

Patient profile

Name	Sex	Age	Place of	residency
The patie	ent was admi	tted via	on	at
History was taken	from the		_ by	а
5th year medical student on		at		•

Chief complaint

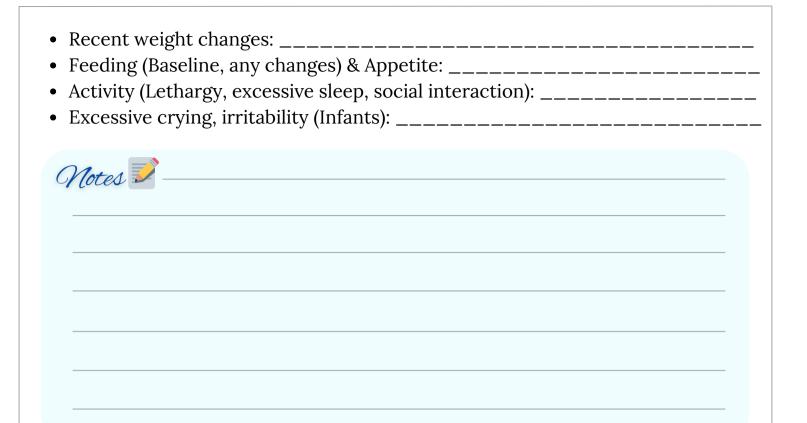
The patient is complaining from ______ for _____ for _____ duration.

History of presenting illness Try to clarify as much as you can :)

The patient was doing well/reltively doing well until she/he started to complain from:

- Site.
- Onset.
- Character & pattern (Constant or progressive).
- Radiation.
- Timing (Continuous or intermittent).
- Exacerbating / relieving factors.
- Severity (affect the sleep, feeding & activity).

Constitutional symptoms



Review of systems

Head

• Injuries, headache, hair loss & scalp infections.

Eyes

• Vision problems, use of glasses, history of discharge, abnormal tearing & injuries.

Ears

• Hearing problems, history of otitis & ear pain or discharge.

Oral cavity & throat

• Sore throat, dental problems, bleeding gum & ulcers.

Nose & respiratory system

- Runny nose, nasal bleeding.
- Cough (Dry or wet, day or night, contionous or intermittent, triggers, relieving factors) & hemoptysis.

- Rapid breathing, difficult breathing & noisy breathing (stridor, wheeze, grunting, snoring).
- History of URTI.

Cardiac system

- Chest pain , palpitation, history of murmurs, tachypnea & orthopnea.
- Exercise tolerance (Fatigue after feeding or activity).
- Excessive sweating after feeding or activity.
- Cyanosis, pallor, cold extremities & edema (swelling in the face or extremities).
- History of rheumatic fever in patient & family.

Gastrointestinal system

- Abdominal pain, abdominal distention, dysphagia & odynophagia.
- Diarrhea, constipation, stool color, stool consistency & blood in stool.
- Nausea, vomiting & hematemesis.
- Jaundice.

Genitourinary system

- Frequency, polyuria, oliguria, dysuria, hematuria, incontinence, bed wetting, character of urine stream.
- Urination baseline (Number of wet diapers).
- Urine color & smell.
- Flank pain & periorbital swelling.
- History of UTI.
- Urethral or vaginal discharge & age of menarche.

Extremities

• Joint or muscle pain, swelling, muscle strength & limitation of movement.

Neurologic system

- Seizures, abnormal movements, tremor & weakness.
- Headache, altered consciousness, dizziness, syncope.

Skin

• Rashes & bruising.

Past medical & surgical history

Previous history of similar complaint:		
Medical illnesses:		
Surgical history:		
History of trauma:		
Previous hospitalizations & ER visits:		
 Medications (Name, dose, frequency, rout, how long): 		
Vaccinations (Type & date):		
• Allergy:		
Blood transfusions:		
Antenatal history		
Mother age:		
Number of pregnancies:		
Any abortions:		
Maternal diseases:		
 Maternal health during pregnancy: 		
1. Complications during the pregnancy (HTN, DM, bleeding, trauma, recurrent		
UTI, fever, anemia):		
2. Drug use:		
3.Smoking and alcohol:		
4. Diet:		
5.Vitamin deficiencies:		
6.Radiation exposure:		
7. Abnormal antenatal scans and screening tests:		
0		

Birth & neonatal history In some cases you need to put this part & feeding in the HPI especially in infants

- Gestational age: ______

- Birth weight: ______
- APGAR score (if known): ______
- Health concerns at birth (Respiratory distress, oxygen therapy, jaundice, anemia, birth injuries, feeding concerns, congenital anomalies): _____
- Length of stay: ______
- Admission to NICU (Why? length of stay):______

Feeding or nutritional history

Infant (0-1 year)

- Breast fed or bottle-fed? ______
- Formula or breast milk (Type of formula, frequency, duration, amount, reasons for any changes in the formula): _____
- Problems related to feeding (vomiting, regurgitation, baby colic, diarrhea):

Children (2–12 years)

- Age at weaning and introduction of soild foods
- Supplementation with vitamins or fluoride.
- Ask the parents to describe what the child typically eats for breakfast, lunch, snacks, and dinner to assess whether the child is receiving adequate nutrition.

Adolescents (13-17 years)

• Ask the patient to describe what they traditionally eat for breakfast, lunch, snacks, and dinner to assess whether the individual is receiving adequate nutrition.

• Eating disorders.

Developmental history

- <u>Developmental milestones.</u>
- The mnemonic **<u>SHADSS</u>** can help structure the interview with an **<u>adolescent</u>**:
 - School: Grades.
 - Home: Relationship with family
 - Activities: Friends & hobbies
 - Depression: Emotions, confidants, thoughts & acts
 - **S**ubstance abuse: Exposure or use of drugs, tobacco & alcohol.
 - Safety: Violence (at home or school) and access to weapons :(

Family history

•	Age of parents and siblings:
•	Family history of illnesses:
•	Deaths in family:
•	Family member with similar complaint:

Social history

•	Parent's employment
•	Insurance
•	Pets
	Smoking
	Psychological diseases

Done by Shahed Atiyat