PCM Guidebook for History Taking and Physical Exams

PATIENT CENTERED MEDICINE
OFFICE OF EDUCATION

RUTGERS
Robert Wood Johnson
Medical School

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This guide is designed to provide the following information:

HOW TO ELICIT A PATIENT CENTERED HISTORY AND HISTORY OF THE PRESENT ILLNESS

Opening and facilitating the interview - Key actions

1. Wash your hands before and after encounter
2. Introduce yourself (state your first and last name and that you are a medical student) to patient and anyone else who is with the patient. Include who you are working with (attending or resident name).
3. Address the patient appropriately (use patient's last name or preferred name and personal pronoun) Identify patient with first and last name and ask how they would like to be addressed.
4. Explain the purpose of the interview
5. Offer a social comment or ask a non-clinical question to put patient at ease
6. Assure privacy and pull curtains as appropriate
7. Assure comfort
8. Sit down in a chair if feasible
9. Allow the patient to express themself
10. Ask if patient has any questions and respond to questions appropriately
11. Adapt your language, pace, and posture in response to the patient
12. Present yourself professionally both verbally and nonverbally
13. Demonstrate empathy, concern, and compassion

Closing the Interview – Key actions

1. Consider summarizing key history and physical exam findings
2. Provide an explanation of what you think is going on – working diagnosis, other possible diagnoses
3. Provide specific next steps
4. Ask patient/family if they have questions
5. Ensure understanding – “teach-back”
6. Thank patient.

Outline for Eliciting Medical History

Introductory Data
Patient name
Age
Personal physician
Source of history and estimation of reliability

HISTORY

1. Chief Concern/Complaint
   Elicit in the patient's own words, including the duration and elicit why the patient seeks help now (e.g., *"How can I be of help today? What would you like help with today? or, I understand that you're here for…Could you tell me more about that?"--"What else?"*)

   2. History of the Present Illness
   Characteristics (OPQRSTU)
   Onset
   Precipitating, Palliating,Place
   Quality **R**adiation
   Severity
   Temporal
   Understanding

Chronology

Date and time of onset

Tempo or mode of onset (acute, subacute, gradual)

Setting/Context (physical setting, life changes)

Duration

Course since onset (stable, intermittent, progressive)

Determine if history of similar symptoms in the past

Modifying Factors

Precipitating and aggravating factors

Relieving factors

Effect of medications or treatment (self-prescribed or by others)

Associated Symptoms

Symptoms of the same organ system

Symptoms of other organ systems

Understanding: Elicit the Patient's Perspective [SEE APPENDIX 1]

1. Assess the patient's point of view ("explanatory model(s) of health & illness")
2. Ask for the patient's ideas about his/her problem.
3. Ask about the patient's experiences.
4. Explore the impact on the patient's life and psychosocial context
5. Elicit patient-specific requests and goals
6. Elicit any hidden fears, concerns, or worries

ETHNIC: A FRAMEWORK FOR CULTURALLY COMPETENT CLINICAL PRACTICE [SEE APPENDIX 2]

E: Explanation
T: Treatment
H: Healers
N: Negotiate
I: Intervention
C: Collaboration

BATHE: A USEFUL MNEMONIC FOR ELICITING THE PSYCHOSOCIAL CONTEXT: [SEE APPENDIX 3]

B: Background
A: Affect
T: Trouble
H: Handling
E: Empathy

The Past Medical History

General Health
Date of last complete examination
Childhood illnesses
Adult illnesses (hypertension, coronary artery disease, hyperlipidemia, diabetes, stroke, chronic lung disease, anemia, blood disorders, depression, present or past use of psychiatric services) Immunizations and dates especially tetanus booster, pneumovax, influenza, etc.
Most recent PPD
Surgeries (procedures and dates)
Transfusions
Trauma
Hospitalizations (reason, outcome, dates)
Ob-Gyn history
- Number of pregnancies, abortions, miscarriages, complications of pregnancies, living children
- Birth control, last Pap test and results, last mammogram and results
- Dates for menarche, menopause

Medications and Allergies

All medications with dose, route, frequency, when last taken
Include home remedies, borrowed medicines, over the counter drugs, herbal remedies, other complementary/alternative healing modalities
Acetaminophen, ASA, NSAIDS, birth control pills, vitamins
For allergies-ask about and document type of reaction
Reactions to contrast media
Include intolerance (nausea, dyspepsia, etc)

Family History (3 generations)

Parents, siblings, children, grandparents, spouse, partner(s)
- For living-age, health
- For deceased-age, cause

Include genetically significant diseases and chronic illnesses (family history of diabetes, cardiovascular disease, cancer, renal disease, neuromuscular disease, bleeding diathesis, psychiatric illness, substance abuse) and significant communicable diseases (TB,HIV, HEP)

Include any appropriate psychosocial or risk factor information

Primary decision-maker(s) in family

FAMLIES

A USEFUL MNEMONIC FOR ASSESSING THE TYPES OF SUPPORT PROVIDED TO PATIENTS BY THEIR FAMILY MEMBERS

F: **F**inancial
A: **A**dvocacy
M: **M**edical Management
L: **L**ove
I/E: **I**nformation & **E**ducation
S: **S**tructural Support

Developed by Dr. David Swee, Department of Family Medicine and Community Health, Rutgers RWJMS

Social History (where, with whom, and how a patient lives)

Birthplace, significant travel or migration history, and current residence
Education, occupation, occupational exposures, environmental exposures (home, community), past, current, or future
Lifestyle-home situation, social supports, hobbies, pets
Socioeconomic issues

THEESEUS
[SEE APPENDIX 4]

A MNEMONIC FOR ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

T: Transportation
H: Housing
E: Eating
E: Education
S: Safety
E: Economics
U: Utilities
S: Social Supports

Occupational Health Screening Questions

What type of work do you do?

Do you think your health problems might be related to your work?

Are your symptoms different at work and at home? Are you currently exposed to chemicals, dusts, metals, radiation, noise or repetitive work?

Have you been exposed to chemicals, dusts, metals, radiation, noise or repetitive work in the past?

Are any of your co-workers experiencing similar symptoms?

If the answers to one or more of these questions suggest that a patient's symptoms are job related or that the patient has been exposed to hazardous material, a comprehensive occupational history should be obtained.

http://www.aafp.org/afp/1998/0915/p935.html#afp19980915p935-f1

Relational Status/Sexual History (Note: this subject will be addressed in greater detail during PCM 2's Human Sexuality week)**:** Number of relationships and duration

[SEE APPENDIX 5]

Sexual history - adapted from http://www.aafp.org/afp/2002/1101/p1705.html

Questions about sexual health should be asked in a straightforward, yet sensitive manner. If you are uncomfortable or believe the patient may feel uncomfortable discussing the sexual history, an explanation may be helpful. For example, consider saying, "Sexual health is important to overall health; therefore, I always ask patients about it. If it's okay with you, I'll ask you a few questions about sexual matters now." Assurances of confidentiality may help, especially with adolescent patients or patients with more than one sexual partner.

Avoid using terms that make assumptions about sexual behavior or orientation. Ask about a patient's sexual orientation and use the term "partner" rather than "boyfriend," "girlfriend," "husband," or "wife." Ask patients how many partners they have rather than whether or not they are married and/or monogamous. Patients will generally say that they are married and monogamous, if that is the case, when asked about partners.

