stroke. Put that in this section, as well.)
HEENT: PERRL, EOMI, no LAD
CV: RRR, nl S1+S2, Ø m/r/g
Lungs: CTAB, Ø w/r/r/c
Abd: Soft, NT/ND, +BS, no rebound, no guarding, no hepatomegaly, no masses
Ext: Ø c/c/e

Labs/Studies
(Put a P with a circle around it to indicate pending labs; fill them in later when the results are available)
Write all daily labs and trends in here (e.g. Hgb 9.2 ↓ 10.3)



A/P: Assessment & Plan
This has many formats, the main two are:

1. Problem based (as below)
2. Systems based (i.e. list ID, then under that heading have all current infections, their status and the treatment; second list CV, list all problems such as HTN or CAD that relate to that system, their status and the treatment, and so on for all systems)

Ask your attending which of the above systems they prefer, and follow that model. The first sentence is critical as it is usually the first sentence in your presentation. While there are many ways of structuring the initial assessment sentence (and many attendings have their own particulars), it generally follows one of the two following formats:

New patient: [**Description of patient] with [relevant PMH] presents with [symptoms/signs/concerning labs/imaging**] concerning for [**differential**].
The patient is a [28-year-old female] with [PMH of sickle cell disease, DM II, HTN, GERD, and anxiety] who presents with [left leg pain and increased reticulocyte count] concerning for [sickle cell crisis].

Patient you have been seeing all week: *43-year-old female who presented with RUQ pain found to have biliary colic and admitted for pain management, stable on current pain regimen. (The status of the patient.)*

1. Sickle Crisis
   - Hemoglobin, reticulocyte count stable
   - Pain currently controlled on Dilaudid PCA and PO oxycontin
   - T/C switching to IV morphine today
2. DM
   - Controlled on metformin
   - Creatinine levels WNL, continue metformin
   - Continue SSI (sliding scale insulin)
3. HTN
   - Controlled, continue on current meds
4. GERD
   - Controlled, continue on current meds
5. Anxiety
   - Controlled during the day, but patient continues with insomnia
   - T/C adding Ambien PRN
6. FEN (food, electrolytes, nutrition)
   - Now with good PO intake, can decrease IV fluids to 100 mL/hr
   - T/C diabetic diet given PMH
7. DVT Prophylaxis
   - SCDs (sequential compression devices)

8. Disposition
   - Full code
   - D/W (discuss with) team possible D/C (discharge) this week

Signature: Last name, MSIII

Extra Hints

- Put what day of the antibiotic it is today. If it is the 4th day in a total of 14 days then put "Day 4/14"
- The addition of T/C (to consider) and the words "discuss with team" are great to use in front of what you want to do. You can also add question marks after things if you are unsure. People want to see what you are thinking, but also want others to know when they read this that these things are not definite yet (the "MSIII Progress Note" at the top should imply that, but people don't always notice).
- Writing out medication names and doses is tedious, but sometimes very helpful to get you to remember what medication your patient is on and what dosing regimens are for the medication.
- Make a copy of your note in the morning after you write it. That way if someone asks you something you don't remember (the vitals, the sodium today, etc.) you can just pull it out of your pocket and look at it. Depending on the service, you may wait until after rounds to place the note in the chart.

Tips for IM at Jefferson

- Signout: Signout is a way for the day team and night team to exchange critical information about the patients. Help your team by keeping signout updated. Generally, update the tasks to reflect what has been done and needs to be followed up. Update to reflect changes in clinical picture (e.g. imaging gave you a diagnosis). Document any changes in medication. Always add a patient's PCP or family members' phone numbers. Discuss with your team if they have preferences.
- Discharge: Discharge instructions can be started as soon as a patient is admitted to your service. Help your team by keeping discharge instructions updated with the latest results. List important diagnostic imaging, lab work, follow up appointments, and fill in the disease-related sections relevant to your patient (i.e. Warfarin, Diabetes, Heart Disease). You generally cannot do the medication section on your own. Summary sections are required if you are transferring care to another facility.
- Consults: Your team will often have you call in consults. Be ready with a concise presentation about your patient and be clear about what you hope the consulting team can provide.

How to Page Your Team

Short range pager: 22+ pager ID
Long range pager: 877-656- pager ID

Neurology

S: NAE O/N (no acute events overnight). Pt continues to c/o (complain of) weakness in LLE, now improving.
O: VS: T: 37.1 P: 82 BP: 124/84 R: 22 PE:

Gen: NAD, resting comfortably in bed
HEENT: atraumatic, normocephalic; TM clear with visible landmarks; sclera and conjunctiva clear; no LAD, no neck masses or asymmetry, no carotid bruit
CV: RRR, normal S1 and S2, no S3, S4, murmurs, rubs, or gallops
Lungs: CTAB, no wheezes, rales, or rhonchi
Abd: soft, NT/ND, +BSx4 quadrants, no masses palpable, no organomegaly
Skin: no rashes, lesions, petechiae
Ext: 2+ pedal pulses bilaterally, no c/c/eNeuro: (normal exam)

