

CHAPTER 23

THE PATIENT HISTORY AND DOCUMENTATION

Overview

The medical assisting student is introduced to how important an accurate, complete, and up-to-date patient medical history is to the quality of care provided by the provider and the health care team. Students explore the communication issues and challenges involved in taking histories from patients, emphasizing respect and attention to the patient's emotional needs while maintaining the level of information necessary to complete the history for the patient's permanent record.

Lesson Plan

I. LEARNING OUTCOMES	ABHES	CAAHEP
A. Define, spell, and pronounce the key terms as presented in the glossary.	MA.A.1.9.a	IV.P.1
B. Explain the purpose of the medical history.	MA.A.1.1.d; MA.A.1.8.c-d	V.C.2–3, V.P.1–2
C. Recall three functions to complete prior to a patient's appointment.	MA.A.1.5.g	IV.C.3, 7; IV.A.4, 7, 9, 10
D. Compare/contrast the cross-cultural concerns between patients and providers.	MA.A.1.4.a	IV.P.8
E. Describe the four nonmedical information forms to be signed by patients.	MA.A.1.1.d; MA.A.1.9.a	IV.C.1–6; IV.P.1–4
F. Discuss the medical assistant's general approach to the patient intake interview.	MA.A.1.5.g	IV.C.3, 7 IV.A.4, 7, 9, 10
G. Recall at least four circumstances to address in displaying cultural awareness.	MA.A.1.8.cc	IV.C.3–4., IV.A.1–3
H. Develop a strategy for communicating across the life span with patients.	MA.A.1.9.a	
I. Identify the components of the medical health history and their documentation.	MA.A.1.9.a	IV.C.6; IV. P.1;
J. Obtain a medical history from a patient.	MA.A.1.4.a	IV.C.6, 12
K. Restate the function and meaning of SOAP/SOAPER and CHEDDAR charting.	MA.A.1.9.a	IV.C.6; IV. P.1–2;
L. List the characteristics of the patient's chief complaint and the present illness.	MA.A.1.9.a	IV. P.1–2;
M. Compare/contrast the patient's medical, family, and social histories.	MA.A.1.9.a	
N. Discuss the rationale for including adult immunizations in health histories.	MA.A.1.9.a	V.C.6
O. Explain how the review of systems is obtained and documented.	MA.A.1.8.b	IX.P.3
P. State five reasons why the medical record is important.	MA.A.1.4.b	
Q. Identify three areas of concern regarding HIPAA compliance and the patient's chart.	MA.A.1.4.a	IV.C.6, 12.; IV.P.8
R. Recall the rules for charting and documenting in the patient's chart.	MA.A.1.4.a	IV.C.6, 12
S. Compare/contrast SOMR and POMR.	MA.A.1.4.a	

T. List the advantages of electronic medical records.	MA.A.1.7.b(2)	V.C.11
U. Review common charting abbreviations.	MA.A.1.3.d	IV.C.11
V. Describe the organization of a medical record.	MA.A.1.8.hh	V.C.5–6, V.P.3,
W. Analyze the professionalism questions and apply them to this chapter's content.		

II. PROFESSIONALISM QUESTIONS

A. Communication

1. Did you introduce yourself? Did you identify the patient through name and birth date or other identifying feature?
2. Did you speak at the patient's level of understanding?
3. Did you display appropriate body language?
4. Did you respond honestly and diplomatically to the patient's concerns?
5. Did you apply active listening skills?
6. Did you maintain eye contact with the patient during communication?
7. Did you refrain from sharing your personal experiences?
8. Did you accurately and concisely update the provider on any aspect of the patient's care?

B. Presentation

1. Did you do something to bond with the patient?
2. Did your actions attend to both the psychological and the physiologic aspects of the patient's illness or condition?
3. Did you attend to any special needs of the patient? Did you first ask if assistance was needed, rather than taking charge?
4. Were you courteous, patient, and respectful to the patient?
5. Did you display a calm, professional, and caring manner?

C. Competency

1. Did you pay attention to detail?
2. Did you apply critical thinking skills in performing patient assessment and care?
3. Did you recognize the importance of local, state, and federal legislation and regulations in the practice setting?