Examples of questions:
Are you dating
anybody?
Are you currently in an intimate relationship?
What's your level of commitment to your
partner? Gender of significant other or partner
Are you sexually active?
Do you have sex with men, women, or both?

Domestic Violence - when asking, normalize and be specific: e.g.

"Domestic violence has become a public health epidemic. It is important to ask patients about possible violence in their relationships. Within the past year, have you been kicked, slapped, or otherwise physically hurt by someone?"

*In taking a sexual history, remember the five "**P**s":*
Partners
Sexual **P**ractices
Past STDs
Pregnancy history and plans
Protection from STDs.

The following guidelines may be helpful in eliciting concerns about sexuality or gender identity:

Do you have any sexual concerns or questions you'd like to discuss?

Do you have any concerns or questions about your sexuality? Sexual identity? Or sexual desires?

Are your sexual desires for men, women, or both?

Do you feel comfortable with your sexuality and sexual identity?

Use language mirroring the patient's language

Sexual Orientation
How do you identify in terms of sexual orientation?
Do you think of yourself as:
o Lesbian, gay or homosexual
o Straight or heterosexual
o Bisexual
o Something else
o Don't know

Are you attracted to/*Have you had sexual contact with:*
__ Men __Women __Transgender Men
__Transgender Women __Another

Gender Identity
"In addition to sexual orientation, I also talk to all my patients about gender identity. Do you know what I mean by that?"

"Some people may feel like their physical bodies do not match with the gender they most identify. For example, a biological male may identify as a woman. Knowing your gender identity also will allow me to care best for you."

SEE APPENDIX 5 for follow-up gender identity questions

Military Service History

Tell me about your military experience
When and where do you / did you serve? What do you / did you do while in the service? How has military service affected you?

If yes to above, obtain more detailed military health history (http://www.va.gov/oaa/pocketcard/)

WARRIORS [SEE APPENDIX 6]

W - War and Military Experience
A - Affect
R - Relationships
R - Risk Factors and Responses
I - Injuries/Illnesses/Injustices Experienced
O - Opportunities and Challenges Faced
R - Resources, Supports, and Interventions
S - Service Delivery Experiences

Developed: Robert C. Like, MD, MS,
Department of Family Medicine and Community Health, Rutgers RWJMS

Habits – Health Promotion and Disease Prevention

What do you do to stay healthy and well? What behavioral risk factors do you have?

Exercise *e.g. "What is the most physically active thing you do in the course of a day? What physical activities do you enjoy and how often do you do them?"*

Diet *(restrictions, consumption of fast foods, attentiveness to labels on foods, calcium intake, caffeinated beverages)*

Sleep *(is patient getting sufficient sleep? Is the difficulty initiating or maintaining sleep? Daytime sleepiness? Snoring?*

Tobacco *(past or present, when started and quit, how many packs per day, chewing tobacco)*

Alcohol *consumption (drinks per day, the beverage); present and past use*

Illicit Drugs marijuana, heroin, cocaine, etc; present and past use

Screening for alcohol problems

CAGE mnemonic

*Have you ever felt you should **Cut** down?*
*Have people **Annoyed** you by criticizing your drinking?*
*Have you ever felt **Guilty** about your drinking?*
*Have you ever needed an **Eye-opener** (first drink in morning to steady nerves or get rid of hangover)*

Functional Status Assessment [SEE APPENDIX 7]

Are there any physical, behavioral, or developmental disabilities?

ADL's (activities of daily living) are basic activities such as bathing and showering, personal hygiene and grooming, dressing, toilet hygiene, functional mobility (e.g., transferring, walking, moving from one place to another, and self-feeding

IADL's (instrumental ADL's) are more complex tasks requiring a combination of physical and mental function such as using the telephone, preparing meals, arranging transportation, managing finances

Any other mobility or functional challenges?

Patient Engagement (SEE APPENDIX 8)

Health Confidence: How confident are you that you can control and manage most of your health problems? (rating scale 1-10)

Health Information: How understandable and useful is the information your doctors or nurses have given you about your health problems or concerns? (rating scale 1-10).

Communication Needs Assessment:
Health Literacy/Language/Disabilities

How comfortable are you with your ability to read, write, and/or understand documents?

Health Literacy Assessment

Single Item Literacy Screener (SILS):
"How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"
"How comfortable do you feel with your ability to read?

What is your primary or preferred language?
What languages are spoken at home?
Any special communication needs? (e.g., vision, hearing, kinesthetic, or other sensory challenges)
Any other intellectual or cognitive challenges?

Socio-Cultural History

How would you self-identify in terms of your ethnicity/race/socio-cultural background?
Birthplace/Country or State of Origin?
Migration history?
Any immigrant/refugee experiences?
How was/is information about health, illness, and wellness communicated in your family and community?

Health promotion/disease prevention/wellness behaviors?
What were your health and illness seeking behaviors?
Any use of alternative/complementary medicine or folk healers?

Spiritual History

Faith and belief
Importance and influence
Member of group
Wishes regarding palliative and end of life care/resuscitation
Mnemonics for taking a spiritual history:

FICA mnemonic

F: Faith & Belief
I: Importance
C: Community
A: Address in Care

http://www.mywhatever.com/cifwriter/library/70/4966.html

HOPE mnemonic

H: Sources of **h**ope
O: Organized religion
P: Personal spirituality & **p**ractices
E: Effects on medical care and **e**nd-of-life issues

(http://www.aafp.org/afp/20010101/81.html)

How to Elicit a Review of Systems (ROS)

The purpose of the Review of Systems is to pursue symptoms which may be related to an undetermined disease. It serves to remind patients of symptoms which they may have forgotten and to allow the physician to systematically review each organ system so that no significant symptoms will be overlooked. Some parts of the Review of Symptoms may be more appropriately elicited when determining the history of the present illness. The following list gives both the lay terms and the medical terms which should be used when completing the write-up. This list is not meant to be all-inclusive. A head to toe approach is used.

A good way to begin the ROS is to ask the patient,
"How would you rate your overall health?"
(rating scale: Excellent, Very Good, Good, Fair, Poor)

General Health

Energy level
Weight loss or gain
Change in appetite
Malaise
Chills/fevers/sweats
Environmental allergies

Skin

Rash (exanthem)
Itching (pruritis)
Sweating
Change in skin color (hyper or hypopigmentation, yellow color-jaundice)
Change in hair texture or growth pattern
Changes in nails
Lesions or ulcerations
Changes in moles, birthmarks or spots on body
Red, scaly crusted areas, which do not heal
History of skin cancer

Head

Headache (include associated neurologic Symptoms; diurnal timing; positional nature)
Head injury
Facial pain
Sinus infections (sinusitis)

Eyes

- Visual changes
- Corrective lenses
- Date of last eye exam
- Double vision (diplopia)
- Blurred vision
- Halos
- Tearing (increased or decreased lacrimation)
- Inflammation (conjunctivitis)
- Discharge
- Spots, flashes (scotomota)
- Sensitivity to light (photophobia)
- Pain
- Trauma
- Cataracts
- Glaucoma

Ears

- Deafness
- Noise in ear (tinnitus)
- Ear pain (auralgia)
- Discharge (blood or pus or other)
- Infections

Nose and sinuses

- Change in sense of smell (olfaction)
- Obstruction
- Discharge (rhinorrhea)
- Post-nasal drip
- Nose bleed (epistaxis)

