

SURGERY HISTORY FORMAT

Summary:

1. Identification

2. Chief Complaints

3. History of Presenting Illness (HOPI) (DOPSAT + SOCRATES for pain)

4. Past History (medical + surgical)

5. Personal History

6. Family History

7. Drug History

8. General Physical Examination

9. Systemic Examination

10. Local Examination

11. Provisional Diagnosis

12. Differentials

1. Identification Data

- Name of Patient:
 - Age / Gender:
 - Marital Status:
 - Occupation (exact nature of job):
 - Address:
 - Hospital No.:
 - Ward/Unit:
 - Date of Admission:
 - Date of Examination:
 - Mode of Admission (MOA): Emergency / OPD / Referred
 - Informant: Self / Wife / Son / Daughter / Mother /
Father
 - History Reliability: Reliable / Partially reliable
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2. Chief Complaints (with duration)

1. Complaint 1 — duration
2. Complaint 2 — duration
3. Complaint 3 — duration

(Always write in patient's words where possible)

3. History of Presenting Illness (HOPI)

Start from when the patient was completely well → chronological order → present condition.

Use DOPSAT Framework (where applicable):

- Duration
- Onset
- Progression
- Symptoms associated
- Aggravating/Relieving factors
- Treatment taken

For Pain — Use SOCRATES:

- Site
- Onset (sudden/gradual)
- Character (sharp, dull, colicky, burning)
- Radiation
- Associated symptoms
- Timing
- Exacerbating / relieving factors
- Severity (VAS score)

Include:

- Constitutional symptoms (fever, weight loss, anorexia)
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4. Past History

A. Medical History

- Ischemic Heart Disease (IHD)
- Hypertension (HTN)

- Diabetes Mellitus (DM)
- Tuberculosis (TB)
- Asthma
- Hepatitis
- Any other chronic illness

B. Surgical History

- Previous hospital admissions (Date + Reason)
- Previous surgeries (Type + Date)
- Post-operative complications (if any)
- History of anesthesia complications

S. Drug & Treatment History

- Current medications (dose + duration)
- Anticoagulants
- Steroids
- Insulin / OHA
- Previous treatment for current illness
- Drug allergies (specify reaction)

6. Personal & Social History

- Married / Unmarried
- Number of children
- Occupation (sedentary/heavy labor)
- Smoking (packs/day × years → pack years)
- Alcohol
- Substance abuse
- Dietary habits
- Socioeconomic status
- Housing (own/rented; ventilation good/poor, water filter/unfiltered, food healthy/junk))
- Physical activity
- Recent Travel

7. Family History

- DM

- HTN
 - IHD
 - TB
 - Malignancy
 - Similar illness in family
 - Genetic disorders
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8. GENERAL PHYSICAL EXAMINATION (GPE)

Vitals

- Temperature
- Pulse (rate, rhythm, volume, character)
- Blood Pressure
- Respiratory Rate
- Oxygen Saturation

General Appearance

- Level of consciousness
- Build & nutrition

- Distress (pain, dyspnea)

General Signs

- Pallor
- Icterus (Jaundice)
- Cyanosis
- Clubbing
- Lymphadenopathy
- Pedal edema
- Dehydration
- Any scars
- Any other significant findings

9. SYSTEMIC EXAMINATION

-> Respiratory System

Ask about:

- Cough (dry/productive)
 - Sputum (color/blood)
 - Hemoptysis
 - Dyspnea
 - Orthopnea
 - PND
 - Wheeze
 - Pleuritic chest pain
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-> Cardiovascular System

Ask:

- Anginal chest pain
- Palpitations
- Dyspnea on exertion
- Orthopnea
- PND
- Syncope
- Pedal edema

- Claudication
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-> Gastrointestinal System

Ask:

- Nausea
 - Vomiting (bilious/blood)
 - Hematemesis
 - Abdominal pain
 - Distension
 - Dysphagia
 - Heartburn
 - Altered bowel habits
 - Constipation / Diarrhea
 - Blood in stool
 - Melena
 - Tenesmus
 - Jaundice
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-> Genitourinary System

Urinary:

- Dysuria
- Frequency
- Urgency
- Nocturia
- Hesitancy
- Poor stream
- Hematuria
- Flank pain

Male:

- Scrotal swelling
- Erectile dysfunction

Female:

- Menstrual history
- Vaginal discharge
- Postmenopausal bleeding

-> Nervous System

- Headache
- Seizures
- Loss of consciousness
- Focal weakness
- Numbness
- Speech difficulty
- Visual disturbance
- Tremors
- Gait imbalance

-> Musculoskeletal System

- Joint pain
- Swelling
- Morning stiffness
- Back pain
- Restricted movement

- Muscle weakness
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-> Endocrine System

- Heat intolerance
 - Cold intolerance
 - Weight gain/loss
 - Polyuria
 - Polydipsia
 - Polyphagia
 - Neck swelling
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-> Hematological / Lymphatic

- Easy bruising
 - Recurrent infections
 - Lymph node swelling
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10. LOCAL EXAMINATION

(Modify according to case: hernia, breast lump, thyroid swelling, varicose veins, ulcer, etc.)

Follow:

1. Inspection
2. Palpation
3. Percussion (if applicable)
4. Auscultation (if applicable)
5. Special tests

Mention:

- Site
- Size
- Shape
- Surface
- Borders
- Consistency
- Tenderness
- Temperature

- Mobility
 - Reducibility
 - Transillumination (if relevant)
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11. PROVISIONAL DIAGNOSIS

Based on:

- Most likely diagnosis
- With key supporting features

Example:

"Based on history and examination, this is most likely a case of right indirect inguinal hernia."

12. DIFFERENTIAL DIAGNOSIS

List 2-4 relevant differentials.

Example:

- Direct inguinal hernia
 - Femoral hernia
 - Lipoma of spermatic cord
 - Hydrocele
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- How to List Negatives in a Case Presentation -

Instead of listing negatives randomly, say:

- There is no history suggestive of respiratory symptoms such as cough, hemoptysis, dyspnea, orthopnea, or wheeze. There are no cardiovascular complaints like chest pain, palpitations, syncope, claudication, or pedal edema.
- There are no gastrointestinal symptoms such as nausea, vomiting, hematemesis, abdominal distension, altered bowel habits, melena, or jaundice.

- There are no genitourinary complaints including dysuria, increased frequency, hematuria, flank pain, or urinary hesitancy.
- There are no neurological symptoms such as headache, seizures, loss of consciousness, focal weakness, sensory deficits, speech disturbance, or visual complaints.
- There are no musculoskeletal complaints including joint pain, swelling, morning stiffness, back pain, or restricted movements.
- There are no endocrine symptoms such as heat or cold intolerance, weight changes, polyuria, polydipsia, or neck swelling.

- There is no history suggestive of hematological or lymphatic disorders such as easy bruising, recurrent infections, or lymph node enlargement.”
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-> The End <-