1.) Mental status AAOx3 (or lethargic/obtunded/etc) N/R/C intact WORLD ←→ DLROW Recall 3/3	Awake, Alert, Oriented to person, place, time Naming, repetition, comprehension intact Spells world backwards Recall 3 named objects (red, ball, pen) after 2 minutes
2.) CN PERRL, EOMI, V1-V3 intact, FS, palate elevates symmetric, TM, SCM 5/5	Pupils equal, round, and reactive to light Extraocular muscles intact Sensation in V1-V3 intact Face symmetric Palate elevates symmetric Tongue midline 5/5 strength in sternocleidomastoid
3.) Motor Nl B+T 5/5 strength x4 No fix, no drift	Normal bulk and tone 5/5 strength in all 4 extremities No fix or drift
4.) Sensation Intact to LT/PP/Temp/Vib/Prop No agraph, no astereo	Intact to light touch, pin prick, temperature, vibration and proprioception No astereoagnosia No agraphesthesia
5.) Coordination FTN, RAM, and HTS intact	Finger-to-nose, rapid alternating movements, heal-to-shin intact
6.) Gait Narrow based, no ataxia, intact to tandem and heal-toe, negative Rhomberg	

7.) Reflex: Grade 4+ (clonus), 3 (hyperactive), 2 (nL), 1 (Hypo), 0 (none)

Arrow at feet: Babinski upgoing (+) or downgoing (-,nl)

Biceps C5

Triceps C7

Brachioradialis C6

Patellar L4

Achilles S1

Babinski (up/down)

A: 64 y/o M with PMH atrial fibrillation presents with L-sided weakness and found to have R MCA ischemic stroke on CT. L-sided weakness continues to improve, with patient exhibiting increased strength. Pt maintained on warfarin with INRs now in therapeutic range.

P:

1.Neuro: Continue PT/OT for L sided weakness
2.CV: Continue warfarin at current dose with daily INR
3.FEN/GI: Cardiac diet
4.Prophylaxis: SCDs (sequential compression devices), OOB (out of bed) with assistance as tolerated
5.Dispo: Pending INR in therapeutic range and homecare

Surgery

Surgery notes are typically shorter than what you will write on other services, such as IM. **Always** include post-operative day (the day of surgery is day #0) and the procedure that was performed. **Ins & Outs** (I&Os) are particularly important on many surgical services, so check all tubes/drains and record their outputs. **Bowel recover**y (passing gas or stool) as well as **diet** are also important in post-op patients, be sure to ask and document! Comment on whether or not the patient has been out of bed (OOB) and remark on **ambulation**. If bandages are to be removed on POD#1, this is typically a helpful task that can be handled by the medical student while pre-rounding. After you remove the bandage, inspect the wound and remark whether or not it is **clean, dry and intact** (CDI).

Progress Note

6/5/16 (Date) 0500 (Time) Progress Note MSIII Green Surgery
S: 33 yo female admitted for appendicitis, hospital day #3, POD (post-op day) #2, s/p appendectomy. Abx – Flagyl day #1 of 7. Patient having some peri-incisional pain, however pain is well controlled with PCA (patient controlled analgesia pump). No drainage from incision site, (+) ambulation, (+) BM and flatus. Currently on clear liquid diet and is tolerating it well. Foley still in place. (-) N/V, (-) SOB, no overnight issues.

O: VS: Tmax 38.3, Tc 38.1, BP 120/80, P 75, RR 16, O2 99% on RA
I/O: 1250/2000 x 24hrs, 1000/1200 since midnight, UO (Urine Output) 1100 cc in 24 hours, 46cc/hr, JP (Jackson-Pratt drain) 200cc in 12 hrs, 16cc/hr
(If patient has NG (nasogastric) tube or other drains you would record their 12hr output here also)
Gen: NAD, AAOx3
CV: RRR, (+) S1/S2, (-) m/r/g
Lungs: CTAB, (-) w/r/r/c
Abd: (+) tenderness on palpation in RLQ (right lower quadrant), ND, (+) BS Incision: C/D/I, (-) erythema, staples intact, JP drain in place
Ext: (-) C/C/E, 2+ dorsalis pedis bilaterally, (-) calf tenderness, calf SCDs in place.
Labs: CBC, BMP, UA, etc.
Imaging: CXR negative, etc

A/P: 33 yo female, POD # 2, s/p appendectomy. Patient doing well.
1. Low grade fever – likely secondary to atelectasis
   - Continue incentive spirometry
   - Continue Flagyl antibiotics
   - T/C blood cultures if continued fever
   - Encourage ambulation
2. Pain is improving
   - T/C switching PCA to oral analgesic
3. Diet – tolerating clear liquids
   - Advance to house/regular diet
4. Good urine output
   - D/C Foley
5. Prophylaxis
   - Continue incentive spirometry
   - Continue SCDs
6. Dispo: Pending PO pain mgmt. and inc oral intake

Pre-Operative Note
6/2/16 600 Pre-OP Note MSIII Green Surgery
Pre-op dx: Appendicitis
Labs: CBC, BMP, PT/PTT results
CXR: Clear
ECG: Normal sinus rhythm, within normal limits
Blood: Typed and crossed x 2 units
Anesthesia: Pre-op completed consent for anesthesia is signed and in the chart
Consent: Signed and in the chart
Orders: 1 gm cefoxitin OCTOR (on call to OR), NPO (nothing by mouth) after midnight

