SAMPLE FORMAT FOR A PATIENT INTERVIEW

INTRODUCTION

- Hello Mr./Ms._____
- I am (name), (identify level of training)
- I would like to spend some time with you gathering information about your health, (request permission)

OPENING

- How can I help you today OR what brings you in today?
- Can you tell me a little bit more about your problem?

SPECIFIC DETAILS TO ASSESS

- Onset
  - When did it start?
- Context
- What was happening when you first noticed the problem?
  - Location
    - If a pain symptom, or a symptom with a location
  - Radiation
    - If there is pain- to where does it move?
- Character
  - Describe what the symptoms are like
- Timing and duration
  - When does it happen, how long does it last?
- Severity/ intensity
  - How intensive are the symptoms
- Modifiers
  - What makes this better?
  - What makes this worse?
- Associated symptoms
  - Anything else going on?

LIFE IMPACT

- Identify patient's concerns or agenda.
  - Impact on day-to-day living?

PAST MEDICAL HISTORY

- Current medical problems
- Prior illnesses
- Prior surgery
- Current medications
- Allergies
- Exposure history
    - Work or environmental
- Preventive health care
    - Doctor visits, dental care

FAMILY HISTROY

- Age, living status and health questions related to:
    - Father/mother
    - Siblings
    - Children
    - Other family member

SOCIAL HISTORY

- Living arrangements
    - Where and with whom
- Relationship/marital status/partner
- Education/occupation
- Social stressors
- Substance use:
    - Current/past/what and how much
    - Tobacco
    - Alcohol
    - Drugs

Review of Systems "Cheat Sheet"

This is not an all inclusive list, it is meant to help guide the interview

Questions (written in lay language)

General

Any recent fever, chills or night sweats?
Have you gained or lost a lot of weight without trying lately?
Have you felt unusually tired or sleepy lately?

Skin

Any area of skin dry and/or itchy?
Any rashes, bumps, sores anywhere?
Do you bruise easily?
Any moles that are changing in shape, color, or size?
Any changes in your hair? Any changes in your nails?

Head

Have you been dizzy or feel like room is spinning?
Have you fainted or passed out recently?
Do you have headaches? Are they more frequent/less frequent than normal?
Any history of head injury?

Eyes

Have you had any problems with your eyes lately? Like blurry vision, pain, watery eyes, redness, or itching? How is your vision?
Do you wear glasses? Do you wear contact lenses?

Ears

Have you had problems with your ears like any ringing in your ears, pain, or hearing problems?
Have you had any problems with ear infections?
Have you ever had tubes placed in your ears?

Nose

Any trouble with your nose like nosebleeds change in mucus or frequent sneezing? Any problems with a stuffy or runny nose?

Mouth and Throat

Any recent sore throat or sores in your mouth?
Any problems with your teeth or gums...like pain, bleeding, or loose teeth?
Any recent hoarseness in your voice?

Neck

Notice any new lumps or bumps? Anything feel sore, painful, or stiff? Is there any pain when you move your neck in any direction?

Chest/Respiratory

Do you have any trouble catching your breath or feel short of breath?
Do you have trouble breathing after walking a little ways? How far can you walk before needing to stop?
Do you ever have pain when you take a deep breath?
Any new cough or coughing anything up? What's it look like?
Have you ever had a positive test for tuberculosis?
Have you been exposed to anyone with tuberculosis?

CV

Do you ever have any chest pains? Then could ask about the nature of the CP and associated symptoms
Do you ever feel like your heart is racing or skipping beats?
Any shortness of breath at rest or with small amounts of exertion?

Can you lay flat in bed, or does that make you short of breath? If not, how many pillows do you need? Do you ever wake up at night short of breath?
Have you ever been told that you have a heart murmur?
Have you ever had Rheumatic fever?

Vascular
Do you have any pain in your legs or hips when you walk? –does it get worse the farther you walk?
Any problems with your legs like hair loss or sores that won't heal? Any swelling?
Do you have veins that stick out or cause you any problems?

Breasts
Have you noticed any lumps, pain, tenderness or discharge from your nipples? Any areas of color changes on your breasts? Have you ever had a mammogram? When was your last mammogram? (mammogram questions usually for patients over 40)

Gastrointestinal (GI)
Any problems with your stomach or belly lately? Like nausea, vomiting, diarrhea, pain, or constipation?
Any heartburn?
How about bowel habits? Have they changed recently or have you noticed blood or black colored stools
Do you use antacids? Do you use laxatives?
Have you ever had gallstones?
Have you ever had hepatitis?

Genitourinary (GU)
Have you had any changes in the amount of times you go to the bathroom in a day?
Do you have to get up at night and go to the bathroom?
Do you feel like you need to go but when you get there you can't?
Any pain when you urinate?
Any blood in your urine?
Any pain in your lower back or sides?

