Health Narrative Outline

The Chief Complaint (CC):
Main reason(s) for seeking treatment.

History of Present Illness (HPI):
This covers all events leading to the main concern or problem.
Events that occurred after arrival are covered in a separate summary paragraph that follows the previous history. It also includes a description ("PPQRST") of each significant symptom:

- Palliative and Provocative factors: What were you doing when the pain/ condition started? What caused it? What makes it better or worse? What seems to trigger it? Stress? Position? Certain activities?
- Quality of the symptom (sharp, dull, etc.)
- Radiation of the symptom (esp. for pain) within the body:
- Severity
- Timing

Any pre-existing illness or chronic, relapsing problems, it is important to give relevant past history.
Having an awareness of this data will provide contextual information that will allow a better understanding of the most recent complaint or interpret a new symptom complex.

Past Medical History (PMH):
Include a brief description (including approximate date of diagnosis and nature of treatment for all significant illnesses with which there has been a diagnosis.
Items that were noted in the HPI do not have to be re-stated. You may simply write, "See above," in reference to these events.
All other historical information should be listed. Detailed descriptions are generally not required.
All previous surgeries and hospitalizations should also be included.
Information here can be dated back to childhood and/or before birth.

Medications (MEDS)/ Supplements:
Includes all currently prescribed medications as well as over-the counter and non-traditional therapies such as supplements and herbs. The name of each, dosage, and frequency should be noted.

Allergies/Reactions (All/RXNs):
All allergies and unusual reactions should be noted, particularly those that occurred with medications.

Social History:
This is a broad category which includes:

- Alcohol Intake: Specify the type and quantity.
- Cigarette smoking: Number of packs used per day and the number of years smoked. When multiplied this is referred to as "pack years." If you quit, make note date(s).
- Other Drug Use: Specify type, frequency and duration.
- Marital Status:
- Sexual History:
- Other. . . travel, pets, hobbies, etc.

Work History:
Type, of work, duration, exposures.

Family History:
This includes history of illnesses within the immediate family. In particular, a history of cancer, coronary artery disease or other heritable diseases among first degree relatives.

Obstetrical History (where appropriate):
Includes *gravida, parity, abortions, pregnancy complications, and nature of deliveries.
*Gravida indicates the number of times there has been pregnant, regardless of whether these pregnancies were carried to term. A current pregnancy, if any, is included in this count.

Review of Systems (ROS):
Pertinent positives and negatives related to the chief complaint.

- Skin
- Head
- Eyes
- Ears
- Nose and Sinuses
- Throat and Mouth
- Neck
- Breasts
- Respiratory
- Cardiac
- Gastrointestinal
- Urinary
- Genital
- Peripheral Vascular
- Musculoskeletal
- Neurological
- Hematological
- Endocrine
- Psychiatric
- Temperature – cold/ hot hands, feet or body; time of day
- Sweat – too much/little, appropriately
- Appetite/ cravings
- Thirst
- Taste
- Urination – quality, color frequency, etc.
- Bowel movement - bowel movement quality/ frequency, etc.
- Pain
- Sleep
- Menses – # of days, quality, color, etc.

If available fill in the section below or attach copies of information.

Physical Exam:
Vital Signs: (pulse, blood pressure, respiration rate, temperature)

Lab Results, Radiologic Studies, EKG Interpretation, Etc.:
Summary of both normal and abnormal findings from recent studies or assessments should be listed