D. Initiative

1. Were you flexible and dependable?
2. Did you assist coworkers when appropriate?

E. Integrity

1. Did you demonstrate sensitivity to patient's rights?
2. Were you respectful of others?
3. Did you protect personal boundaries?
4. Did you demonstrate respect for individual diversity?
5. Did you demonstrate an appreciation for the patient's attitude toward the illness or condition?
6. Did you protect and maintain confidentiality?

III. REFERENCES

- A. Lindh, Wilburta Q., Pooler, Marilyn S., Tamparo, Carol D., Dahl, Barbara M., & Morris, Julie A., *Delmar's Comprehensive Medical Assisting: Administrative and Clinical Competencies*, 5e
- B. See text Chapter 23, References/Bibliography
- C. Any other teacher-preferred reference material

IV. VISUAL AIDS

- A. Computer access to identified Internet resources
- B. Samples of SOMR and POMR records
- C. Any teacher-preferred visual aids (PowerPoint, etc.)

V. EQUIPMENT AND MATERIALS

- A. Computer, TV monitor, and Internet access
- B. Samples of demographic data form, financial information form, medical history form, computerized health history, and release of information form

- C. Patient charts showing different methods of charting/documentation
- D. See IV: Visual Aid

VI. SAFETY

- A. Basic classroom procedures
- B. Follow Standard Precautions
- C. Read provider's orders carefully
- D. Manage patients with care

VII. PREPARATION

- A. Arrange for Internet access/visual aids equipment.
- B. Collect materials.
- C. Review Chapter 23 in the text, the Study Guide, the Competency Manual, and the Instructor's Manual.

VIII. INTRODUCTORY REMARKS/ACTIONS

- A. Read Learning Outcomes in the text with students to introduce the chapter.
- B. Have patient history items and printed materials displayed to stimulate interest.
- C. Ask, "Who has had a medical history taken lately?"
- D. Ask a student to share the experience to spark class discussion. Following this, ask the class, "From what you've heard, what do you think of the way this medical history was taken?"

IX. PRESENTATION

- A. The Purpose of the Medical History
 - 1. Basis for all treatment rendered by physician or any other provider
 - 2. Helps to guide treatment for patient
 - 3. Medical chart
 - a. Gives base for statistical analysis
 - b. Serves as a legal record
 - c. Should include everything concerning patient treatment
- B. Preparing for the Patient
 - 1. Make certain that the examination room is ready, all necessary supplies are available, and you are familiar with the patient's chart
 - 2. Bring the patient from the reception area to where the interview will take place
 - 3. Introduce yourself and speak plainly
 - a. Determine if any assistance is needed for the patient
 - b. If necessary, offer assistance with your friendly greeting
 - c. Accompany patient to the examination room and close the door
 - d. Seat the patient comfortably and sit face-to-face to begin the interview
 - e. Build rapport with the patient
 - f. Use the patient's name often, making certain you pronounce it correctly
 - g. Think globally as the interview begins
- C. A Cross-Cultural Model (see Patient Education in the text)
 - 1. Every patient interview is cross-cultural
 - 2. Health and illness are inseparable from social/cultural beliefs
 - 3. Patient's chief concern: illness
 - 4. Provider's chief concern: disease
 - 5. Patient's idea of treatment success: managing illness
 - 6. Provider's idea of treatment success: control disease problems
 - 7. Questions to ask patients:
 - a. What do you think caused your problem?
 - b. When do you think it started?
 - c. What effect does it have on you?
 - d. What are your concerns from this problem?
 - e. What kind of treatment do you expect?
 - 8. These questions help you respect patients' perspectives