Musculoskeletal
Have you had any recent muscle cramps? What about muscle weakness or stiffness?
Has there been a change in how far or how much you can move your arms, legs, fingers or toes?
What about pain or stiffness in your knees, hands, back, or hips?

Neurologic/Psych
Have you noticed any new tingling or numbness in your fingers, toes, arms or legs?
Any unusual memory loss? Any dizziness or loss of balance? Do you feel like you are steady on your feet when you walk? Have you had any falls?
Any mood changes? Do you feel down or depressed? Have you lost interest or pleasure in doing things?
Do you ever see things or hear things other people can't? (most likely would not routinely ask this and reserve it for patients in whom this is a concern)

Male/Female Genitalia (to be used when pertinent to interview and/or chief complaint)
Any sexual problems? Loss of sex drive?
Any pain with sex?
Any itching, rash, or discharge?
Any lesions or sores?
Any hernias?
(For female patients) Do you have menstrual periods? When was your last menstrual period? When was your last Pap smear?

This is for PTs to fill out to the best of their ability.
If PT fills out a minor complaint and is in good health, run by PA or physician for traige.

Name_____ Birthdate_____

Office use only:
Volunteer Name Waiting room volunteer fills out_____
Date _____ MR#_____

What Brings You Here? (Please check all that apply) Refills_____ Follow-up____

Main Concern:

_____

Refills
List medications needed for refill – last dose taken (e.g. Ibuprofen 200mg – two nights ago)

_____ _____

_____ _____

_____ _____

Current Health Since Last Visit

How are you feeling since last visit? **(Circle)** Better Worse Constant Can't say

If better, what helped? _____

When did your symptoms start? _____

Please **circle** the symptom(s) you are currently experiencing:

General: **fever / weight loss / tiredness / anxiety / headache / depression**

Eye/Ear/Nose/Throat: **bleeding gums / blurred or double vision / earache / hoarseness / persistent cough / sinus problems**

Muscle/Joint/Bone: **Pain, weakness or numbness in: back / neck / joints / feet / legs / hands**

Gastrointestinal: **diarrhea /constipation / rectal bleeding /heartburn / indigestion / nausea or vomiting**

Genito-Urinary: **blood in urination / bladder control poor / painful urination / frequent urination**

Cardiovascular: **Chest pain / rapid heart beat / high blood pressure / heart murmur / poor circulation / swelling of ankles**

Skin: **rash / itching / redness**

Men only: **penis discharge / sores on penis**

Women only: **bleeding between periods / nipple discharge / vaginal discharge / vaginal dryness / vaginal itching**

Are you pregnant? **Yes / No** *Date of last menstrual period:*_____

Last Name: First Name: MI: MR#:

Sex: _____ DOB: _____ Vet: Y N **Make sure information is correct and fill in if there are any blanks.**

Patient Address & Phone Number

_____

_____

_____

PCP: Y N –If yes, Providers Name and Location:

Name:_____

Location:_____

Phone #:_____

Insurance: Medicaid Medicare Other_____

Health History

Ask Qs about health HX every visit: make sure to note changes

List of Previous Medications: _____ _____

What the PT has taken in the past, but is no longer taking. _____ _____

What the PT is currently taking. _____ _____

Do NOT include what you are perscribing NEW today. _____ _____

***** Always backslash (\) through things that you asked but did not apply*****

Allergies to medications, food or substances: Ask if PT has allergies to any medications, or any specific allergies such as food allergies.

PCN (Penicillin) ASA (Aspirin) Latex Sulfa (I.e. Septra, Bactrim, Azulfidine) None Other: _____

DX & Conditions (circle):

Alcoholism	Diabetes I	HIV/AIDS	Stroke
Anemia	Deep Vein Thrombosis	Hypertension	Thyroid problems
Arthritis	Depression	Headaches	Other:
Asthma	Breathing Problems	Myocardial Infarction	List any other conditions not listed
Bipolar	Heart Burn	Pulmonary Embolism	_____
Cancer	Hepatitis B	Pneumonia	_____
Congestive Heart Failure	Hepatitis C	Psychiatric care	_____
Coronary Heart Disease	High Cholesterol	Schizophrenia	

CAD - coronary artery disease
MI - myocardial infarction (heart attack)
HTN - hypertension
DM - diabetes
CVA - cerebrovascular accident (stroke)
CA - cancer
Psych - i.e. depression, schizophrenia, etc.

Family History:

CAD MI HTN DM CVA CA Psych

Other_____

Social History: If social habits have changed than what's written, note date and change.

Alcohol: none / occasionally / moderately / heavy Quit date: _____

Tobacco: none / prior _____ pack year/ Current _____ packs per day Quit date: _____

Drug use: none / Is there anything else you take? I.e. Marijuana, cocaine, heroine, perhaps prescription medications not prescribed to you?