Trauma
Pain

Mouth and throat

Sore tongue
Sore gums
Bleeding gums
Ulcers
Problems with dentition
Dentures
Last visit to the dentist
Hoarseness, changes in the voice
Sore throat
Difficulty swallowing (dysphagia)
Pain with swallowing (odynophagia)

Neck

Masses
Swollen glands (enlarged lymph nodes)
Limitation of motion, stiffness
Thyroid enlargement (goiter)
Tenderness
Trauma

Breasts

Knows self-exam
Last mammogram
Tenderness
Asymmetry
Mass
Nipple discharge
Milky discharge (galactorrhea)
Change in size

Respiratory

Pain in chest
Difficulty breathing, shortness of breath (dyspnea)
    define problem
Cough
Sputum production (amount, odor, color, blood
    (hemoptysis), change in color)
Wheezing
Bronchitis
Pneumonia

Cardiovascular

Pain (location, radiation, with rest or exercise)
Shortness of breath related to effort (dyspnea on
    exertion)
Shortness of breath while lying flat (orthopnea)
How many pillows used to sleep (e.g. “Two pillow
    orthopnea”)

Sudden awakening with shortness of breath (paroxysmal nocturnal dyspnea)
Cough-pink or frothy
Fluttering in chest or awareness of heartbeat (palpitations)
Heart rhythm disturbance
Blue lips or nails (cyanosis)
Ankle swelling
Leg pain on walking (claudication)

Gastrointestinal

Appetite (increased-polyphagia, decreased-anorexia)
Difficulty swallowing liquids or solids (dysphagia)
Pain on swallowing (odynophagia)
Heartburn, burning behind sternum or in throat (pyrosis)
Nausea
Vomiting (amount, blood red (hematemesis), coffee grounds)
Abdominal pain
Distension
Rectal gas (flatus)

Bowel habits
- Diarrhea
- Constipation/use of laxatives
- Change in caliber
- Change in color
  - Black tarry (melena)
  - Bright red blood per rectum (hematochezia)

Rectal bleeding, itching, hemorrhoids
Yellow skin (jaundice)
History of hepatitis
History of ulcers
Fatty food intolerance

Genitourinary

Burning on urination (dysuria)
Urgency
Frequent urination of small amounts (frequency)
Frequent urination of large amounts (polyuria)
Waking to urinate (nocturia)
Difficulty starting stream
Decrease in force of stream or dribbling
Incontinence (ask about loss of urine on coughing or straining)
Flank pain
Suprapubic pain
Blood in urine (hematuria)
Kidney stones
Swelling in groin
Trauma

More than one attack per year of bladder infection

Female Genitalia

Lesions
Itching (pruritis)
Discharge
Pain on intercourse (dyspareunia)

Male genitalia

Lesions
Discharge
Impotence
Penile pain
Scrotal masses
Testicular masses
Prostate problems

Musculoskeletal

Pain in joints (arthralgia)
Inflamed joints, swelling, increased heat in joints (arthritis)-Which joints
Joint stiffness (morning stiffness or with activity)
Migratory joint pains
Limitation of joint motion
Back pain
Neck pain
Muscle pain (myalgias)
Muscle weakness (group of muscles or generalize)
Loss of muscle mass (atrophy)

Bone pain
Fractures
Problems with gait
Ability to perform activities of daily living, other limitations

Peripheral Vascular

Pain or cramping in legs, calves, thighs or hips while walking (claudication)
Swelling of legs or ankles
Varicose veins
Coolness of extremity
Extremity hair loss
Discoloration of extremity

Neurologic

Change in memory
Change in thinking
Disturbance in motor function (weakness, paralysis, poor coordination, tremors, involuntary movements)
Disturbance in sensory function
Loss of sensation (anesthesia)
Diminished sensation (hypesthesia)
Strange sensation, tingling, burning (paresthesia) Increased sensation (hyperesthesia) Disturbances of taste, hearing, vision, smell Disturbance of consciousness (loss of consciousness, syncope, confusion)

Disturbance of equilibrium, balance (ataxia)
Inability to speak (aphasia)
Difficulty with articulation (dysarthria)
Seizures
Spinning sensation (vertigo)
Dizziness, lightheadedness
Passing out (syncope)

Endocrine/Metabolic

High blood sugar (hyperglycemia)
Increased thirst (polydipsia)
Large volume of urine (polyuria)
Intolerance to heat or cold
Excessive sweating
Loss of hair or increased hairiness
Change in skin texture, dryness
Increased body fat, thin arms
Change in glove size
Loss or gain of weight
Diminution in menses or irregular menses
Recurrent bone fractures

Hematopoietic and lymphatic

History of blood transfusion
Paleness
“Low blood” (anemia)
Weakness or breathlessness
Blood loss
Heavy menstrual bleeding

Easy bruising or bleeding
Bleeding gums
Enlarged lymph nodes
Repeated episodes of jaundice

Psychiatric

Mood, affect, suicidal ideation/intent, psychotic symptoms (e.g., thought or sensory disturbances)

THE PERFORMANCE OF THE PHYSICAL EXAMINATION OF THE ADULT

The written physical exam sequence follows a conventional order (see end of this book), but the actual physical examination may be performed with multiple sequences depending upon the clinical situation, context, and venue.

The general principle is to develop your own approach, the one with which you are the most comfortable and the one that minimizes patient position changes. Ensuring comfort and patient privacy and communicating what you are doing to the patient are paramount.

Principles of Draping Patients for Physical Exams
https://www.youtube.com/watch?v=Q6oCdxISRCE
Pay attention to the following 10 principles:
consent, privacy, exposure, security, control, comfort, warmth, cultural considerations, age & gender, respect

Here are several important tips:

- *Always wash your hands before examining the patient.*
- *Explain what you are going to do and ask for permission to proceed with the physical exam. Briefly preface each part of the exam.*
- *Try to do as much of your exam as possible standing on the patient's right side.*
- *Use touch appropriately - a hand on the patient's shoulder while auscultating the heart can make the patient feel more comfortable.*
- *Be cognizant that your body parts are not inadvertently touching the patient.*
- *Maintain appropriate eye contact to assess for patient pain or discomfort during the exam.*
- *Do not take the patient's clothes/gown off, ask them to do it. You can offer to assist them in retying the gown after the exam is completed.*
- *Female patients should lift their left breast if you need to examine the PMI.*
- *For breast exams, one side should be draped while the other side is examined. The only time both sides should be simultaneously undraped is if you are specifically examining for symmetry.*
- *If a patient is wearing a gown and you need to examine the abdomen, it is more practical to drape the pelvis and bring the gown up (instead of draping the chest and bringing the gown down).*
- *For pelvic exams, the patient should be fully gowned (with the gown extending as distally down the thighs as will allow for a comprehensive exam).*

The following is a suggested sequence when you encounter a patient lying supine in bed

Patient lying supine in bed

General appearance

Facial expression

Vital signs- (Use correct cuff size for blood pressure)

Palpate blood pressure right arm
Auscultate blood pressure right arm
Auscultate blood pressure left arm

Patient sitting up in bed

Orthostatic vital signs

Orthostatic changes left arm

Patient sitting with legs dangling off side of bed

Vital signs

Radial pulse for rate and regularity
Respiratory rate and pattern

Head

Inspect cranium (frontal, temporal, parietal, occipital) for depression
Palpate cranium
Inspect hair
Palpate hair
Inspect scalp

