

# HISTORY FRAMEWORKS

Developed by

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## Complete Medical History and Write-up Framework

- I. **Chief Complaint (cc)**
- II. **History of Present Illness (HPI)**
  - A. Seven Cardinal Features of the presenting symptom (cc)
    1. Quality
    2. Location
    3. Chronology
    4. Setting and Onset
    5. Severity
    6. Modifying Factors
    7. Associated Symptoms
  - B. Pertinent positives and negatives\*: Use the Review of Systems of the systems that your differential falls in, for example, chest pain could be secondary to Cardiac, Respiratory, GI, or musculoskeletal systems.
  - C. Pathophysiologic Features, for example, if the patient has a headache an understanding of increased intra-cranial pressure would tell you to ask about early morning headache and vomiting.
  - D. Risk factors (including epidemiologic factors)
  - E. Chief Concern
- III. **Past Medical and Past Surgical History**
  - A. Adult Medical Illnesses
  - B. Adult Surgical History
  - C. Psychiatric History
  - D. Childhood Illnesses
    - D1. (Birth and Developmental History)\*\*
  - E. Injuries
  - F. Medications
  - G. Allergies\
  - H. Transfusions
  - I. Pregnancies

† Slightly modified by Scott D. Wellman

- IV. Social History/Habits and Risk Behavior
  - A. Birthplace
  - B. Education
  - C. Work and Work History including exposure to hazardous materials
  - D. Marital/Relationship Status
  - E. Quality/Quantity of Social Relationships
  - F. Diet (see Appendix 3 and 4)
  - G. Exercise (see Appendix 3 and 4)
  - H. Tobacco Use (see Appendix 3 and 4)
  - I. Alcohol Use (see Appendix 3 and 4)
  - J. Drug Use (see Appendix 3 and 4)
  - K. Sexual Behaviors History (see Appendix 3 and 4)
  - L. Domestic Violence
  - M. Injury Prevention (seat belts, bicycle helmets, etc.) (see Appendix 3 and 4)
  
- V. **Family History**
  - A. Significant **Illnesses** in 2-3 generations of family
    - Ages and health status of **siblings**—document
    - Ages and health status of **parents**—document
    - Ages and health status of **grandparents**—document
    - Ages and health status of **children**—document
  - B. Common **Diseases** with known genetic links
    - 1) familial incidence of arthritis, cancer, diabetes, hypertension, myocardial infarction, stroke, mental illness, alcoholism
    - 2) any other illness that **runs in the family**
    - 3) Is there anyone in the family that has a problem like yours?
  
- VI. **Health Care Maintenance (Prevention and Screening)** (see Appendix 5)
  - A. Cancer Screening (breast, cervical, skin, prostate, colon)
  - B. Immunizations
  - C. High Risk Population Screening (e.g. HIV testing for those with high risk behavior)
  - D. Other (cholesterol, vision, hearing, dental, sun exposure)
  - E. Values History
    - 1. Health Care Proxy
    - 2. Advanced Directives

VII. **Review of Systems (ROS)** (see Appendix 1 and 2)

- |                           |                     |
|---------------------------|---------------------|
| A. Constitutional         | B. Skin             |
| C. Head                   | D. Eyes             |
| E. Ears                   | F. Nose             |
| G. Mouth                  | H. Throat           |
| I. Breasts                | J. Respiratory      |
| K. Cardiovascular         | L. Gastrointestinal |
| M. Urinary                | N. Genital          |
| O. Menstrual-Reproductive | P. Endocrine        |
| Q. Musculoskeletal        | R. Hematological    |
| S. Nervous System         | T. Psychiatric      |

- **\*Pertinent Positive** is a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint **which is present** in the patient.
- **\*Pertinent Negative** is a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint **which is absent** in the patient.

