Houston Christian University

School of Nursing and Allied Health

MSN History and Physical Examination Case Write Up Assignment

The purpose of the History and Physical Examination Case Write-Up Assignment is for your instructor to "see" what you are doing in clinical and "see" how you are making clinical decisions. For these write-ups, you will select a patient seen in your current clinical rotation. You will “write-up” the visit, omitting any identifying patient factors. In future semesters, you will continue to build on your write ups and demonstrate comprehensive advanced practice thinking.

Make sure to start “fresh”. Do not copy and paste from any examples, templates, other students work or even your own work. Be honest in your write up. If you realize that you have forgotten to assess something or forgot a certain part of the teaching, just add an Addendum at the bottom of the write-up saying what should have been done. Your clinical faculty do not expect perfect write-ups, but do expect that you use every patient encounter and subsequent write-up as a time to learn and to evaluate and improve your own practice.

Note that you **CANNOT redo write-ups**. A grade cannot be improved by redoing a write up. Faculty will not read and comment on rough draft of write-ups

All case write ups are to be submitted to the appropriate assignment category by the due date. Late submissions to the appropriate assignment category will incur a 5pt/day penalty (no maximum) including weekends unless an extension has been requested and approved at least 72 hours before due date.

When submitting case write up in Blackboard, the assignment will submit to a plagiarism detection software. The plagiarism detection software is used by HBU to identify plagiarized assignments. We are aware of the difference between high "copy matches" due to copied things such as titles/headings and significant matches that were inappropriately copied from another paper. If a paper has significant or complete sections of copied material, a grade of zero will incur.

These write-ups will require a complete history, head to toe or extensive ROS and physical examination (PE). Visits which may necessitate a comprehensive ROS, physical exam, and write-up include annual physical, well-woman exam (may not always include head to toe, but could be the only preventive care most women receive), well-child exam, new or established patients with complex or chronic diseases or comorbidities, non-specific complaints, such as fatigue, generalized weakness or body ache, dizziness, etc. Make sure that you select an appropriate patient so that you can meet all the requirements of the assignment. This write up should be **2-6 pages (excluding title page, reference page and templates).**

This assignment is designed to promote the development of the following: AACN Essentials (2022): Domains 1, 2, 4, 6, and 9 and NONPF NP Core and Population-Focused Competencies (2012;2017): Scientific Foundational, Practice Inquiry, Technology and Information Literacy, and Independent Practice.

Case Write-up Outline

Following the format of: https://meded.ucsd.edu/clinicalmed/write.htm.

Subjective:

Chief Complaint: This should be in quotes: "I've had a cough and sore throat for 2 days."

History of Present Illness: One of the most important parts of the assessment. Check the list of important questions to ask (OLD CARTS or PQRST). As you become more proficient in physical exam and lab testing, the HPI does not decrease in importance - your ability to use it in diagnostic reasoning just increases.

Past Medical History: Past or present illness. Be careful with "blindly" copying history from a prior clinical note.

Past Hospitalizations: Past hospitalizations with reason for admit, duration of stay, and rough dates

Past Surgical History: Past surgeries and rough dates when possible.

Medications: List name, dose, frequency and indication (why are they taking it?) Do NOT omit PRN medications and how often the medications are taken. This is one way to check whether you've put all important information in your patient history. If a patient is taking Metformin and there's no related information on the history and/or diagnosis list, something is missing.

Allergies: Medications, Food allergies when applicable. Specify what type of reaction next to the allergy if known by the person you are collecting history from (E.g., Penicillin-rash)

Social History: This includes several factors: alcohol use, cigarette use, sexual history, work history are a few examples. Include health promotion information such as exercise and immunizations. Immunizations are important - we want to know the date of an adult patient's last tetanus immunization. Be specific, don't just say UTD. For pediatrics: list dates for all immunizations.

Other pediatric specifics: list who all lives in home with patient, how many siblings with ages next to them, type of home, any pets inside/outside home & what type of pet, any smoking in home, any guns in home; if young child - are they in daycare or if babysitter or family member or parent stay home with child, are they in school & what grade and what type of grades does the child make, list any extracurricular activities, any problems with school or teacher, any recent social or home changes. If they are pre-teen and older - add alcohol use, smoking, sexual history, work history, etc.