Face

Inspect face
Inspect skin on face

Eyes

Visual acuity both eyes (pocket Snellen's Chart)
Inspection of external eye structures
Visual fields both eyes
Eye alignment both eyes
Pupillary response to light both eyes
Extraocular muscle function both eyes
Test for convergence
Ophthalmoscopic examination both eyes

Ears

Inspect external ear structures both sides
Palpate external ear structures both sides
Check auditory acuity both sides
Perform Rinne's test both sides
Perform Weber's test

Perform otoscopic examination both sides
Inspect external canal both sides
Inspect tympanic membrane both sides

Nose

Inspect nose
Palpate nasal skeleton
Palpate frontal ethmoid and maxillary sinuses both sides

Inspect nasal septum both sides
Inspect turbinates both sides
Test olfactory nerve function (this will not typically be part of routine testing)

Mouth

Inspect outer and inner surfaces of lips
Inspect buccal mucosa
Inspect gingivae
Inspect teeth
Observe Stenson's and Wharton's ducts
Inspect hard palate
Inspect soft palate
Inspect tongue
Test hypoglossal nerve function
Inspect floor of mouth
Palpate floor of mouth
Palpate tongue
Inspect tonsils both sides
Inspect posterior pharyngeal wall

Observe uvula as patient says "Ah"
Test gag reflex

Remainder of Cranial Nerve exam should be done as part of the Neurologic Exam.

Neck

Inspect neck both sides
Palpate neck both sides

Evaluate position of trachea
Palpate lymph nodes of head and neck
(occipital, posterior auricular, posterior cervical, superficial and deep cervical, tonsillar, submaxillary, submental, anterior auricular)
Palpate thyroid gland by anterior approach

Neck

Palpate thyroid gland by posterior approach
Palpate supraclavicular lymph nodes both sides

Posterior chest

Inspect back
Palpate back for tenderness on vertebral column and both sides
Test for costovertebral angle tenderness
Evaluate chest excursion both sides
Test for tactile fremitus both sides
Percuss posterior chest both sides

Evaluate diaphragmatic excursion right side
Auscultate posterior chest to mid-axillary line both sides

Sacrum

Test for edema
Test for sacroiliac joint tenderness

Anterior chest

Inspect posture
Inspect configuration of the chest (sternum, ribs)
Inspect chest both sides
Test for tactile fremitus both sides
Auscultate anterior chest both sides

Female Breast (dune under supervision)

Inspect breasts, both sides
Inspect breasts during maneuvers to tense pectoral muscles

Heart (sitting)

Inspect for abnormal chest movements
Palpate for point of maximal impulse
Palpate heart - all four position
aortic, pulmonic, tricuspid, mitral
Auscultate for heart sounds, all four positions

Axilla sides

Inspect axilla both sides

Palpate axilla both sides
Palpate for axillary lymph nodes both sides

Patient leaning forward

Heart (leaning forward)

Auscultate with diaphragm at cardiac base

Patient lying supine with head of bed at 30°

Neck vessels

Inspect jugular waveform right side
Auscultate carotid artery both sides
Palpate carotid artery-each side separately

Breasts-male and female

Inspect breasts both sides
Palpate breasts both sides
(Position arm at side and arm over head)
Palpate subareolar area both sides
Palpate nipple both sides

Chest (if already examined when patient is sitting up, no need to repeat)

Inspect chest both sides
Evaluate chest excursion both sides
Palpate for tactile fremitus both sides
Percuss chest both sides
Auscultate breath sounds both sides

Heart

Inspect for movements
Palpate for localized motion all four positions
Palpate for generalized motion all four positions
Palpate for thrills all four positions
Auscultate heart sounds all four positions
Time heart sounds to carotid pulse

Patient lying on left side

Heart

Auscultate with bell at cardiac apex

Patient lying supine with bed flat

Abdomen

Inspect contour of abdomen
Inspect skin of abdomen
Inspect for hernias, palpate inguinal and femoral area for hernia and lymph nodes
Auscultate abdomen for bowel sounds one quadrant
Auscultate abdomen for bruits (aortic & renal)
Percuss abdomen all quadrants
Percuss liver
Percuss spleen
Palpate abdomen lightly all quadrants (tenderness, rigidity)
Palpate abdomen deeply all quadrants (masses, organ size)
Palpate liver
Palpate spleen

Test superficial abdominal reflex
Assess for peritoneal signs: should be assessed by percussion followed by another maneuver such as a light rocking or asking patient to cough
Check for hepatic tenderness
Evaluate hepatojugular reflex
Check for shifting dullness if ascites suspected

Pulses

Palpate radial pulse both sides
Palpate brachial pulse both sides
Palpate femoral pulse both sides
Palpate popliteal pulse both sides
Palpate dorsalis pedis pulse both sides
Palpate posterior tibial pulse both sides
Time radial and femoral pulse both sides

Patient sitting on bed with legs off side

Mental Status Exam

- ***Mental Status*** (Many elements assessed during the course of the interview and the physical exam)
- Marked by a sentence or two signaling a shift from the H&P, *"Now, I'd like to ask you a series of questions which will help me further evaluate your thinking, memory and mood."*
- Mental status describes sum total of examiner's observations
- Can change from hour to hour
- "Slice of time"

A comprehensive mental status exam is comprised of several parts. A mnemonic that can help you remember the exam is **ABC STAMP LICK** *(adapted from Robinson, D.J. (1997). Brain calipers: A guide to a successful mental status exam. London, Ontario: Canada. Rapid Psychler Press.)*

A **Appearance**
1. Overall gestalt: What impression does the patient make?
2. Note particular aspects of appearance (grooming, dress)

B **Behavior/Psychomotor activity**
1. Note nonverbal behavior during the exam
2. Note behavior/attitude toward the exam

C **Cooperation**
Take note if/how cooperative patient is

S **Speech and Language**
Evaluate stream of speech and comprehension

T **Thought process/content**
Suicidal Ideation (SI)? Homicidal Ideation (HI)? Delusions?

A **Affect**
Evaluate affect (affect quality is your impression on how he/she feels).

M **Mood**
Evaluate mood (ask patient to rate on scale of 1-10).

P **Perceptions**
Is the patient experiencing hallucinations? illusions?

L **Level of consciousness**
Evaluate orientation to person, place and time

I **Insight**
1. Assess "good" versus "limited"

C **Cognitive** (Higher Order) Functioning
1. Assess recent and remote memory
2. Assess attention
3. Assess judgment
4. Assess abstract thought, calculation ability, object recognition, praxis

K **Knowledge base** (Be aware that some questions may be culturally biased).

Depression Screening [SEE APPENDIX 8]

Neurologic:

Mental Status Exam overlaps with components assessed in Psychiatric Mental Status Exam.

Cranial Nerves: Optic, Oculomotor, Trochlear and Abducens Cranial Nerves assessed in **Eyes Exam.** Assess muscles of mastication and forehead/maxillary perioral/chin regions for sensation (trigeminal). Assess eyelids closure and smile strength/symmetry (facial).

Hearing assessed per Ears Exam (Vestibulococclear). Assess symmetric palate elevation (Glossopharyngeal; Vagus). Assess head turn (sternocleidomastoid) and both shoulders shrug (trapezius) strength (Spinal Accessory, Hypoglossal).