\*\* ( ) tasks pertain to Pediatric History

## Review of Systems (ROS) - Medical Terms

1. **CONSTITUTIONAL SYMPTOMS:** Fever, night sweats, chills, fatigue, anorexia, insomnia, weight change, weakness, irritability.
2. **SKIN:** Change in moisture, temperature, color or texture, lesions, rashes, itching, bruising, bleeding disorders, changes in hair or nails.
3. **HEAD:** Change in head size, headache, trauma.
4. **EYES:** Vision changes, glasses, blurring, eye pain, diplopia (double vision), scotomata (blind spots), flashes of lights, injury, irritation, discharge, photophobia, excessive tearing.
5. **EARS:** Hearing loss, pain, infections, discharge, tinnitus, vertigo.
6. **NOSE:** Dryness, bleeding, pain, discharge, coryza, epistaxis, obstruction, sinus pain, change in smell.
7. **MOUTH:** Condition of teeth, pain in mouth or tongue, bleeding gums, lesions in mouth, tongue or lips.
8. **THROAT:** Soreness, hoarseness, dysphagia.
9. **BREASTS:** (both sexes) Pain, swelling, discharge, masses, breast self-exam.
10. **RESPIRATORY:** Cough (acute or chronic), sputum production, hemoptysis, dyspnea, wheezing, occupational exposure, chest pain, pleurisy, orthopnea.
11. **CARDIOVASCULAR SYSTEM:** Chest pain, exertional dyspnea (shortness of breath), paroxysmal nocturnal dyspnea, orthopnea, palpitations, syncope, peripheral edema, cyanosis, murmur, intermittent claudication, Raynaud's phenomenon, varicose veins, phlebitis.
12. **GASTRO-INTESTINAL TRACT:** Dysphagia, odynophagia, appetite, heart burn (acid indigestion), eructation (belching), regurgitation, bloating, abdominal pain or discomfort, fullness, distention, pain, nausea, vomiting, hematemesis, jaundice, bowel habit change, rectal pain, hemorrhoids, hernia, hematochezia, melena, diarrhea, constipation.
13. **URINARY SYSTEMS:** Dysuria, frequency, urgency, polyuria, nocturia, incontinence, flank pain, hematuria, retention, dribbling, hesitancy, poor stream, back or costovertebral angle (CVA), tenderness.

14. **GENITAL SYSTEM:**
- a. Gynecological: discharge, itching, genital lesions
  - b. Male Genitalia: pain, lumps, urethral discharge, testicular pain or swelling
  - c. Sexual Problems: dissatisfaction, dyspareunia, potency, recent change in pattern.
15. **MENSTRUAL-REPRODUCTIVE HISTORY:** Dysmenorrhea, intermenstrual bleeding, changes in cycle, amenorrhea, menorrhagia, metrorrhagia. Time, type, and location of any pain or other associated symptoms, (hot flashes, sweating), post-menopausal bleeding. Emotional reaction to menarche and menopause.
16. **ENDOCRINE SYSTEM:** General (weight change, easy fatigue, behavioral changes), thyroid disease (goiter, heat or cold intolerance, sweating, exophthalmos, tremor, skin and hair changes), diabetes (polyuria, polydipsia, vaginal discharge and itching, skin infections), pituitary disease (change of facial features, hands, feet). Secondary sex characteristics, habitus, hair distribution. Impotence, libido, sterility. Neck surgery/irradiation.
17. **MUSCULO-SKELETAL SYSTEM:** Bone pain, tenderness, swelling, stiffness, limitation of movement of neck, trunk, extremities. Weakness. Trauma, fracture. Swelling backache and leg cramps.
18. **HEMATOLOGICAL:** Lymph node enlargement, pain, anemia, bleeding, bruising.
19. **NERVOUS SYSTEM:** Syncope (faint), dizziness, convulsions, vertigo, difficulty with speech or swallowing, localized or generalized symptoms, tremor, weakness, pain, numbness, paresthesia, incoordination, difficulty with bladder or bowel control.
- a. Cranial nerve symptoms: change in smell, Diplopia, change in vision, blind spots, difficulty with speech, swallowing, or chewing, facial numbness or drooping, change in hearing, tinnitus
  - b. Motor system: paralysis, atrophy, involuntary movements, seizures, gait, incoordination
  - c. Sensory system: pain, paresthesia, hyperesthesia, anesthesia
  - d. Mentation: orientation, memory. Reading and writing. Loss of consciousness.
20. **PSYCHIATRIC:** Rapid changes in mood, memory loss, phobias, hallucinations, sleep disturbances, problems with coping, suicide, (attempts or thoughts), anhedonia, frequent crying.

## **Review of Systems (ROS) - Lay Terms**

**GENERAL:** Any problems with your sleep? energy level? appetite? Any recent change in your weight? Any fever, chills? Any problem with excess thirst? Does the heat or cold bother you more than it bothers most people?

**SKIN:** Any problem with your skin...itching, bruising, growths? changes in moles or a freckle? Any problem with skin moisture...too dry, too oily?

**HEAD:** Have you ever had a serious head injury or gotten knocked out? Any problem with headaches, dizziness, blackouts?

**EYES:** Do you have any trouble with your vision? blurred vision? double vision? Do you ever see spots or flashes? (Any history of eye infections? injuries? Any problem with discharge or tearing? Do bright lights bother your eyes?

