

General Instructions for Completing the Patient Data Base

SUBJECTIVE SUMMARY

CHIEF COMPLAINT OR PROBLEM: The patient's statement of his/her problem, often best expressed in his/her own words.

SUBJECTIVE SUMMARY OF PROBLEM: Characterization of the details of the symptom or condition should include the following areas in the following format when possible.

Current Problem: Description should include:

1. **Chronology** - onset and course (progression, frequency) the problem has followed
2. **Location** - where the problem is located including radiation (be anatomically precise)
3. **Quality** - character and intensity
4. **Quantity** - how much, how severe
5. **Aggravating and Ameliorating Factors** - what makes it worse/better
6. **Associated Manifestations**
7. **Past History of same or related problem(s)** - include problem of diagnosis, therapeutics and outcome (resolved or currently active)

Review of Systems: You need only deal with systems related to the problem. Include positives and negatives (+)

Past Medical History: Note the presence or absence (+) of information which may be relevant in the evaluation of the problem

Family History: Note the presence or absence (+) of information which may be relevant in the evaluation of the problem

Current Medications: List drug name and dosage for all current medications (RX and OTC)

Medical Genogram: Refer to pages 30-34. Draw genogram on reverse side of Patient Data Base form, pages 28-29.

OBJECTIVE SUMMARY

VITAL SIGNS: BP, Pulse, respirations, temperature, weight, height

PHYSICAL FINDINGS: An appropriate directed physical examination should be recorded with all pertinent areas described. The patient's general appearance should be noted first followed by descriptions of the specific areas examined (e.g. eyes, ears, nose, throat, neck, respiratory, cardiovascular, abdomen, extremities, neurologic, etc.)

CURRENT LABORATORY DATA: Significant laboratory or other studies related to the area being evaluated (e.g. chest X-ray, CBC, EKG, etc.)

ASSESSMENT

Identify the major or primary assessment supported by the Patient Data Base and any other associated assessments. This should include patient Health Risk Assessment for age, sex and history.

All assessments should be numbered:

- #1
- #2

PLAN

A separate plan should be developed for each assessment and numbered to correspond with the assessment number. Each plan should be divided into Diagnostics (Dx.), Therapeutic (Th.), Patient Education (Pt. ed.), and Health Promotion Strategies (Hl.pro.) sections as shown below.

- #1 Dx.
 Th.
 Pt. ed.
 Hl. pro.

- #2 Dx.
 Th.
 Pt. ed.
 Hl. pro.

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CRITIQUE

Comments by the precepting physician concerning accuracy of information, style of presentation and content of the Patient Data Base should be made here.

PATIENT DATA BASE

STUDENT _____ SITE

SUBJECTIVE SUMMARY

CHIEF COMPLAINT OR PROBLEM:
SUBJECTIVE SUMMARY OF PROBLEM:

OBJECTIVE SUMMARY

VITAL SIGNS:
PHYSICAL FINDINGS:

CURRENT LABORATORY DATA:

ASSESSMENT

PLAN

CRITIQUE