Motor: Palpate to assess muscle bulk and tone. Observe for extra movements at rest and with actions (e.g. tremor). Use confrontation testing to assess muscle strength at each deltoid, elbow, wrist, grip, hip, knee, ankle and big toe. Assess finger dexterity.

Reflexes: Test using reflex hammer at each tendon of triceps, biceps, brachioradialis, patella, Achilles posterior ankle. Elicit for Babinski response.

Coordination/Cerebellar: Assess for hands rapid alternating movements, finger-to-nose, heel-to-shin.

Sensation: Assess for distal limbs primary sensation using cold tuning fork, light touch, two-point discrimination, pin sharp vs. dull, vibration, and joint proprioception. Assess cortical higher order senses by double simultaneous sensation of light touch on limbs (extinction, neglect), graphesthesia (tracing number on palm), ability to ID dime versus quarter in fingers with eyes closed (stereognosis). Assess Romberg sign.

Gait/Stance: assess stance, posture, stability, leg swing, tandem gait, heel and toe walking.

Musculoskeletal: ***It is fine to combine elements of sensorimotor neurologic exam with musculoskeletal exam when assessing at shoulder, elbow, wrist, hand, hip, knee and ankle.***

Neck (Musculoskeletal System)

Test range of motion and strength both sides

Hands and Wrists (Musculoskeletal)

Inspect hand and wrist both sides

Inspect nails both sides
Palpate shoulder joint both sides
Palpate interphalangeal joints both sides
Palpate metacarpophalangeal joints both sides

Elbows

Inspect elbows both sides
Test range of motion both sides
Palpate both sides

Shoulders

Inspect both sides
Test range of motion both sides
Palpate shoulder joint both sides

Shins

Inspect both sides
Test for edema both sides

Feet and Ankles (Musculoskeletal and Nervous System)

Inspect feet and ankles
Test range of motion both sides
Palpate Achilles tendon both sides
Palpate metatarsophalangeal joint both sides
Palpate metatarsal heads both sides
Palpate ankle and foot joints both sides

Knees (Musculoskeletal and Nervous System)

Inspect both sides
Test range of motion both sides
Palpate patella both sides
Ballot patella if effusion is suspected
Test patellar reflex both sides

Patient standing with back to examiner

Hips

Inspect hips
Test range of motion

Spine (Musculoskeletal)

Inspect spine
Palpate spine
Test range of motion

In this course the examination of the genitalia will only be performed under supervision. The following suggests a method to include these examinations within the sequence of the full exam.

While still lying supine with bed flat

Male genitalia

Inspect skin and hair distribution
Observe inguinal area while instructing patient to bear down
Inspect penis
Inspect scrotum
Palpate for inguinal nodes both sides
Elevate scrotum and inspect perineum

Have man stand in front of seated examiner

Male genitalia

Inspect penis
Inspect external urethral meatus
Palpate shaft of penis
Palpate urethra
Inspect scrotum
Palpate testicle both sides
Palpate epididymis and vas deferens both sides
Observe inguinal area while instructing patient to bear down
Test superficial cremasteric reflex

Transilluminate any masses
Palpate for hernias both sides

Have man turn around and bend over bed

Rectum

Inspect anus
Inspect anus while patient strains
Palpate anal sphincter
Palpate anal walls
Palpate rectal walls
Palpate prostate gland
Test stool for occult blood

Rectum can also be examined with patient lying on side (Sim's position) in both males and females.

Help woman to the lithotomy position

Female Genitalia

Inspect skin and hair distribution
Inspect labia majora
Palpate labia majora
Inspect labia minora, clitoris, urethral meatus and introitus
Inspect area of Bartholin's glands both sides
Inspect perineum
Test for pelvic relaxation
Perform speculum examination
Inspect cervix
Obtain Pap smear
Inspect vaginal walls
Perform bimanual examination
Palpate cervix and uterine body
Palpate adnexa both sides
Palpate rectovaginal septum
Check stool for occult blood

The Pediatric Patient
History and Physical Examination

General:

Pediatric patients are represented by four major clinical distinct age categories:

1) Newborn - 0-6weeks
2) Infant –toddler- 8weeks- 3 years
3) Child – 3-10 years
4) Adolescent - 10 – 17 years

Major differences in the history and physical examination for pediatric patients are the following:

- History is given by parent or caregiver
- Growth and developmental are essential parts of the history and physical assessments
- Vital signs vary with age
- Examination for congenital abnormalities is important

Consideration of the developmental stage of the patient is key in performing a successful pediatric examination.

THE PERFORMANCE OF A NEWBORN HISTORY AND PHYSICAL EXAMINATION

History:
It is important to start with the mother's prenatal history and maternal history as any factor that affects the mother may have manifestations in the newborn.

Maternal history – Any chronic illnesses

Prenatal History:
Identify any risk factors such as - smoking, medications, alcohol, drugs of abuse, prescription drugs, non-prescription medications, any sexually transmitted diseases, HIV status, Hepatitis immunity, Rubella immunity.

Prenatal care - duration, complications, abnormal bleeding, restrictions, surgeries
Illnesses during pregnancy diabetes, hypertension, seizures

Previous pregnancies - Twins, multiple births.
Gravida # of pregnancies
Para- # full-term
#premature
#abortions
#living
Type of delivery - vaginal, caesarean section
Complications

Newborn History:

Birth weight - and approximate gestational age
Nutrition -Breast or formula fed

Problems in the newborn period such as prematurity, respiratory distress, jaundice (if yes when and how treated?) and infections.

Immunizations given
Surgeries
Medications and allergies

Physical Examination of Newborn

The challenge for performing the newborn exam is to remember three important points:

1) Look for congenital abnormalities
2) remember to keep newborn warm while examining
3) Gentle handling

Plot parameters - head circumference, weight, and length see if infant is Appropriate for gestational age (AGA) , small for gestational age (SGA) or large for gestational age (LGA)

The newborn examination can be performed in the crib, bassinet or on the examining table.

Approach to newborn:

Appearance:

1) observe newborn in resting state- general appearance, color, size, morphologic features
2) look for signs of acute or chronic illness as evidenced by skin color, respiration, hydration ,cry

Vital signs:
- Look at variation in respiratory rate, heart rate
for newborn, refer to table for upper and lower limits of normal

General Physical examination:
We often recommend starting with the heart while the infant is quiet in order to fully appreciate any abnormal heart sounds such as murmurs.

HEENT:
Head:
- Observe measure, and describe head size and shape, symmetry, facial features, ear position, dysmorphic features
- Palpate Anterior fontanel, posterior fontanel and sutures

Eyes:

- Identify the red reflex

Nose:

- Patency of nares, flaring, mucus

Mouth:

- Abnormalities in development palate, lip, gums

Neck:

- Any abnormal clefts, sinuses, rotation

Ears:

- In general tympanic membranes usually not visualized, look for normal shape, external defects

Chest:

- Observe, measure and interpret rate, pattern and effort of breathing
- Identify normal variations of respiration and signs of respiratory distress, grunting, flaring, retractions
- Listen to breath sounds
- Observe and describe breast tissue-

Cardiovascular:

Heart:

- Listen for heart sounds S1,S2, any extra heart sounds - (can be normal in newborn) listen for Murmurs, rubs
- Identify pulses in upper and lower extremities
- Observe precordial activity
- Identify central versus peripheral cyanosis
- Assess capillary perfusion

Abdomen:

- Assess for distention, tenderness, and masses through observation, auscultation, palpation
- Palpate, percuss liver, spleen

Umbilical:

- Examine for hernia, infection

Genitalia:

- Examine for appearance of Labia majora, minora, clitoris, any discharge or bleeding, any congenital abnormalities. (ambiguous genitalia)
- Males palpate for descended testes in scrotum bilaterally. Look for any abnormal swelling inguinal area- hernias, scrotum- hydrocoele, observe appearance of penis for placement of urethra
- Look for any misplaced urethral opening (hypospadias)

Rectal:
- Examine for patency, normal sphincter placement and tissue appearance (imperforate anus)

Extremities:
- Examine the hips of a newborn for developmental dysplasia of the hip using Ortolani and Barlow maneuvers.