D. Patient Information Forms

1. Demographic Data Form (Figure 23-1)
 - a. Name; address; home, work, and cell phone numbers; date of birth
 - b. Social Security number, insurance data, emergency contact person
2. Financial Information Form (Figure 23-2)
 - a. Financial policy of clinic, billing, insurance, finance charges
 - b. Minor patients, missed appointments
 - c. Patient signs and receives a copy
3. Privacy Information Form
 - a. Since 2004, any release of patient PHI must be disclosed
 - b. See for details <http://www.hhs.gov/ocr/privacy/>
 - c. Civil penalties for failure to comply
4. Release of Information Form (Figure 23-3)
 - a. Authorizes release of health care information to specific individuals
 - b. Must be in writing, signed, and dated
5. Medical History Form
 - a. Present health history, including why patient is being seen
 - b. Past health history, both personal and family
 - c. Social history, including marital status, sexual orientation, occupation
 - d. Military service dates and assignment
 - e. Body systems review/questionnaire
 - f. Medications patient currently taking, including over-the-counter, prescription, and herbal
 - g. Provider's review of system (ROS)
6. Computerized Health History
 - a. Patient-generated
 - b. Provider-generated

E. The Patient Intake Interview

1. Interacting with the Patient
 - a. Put patient at ease (Table 23-1)
 - b. Guide conversation
 - c. Keep on track
 - d. Explain terms as needed
 - e. Update history as needed
 - f. Remain professional and not embarrassed by any of the patient's comments
 - g. Note the chief complaint
2. Displaying Cultural Awareness
 - a. Patient who does not speak English
 - b. Patient who may be deaf
 - c. If interpreter is needed; complete the business associate contract (HIPAA)
 - d. Cultural barriers addressed
 - e. Patient who may have other special needs
 - f. Medical assistant to listen carefully and communicate effectively
3. Being Sensitive to Patient's Needs
 - a. Patient may be frightened, hostile, or depressed
 - b. Be aware of nonverbal and verbal communication
 - c. Know when touch is appropriate
 - d. Respect boundaries
 - e. Be patient and understanding
 - f. Calm upset patients
 - g. Patient may express a particular need
4. Dealing with sensitive topics (Critical Thinking box in text)
 - a. Ask questions in later stages of interview
 - b. Use casual direct eye contact without staring
 - c. Pose questions in matter-of-fact tone
 - d. Adopt nonjudgmental demeanor
 - e. Use "normalize" technique when appropriate

- F. Communication Across the Life Span
 - 1. Patient's age is important in communications
 - a. Infants—you communicate with two patients: parent and infant
 - b. Older children—provider may wish to examine alone
 - c. Teenagers—sets the stage for care in adulthood
 - d. Elder adults—may be accompanied by another person, either by choice or by necessity
 - e. May have HIPAA waiver signed by patient when a second person is in attendance
- G. The Medical Health History
 - 1. Personal data from demographic form
 - 2. Chief complaint
 - 3. Present illness
 - a. Medications
 - b. Allergies
 - c. Other providers or alternative therapy practitioners being seen
 - 4. Medical history
 - 5. Family history
 - 6. Social and occupational history
 - 7. Review of systems by physician or provider
- H. SOAP/SOAPER and CHEDDAR
 - 1. SOAPER method of charting (Figure 23-6)
 - a. S = Subjective data; patient's complaint in own words
 - b. O = Objective, observable, measurable findings
 - c. A = Assessment; probable diagnosis based on subjective and objective factors
 - d. P = Plan for treatment, medications, instructions, return visit information
 - e. E = Education for the patient
 - f. R = Response of patient to education and care given
 - 2. CHEDDAR is another style of charting
 - a. C = Chief complaint, presenting problems, subjective information
 - b. H = History, social and physical, of the presenting problem; contributing data
 - c. E = Examination; body systems review
 - d. D = Details of problem(s) and complaint(s)
 - e. D = Drugs and dosages; list of current medications, dosages, frequency
 - f. A = Assessment; diagnostic evaluation, further testing, medications
 - g. R = Return visit, if applicable
- I. Chief Complaint (CC)
 - 1. Noted in as few words as possible; can quote the patient
 - 2. Subjective data; be specific about cause, time of onset, and complaint
 - 3. Characteristics may include:
 - a. Location
 - b. Radiation
 - c. Quality
 - d. Severity
 - e. Associated symptoms
 - f. Aggravating factors
 - g. Alleviating factors
 - h. Setting and timing
- J. Present Illness
 - 1. Usually reflected in CC
 - 2. May be expanded using the characteristics a. through h. under 3. above
 - 3. May include other problems experienced, medications, and allergies
- K. Medical History (Procedure 23-1)
 - 1. Surgeries
 - 2. Allergies and medications (reviewed at every visit)
 - 3. Health problems
 - 4. Major illnesses
 - 5. Release of information form