**EARS:** Do you have any difficulty with your hearing or ringing in your ears? pain in your ears? itching? drainage? Do you have any difficulty with dizziness? a sensation that the room is spinning around you?

**NOSE/THROAT/MOUTH:** Any mouth or throat problems...hoarseness, difficulty swallowing, pain, or swelling? Any problems with your teeth or gums?

**BREASTS:** Any problems with pain, swelling in your breast? Any discharge? lumps? Do you regularly check your breasts for lumps?

**RESPIRATORY:** Do you get short of breath or have pain with breathing? Do you get short of breath with activity? Do you ever wheeze? Do you ever wake up at night short of breath? (Can you go up one/two flights of stairs without stopping? Would you have to stop to catch your breath at the top?) Do you cough up phlegm or blood? Have you ever had a job where there was a lot of dust exposure? where people developed breathing problems as a result of working there?

**CARDIOVASCULAR:** Do you ever have chest pain? Do you ever wake up in the middle of the night short of breath? Have you increased the number of pillows that you sleep on to help you breath at night? Do you have skipped or rapid beating of your heart? Have you ever passed out? Do you have a problem with swelling or cramping in your legs? Have you ever noticed a color change in your fingers or toes when exposed to cold temperature? Do you have varicose veins? Any history of phlebitis or clots in your legs?

**GI:** Do you ever have trouble swallowing or painful swallowing? Any problems with heart burn? Have you been sick to your stomach? Have you vomited? ever vomited blood? Do you have belly pain, cramps or bloating? Any problems with bowel movements? (Diarrhea? Constipation? Noticed any blood in your stools or black or tarry stools?) Any history of jaundice or hepatitis?

GU: Do you have any problems with urination? (Any burning when you pass your urine? Are you passing urine more frequently? When you feel the urge to urinate, do you feel like you have to go right away? Is the force of your urine stream as strong as it always was? Do you have incontinence...trouble controlling your urine?) Any history of kidney stones or kidney infection? Do you have or have you had blood in your urine?

**GENITAL SYSTEM:**

- a. Gynecological - Do you have any vaginal discharge, itching, growths or lumps?
- b. Male Genitalia - Do you have any discharge from your penis? pain, lumps, or growths? testicular pain or swelling?
- c. Sexual Problems - Are you satisfied with your sexual function? What difficulties do you have, if any? Has your desire for sexual activity changed recently? Do you have pain with intercourse?

**MENSTRUAL-REPRODUCTIVE HISTORY:** Do you have any difficulties with your periods? pain? bleeding between periods? irregular cycles? intervals without periods? heavy bleeding? prolonged periods? bleeding after menopause completed? Do you have any general reactions to beginning or ending your periods?

**ENDOCRINE SYSTEM:** Do you have any change in weight? energy level? unexplained changes in behavior? Any neck growths? feelings of warmth or cold when others are not? excessive sweating? eye bulging? shaking of your hands that is not voluntary? loss or thinning of hair? Any excessive thirst? frequency of urination? Any change in facial features/appearance? size of hands or feet? Any loss of pubic hair? hair growth in locations you haven't had it before?

**MUSCULO-SKELETAL SYSTEM:** Do you have any bony pain? tenderness? joint pain? swelling? or stiffness? Do you have limited movement of any joint or in neck/back that seems greater than others? Do you have any weakness? back pain?

**HEMATOLOGICAL:** Do you have any lumps in your neck? under your arms? or in your groin? history of low blood counts/anemia? bleeding or bruising?

**NERVOUS SYSTEM:** Do you have any fainting, dizziness, convulsions/seizures or “fits”? difficulty with or change in speech? swallowing? hand or head shaking that isn’t voluntary? localized weakness, pain, numbness or tingling? difficulty with balance? bladder or bowel control?

- a. Cranial nerve symptoms - Do you have any change in smell? vision (double vision, blurry vision?) speech, swallowing, chewing? Any drooping of the face or eyes? change in hearing? ringing or buzzing in your ears?
- b. Motor system - Any paralyzed part of the body? loss of muscle bulk? involuntary movements? difficulty with walking? coordination?
- c. Sensory system - Any pain, numbness, tingling, or increased sensitivity of a body part?
- d. Mentation - Any change in your thinking? sense of where you are? your memory? reading or writing ability?

**PSYCHIATRIC:** Any change in mood? new fears/phobias? Do you ever see or hear things that aren’t there? Do you have any difficulty sleeping? coping with life stresses? feelings about ending your life? plans to end your life? Do you cry frequently and for no reason? Do you no longer get pleasure from things that used to give you pleasure?