Back:
- Examine the back for any defects and abnormal tufts of hair, sacral dimples, pits, or masses

Neurologic:
- Elicit the primitive reflexes- Moro, Palmer and - - -
- Plantar grasp, suck, rooting, babinski
- Assess the tone- in general should be able to form a “C” when held by stomach, and arms should not slip through grasp
- Assess developmental for age- fix and follow

Skin:
- Describe and assess turgor, perfusion, color, hypo and hyperpigmented lesions and rashes through observation and palpation
- Identify jaundice, petechiae, purpura, bruising, vesicles

THE PERFORMANCE OF AN INFANT-TODLER (8 WEEKS TO 3 YEARS) HISTORY AND PHYSICAL EXAMINATION

Infant –Toddler – (8weeks – 3 years)

History:
As with the newborn history it is important to review mother's prenatal history and the birth history and neonatal course.

Growth:
Any problems with weight, height, head growth

Developmental history is important and should focus on relevant milestones for gross motor, fine motor, social, and communication.

Nutrition history should include type of feedings- breast, bottle, - frequency and amounts. If solids are included in the diet it is important to know what they are eating, when, how (spoon, bottle) and quantity. Any problems noted with particular foods.

Sleep history is important where does the infant/child sleep, how many hours, naps

Elimination - frequency of urination, stools and description.

Behavior, tantrums, difficulties, how parents perceive their behavior.
Immunization history and preventive screenings.

Physical Examination:
It is important to consider the developmental stage in determining how to approach the physical examination.

With infants the focus of examination is to detect any congenital defects or acquired problems.

In general most infants can be examined on the table without difficulty until around 9 months. After 9 months infants might have stranger anxiety and separation from the parent may not be tolerated.

In this case examination may be performed while the child is held by the parent for most of the examination.

In general the examination should include:

Growth parameters - Head circumference (until age 2 years), weight and length should be measured and plotted on the growth curve.

General appearance - How does the infant/toddler appear

Head - Anterior fontanelle, size –shape (closes 12-18 months), posterior fontanelle closes 6 weeks. Observe head shape.

HEENT-

Eyes - red reflex-, papillary response to light (strabismus- around 4 months age) , track and follow all ages. Fundoscopic > 1year if cooperative.

Ears- Visualize tympanic membranes- color, light reflex, bony landmarks

Nose – position and contour of septum, color of mucous membranes, inferior and middle turbinates, drainage site of maxillary and ethmoid sinuses

Neck – adenopathy, mobility, masses

Chest - asymmetry – Lungs- auscultate breath sounds

Heart - Listen for murmurs, Normal heart sounds –S1S2

Abdomen - masses, organomegaly

Genitalia - observe for any congenital anomalies- hypospadias, undescended testes, labial adhesion, imperforate hymen, ambiguous appearance
Hernias?

Extremities - range of motion, pulses, femoral, brachial, radial- color, capillary refill

Back - any abnormal tufts of hair, dimples, curvature.

THE ADOLESCENT HEALTH HISTORY

HEADSS: The "Review of Systems" for Adolescents

H - Home
E - Education
A - Activities/Employment
D - Drugs
S - Suicidality
S - Sex

http://virtualmentor.ama-assn.org/2005/03/cprl1-0503.html

THE WRITTEN PHYSICAL EXAMINATION

(The written history follows the framework and should precede the written physical examination.)

Objective recording of findings of inspection, auscultation, percussion, palpation.

TIPS: be specific about abnormalities, use drawings, metric measurements of lesions, report findings not diagnostic impressions. The following gives a general framework to record your examination. It is by no means meant to be all inclusive.

General appearance (statement of general appearance and general health)

Vital signs temperature-record route, blood pressure both arms, orthostatics, respiratory rate, pulse

Skin (skin, nails, hair)-color, temperature, turgor, moisture; presence of skin lesions, petechiae, purpura

Head-symmetry, evidence of trauma (eg, normocephalic, atraumatic)

Eyes-visual acuity, visual fields, extraocular movements, conjunctivae, sclerae, cornea, pupils (size in mm, equality, shape, reactivity to light and accommodation PERRL) ophthalmoscopic findings including disc (sharpness of disc margin and cup to disc ratio), vessels, retina, macula

Ears-gross assessment of hearing, external (pinnae, mastoids), external canal, Rinne's (air conduction vs. bone conduction) and Weber's (any lateralization), tympanic membranes (color, visualization of landmarks, light reflex)

Nose-deviation, mucosa, septum, inferior turbinates

Sinuses-tenderness of maxillary and frontal sinuses

Throat-breath if indicated, quality of voice, color of lips, buccal mucosa, presence and quality of dentition, gingivae, tongue (midline), posterior pharynx, tonsils (size, exudates) uvula (midline and elevates normally), is gag reflex intact

Neck-range of motion (full or limited) trachea (midline), neck vein distension, carotids (pulse, bruits), thyroid (general enlargement, mass)

Chest-AP diameter (increased or decreased), respiratory excursion, percussion (resonant or dull), tactile fremitus increased or decreased, auscultation (clear, wheezes, rhonchi, rales), egophony, listen to inspiratory and expiratory phases of breathing

Breasts-symmetry, masses, dimpling, discharge

Heart-location of point of maximal impulse, presence of heaves or thrills, is rhythm regular with regular rate or irregularly irregular, intensity and duration of S_1 S_2, splitting, presence of S_3 S_4, murmurs with their grade, site of loudest intensity, radiation, presence of rubs, gallop

Vascular-quality of pulses (carotid, radial, femoral, popliteal, posterior tibialis), presence of bruits in carotid, renal, femoral or abdominal arteries, presence of clubbing or edema

Abdomen-scaphoid or obese, distension, skin lesions, visible pulsations, presence and quality of bowel sounds, note guarding, tenderness, rigidity, percussion note, span of liver, is spleen tip palpable, are kidneys palpable

Back-deformity, tenderness, costovertebral angle tenderness, sacroiliac tenderness

Rectal-skin lesions, hemorrhoids, fissures, size and consistency of prostate gland, sphincter tone, masses, bleeding, check for occult blood
(Generally deferred during routine examination)

Genitalia-Defer during your routine examination

Male: circumcised, lesions, discharge, testicular or epididymal mass, inguinal hernia

Female: comment on external genitalia, speculum visualization of cervix and vagina, bimanual exam for cervical motion tenderness, uterus, adnexae

Lymphatic-note presence of adenopathy in all chains. Comment on size, consistency, mobility of enlarged nodes

Musculoskeletal-edema in extremities, joint inflammation (swelling, tenderness, redness), effusion, synovial proliferation, range of motion, muscle wasting and weakness

Neurologic Exam (Complete, Detailed):
Cognition: Alert, awake and oriented to time place, person, & situation (A&Ox4).
Speech is fluent and clear. Repeats, reads and names well.
Follows 3-step right-left commands. No neglect.
Recall is 3/3 at 5 minutes (if errors, may include x/3 at 5 min using category or recognition clues). Long term memory intact (e.g. able to state recent news events).