- L. Family History (Patient Education box)
 - 1. Familial and hereditary health problems
 - 2. Age of family members; cause of death and age at the time
 - 3. Clues to patient's present condition
- M. Social History
 - 1. Spouse/partner status
 - 2. Sexual habits
 - 3. Hobbies
 - 4. Use of alcohol, recreational drugs, tobacco
 - 5. Lifestyles/behaviors that put patient at risk
 - 6. Home environment assessment questions
- N. Review of Systems (ROS)
 - 1. Preparation for provider
 - 2. Orderly and systemic check of each part of anatomy (Table 23-2)
 - 3. Documents positive and negative findings
 - 4. Used to make differential/clinical diagnosis
 - 5. Contents of the medical history documents integral parts of patient's health
- O. Patient's Record and Its Importance (manual or electronic)
 - 1. Confidential information
 - 2. Foundation for planning patient care
 - 3. Basis for communication among caregivers
 - 4. Legal document
- P. HIPAA Compliance
 - 1. Focuses on three vulnerable areas:
 - a. Paper record storage and computer/server areas
 - b. Fax machines
 - c. Workstations
- Q. Contents of Medical Records
 - 1. Informed consent forms
 - 2. Physical examination outcomes
 - 3. Laboratory and diagnostic test results
 - 4. Diagnosis and plan of treatment
 - 5. Surgical reports
 - 6. Progress reports
 - 7. Follow-up care
 - 8. Telephone calls related to care
 - 9. Discharge summary
 - 10. Other communications from providers, laboratories, etc.
 - 11. Patient's records from other providers
 - 12. Medication history
- R. Continuity of Care Record (CCR)
 - 1. Developed by a number of medical groups
 - 2. Makes it easier to transport patient medical information among providers
 - 3. Improves continuity of care and reduces errors
 - 4. Includes the following:
 - a. Patient and provider information
 - b. Insurance data
 - c. Patient's health status
 - d. Recent care given
 - e. Recommendations for future care
 - f. Reason for referral
 - 5. Most likely would include advance directives
 - 6. To be completed by providers (primary and ancillary), nurses, medical assistants
 - 7. Can be transferred electronically
- S. Methods of Charting/Documentation
 - 1. Source-Oriented Medical Records (SOMRs)
 - a. Chronological set of notes for each visit
 - b. May be typed by medical transcriptionist from provider's dictation (Figure 23-7)

2. Problem-Oriented Medical Records (POMRs)
 - a. Database: history and examination results (core of record)
 - b. Problem list: identified with assigned numbers
 - c. Diagnostic/treatment plan: documented chronologically for each problem
- T. EMRs (Figure 23-9 and Figure 23-10)
 1. Mandated by 2014
 2. Can be a part of TPMS
 - a. Available 24 hours a day
 - b. Can be accessed from outside location
 - c. Available to more than one person at a time
 - d. Storage is simple
 - e. Fewer errors than in handwritten data
 - f. Software capability of “flagging” queries to providers
 3. Charting rules are similar to those in the paper record
- U. Rules of Charting (Table 23-3 and Table 23-4)
 1. Charting required for every patient contact related to care
 2. Must be accurate, clear, complete, timely, and entered properly
 3. “Act not charted” is considered an “act not done”
 4. Abbreviations used in charting kept to a minimum (Table 23-6)
 5. Medical record must be understandable to any person reading it
 6. Chart organization:
 - a. Must be kept in orderly, predetermined fashion
 - b. Chronological order
 - c. Manual record to use both sides of chart for specific data
 - d. Contents of the miscellaneous section
 - e. Specific order to be understood by each member of the clinic staff
- X. APPLICATION
 - A. Use the Learning Outcomes at the beginning of Chapter 23 in the text as questions to assess comprehension.
 - B. See the Classroom Activities section below for numerous application activities.
 - C. Assign students to complete Chapter 23 in the Study Guide.
 - D. Complete the Procedure in Chapter 23, using the Competency Manual to evaluate.
- XI. EVALUATION
 - A. Evaluate any assigned application activities.
 - B. Evaluate student participation during classroom activities.
 - C. Grade responses to Chapter 23 in the Study Guide.
 - D. Evaluate student performance on Chapter 23 Procedure.
 - E. Assign credit for group participation activities.