Operative Note
6/2/16 1100 OP Note MSIII Green Surgery
OP Note: Green Surgery Team
Pre-op dx: Appendicitis
Post-op dx: Appendicitis
Procedure: Open Appendectomy
Surgeons: Write attendings, residents, med student present for the surgery (MSIII)
Anesthesia: General
Fluids: 1200ml LR
UO (urine output): 500cc
EBL (estimated blood loss): 50cc
Op findings: No perforation
Specimen: Appendix sent to pathology
Drain: JP drain
Complications: None

Post Operative Orders: ADC VANDALISM
6/2/16 1300 Post-OP Orders MSIII Green Surgery
Admit: 3 West
Diagnosis: Appendicitis s/p appendectomy
Condition: Stable
Vitals: q (every) shift
Allergies: NKDA (no known drug allergies)
Nursing orders: Strict I/Os, SCDs, Foley catheter to gravity, incentive spirometry
Diet: NPO
Activity: as tolerated
Labs: CBC, BMP in AM
IV fluids: D5 ½ NS + 20 KCL at rate of 100cc/hr
Studies: CXR
Meds: Abx: Cefotaxime 1g IV q8hrs for 24 hours

Prophylaxis: Heparin 5000 units SC
Analgesic: PCA (patient controlled analgesic) pump
Any pre-op medications the patient has been on and PRN meds
Call house officer if HR > 100 or < 60, BP > 180/100 or < 90/60, Temp > 39.5

Post Operative Note (*at least 6 hours after surgery***)**
6/2/16 1800 Post-OP Note MSIII Green Surgery
Status: s/p appendectomy, patient having mild discomfort
Neuro: AAOx3
VS: stable/afebrile
I/O: 1000ml LR
UO: 500cc x 6 hours
Labs: CBC, BMP in am
Physical Exam:
CV: RRR, (+) S1/S2, (-) m/r/g
Lungs: CTA B/L
Abd: Soft, RLQ tenderness, (-) bowel sounds, dressing C/D/I

A/P: 33 yo female s/p appendectomy POD #0 in stable condition

1. IV hydration
2. Pain management with PCA
3. 1g cefotaxime IV q8hrs for 24 hours
4. DVT (deep vein thrombosis) prophylaxis: SCDs (sequential compression devices), heparin 5000 units sc

Obstetrics and Gynecology

Ob/Gyn notes blend elements of internal medicine and general surgery, and obviously focus on a specific patient population. Obstetric notes are unique in that they address the conditions of 2 patients. Completeness is paramount. The gravida-para system (G#P####) should **always** be included in Ob/Gyn notes and you must know each item of this system for each patient.

Gravida: Number of times pregnant, regardless of whether these pregnancies were carried to term. Current pregnancy is included in this count. Twin pregnancy is counted as 1.

Para: TPAL (full **T**erm/**P**re-term/**A**bortions/**L**iving children)

G5P3114 = 5 pregnancies, 3 term births, 1 preterm birth, 1 abortion/miscarriage, 4 living children

L&D History & Physical
CC: (vaginal bleeding VB / contractions CTX / loss of fluid LOF / fetal movement FM)
HPI: __ y/o GXPXXXX with LMP (last menstrual period) of __ and an EDC (estimated date of confinement) of __ confirmed/changed by a 1st trimester U/S, at __ weeks EGA (estimated gestational age) who p/w __. She states that her CTX began at __ and are now q__ minutes. She currently admits/denies nausea, vomiting, RUQ pain, headache, blurred vision, vaginal bleeding, or decreased fetal movement. Prenatal course was significant for __.

Prenatal Labs:

First visit at __ weeks	EGA: _____
Weight Gain: _____	BP Range: _____
Blood type/Rh/Ab screen	Triple screen
CBC	UA/UCx
GTT/glucose screen	GBS
Rubella	RPR
HIV	HBsAg
Pap	GC, chlamydia

U/S (dates, changes to EGA, location of placenta, position of fetus, fetal anatomy, amount of amniotic fluid)

Ob Hx: year/EGA/type of delivery/type of c/s incision/gender/wt/complications
Gyn Hx: menarche/cycle Hz and length/STDs/PID/Paps
PMHx: standard questions + HTN/DM/MVP/asthma/thyroid/renal/VTE
PE: Vitals
FHT (fetal heart tracing): baseline, variability, +accels, - decels
Tocometry: CTX q _mins, regular
Standard exam (CV, Pulm)
Fundal height/Leopold's/reflexes/cervical exam
Examine for ROM (i.e. nitrazine/ferning/pooling)
Cervical exam (only do supervised): 3 cm / 50% effaced / 0 station

Plan: __ yo GXPXXX at __ EGA in active labor/PPROM/preeclampsia/postdates, etc. FHT (non-)reassuring/reactive, Category 1. – plan for management
Other Ob Dx (GBS/GHTN/GDM/SGA) – plan for abx/labs/etc.
Medical Dx (asthma/MVP/thyroid/anemia) – plan

Delivery Note

06/20/08 0600 Delivery MSIII Note
SVD of a viable ♂/ ♀ infant with Apgars of __/__, weight of __ under __ anesthesia from the __ position. The infant's head was delivered in a controlled fashion. Meconium was not present/thick/thin. The mouth and nares were bulb suctioned prior to delivery of the body. Nuchal cord x1, 2 (if applicable). The body delivered easily. The cord was clamped and cut and the infant was transferred. Cord was 2/3 vessel and bloods & gases were obtained. The placenta was delivered spontaneously, intact/with __ complication. The fundus was firm with minimal bleeding. Inspection of the vagina and cervix revealed 1/2/3/4o lacerations. Lacerations were repaired with [3.0 vicryl] with hemostasis and restoration of anatomy. The EBL was __mL. The attending was __ with assistant __. The mother was taken to postpartum in good condition. The infant was taken to the term nursery/trans nursery/ICN.