CN 2-12: See **Eyes for II, III, IV, VI testing.** Trigeminal sensation is intact and the muscles of mastication have normal strength. The face is symmetric with full smile. Hearing is grossly symmetric.
Palate elevates in the midline. Voice is normal. Shoulder shrug is normal. The tongue has normal and symmetric motions without fasciculations.

Motor Exam: Muscle bulk and tone are normal. No tremor or other abnormal movements are noted.

Strength: There is no pronator drift. Strength in the upper and lower extremities is normal. This includes 5/5 in Bilateral deltoids, biceps, triceps, wrist flexor/extensor, finger extensors, grips. Finger dexterity is normal. 5/5 in Bilateral hip flexion, hamstrings, quadriceps, tibialis anterior, gastrocnemius, and extensor hallucis longus.

Deep Tendon Reflexes: Deep tendon reflexes of the biceps, triceps, brachioradialis, patellars, and ankle jerks are 2+ bilaterally. Toes are downgoing (or mute) bilaterally [Babinski absent]. Clonus is absent.

Cerebellar: Finger to nose and heel to shin are normal. Rapid alternating movements are normal. No dysdiadochokinesis.

Sensory Exam: Romberg absent. Normal vibratory, cold, pinprick, joint proprioception and light touch sensation in the upper and lower extremities.

Gait: Base is narrow. Symmetric and able to walk on heels, toes and tandem with good speed independently without difficulty.

SUMMARY

This should be a processing of the data collected in the history and physical exam. For the purpose of this course, you should just synthesize information regarding the chief complaint and attempt to construct a differential diagnosis for the chief concern/complaint. Ultimately as you progress through your training and into clinical practice, the history and physical will take a more focused form. For patients who have multiple medical problems, you may need to do this for each problem.

After eliciting historical data and performing a physical examination, you need to "put it all together."

- After documenting the history and the physical examination, write a summary synthesizing the information gathered in the history of the present illness, including findings, pertinent negative and positive.
- Enumerate a Problem List (after the summary)
- Develop an Assessment for each problem
- Include a differential diagnosis. The differential diagnosis should include the most likely, the most serious, the most treatable and the unusual for a patient of this age. Consider also the potential underlying pathophysiology
- Include a brief diagnostic/management plan.
- Consider biopsychosocial hypotheses you generated as you elicited the history.

The mnemonic **SCUT** can be helpful:

Serious – what is serious?
Common – what is common?
Unusual – what is unusual?
Treatable – what is treatable?

Another useful differential diagnosis mnemonic is **I VINDICATE**:

I - Iatrogenic
V - Vascular
I - Infection/Inflammatory
N - Neoplasm
D - Degenerative
I - Idiopathic
C - Congenital
A - Autoimmune
T - Trauma/Toxins
E - Endocrine (metabolic)

http://www.fammedref.org/mnemonic/differential-diagnosis-i-vindicate

Some helpful steps:

- What are the abnormal findings?
- Can they be clustered? E.g. fever, cough, chest pain and wheezing
- Interpret the findings and give the likely differential
- Consider tests you would want to perform and initial management.

EXAMPLE: *In summary, the patient is a 24 y/o female with a history of mild asthma presenting with two days of fever, productive cough, and right-sided chest pain with diffuse wheezing and rales on the right side posteriorly.*

PROBLEM LIST:

1. *Cough/Fever*
2. *History of Asthma*

The most common etiology for these findings is an acute exacerbation of asthma precipitated by pneumonia. The most serious is acute anaphylaxis. The most unusual is super infection or rheumatologic disorder. The most treatable is a community acquired pneumonia with asthma.

DX: Diagnostic plan includes: pulse oximetry, measurement of peak expiratory flow, a PA and Lateral CXR, sputum for gram stain and culture.
RX: Management/treatment plan includes albuterol inhaler, oral steroids and antibiotics.
ED: Patient education – assess patient's health confidence and understanding of and ability to adhere with management/treatment plan for pneumonia and asthma, insure adequate hydration, recommend any needed home or environmental assessments/ interventions, address any additional questions or concerns patient may have.
DISP: Disposition – schedule appropriate follow-up visits and what to do if symptoms persist or worsen.

[These Appendices are frameworks and not meant to be memorized.]

APPENDIX 1

Elicit the Patient's Perspective

1. **Assess the patient's point of view ("explanatory model(s) of health and illness")**

"Inquiring about a patient's or family's explanatory model works best in the context of a meaningful relationship. The inquiry is best initiated with a statement of respect such as, *"I know different people have very different ways of understanding illness…Please help me understand how you see things."*
EPERC - End of Life/Palliative Education Resource Center. Hallenbeck J. The Explanatory Model, 2nd Edition. Fast Facts and Concepts. August 2005; 25.

Selected Illness Explanatory Model Questions

"What do you call your problem?"
"What do you think is causing your problem?"
"Why do you think it started when it did?"
"How bad is your illness? Do you believe it will last a long or short time?"
What does your illness do to you? How does it work?"

Arthur Kleinman, MD, Harvard Medical School

2. **Ask for the patient's ideas about his/her problem**.

"Is there anything special about your problem that worries or concerns you?" ("hidden agendas")

3. **Ask about the patient's experiences**.

"Have you ever had this problem before? What have you done to treat this so far?"
"Has anyone else in your family, friends, or other people you know had this problem? What did they do?"
"Have you ever read or heard anything about this problem in the media?"

4. **Explore the impact on the patient's life. Check context:**

"How has the illness affected your daily activities/work/family?"
"What are the main problems your illness has caused for you?"
"What do you fear most about your illness?"

Elicit patient specific requests and goals.
Determine the patient's goal I seeking care:

"When you were thinking about this visit, how were you hoping I could help." ***or*** *"What type of treatment do you think you should receive? What are the most important results you want to achieve?"*

APPENDIX 2

ETHNIC: A FRAMEWORK FOR CULTURALLY COMPETENT CLINICAL PRACTICE

E: Explanation

What do you think may be the reason you have these symptoms?

What do friends, family, others say about these symptoms?

Do you know anyone else who has had or who has this kind of problem?

Have you heard about/read/see it on TV/radio/newspaper/internet? (If patient cannot offer explanation, ask what most concerns them about their problems.)

T: Treatment

What kinds of medicines, home remedies or other treatments have you tried for this illness?

Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it.

What kind of treatment are you seeking from me?

H: Healers

Have you sought any advice from alternative/folk healers, friends or other people (non-doctors) for help with your problems? Tell me about it.

N: Negotiate

Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate your patient's beliefs.

I: Intervention

Determine an intervention with your patient. May Include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g. foods eaten or avoided in general, and when sick).

C: Collaboration

Collaborate with the patient, family members, other Health care team members, healers and community resources.

