

Patient Note Example One

The patient note on the following page is written primarily in a narrative style. The History is written in full or nearly full sentences, and the Physical Examination also has fairly complete phrases. Note that there are only four studies ordered under the Diagnostic Workup section; this is acceptable.

There are some abbreviations not included in the glossary (pages 32-33), but they are common enough to be recognizable by the practicing physicians rating the notes. The note is written in cursive script, but it is legible.



PN Number

Test Date

Candidate

Rater ID

Session

□ □ □ □ □ □ □ □ □ □

Room Number

Candidate Number

Encounter Number

HISTORY - Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.

48 year old ♀ c/o chest pain. Began 1.5 hrs. ago, pain is burning in character, no radiation, sl SOB, sl U/ and diaphoresis. Pain resolved after 20 mins without treatment. No pain now. Has had several similar episodes over past 2-3 mos, usually after a heavy meal or exertion with some relief by antacids. Has Hx of elevated cholesterol but no follow-up or treatment. Play tennis weekly, ex-smoker x 3 yrs. (30 packs/yr), denies unusual stress. Mother c/ NIDDM and brother with unknown heart problem. No Hx HTN, DM but has not seen MD x 2 yrs.

PHYSICAL EXAMINATION - Indicate only pertinent positive and negative findings related to patient's chief complaint.

No obvious distress, minimizing symptoms, anxious to leave. BP of 160/80 noted.

Chest - no tenderness, clear BS bilaterally without wheezes, rhonchi or rales.

Heart - apical impulse not displaced, regular rhythm, no (M) or rubs.

Abdomen - nondistended, BS⁺, no masses or organomegaly. 1⁺ tenderness in epigastrium without rebound.

DIFFERENTIAL DIAGNOSIS - In order of likelihood write no more than 5 differential diagnoses for this patient's current problems.

1. Esophageal reflux disease
2. Peptic ulcer
3. Coronary artery disease
4. Cholecystitis
5. Musculoskeletal chest pain

DIAGNOSTIC WORK UP - Immediate plans for no more than 5 further diagnostic studies

1. Stool for OB
2. EKG
3. CXR
4. endoscopy
- 5.

Patient Note Example Two

This patient note is written in more of a telegraphic or “bullet” style. There are no complete sentences, although there are some phrases where appropriate. In some parts of the History in particular, there are one or two words that stand alone. The writer of this note has chosen to transcribe the patient’s blood pressure from the doorway information. You may wish to include vital signs if they are particularly relevant to the case.

In this note only four items are listed in both the Differential Diagnosis and in the Diagnostic Workup sections; again this is acceptable. This sample also has some abbreviations or symbols not included in the glossary (pages 32-33) but, as in Example One, they are generally recognizable. This note is printed throughout, although a mixture of cursive script and printing would also be acceptable, provided both were legible.



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HISTORY - Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.

48 YO ♀ CC - CHEST PAIN X 30 MINS

HPI - STARTED AFTER HEAVY MEAL

- ⊕ NAUSEA

- SLIGHT SWEATING, SOB

- RESOLVED SPONTANEOUSLY

- SIMILAR EPISODES OVER LAST 2-3 MOS, AFTER HEAVY MEALS OR EXERTION

- ALSO RETROSTERNAL BURNING WHILE PLAYING TENNIS, PARTIAL RELIEF W/ ANTACIDS

PMH - ↑ CHOLESTEROL, NO TREATMENT NO HTN OR DM

HABITS - SMOKED 30 PK YRS, STOPPED 3 YRS AGO

PHYSICAL EXAMINATION - Indicate only pertinent positive and negative findings related to patient's chief complaint.

BP 160/80 - APPEARS COMFORTABLE

CHEST - CLEAR BS BILAT, NO CRACKLES

HEART - REG RHYTHM, NO (M) OR RUB

CLEAR S₁, S₂

ABD - NL SOUNDS, NO MASSES, NO TENDERNESS

LIVER NOT ENLARGED

EXTREMS - NO EDEMA, PULSES INTACT

DIFFERENTIAL DIAGNOSIS - In order of likelihood write no more than 5 differential diagnoses for this patient's current problems.

1. MYOCARDIAL INFARCTION
2. ACID REFLUX
3. MUSCLE STRAIN
4. ANXIETY REACTION
- 5.

DIAGNOSTIC WORK UP - Immediate plans for no more than 5 further diagnostic studies

1. EKG
2. CARDIAC ENZYMES
3. U/S OF GALLBLADDER
4. UPPER GI SERIES
- 5.