Family History: It is generally appropriate to go back at least two generations. State family member (mom/dad/maternal grandparents/paternal grandparents/siblings/etc.), their age & if

they're alive (if they are deceased, write deceased), write any conditions or illnesses next to each person, write unknown if history not known

Obstetrical History: When appropriate, document number of pregnancies and other relevant information.

Birth History: applicable for pediatric write ups especially for young pediatric patients

Review of Symptoms (ROS): Should be extensive and include every system. Always address growth and development in pediatric patients. Nutrition should be addressed, especially in pediatric patients. In childbearing women (any teen or female who have reached menarche), make sure to document date of last menstrual period (LMP) and methods of contraceptive use on every visit on any woman capable of becoming pregnant (having menses and has not had a tubal ligation/hysterectomy). Every visit - If you order such a medication without documenting the above information, **we have to assume that the patient could be pregnant** (as would any lawyer in a lawsuit). For a young teen you can put "not sexually active" (but make sure you have asked). This is sometimes tricky with teens being seen for general health problems but so very important. If in any doubt, ask the parent to step out for a moment so that you can talk to the teen alone. Data should be systemically presented.

Objective:

Vital signs: (BMI should be included on every visit)

Physical examination - This is head to toe detailed and thoroughly describe findings within ALL systems. Do not put within normal limits (WNL). Make sure to describe all findings. Findings should be displayed in a systematic fashion.

Any laboratory findings, diagnostic imaging available at the time of the visit should be documented. Do not include testing that was ordered during the visit but results were not available.

TIP:

> Make sure to proper distinguish between subjective and objective data. Subjective data, as the name suggests, is the information you gather by interviewing the patient, family, or significant other. This will include data from chief complaint, social/family history, and Review of System (ROS). Objective data will include those information or data you elicited through physical examination, vital signs and/or diagnostic test results. Note that statement such as "Denies chest pain, sob, dysuria, vaginal bleeding, diarrhea, etc." should be in the subjective section (ROS) of your note, and not in PE section. Do not write "Alert and oriented; no tenderness; no erythema; breath sounds clear; no spine curvature" under ROS or subjective section. These are objective findings. You elicited these data through your physical examination of the patient.

Assessment:

In future semesters, you will begin to form your differential diagnoses and presumptive diagnoses. This is documented under the assessment. Your assessment should always be supported by findings in your history and physical exam. For this write up, you will list any diagnoses made by

your preceptor. You will complete a pathophysiology template for each diagnosis made by your preceptor. You should use resources from the previous courses and other current evidence-based sources to complete your pathophysiology templates. Cite appropriately. The pathophysiology template can be located in Appendix A.

Plan:

In future semesters, you will order medications, labs tests, referrals, conduct patient teaching and determine when the patient needs to follow-up. For this write up assignment, you will present the plan created by your preceptor. Please be sure this information is organized under each diagnosis; keeping it organized helps the write up flow well to where the reader is able to get a clear picture of everything you did during the patient encounter. You will create a medication card for each medication your preceptor ordered/refilled/continued. You should use resources from previous courses and current evidence-based sources to complete your medication cards. Cite appropriately. The medication card template can be located in Appendix B.

Templates will require APA-formatted in-text citations and sources should be included on an APA reference list.

Addendum

*******Remember to add an additional note at the end of the write up if you realized anything was missing from the encounter that should have been done or ordered. Put it at the end of your write up and label it: **Addendum *****

MSN History and Physical Examination Case Write-Up Rubric

Criteria	Exceeds Expectations	Meets Expectations	Below Expectations	No Effort
Chief Complaint (CC)	**3 Points** Includes CC includes the reason for visit, is appropriate for the type of write-up AND is in the patient/ family's own words.	**2 Points** Includes CC that includes the reason for visit, is appropriate for the type of write-up but is not in the patient/family's own words	**1 Point** CC is not appropriate for the type of write-up AND is not in the patient/family's own words	**0 Points** Not included
History of Present Illness (HPI)	**10 points** Provides a comprehensive HPI that includes all the pertinent information and excludes irrelevant information. HPI is focused and detailed. Does not include any objective data	**7 points** Provides a HPI that includes pertinent information but misses 1 -2 key components and/or includes information that is irrelevant to the patient visit. HPI is somewhat focused. Does not include objective data.	**4 points** Provides a superficial HPI that misses 3 or more key components and/or does not include all pertinent information, includes irrelevant information OR includes objective data	**0 Points** Not included
Medications	**3 Points** Documents a comprehensive medication list that includes drug name (brand and generic), dosage, route, frequency and indication. Allergies are documented and includes reaction. Includes NDKA, if applicable.	**2 Points** Documentation includes medication list but omits 1-2 details. Allergies are documented but does not include reaction.	**1 Point** Documentation includes medications but omits 3 or more details. Allergies are not documented	**0 Points** Not included
Pertinent History	**10 Points** Provides comprehensive past	**7 Points**	**4 Points** Provides a history but history of	**0 Points** Not included