Dr. Lackritz also provides a fill-in-the blank delivery note in her "Survival Guide."

Postpartum Note

06/21/08 0800 PPD#1 MSIII Note
(Day of delivery = PPD (post-partum day) 0)
S: Pain, able/unable to tolerate PO, able/unable to ambulate, +/-BM, +/- voiding, +/-N/V, +/-CP/SOB/HA/dizziness/breast tenderness, presence of lochia (postpartum vaginal bleeding: basically ask if it is lighter than, same as, or heavier than a period). Breastfeeding vs. bottle feeding, does/does not desire circumcision, post-partum contraceptive method
O: VS: Tc: 98.7 Tmax: 98.9 P: 100 RR: 14 BP: 120/80
I/O: PO/IV intake / urine/emesis/etc
CV: RRR, +S1+S2, no m/r/g
Pulm: CTAB, no w/r/r
Abd: soft, F (fundus) = U-1 (one fingerbreadth below the umbilicus), firm, NT (non-tender)
Ext: no LE edema
Labs: Mother A+, infant AB+, RPR neg, Rubella immune
CBC: (pre-delivery and post-delivery values)
A: _ yo GXPXXXX PPD #1 s/p SVD
P:
1. AF VSS (afebrile, vital signs stable), pt doing well
2. Check CBC
3. Other medical problems
4. Breastfeeding, contraception

C/S Operative Note
Pre-Op Dx: (breech, NRFHT, maternal exhaustion, failure to dilate, arrest of labor)
Post-Op Dx: "Same"
+ Delivery of live ♂/♀, weight, Apgars
+ Did you find anything else during the surgery?
Procedure: Primary or repeat C/S, type of incision
+ Other procedures such as tubal ligation, hysterectomy
Surgeon: Ima Surgeon, MD
Assistants: Fellows, residents, and students
Anesthesia: General, spinal, epidural
EBL: X mL
Fluids Administered: Type of fluids given X mL
Urine output: X mL
Findings: Live ♂/♀ infant, weight, Apgars
+ Color of amniotic fluids/meconium
+ Presence of adhesions
+ Appearance of ovaries and tubes
+ Other findings, such as abruptions, cord knots, etc.
Complications: Check with attending or resident for description
Specimens: Cord blood & gases, placenta, cultures, tissue samples
Drains: Foley catheter
Instrument and Pad Count: Correct (usually)
Post-Op Condition of Mother: Stable/intubated/etc.
Post-Op Condition of the Newborn: Stable/intubated/etc. and which nursery baby is going to (term, transitional, or ICN).

C/S Post-Operative Note

Take the format of the postpartum note and title it POD #1. Usually the patients are on strict I&O for the first day (IV fluid, foley, etc). Also, comment on the incision site and whether it is C/D/I (clean, dry, intact) and closed with staples/suture.

Magnesium Note
S: Ask about SOB, HA, visual disturbances, N/V RUQ pain
O: Vital signs, fetal heart tones and contractions, urine output (Mg should cause diuresis), general appearance (Mg can cause lethargy), Cardiovascular, Lungs (Mg can cause pulmonary edema), Abdomen, Extremities (assess patellar and Achilles reflexes, assess for clonus)
Labs: Mg level every 6 hours
A/P: _ yo GXPXXXX at gestational age _, on MgSO4 for PTL or Preeclampsia. No signs/symptoms of Mg toxicity.

Pre-operative, Operative, and Post-operative notes *for all Gynecology patients are the same as the surgery notes (see the General Surgery section in this guide).*

Psychiatry

As this note is different from the other notes, first is a breakdown of the **Mental Status Exam** (Psych's physical exam, not to be confused with the mini-mental status exam) and second is an example of a SOAP note. It is important to remember that the "subjective" section of the SOAP note often includes parts of the Mental Status Exam.

Mental Status Exam (MSE)

(Be descriptive enough to pick the patient out of a waiting room)

Appearance
- Appears stated age, appears older/younger than stated age
- Build: average, thin, overweight, obese, cachectic
- Dress and grooming: well-groomed, appropriately dressed, unkempt, disheveled, in hospital gown, track marks, etc.
- Posture and gait: steady, ataxic, shuffling

Behavior
- Alertness and consciousness: awake, alert, arousable, obtunded
- Activity: calm, agitated, slowed, resting tremor, tics, etc.
- Eye contact: good, intermittent/poor, none, avoidant, intense
- Attitude toward interviewer: cooperative, hostile, suspicious, guarded

Speech
- Rate, volume, prosody, clarity, tone (pressured, quiet, slowed)

Mood (a quote from the patient that summarizes how they feel)
- Examples: "good," "fine," "not well," "angry," "depressed," "okay"

Affect (objective assessment of patient's emotion)
- Quality – depth and range of feelings displayed: full, flat, blunted, constricted
- Motility – how quickly emotional state shifts: stable, labile
- Appropriateness – is affect congruent with stated mood: appropriate vs. inappropriate, mood-congruent vs. mood-incongruent

Thought Process
- Logical, goal-oriented, circumstantial, tangential, loose associations, racing, incoherent, concrete, blocked, flight of ideas, perseverating, etc.