Classroom Activities

1. Have students define any terms in a medical history they do not understand and write the definitions in a notebook.
2. Have students role-play as medical assistant and parent, with the student medical assistant having the job of taking the child’s medical history.
3. Make flash cards with terms and definitions from medical history forms and have students quiz each other in pairs or small groups.
4. Make copies of several different types of medical history forms. (Obtain them from local medical offices or clinics.) Have students role-play a medical assistant and patient in completing the forms and then reverse roles. Give students a stopwatch or other timepiece to record how long it actually takes to accurately obtain the requested information and record it legibly.
5. Establish chart information and have students note the documentation in chart form.

Answers to Critical Thinking Boxes

With two others in your class, role-play a scenario where one person is the patient, another is the medical assistant, and the third is an observer. A social history is being taken. As the medical assistant you ask the patient about the use of any recreational drugs or chemicals. The patient responds, “Yes.” What additional questions will you ask the patient? What will you include in the medical record?

Answers will vary. The medical assistant will want to say the following: “Please identify the drugs you use.” Once they are listed, the next question is, “How often do you use these drugs?” You may need to help the patient by providing some options for such as “daily, twice a week, monthly?” You might also ask if the use of the substances interferes with daily living or work responsibilities. Chart the patient’s response in his or her own words. If the patient refuses to respond to the questions and wishes to communicate no further, indicate this so that the provider can follow up in the examination of the patient.

Answers to Case Studies

Case Study 23-1

Refer to the scenario at the beginning of the chapter.

Maria Jover, a patient of Dr. Elizabeth King at Drs. Lewis and King, has finally convinced her teenage son to make an appointment for a physical. Adam Jover is 17 years old, outgoing, fun loving, and apparently healthy. But Maria is concerned that he may be engaging in harmful social activities and hopes that by seeing Dr. Winston Lewis, Adam may discover ways to protect himself and his health. Adam agreed to the appointment but is adamant that his mother not accompany him. At the ambulatory care setting, it is decided that Adam might be more forthcoming with a male medical assistant, so Joe Guerrero, CMA (AAMA) is scheduled to take Adam’s medical history before Dr. Winston does an ROS.

1. When Joe Guerrero first sits down with Adam to take the history, he notices that Adam is ill at ease and nervous. What can Joe do to reassure Adam that his privacy will be protected?

The medical assistant must be as thorough as possible while respecting the patient’s privacy and must help Adam understand that a complete and thorough medical history enables the provider to advise patients on how to prevent any future problems.

2. When Joe attempts to take the social history, Adam seems evasive about answering Joe’s questions and finally admits that he doesn’t want his mother, Maria, to know about his social activities. What is Joe’s response?

Joe should reassure Adam that patient information is confidential and that his mother has agreed to respect his privacy (since this is the case). Joe can also try to engage Adam in the medical history taking by inviting Adam’s perceptions, such as:

- What are your concerns about this exam?
- Is there any kind of treatment you are nervous about?

Joe should also use his communication skills to get Adam to be responsive; if Joe can develop a relationship with Adam, Adam is more likely to be honest and Joe can be more effective in helping Adam analyze his social behaviors.

3. By the end of the interview, it becomes apparent that Adam may be engaging in some behaviors that put him at high risk for contracting the human immunodeficiency virus. How can Joe provide Adam with guidance without alienating him?

Joe should not be condemning or judgmental but should help Adam protect himself by following proper precautions. If Adam has come to respect and trust Joe, he is more likely to accept his opinion. Joe can give Adam some printed material to educate him about HIV infection; reading about the topic may encourage Adam to rethink some of his behaviors.

