Patient ID:

Source of Information:

CC:

HPI:
1. O = Onset
2. P = Position, Pattern
3. Q = Quality (type of pain)
4. R = Radiation (if pain)
5. S = Severity (1-10)
6. T = Timing (with what activities does it occur)
7. A = Aggravating/Alleviating
8. D = Duration
9. A = Associated Symptoms

Allergies and Adverse Drug Reactions:

Past Medical (PMHx) & Past Surgical History (PSHx):
   Ongoing medical problems:
   Hospitalizations:
   Surgeries:

Medications:

SHx:
Marital status and previous marriages
Children
Occupation of self and spouse or significant other
Education
How long the patient has lived in area
Hobbies, other spare time activities
Financial status (especially regarding health care)
Community and religion
A typical day

Lifestyle Behaviors
Tobacco (all forms)
Alcohol (consider using CAGE questions)
Recreational/Illegal drugs (including IV drugs)
Sexual history
Diet and exercise patterns
Violence/Abuse
Occupational Hazards
FH:

ROS:
GENERAL
ADLS
IADLs:
SKIN
HEMATOPOIETIC
HEAD
EYES
EARS
NOSE
MOUTH
PHARYNX & LARYNX
NECK
RESPIRATORY
CARDIOVASCULAR
GASTROINTESTINAL
URINARY
GENITAL
ENDOCRINE
MUSCULOSKELETAL
NEUROLOGIC
PSYCHIATRIC

Physical Examination:

Objective Data:

Assessment:
  Assessment
  Discussion

Plan:
  Dx (diagnostic testing)
  Rx (therapeutic interventions)
  Pt. Ed.

Site source(s) used to support A/P

Signature

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Kevin Moynahan, MD
Societies Program, 2006
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