Though Content
- Hallucinations: auditory, visual, tactile, olfactory, gustatory
- Delusions: religious, persecutory, paranoid, referential, grandiose, bizarre
- Suicidal or homicidal ideation
- Phobias
- Obsessions/compulsions

Cognition (the mini-mental status exam [MMSE] provides a more complete assessment of patient's cognition)
- Orientation: name, place, time
- Concentration: WORLD ←→ DLROW, serial 7's, etc.
- Memory/Recall: 3 words (e.g. brown, hospital, honesty); immediately and after several minutes

Insight (the patient's ability to recognize their problem and the impact of the problem)
- Good, fair, poor, impaired

Judgement (the patient's ability to make good decisions about everyday activities)
- Good, fair, poor, impaired

Psychiatry Progress Note
SOAP format which should include subjective information, an objective mental status exam, and A/P.

Additional subjective components of importance: SIGECAPS, DIGFAST, personality disorders (borderline, narcissistic, histrionic, etc.) and substance abuse as applicable to the patient.

Major Depression (5/9 is positive)	Bipolar Type I/II (Mania)
Sleep	**D**istractibility
Interest	**I**rresponsible behavior
Guilt	**G**randiosity
Energy	
Concentration	**F**light of ideas
Appetite	**A**ctivity level significantly increased
Psychomotor Retardation	**S**leep is decreased
Suicidal / Homicidal Ideation	**T**alkativeness (pressured speech)

Tip for inpatient and consult Psychiatry is calling "collateral" family and friends. Leave a note every time you call with date and time, even if no one picked up or you left a message. It's important to leave a track record to prove you reached out.

Sample Note
6/21/16 0745 Psychiatry Progress Note MSIII

S: The patient says, "They put a pickle in my brain and fried it," when asked how she was feeling. She denies any problems with sleep, indicating that she slept "9 million hours." She states that she has been eating her meals. The RN notes indicate that the patient was seen interacting with others last night. She endorses AH, denies VH, and denies SI/HI.

O: T: 98.6 P: 100 RR: 16 BP: 120/80
MSE (see previous page): The patient was dressed inappropriately in a dirty sweatshirt, hospital gown, and mismatched shoes. She was malodorous. She made appropriate eye-contact and cooperated with the exam. No abnormal movements; no psychomotor agitation/retardation. Her speech was of normal rate, volume, and prosody, though she mumbled. Her stated mood is "fine," and her affect is congruent with her stated mood. She denies SI/HI (suicidal or homicidal ideation) and denies any VH/TH (visual, tactile hallucinations). She endorses AH (auditory hallucinations), stating that she hears "the president talking to my brain." She

indicates that the voice she hears simply tells her she is “doing a good job.” She denies thought insertion and thought broadcasting. Her insight is poor and her judgment is impaired.

CV: RRR, no m/r/g/S3/S4
Lungs: CTAB
Abd: soft, NT, ND, +BS

A/P: The patient is a 63 yo F with disorganized schizophrenia who is slowly improving on medications.

- Willing to attempt ADLs (activities of daily living) today, an improvement since yesterday
- Continue risperidone at current dose
- Individual/group/milieu (this is written for all patients in the inpatient setting, meaning that they are getting therapy by just being there)
- Mental Health Court tomorrow

Psychiatry Consult and Liaison: You will be writing a full History and Physical on each patient. Follow the guide on H&Ps in the back of the booklet. Remember to include the mental status exam as the majority of your physical exam.

Pediatrics

Pediatrics Outpatient SOAP Note
05/29/12 (Date) 0900 (Time) Pediatric Outpatient Note MSIII

S: 4-month-old male presents for well baby visit
Concerns: no concerns since last visit
Diet: several bottles of Similac with iron per day, no solids (*ask about fluoride and vitamin supplementation*)
Development: normal Denver – babbles and coos, smiles, laughs, holds head up, rolls from front to back, raises body on hands, grasps rattle, recognizes parent's voice
Bowel/Bladder: BMs x 2 per day, soft, slightly formed stool, no straining, no blood, 6-8 wet diapers per day (*toilet training after 21 months*)
Sleep: sleeps in crib in own room on his back, wakes once per night for bottle
Dental: no teeth (*If a child has a tooth it should be brushed, should see dentist at age* 3)
Safety: rear facing car seat in the back seat, sleeps on back, (+) smoke and carbon monoxide detectors (*helmet use, gun safety, pet safety*)
Immunizations: UTD (up to date), needs DTaP (diphtheria, tetanus and acellular pertussis), Hib (Haemophilus influenzae type B), IPV (inactivated poliovirus), PCV (pneumococcal)
For adolescents: drugs/alcohol/tobacco, sexual activity, after-school activities, hours of screen time (TV and computer), school, depression/self-esteem.