	medical history, surgical, family, social, obstetrical history, and birth history (when applicable). History is consistent with other documentation. Includes immunization information	Provides a history but history is superficial Omits 2-3 necessary details	superficial and omits 4 or more details	
Review of Systems	**10 Points** Complete ROS that addresses each physical system ROS is completed with a clear narrative. Do not write within normal limit or other variations. If documented abnormalities, states what is considered 'normal' Does not include any objective data	**7 Points** Incomplete ROS that misses 2-3 components	**4 Points** Incomplete ROS that misses 3 or more components Includes objective data	**0 Points** No ROS attempted
Objective Data	**20 Points** Documents vital signs with documented BMI Documents physical examination: Each system addressed completely and includes pertinent positive and pertinent negative findings. Documents labs, diagnostic tests that are available for that visit.	**14 Points** Documents vital signs but is missing BMI Documents an incomplete physical examination: missing 3 or less components and/or missing up to 3 pertinent positives/negatives Documents labs, diagnostic tests that are available for that visit.	**8 Points** Does not document vital signs Documents an incomplete physical examination: missing 4 or more of the components and/ or missing 4 or more pertinent positives/negatives Fails to document labs, diagnostic tests that are available for that visit. Includes subjective data	**0 Points** Not included

	Does not include any subjective data			
Assessment	**20 Points** Lists all diagnoses made by the preceptor Includes a pathophysiology template for medical diagnosis made by the preceptor Each pathophysiology template is fully completed and contains accurate and current information Template is supported by evidence-based sources	**14 Points** Lists all diagnoses made by the preceptor Pathophysiology template present for each medical diagnosis but missing information OR information is inaccurate Template is not supported by evidence-based sources	**8 Points** Fails to list all diagnoses or diagnosis is not related to patient based on documented history and physical examination Pathophysiology templates present but do not address all diagnoses AND is missing information and/or information is inaccurate and/or template is not supported by evidence-based sources	**0 Points** Not effort
Plan	**14 Points** Provides a plan made by the preceptor. Includes a medication card/ template for each medication the patient is currently taking and any medication ordered by the preceptor. Each medication card/template is fully completed and contains accurate and current information Template is supported by evidence-based sources	**9 Points** Provides a plan made by the preceptor Includes a medication card/template for each medication the patient is currently taking and any medication ordered by the preceptor but missing information OR information is inaccurate Template is not supported by evidence-based sources	**4 Points** Provides a plan that is not relevant to the patient's visit Medication card/template present but does not address all medications AND missing information and/or information is inaccurate and/or template is not supported by evidence-based sources	**0 Points** Not included or inappropriate to patient visit
Formatting/APA	**10 Points**	**7 Points**	**4 Points**	**0 Points**

	No errors in grammar and spelling . No errors in APA format Write-up is in proper format and adheres to the appropriate page limits.	1-2 spelling or grammar errors OR 1-2 APA errors	4 errors in spelling or grammar OR 4 APA errors OR Write-up is not in proper format OR Write up does not adhere to the appropriate page limits	5 or more errors in spelling or grammar OR 5 or more APA errors AND Write up does not adhere to the appropriate page limits

Appendix A

Disease:

Etiology:

Risk factors:

Subjective:

Objective:

Treatment:

Diagnostics:

Appendix B

Generic Name	Trade Name	Classification	Route(s)	Dose/Dose Range
Indications				
Mechanism of Action		**Interactions**	**Common Side Effects/Adverse Effects**	
Contraindications/Precautions				
Patient Teaching				