Documentation of History	
History of present illness (HPI)	• Write present history and positive/negative symptoms
Review of systems (ROS)	• Include pertinent positive/negative associated symptoms
Past medical history (PMH)	• Include past medical conditions diagnosed by doctor and psychiatric conditions • Include ob/gyn history in women • Include birth and developmental history in children
Past surgical history (PSH)	• Include previous operations (including cesarean sections)
Medications	• Include over-the-counter and prescription medications
Allergies	• Include drug allergies and the patient's reaction
Family history	• Include parents and siblings (if pertinent)
Social history	• Include occupation (if pertinent) and support system (who patient lives with) • Include smoking, alcohol, and illicit drug use history • Outside stressors that may be causing symptoms (eg, work, relationship)
Documentation of Physical Examination	
General tips	• Always write vital signs first. • Give a brief comment about patient's general appearance. • Then focus on main systemic examination noting abnormal and relevant positive/negative findings.
Investigations	• Always write the most specific tests first. • List tests in order of priority. • Write all related tests in a single line (eg, CBC, ESR). • Do not write referrals or consultations.

	• Do not write prescriptions. • Recommend breast, renal, pelvic, or genital examinations (if needed).
Vital signs	• Temperature, blood pressure, pulse, and respiratory rate

HEENT	• **Head**
	  ◦ Normocephalic and atraumatic (NCAT)
	• **Eyes**
	  ◦ Pupils equally round and reactive to light (PERRLA)
	  ◦ Visual acuity 20/20 with intact visual fields
	  ◦ Extraocular muscles intact (EOMI)
	  ◦ Fundi without papilledema, lesions, or exudates
	  ◦ Conjunctiva without erythema
	  ◦ No icterus
	• **Ears**
	  ◦ Pinnae without inflammation or tenderness
	  ◦ Tympanic membranes intact without erythema or effusion
	  ◦ Weber midline, Rinne with air conduction > bone conduction (AC > BC)
	  ◦ Hearing grossly intact bilaterally
	• **Nose**
	  ◦ Septum midline with patent nares
	  ◦ No nasal polyps or lesions
	  ◦ No sinus tenderness to palpation
	• **Throat**
	  ◦ Oropharynx clear without tonsillar erythema or exudates
	  ◦ Uvula midline
	  ◦ Normal dentition and gums without ulcers or lesions

Neck	• Supple without lymphadenopathy or thyromegaly • Carotid pulse 2+ without jugular venous distention (JVD) • Trachea midline without accessory muscle use
Lungs/chest	• No chest wall lesions, scars, or tenderness to palpation • Fremitus symmetrical • Resonant to percussion bilaterally • Clear to auscultation bilaterally with vesicular breath sounds • No wheezes, crackles, or rhonchi

Heart	• No visible heaves or lifts • Point of maximal impulse (PMI) at 5th intercostal space in left mid-clavicular line • Normal S1 and S2 without murmurs, gallops, or rubs
Abdomen	• Nondistended without scars, bruises, or visible pulsations • Normoactive bowel sounds throughout without bruits • Tympanic to percussion in all 4 quadrants • Soft and nontender with no rebound tenderness or peritoneal signs • No hepatosplenomegaly • No costovertebral angle (CVA) tenderness
Extremities	• No cyanosis, clubbing, or edema • Pulses 2+ bilaterally throughout
Neurologic	• Patient is alert and oriented to person, place, and time • Cranial nerves (CN) II-XII intact • Motor 5/5 bilaterally in all muscle groups • Sensory grossly intact bilaterally • Deep-tendon reflexes (DTR) 2+ bilaterally, downgoing toes bilaterally • Gait normal without dysmetria or dysdiadochokinesia • Normal Romberg test
Musculoskeletal	• No pain or tenderness to palpation in all joints • Normal range of motion (ROM) in all joints • No abnormalities in spine or paraspinal tenderness to palpation