O: Length: 25in, Weight: 14lbs 8oz, Head circumference: 16.5in, Pulse: 130
Gen: awake, alert, no acute distress, smiling
HEENT: anterior fontanelle open, flat and soft (AFOFS), normocephalic atraumatic (NCAT), (+) red reflexes bilaterally, follows past midline, (-) strabismus, pupils equally round and reactive to light (PERRL), normal tympanic membranes B/L, inferior turbinates slightly pale and boggy, throat clear
Neck: supple, (-) lymphadenopathy (LAD)
Skin: (-) rashes, (-) Mongolian spots
CV: RRR, (+) S1&S2, (-) murmurs, equal radial and femoral pulses
Resp: CTA B/L, (-) wheezes/rhonchi/rales
Abd: soft, (+) bowel sounds, NT, ND, (-) masses, (-) hepatosplenomegaly
Ext: normal range of motion (ROM), (-) Ortolani, (-) Barlow
GU: normal GU with no fusion of labial folds / testicles descended B/L, no hydroceles
Neuro: (+) Moro reflex, (+) grasping reflex, (+) stepping reflex

A/P: 4 month old male presents for well baby visit. No new complaints.
1. Diet: add cereal and then pureed fruits/veggies, only add one new food per week to gauge tolerance
2. Safety: discussed 'child proofing' the house (hot liquids, sharp objects, outlets, cords, etc.) as baby is becoming more mobile
3. Immunizations: received DTaP, IPV, Hib, PVC today
4. Follow up in 2 months

Outpatient Note: Important to document in the Plan what "anticipatory guidance" was given to the parents (i.e. what to expect between Pediatrician visits)

Inpatient Note: Use the Internal Medicine note as a guide but remember to add in a sentence about how the child is eating, sleeping, urinating, and defecating. Also, give I's and O's in ml/kg/hour.
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Sample History and Physical

Below is an example of a thorough History and Physical. It can be used as a guide for an H&P you will do on all admissions and consults throughout the year regardless of the rotation. After the example, there are suggestions of ways to change the H&P for that rotation..

History and Physical
Chief Complaint: "I was driving home and my heart started racing"

HPI: The patient is a 39-year-old female at 27+0 weeks gestation who had a sudden onset of palpitations and dizziness while driving home on the day of admission. The patient describes the palpitations as though her baby was kicking in her chest and her heart was racing. While there was associated dizziness, the patient did not lose consciousness nor did she experience any diaphoresis, nausea, or chest pain. She did become short of breath, but attributes this to feeling anxious about what was happening. She was able to drive to her house without stopping, at which time she rested for half an hour, with no improvement in symptoms. She measured her blood sugar by Accucheck, which was 91, her blood pressure, which was "90 over something," and her pulse, which was 126. Pulse measurement 30 minutes later were 129 and 131, prompting her to call her OB/GYN who suggested that she go to the ER. She was assessed at 6pm last night.

PMH
- Gestational diabetes with her 1st child, which resolved at birth
- Genital herpes

PSH
- Tonsillectomy
- Wisdom tooth extraction
- Episiotomy

Medications
Currently: Prenatal vitamins.
Prior to becoming pregnant: OrthoEvra patch, herbs, megavitamins, lysine PRN
Allergies *(Include REACTIONS)*
Codeine and sulfa drug; urticaria
Family History
Patient is adopted and has no information on her biological parents. She has one living child who is healthy.
Social History
The patient is currently married and lives at home with her husband and her child. She has never used tobacco and denies the use of any illegal drugs including misuse of prescription drugs. She used to drink a glass of wine once a week prior to becoming pregnant. The patient has never used any IV drugs. She has been treated for genital herpes and she prefers to take lysine supplements now instead of anti-viral medication. She indicates she will start acyclovir about two months prior to giving birth. The patient is the Director of Admissions at a private school. She

does feel safe at home. She wears a seatbelt and has firearms at home though they are safely stored and locked. She also has a cat.

Review of Systems:

General: Weight gain with pregnancy, she is always fatigued, no fevers or chills.
Skin: No changes, no itching
Head: No recent headaches or trauma. Dizziness as above in HPI.
Eyes: No recent changes in vision. The patient does not need glasses or contacts.
Ears: No hearing loss, tinnitus, vertigo, discharge, or pain.
Nose: No rhinorrhea, epistaxis, or changes in her sense of smell or taste.
Mouth/Throat/Neck: No sore throat, dysphagia, odynophagia, or change in her sense of taste. No recent bleeding. She has not noticed any new neck masses.
Breast: No changes noted except for an increase in size due to pregnancy
Respiratory: Some shortness of breath (as in HPI), no cough or wheeze.
Cardiovascular: No chest pain. Palpitations as in HPI, no edema.
GI: No nausea, vomiting, or abdominal pain. The patient is constipated which she describes as normal and her stools are hard and brown. There has been no change in color or consistency and there has been no visible blood.
Urinary: No dysuria. She has noted frequency but as expected with her pregnancy. No incontinence.
OB: G2P1001. Patient is due on 11/24/16. She had had preterm contractions in July and was given Indocin and the contractions resolved. She has had no other complications with either this pregnancy or her last (except for the gestational diabetes as noted above).
Musculoskeletal: Patient complains of some bilateral hip pain (from her pregnancy). She has no problems with range of motion or joint pain.
Neurologic: no loss of consciousness. Dizziness as above. Patient also complains of some hand weakness.
Hematologic: No known anemia or easy bruising.
Endocrine: No expressed heat/cold intolerance. No diaphoresis. Patient notes that she could not perform an oral glucose tolerance test during this pregnancy because of adverse reactions to the test during her first pregnancy. There is an assumed diagnosis of gestational diabetes for this pregnancy.
Psychiatric: No recent changes in mood. No anxiety or depression.