Some techniques that Joe can use when dealing with sensitive topics include:

- Asking these questions later in the interview
- Using direct eye contact
- Posing questions in a matter-of-fact tone
- “Normalizing” the situation, e.g., saying, “Many students seem to do this. How does it affect you?”

Case Study 23-2

Harvey DiAntonio is a 58-year-old patient who lives at 45 W. Smith Avenue, Baltimore, Maryland 21208. His date of birth is July 8, 1954. His phone number is 667-1870. He is a Baltimore City fire fighter and has been for 21 years. He has union medical insurance, and Blue Cross/Blue Shield (BC/BS) is his carrier. His number is 211-67-87-56. He also carries major medical and his policy is Diagnostic #4. He has been referred by the fire department practitioner, Dr. Alan Byers. Mr. DiAntonio's complaint is severe "gripping" pain in the anterior mid-chest sometimes radiating to the abdomen, neck, and both arms. Pain seems to occur with strenuous exercise and when walking uphill. Pain usually lasts 20 minutes with each episode. Pain does "ease up" when he ceases activity. Mr. DiAntonio states his episodes have occurred while he was shaving, climbing stairs at work, after a heavy meal, and during sexual intercourse. One episode last week was accompanied with dizziness, nausea, and fatigue. The episodes have been going on now once or twice a month for 5 months. Mr. DiAntonio's history is essentially noncontributory. It is questionable whether this is due to good health or the fact that the patient has not had a physical examination for 8 years. Surgeries include tonsillectomy and adenoidectomy, T&A, 1958, and appendectomy in 1964. Fractured rib, left side, in 1984 due to fire-fighting incident. Usual childhood diseases. Hospitalized for observation, 1962, Sinai Hospital, for an unusually long episode of bronchitis. Social history shows that the patient is a pump operator on the job with much heavy exertion. Smokes 1½ to 2 packs of cigarettes per day and is a moderate drinker. He has a weight problem off and on and tends to eat too much while on duty. Lives in a one-story home. Hobbies include carpentry and music. Some family problems and tension exist as both of his children are in adolescence. Patient describes himself as "fun loving" with a "quick temper" and worries about meeting financial needs of the family. Is in a position to retire from active duty but states he could not tolerate the boredom.

Family history shows both parents deceased—mother of heart attack, age 59, and father of unknown cause at age 49. Has two siblings, one brother with history of hypertension and one sister living and in good health. Has two children both living and well. Family history otherwise negative.

Physical examination revealed a well-nourished, well-developed male in no acute distress at this time. Patient does seem a bit anxious about this examination. T. 98.6 - P. 94 - R. 24 - BP 175/104. Ht. 69, Wt. 198 pounds. HEAD, EYES, EARS, NOSE, THROAT—normal. NECK—supple. Trachea in midline. CHEST—normal in contour. Calcium deposit on left sixth rib probably due to history fracture. HEART—after careful examination with the patient recumbent and the scope placed lightly on the chest wall near the apex, a left atrial sound was heard (presystolic gallop). ABDOMEN—negative. EXTREMITIES—negative. GENITALIA—negative. SKIN—negative. NEUROLOGIC—negative. Laboratory tests performed show a hemoglobin of 11.0 gms. Awaiting results of serum cholesterol, calcium, phosphorus, and blood urea nitrogen. Chest radiograph essentially negative. EKG report showed atrial sounds occurring presystolically with long P-R intervals. DIAGNOSIS: (1) angina pectoris; (2) anemia; (3) hypertension. TREATMENT: Nitroglycerin tabs, sublingually as needed. To return to clinic in 2 weeks to follow medication effects. In consultation with patient, the patient was advised to control physical activity and quantity of food intake. Avoid extreme cold, 8 hours of sleep/night. Avoid emotional upsets. Attempt four meals/day. Low-fat 1,600-calorie diet. No smoking, moderate alcohol intake.

1. Identify the following parts of the case study above and extract from the case study the portion that matches the appropriate medical history component.