Living arrangements:

Street Other Home Shelter

Immunizations:

PPD Status _____ Tetanus_____ Flu_____ Pneumovax_____

Miscellaneous:

PPD status: purified protein derivate - skin test is a method used to DX silent tuberculosis
Tetanus: PT should have a tetanus booster every 10 years.
Flu: recommended to get vaccinated once a year
Pneumovax: protects adults against 23 strains of streptococcus pneumonia bacteria (PPSV23)

The Corazon Clinic
230 East Travis, San Antonio, Texas 78205
(An all volunteer Good Samaritan provision clinic)

Medical Record#:

Name: Most of the time this is filled out in front, but be sure all info is correct. **Date:** **M/F**

DOB:

Reason for visit

The main reason(s) the PT is here today

History of Present Illness

The subjective story of what is going on, in PTs words.

It is a "snapshot" of their issue(s) complete eith symptoms. Start written story with identifiers: 45 Y.O.F C/O...

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> describe what the symptoms are like
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-Associated symptoms
> Anything else going on?

Vitals

Blood Pressure 130/70
Respiration Rate (Breaths/min)
Ox. Sat. 92-100%

BG_____ BP_____ HR_____RR_____ Temp 98-100.5 Pulse O2_____

Weight___

Heart Rate (Pulse) 60-100

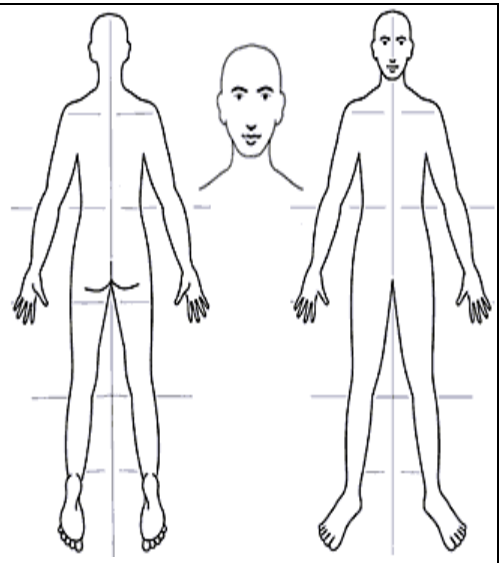
Blood Glucose
Fasting 70-100
Food <125

Notes

This diagram is an objective part of the exam and you should only report what you see.

This is not a place to mark the area of complaint--if a person says "my arm hurts" but it is not tender to touch and doesnt have trauma or visual changes, do NOT mark anything.

When you do mark, describe it. You can use shorthand:
A - abrasion
L - laceration
E - ecchymosis
T - tenderness
S - swelling



Exam

THIS PART OF THE CHART IS OBJECTIVE, WHERE YOU REPORT YOUR FINDINGS.
(For areas not examined write "detailed exam omitted" for one system and DEO for the rest)

Gen Appearance: Does the PT appear in any distress? Is he/she anxious appearing or tearful?

HEENT: Head, eyes, ears, nose and throat exam. Check for trauma on head, see if pupils dilate and the eyes move ewually. Take a look at throat, mouth, nose and ears if c/o a "cold."

Neuro: Is the PT oriented to person, place, time/date, and situation?

Respiratory: Listen to lungs. Notice any wheezing or sounds that are out of the ordinary? Ask PA or ohysician to listen if PT has respiratory complaint.

GI: When you listen to the stomach, are bowel sounds present? When you touch the stomach, does the PT report pain or is it nontender? If tender, where is it tender?

CVS: For cardiovascular exam, you can listen to heart sounds and comment on pulse rate. If unsur e of heart sounds, ask PA or physician.

Musculo/Skeletal: If fhe PT hunched over? Sitting up straight?

Skin: Is the PT's skin warm and dry? Are they diaphoretic (sweaty)? Document any laceration/rashes/beuises here with size, location and appearance.

Gait posture transfer: Gait: How does PT walk? Does PT need assistance?
Transfers: Does PT stand up and sit down with ease?

Always comment

Assessment

An overview of what the PT "has" --a diagnosis

Plan

What are you going to do for the PT.

This is a list of:
- Medications with dosage instructions and for how many wks (Please put "New" or "Trial" by medication that is being started today?

-Instructions you will give PT

-Description of bandages you will apply/crutches you will supply/adult diapers you will provide, etc.

Always list the issue next to the plan:
DM - Metformin 1000mg, 2x daily, for 2 wks

Fungus between toes - Antifunfal cream, 2x daily, for 1 wk
PT in footbath for 10mins @ clinic
Provided 1 pair new socks
Encourage PT to F/U next wk to check feet

Volunteer Name(s)

First and last names of all volunteers