Physical Exam

Vitals: Temp 37.1°C by mouth. Pulse 106/min. BP 106/84 supine. RR 16/min
General: Patient is in no apparent distress, well appearing pregnant woman.
Skin: Some spider veins noted on her upper thighs bilaterally.
Head: Normocephalic, atraumatic
Eyes: Pupils equal, round, and reactive to light. Extraocular eye muscles intact. Anicteric, non-injected.
Ears: No discharge. Tympanic membranes pale bilaterally.
Nose: No polyps or discharge. Nares are symmetrical. No tenderness.

Mouth/Throat: Adequate dentition with some plaque noted on teeth. Moist mucous membranes. No exudates or erythema. No ulcers or lesions.
Neck: Normal range of motion. Trachea is midline. Thyroid exam normal.
Heart: Tachycardic with an irregularly irregular rhythm. Audible S1 and S2. No murmurs, rubs, gallops, S3, nor S4. PMI in 4th interspace in the mid clavicular line. Central venous pressure of 6mmHg with the head at 45 degrees.
Lungs: Clear to auscultation bilaterally. Resonant to percussion. Equal chest excursion. Normal vocal fremitus.
Abdomen: Linea nigra of pregnancy noted on abdomen. No tenderness on palpation. No rebound. Fundal height 27cm (consistent with dates). Normoactive bowel sounds. Tympanic on percussion. Liver span estimated at 9cm in the mid clavicular line. No splenomegaly. No costovertebral angle tenderness.
GU: Patient refused
Rectal: Patient refused
Musculoskeletal: No muscular atrophy. Full range of motion.
Vascular: No carotid bruits

Vessel	Right	Left
Carotid	2/4	2/4
Radial	2/4	2/4
Femoral	2/4	2/4
Popliteal	Unable to appreciate	Unable to appreciate
Posterior Tibial	2/4	2/4
Dorsalis Pedis	2/4	2/4

Lymphatic: No lymphadenopathy (preauricular, posterior auricular, occipital, anterior cervical, posterior cervical, submandibular, submental, supraclavicular, femoral, inguinal)
Neurologic: (also see Neurology Exam, pp. 5-6): Cranial nerve 1 intact to coffee grounds. CN 2 intact to print 2 cm in height held 12 inches from face. CN 3,4,6 intact to tracking a finger. CN 5 intact to bilateral bite on tongue blades. CN 7 intact to puffing cheeks, smiles, growls, closing eyelids, and wrinkling brow. CN 8 intact to normal volume of speech. CN 9,10 intact with equal elevation of palate bilaterally. CN 11 intact to shoulder shrug. CN 12 intact with no tongue deviation on protrusion. Power 5/5 throughout (deltoids, biceps, triceps, wrist extensors, wrist flexors, hip extensors, hip flexors, quadriceps, plantarflexors, dorsiflexors). Sensation was grossly intact when tested with a safety pin. Cerebellar exam was within normal limits with finger-nose-finger and rapid alternating movements. Reflexes: 2+ upper (biceps and triceps) and lower (patellar and Achilles) bilaterally.

Labs/Studies:

8/24 (day of admission):

Sodium 137	TSH: 3.22
Potassium 3.8	
Chloride 106	WBC 13.1
CO2/bicarb 20	Hemoglobin 11.8
BUN 10	Hematocrit 33.9
Creatinine 0.5	Platelets 246
Glucose 86	
Magnesium 1.8	

	Set 1	Set 2	Set 3
TroponinT	< .01	< .01	< .01
CK	< 25	< 20	< 20
CKMB	1.4	1.3	1.1

Urinalysis

Specific gravity 1.008
Clear, yellow
15 mg/dL ketones pH 7.0
Neg for blood, heme, leukocyte esterase, nitrites, urobilinogen, and protein

EKG: Irregularly irregular with some fibrillation waves present

Assessment: Patient is a 39-year-old female with a history of gestational diabetes and genital herpes, who presents with new onset palpitations and dizziness.

Differential Diagnosis:

1. Cardiovascular
    a. Atrial fibrillation
        i. Hyperthyroid
        ii. Structural disease (valvular, myocardial infarction, atrial enlargement)
    b. Ventricular tachyarrhythmia (unlikely)
    c. Pregnancy-induced hypertension from compression of the IVC with increased heart rate as compensation
2. Renal
    a. Hypovolemia
        i. Dehydration
        ii. Hemorrhage
3. Metabolic
    a. Hypoglycemia
    b. Hyperthyroid
4. Psychiatric
    a. Panic attack

Plan

1. CV:
    a. Repeat EKG, echocardiogram, cardiac enzymes
    b. T/C starting diltiazem or a beta-blocker for rate control
2. Labs:
    a. Chem 7, orthostatics, CBC
    b. Blood sugar, TSH level
3. Monitor. Consider PRN benzodiazepines
4. Fluid/Electrolytes/Nutrition: no issues
5. Prophylaxis: SCDs
6. Disposition: Awaiting studies to determine if the event is cardiac in nature

Adaptations for Each Rotation

Internal Medicine: The more information, the better. Anything at all relevant or not relevant can go into the History and Physical. You will likely not be typing out the History and Physical, but will instead be writing it on a blank sheet of paper or a pre-approved form at your rotating hospital. Your preceptors and attending physicians will want to see typical medical student H&Ps which are long, drawn-out, and include a lot of information that might never be asked by a physician again. You may need at least an hour to get that amount of information, especially at first. On the other hand, you may be with an intern who needs to get the information within 15 minutes in the ER so he/she can write orders and admit the patient. A good suggestion is to ask your team to send you down first to interview the patient, and then page them when you are ready (this may not work for them so just go with the flow). Also, if you have to write your H&P on a blank paper, get in the habit of leaving room for the HPI and then labeling all of the other things you will ask on the page like a template, and then you can fill them in directly on the sheet instead of transferring notes later. Then all you will have to do is write the HPI and fill in your labs and A/P section.

Surgery: A challenging H&P to write because you are expected to only write the relevant information, but it can be difficult to know what is relevant to the surgeon. In general, worry less about the social history/sexual history/family history unless it is very pertinent to the disease process that you are being asked to treat. Get a good prior surgical history on your patient including which side the operation was on and how long ago, as well as any complications. Many surgeons like little drawings of the abdomen on the sheet with scars, pain, masses, etc. marked on the drawing.

Ob/Gyn: These are somewhere between a medicine and surgery H&P. It is important to include the Ob and Gyn histories, as well as the pelvic exam. Always start the HPI with the gravidity and parity of the patient.
A sample of a good Ob/Gyn history for a patient would be:

- OB: Patient is G2P1001. She delivered a VMI (viable male infant) via SVD (spontaneous vaginal delivery) in 2000 with a complication of pre-gestational HTN. The HTN has since resolved with no further treatment.
- GYN: 12/28-30/5 (This means the patient began menarche at age 12, has regular cycles every 28-30 days, and bleeds for 5 days typically). She denies menorrhagia (heavy bleeding during the period), metrorrhagia (bleeding in between periods), and dysmenorrhia (very painful menses). She has never had an abnormal pap smear, and has been treated for HSV2. She is currently on Acyclovir for suppression. No other STD history. The patient was on OCP (oral contraceptive pills) for 6 years prior to becoming pregnant, and stopped 6 months prior to becoming pregnant.

Psychiatry: While a long H&P on psychiatry is not unusual, be careful about rambling. You want to capture a "snapshot" of the patient, not record a 6-hour video documentary. Psychiatric patients are difficult because they usually talk too much, or too little. You will need to get only the relevant information and record that in the HPI. Don't forget things like trauma history and how far the patient went in school. Often you will need to collect "collateral" information from family members or those that know the patient best. You will be expected to make phone calls if necessary. Suicidal and homicidal ideation is also important to assess. The physical exam includes the Mental Status Exam as well as usually a section for heart, lungs, and abdomen. Your assessment section is easier than in other H&Ps because you will write it in an "axis" system. The plan typically includes medications and some kind of monitoring.

An example of an axis assessment is:

- Axis I (major psychiatric diagnosis): schizophrenia, paranoid type
- Axis II (personality disorders and mental retardation): Deferred (usually you will not diagnose a personality disorder in an inpatient facility even if it is glaring)
- Axis III (Medical history): HTN, DM
- Axis IV (stressors): homelessness, no family
- Axis V (Global Assessment of Function Score): 30 (look this up on a chart)

Pediatrics: The H&P is essentially the same as for Internal Medicine. Make sure you include whether the child is urinating, defecating, feeding, sleeping, or irritable in the HPI. Also, you will want to include a birth history (i.e. any complications or prematurity) and developmental history in the social section. Example: The patient was born at 7lbs 6oz via SVD (spontaneous vaginal delivery) with no complications during pregnancy or delivery. He has reached all current developmental milestones.

Family Medicine: You will probably never write an H&P for family medicine. If so, just follow the Internal Medicine sample.

Abbreviations Used in this Guide

AAOx3	Awake, alert and oriented x 3 (person, place and time)
BM	Bowel movement
BMP	Basic metabolic panel
+BS	Positive bowel sounds
Ø c/c/e	No clubbing, cyanosis, nor edema
C/D/I	Clean, dry, intact
c/o	Complained of
CBC	Complete blood count
CP	Chest pain
CTAB	Clear to auscultation bilaterally
D/C	Discharge or discontinue (depending on context)
D/W	Discuss with
EBL	Estimated blood loss
F/C	Fevers/ chills
HD	Hospital day
I&Os	Ins and Outs (should specify time period)
JP	Jackson-Pratt drain
m/r/g	Murmurs, rubs, gallops
N/V	Nausea/vomiting
NAD	No acute distress
NKDA	No known drug allergies
NPO	Nothing by mouth
NT/ND	Non-tender, non-distended
PCA	Patient controlled analgesia pump
PCB/SCD	Pneumatic compression boots, sequential compression devices
PMH	Past Medical History
PO	Oral intake
POD	Post-op day
RA	Room air
RR	Respiratory rate
RRR	Regular rate and rhythm
s/p	Status post
+$S1_2$+S2	Audible first and second heart sound
SOB	Shortness of breath
SpO2	Oxygen saturation
SSI	Sliding Scale Insulin
t/c	To consider
Tc	Current temperature
Tmax	Max temp in past 24 hours
TTP	Tender to palpation
UA	Urinalysis
UO	Urine output
VS	Vital signs
w/r/r/c	Wheeze, rales, rhonchi, crackles
WNL	Within normal limits