- Personal data
- Chief complaint
- Present illness
- Medical history
- Family history
- Social history
- Review of systems

Personal data: Harvey DiAntonio

45 W. Smith Avenue

Baltimore, MD 21208

ph. 667-1870

Insurance: BC/BS 211678756

Major Medical—

Diagnostic #4

Referred by: Dr. Alan Byers

DOB 07/08/1954

Chief complaint: Severe “gripping” pain in the anterior mid-chest, sometimes radiating to the abdomen, neck, and both arms.

Present illness: Pain occurs with strenuous exercise, walking uphill, shaving, climbing stairs, after a heavy meal, during sexual intercourse. Pain lasts 20 minutes with each episode, does not stop when he ceases activity. Episode last week included dizziness, nausea, and fatigue. Episodes ongoing once or twice per month × 5 months.

Medical history: Essentially noncontributory. Has not had physical examination for eight years.

Surgeries: T & A, 1958

Appendectomy, 1964

Fractured rib L, 1984

Usual childhood diseases

Hospitalization:

Observation, 1962—Sinai Hospital

Dx bronchitis

Family history: Both parents deceased, mother age 59—MI, father age 49 cause ?—brother living, hypertension—sister alive and well—two children alive and well (adolescents).

Social history: Firefighter—pump operator—heavy exertion, smokes 1 1/2–2 packs of cigarettes per day, over-eats while on duty; hobbies—carpentry, music. Describes self as “fun-loving,” “quick tempered,” worries about finances. Eligible to retire, but prefers to remain working.

Review of systems: Well-nourished, well-developed male in no acute distress. Somewhat anxious. Wt. 198 pounds, BP 175/104—T. 98.6—P. 94 (reg.)

HEENT normal

Neck supple

Trachea midline

Chest normal in contour—calcium deposit L 6th rib noted on X-ray, otherwise neg., probably due to old fracture.

Heart presystolic gallop

Abdomen negative

Extremities negative

Genitalia negative

Skin negative

Neurologic negative

Laboratory Hgb 11.0 gm

EKG presystolic atrial sounds, long P-R interval

Impression:

1. angina pectoris

2. anemia

3. hypertension

Plan: nitroglycerin tab sublingually as needed, watch quantity of food intake, low-fat 1,600 calories, 4 meals/day, avoid extreme cold, sleep 8 hours/night, avoid emotional upsets, no smoking, moderate alcohol intake.

Return in 2 weeks

2. Using appropriate terminology and abbreviations, make a charting entry for Mr. DiAntonio by using the SOAPER method of charting.

A SOAPER chart note for Harvey DiAntonio is less likely to be created when such a detailed history and physical (H&P) is obtained. However, some clinics will use the SOAPER method of charting even in the H&P. Students can be asked to identify the SOAPER entries as they appear in the H&P, or they can be asked to write a brief SOAPER chart note for one of the diagnoses. The following is an example of an appropriate SOAPER for only the angina pectoris diagnosis:

Harvey DiAntonio

Date of Birth 07/08/54

09/27/XX

S: Patient reports severe “gripping” pain in the chest, sometimes abdomen, neck, and arms; occurs with strenuous exercise; usually lasts 20 minutes.

O: Well-nourished, well-developed male in no acute distress. T. 98.6; P. 94; BP 175/104. Ht 69 in. Wt 198 lbs. EKG confirms left atrial sounds heard (presystolic gallop) with P-R intervals.

A: Angina pectoris

P: Nitroglycerin tabs, sublingually as needed.

E: Discussed diet, appropriate physical activities, and stress reduction with patient.

R: Follow-up appointment in 2 weeks. Elizabeth King, MD/jg

Answers to Certification Review

1. a. make the appointment for the patient and obtain the services of an interpreter to be present
2. c. Have you noticed any changes in your condition since your last visit?
3. b. ask helpful questions to help the patient express specific problems or symptoms
4. a. are chronologic notes beginning with the patient's first visit
5. a. demographic data
6. d. a and c
7. b. cross-cultural interviewing and communication skills
8. d. all the above
9. c. the CC, problems, conditions, treatment, and responses to care
10. a. SOAP

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