Adapted from: Levin, SJ, Like, RC and Gottlieb, JE. ETHNIC: A framework for culturally competent clinical practice. In Appendix: Useful clinical interviewing mnemonics. Patient Care 2000; 34(9): 188-189

APPENDIX 3

BATHE: A USEFUL MNEMONIC FOR ELICITING THE PSYCHOSOCIAL CONTEXT

B: Background

A simple question. "What is going on in your life?" elicits the context of the patient's visit.

A: Affect

(The feeling state) Asking "How do you feel about what is going on?" or "What is your mood?" allows the patient to report and label the current feeling state.

T: Trouble

"What about the situation troubles you the most?" helps the physician and patient focus, and may bring out the symbolic significance of the illness or event.

H: Handling

"How are you handling that?" gives and assessment of functioning and provides psychological support.

From: Stuart MR, Lieberman, JA III, Rakel, RE (FRW). The Fifteen Minute Hour: Therapeutic Talk in Primary Care, 4th Edition. Oxford and New York: Radcliffe Publishing, 2008

APPENDIX 4

THEESEUS – A MNEMONIC FOR ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

T: Transportation (e.g., auto, bus, taxi)

H: Housing (e.g., home owner, renter, living arrangements, housing stock)

E: Eating (e.g., typical diet/nutrition, adequacy of food supplies, meals on wheels, food deserts)

E: Education (e.g., educational attainment, literacy, numeracy, health literacy)

S: Safety (e.g., interpersonal, physical, community, environmental)

E: Economics (e.g., current and long-term financial assets, budget for food, clothing, medications)

U: Utilities (e.g., electricity, gas, water, heating, phone, internet)

S: Social Supports (e.g., family, friends, work, religious, recreational, community)

Developed by: Robert C. Like, MD, MS
Department of Family Medicine and Community Health
Rutgers Robert Wood Johnson Medical School © 2017

APPENDIX 5

Selected Sexual Health History/LGBTQIA+ Resources

AMA Video: Patient *Sexual Health History: What You Need to Know to Help*
http://www.bigshouldersdubs.com/clients/AMA/23-AMA-HealthHistory.htm

CDC A Guide to Taking a Sexual History
https://www.cdc.gov/std/treatment/sexualhistory.pdf

LGBT Mental Health Syllabus
http://www.aglp.org/gap/2_sexualHistory

Sexual Health: An Adolescent Provider Toolkit
https://partnerships.ucsf.edu/sites/partnerships.ucsf.edu/files/images/SexualHealthToolkit2010BW.pdf

LGBTQIA+ Terms and Definitions
http://www.lgbtss.dso.iastate.edu/library/education/terms

LGBT Resource Center – Gender Pronouns
https://uwm.edu/lgbtrc/support/gender-pronouns/

The Gender Unicorn

Graphic by: TSER

Gender Identity

- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression/Presentation

- Feminine
- Masculine
- Other

Sex Assigned at Birth

Female | Male | Other/Intersex

Sexually Attracted To

- Women
- Men
- Other Gender(s)

Romantically/Emotionally Attracted To

- Women
- Men
- Other Gender(s)

To learn more go to:
www.transstudent.org/gender

Design by Landyn Pan

Two-Step Gender Identity and Birth Sex Question

What is your current gender identity?
o Male
o Female
o Female-to-Male (FTM)/Transgender Male/Trans Man
o Male-to-Female (MTF)/Transgender Female/Trans Woman
o Genderqueer, neither exclusively male nor female
o Additional Gender Category/(or Other), please specify
o Decline to Answer, please explain why

What sex were you assigned at birth on your original birth certificate?
o Male
o Female
o Decline to Answer, please explain why

Documentation
"Is it OK with you if I record this information in your medical record or would you prefer I not?"

Sources:
Obedin-Maliver J, Lunn MR. *So… How do I ask that?* 6th Annual UCSF LGBTQI Health Forum. University of California, San Francisco, San Francisco, CA, February 22, 2014.
http://thefenwayinstitute.org/documents/Policy_Brief_HowtoGather..._v3_01.09.12.pdf

APPENDIX 6

WARRIORS MNEMONIC: AN INTERVIEWING AND ASSESSMENT FRAMEWORK FOR PROVIDING CULTURALLY COMPETENT PATIENT-CENTERED CARE TO OUR VETERANS AND MILITARY SERVICE PERSONNEL

W: Please tell us more about yourself and your **war and military service experience.**
A: What are your feelings **(affect)** about having served in the military?
R: What **relationships** have been or are currently important to you?
R: What **risks** have you been exposed to and how have you **responded**?
I: What **illnesses, injuries, or injustices** have you had relating to your military service?
O: What **opportunities and challenges** have you faced following your military service?
R: What **resources, supports, or interventions** have been helpful to you and/or are still needed?
S: What **service delivery experiences** have you had with the VA system and/or the civilian health care system?

Developed by: Robert C. Like, MD, MS
Center for Healthy Families and Cultural Diversity
Department of Family Medicine and Community Health
Rutgers-Robert Wood Johnson Medical School © 2013

APPENDIX 7

Functional Status Assessment

Any physical, behavioral, or developmental disabilities?

- Purposes of functional assessment

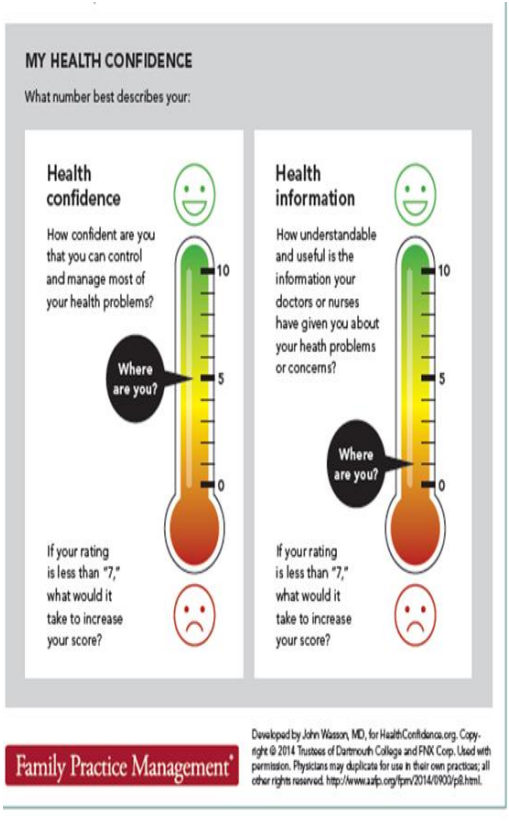
    1. to indicate presence and severity of disease
    2. to measure a person's need or care
    3. to monitor change over time
    4. to maintain an optimally cost effective clinical operation.

- Components of functional assessment – Vision and hearing, mobility, continence, nutrition, mental status (cognition and affect), affect, home environment, social support, ADL – IADL.
- ADL's (activities of daily living) are basic activities such as transferring, ambulating, bathing, etc.
- IADL's (instrumental ADL's) are more complex tasks requiring a combination of physical and mental function such as using the telephone, preparing meals, arranging transportation, managing finances.

https://consultgeri.org/try-this/general-assessment

APPENDIX 8

Patient Engagement



APPENDIX 9

Patient Health Questionnaire (PHQ-2) for Depression screening

How often over the past two weeks have you experienced either of the following problems:

1. Having little interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?

NOTES: