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History of present illness example

Obtaining an accurate history is the critical first step in determining the etiology of a patient's problem. A large percentage of the time, you will actually be able to make a diagnosis based on the history alone. The value of the history, of course, will depend on your ability to elicit relevant information. Your sense of what constitutes important data will grow exponentially in the coming years as you gain a greater understanding of the pathophysiology of disease through increased exposure to patients and illness. However, you are already in possession of the tools that will enable you to obtain a good history. That is, an ability to listen and ask common-sense questions that help define the nature of a particular problem. It does not take a vast, sophisticated fund of knowledge to successfully interview a patient. In fact seasoned physicians often lose sight of this important point, placing too much emphasis on the use of testing while failing to take the time to listen to their patients. Successful interviewing is for the most part dependent upon your already well developed communication skills. What follows is a framework for approaching patient complaints in a problem oriented fashion. The patient initiates this process by describing a symptom. It falls to you to take that information and use it as a springboard for additional questioning that will help to identify the root cause of the problem. Note that this is different from trying to identify disease states which might exist yet do not generate overt symptoms. To uncover these issues requires an extensive "Review Of Systems" (a.k.a. ROS). Generally, this consists of a list of questions grouped according to organ system and designed to identify disease within that area. For example, a review of systems for respiratory illnesses would include: Do you have a cough? If so, is it productive of sputum? Do you feel short of breath when you walk? etc. In a practical sense, it is not necessary to memorize an extensive ROS question list. Rather, you will have an opportunity to learn the relevant questions that uncover organ dysfunction when you review the physical exam for each system individually. In this way, the ROS will be given some context, increasing the likelihood that you will actually remember the relevant questions. The patient's reason for presenting to the clinician is usually referred to as the "Chief Complaint." Perhaps a less pejorative/more accurate nomenclature would be to identify this as their area of "Chief Concern." Getting Started: Always introduce yourself to the patient. Then try to make the environment as private and free of distractions as possible. This may be difficult depending on where the interview is taking place. The emergency room or a non-private patient room are notoriously difficult spots. Do the best that you can and feel free to be creative. If the room is crowded, it's OK to try and find alternate sites for the interview. It's also acceptable to politely ask visitors to leave so that you can have some privacy. If possible, sit down next to the patient while conducting the interview. Remove any physical barriers that stand between yourself and the interviewee (e.g. put down the side rail so that your view of one another is unimpeded... though make sure to put it back up at the conclusion of the interview). These simple maneuvers help to put you and the patient on equal footing. Furthermore, they enhance the notion that you are completely focused on them. You can either disarm or build walls through the speech, posture and body languarge that you adopt. Recognize the power of these cues and the impact that they can have on the interview. While there is no way of creating instant intimacy and rapport, paying attention to what may seem like rather small details as well as always showing kindness and respect can go a long way towards creating an environment that will facilitate the exchange of useful information. If the interview is being conducted in an outpatient setting, it is probably better to allow the patient to wear their own clothing while you chat with them. At the conclusion of your discussion, provide them with a gown and leave the room while they undress in preparation for the physical exam. Initial Question(s): Ideally, you would like to hear the patient describe the problem in their own words. Open ended questions are a good way to get the ball rolling. These include: "What brings your here? How can I help you? What seems to be the problem?" Push them to be as descriptive as possible. While it's simplest to focus on a single, dominant problem, patients occasionally identify more then one issue that they wish to address. When this occurs, explore each one individually using the strategy described below. Follow-up Questions: There is no single best way to question a patient. Successful interviewing requires that you avoid medical terminology and make use of a descriptive language that is familiar to them. There are several broad questions which are applicable to any complaint. These include: Duration: How long has this condition lasted? Is it similar to a past problem? If so, what was done at that time? Severity/Character: How bothersome is this problem? Does it interfere with your daily activities? Does it keep you up at night? Try to have them objectively rate the problem. If they are describing pain, ask them to rate it from 1 to 10 with 10 being the worse pain of their life, though first find out what that was so you know what they are using for comparison (e.g. childbirth, a broken limb, etc.). Furthermore, ask them to describe the symptom in terms with which they are already familiar. When describing pain, ask if it's like anything else that they've felt in the past. Knife-like? A sensation of pressure? A toothache? If it affects their activity level, determine to what degree this occurs. For example, if they complain of shortness of breath with walking, how many blocks can they walk? How does this compare with 6 months ago? Location/Radiation: Is the symptom (e.g. pain) located in a specific place? Has this changed over time? If the symptom is not focal, does it radiate to a specific area of the body? Have they tried any therapeutic maneuvers?: If so, what's made it better (or worse)? Pace of illness: Is the problem getting better, worse, or staying the same? If it is changing, what has been the rate of change? Are there any associated symptoms? Often times the patient notices other things that have popped up around the same time as the dominant problem. These tend to be related. What do they think the problem is and/or what are they worried it might be? Why today?: This is particularly relevant when a patient chooses to make mention of symptoms/complaints that appear to be long standing. Is there something new/different today as opposed to every other day when this problem has been present? Does this relate to a gradual worsening of the symptom itself? Has the patient developed a new perception of its relative importance (e.g. a friend told them they should get it checked out)? Do they have a specific agenda for the patient-provider encounter? For those who favor mnemonics, the 8 dimensions of a medical problem can be easily recalled using OLD CARTS (Onset, Location/radiation, Duration, Character, Aggravating factors, Relieving factors, Timing and Severity). The content of subsequent questions will depend both on what you uncover and your knowledge base/understanding of patients and their illnesses. If, for example, the patient's initial complaint was chest pain you might have uncovered the following by using the above questions: The pain began 1 month ago and only occurs with activity. It rapidly goes away with rest. When it does occur, it is a steady pressure focused on the center of the chest that is roughly a 5 (on a scale of 1 to 10). Over the last week, it has happened 6 times while in the first week it happened only once. The patient has never experienced anything like this previously and has not mentioned this problem to anyone else prior to meeting with you. As yet, they have employed no specific therapy. This is quite a lot of information. However, if you were not aware that coronary-based ischemia causes a symptom complex identical to what the patient is describing, you would have no idea what further questions to ask. That's OK. With additional experience, exposure, and knowledge you will learn the appropriate settings for particular lines of questioning. When clinicians obtain a history, they are continually generating differential diagnoses in their minds, allowing the patient's answers to direct the logical use of additional questions. With each step, the list of probable diagnoses is pared down until a few likely choices are left from what was once a long list of possibilities. Perhaps an easy way to understand this would be to think of the patient problem as a Windows-Based computer program. The patient tells you a symptom. You click on this symptom and a list of general questions appears. The patient then responds to these questions. You click on these responses and... blank screen. No problem. As yet, you do not have the clinical knowledge base to know what questions to ask next. With time and experience you will be able to click on the patient's response and generate a list of additional appropriate questions. In the previous patient with chest pain, you will learn that this patient's story is very consistent with significant, symptomatic coronary artery disease. As such, you would ask follow-up questions that help to define a cardiac basis for this complaint (e.g. history of past myocardial infarctions, risk factors for coronary disease, etc.). You'd also be aware that other disease states (e.g. emphysema) might cause similar symptoms and would therefore ask questions that could lend support to these possible diagnoses (e.g. history of smoking or wheezing). At the completion of the HPI, you should have a pretty good idea as to the likely cause of a patient's problem. You may then focus your exam on the search for physical signs that would lend support to your working diagnosis and help direct you in the rational use of adjuvant testing. Recognizing symptoms/responses that demand an urgent assessment (e.g. crushing chest pain) vs. those that can be handled in a more leisurely fashion (e.g. fatigue) will come with time and experience. All patient complaints merit careful consideration. Some, however, require time to play out, allowing them to either become "a something" (a recognizable clinical entity) or "a nothing," and simply fade away. Clinicians are constantly on the look-out for markers of underlying illness, historical points which might increase their suspicion for the existence of an underlying disease process. For example, a patient who does not usually seek medical attention yet presents with a new, specific complaint merits a particularly careful evaluation. More often, however, the challenge lies in having the discipline to continually re-consider the diagnostic possibilities in a patient with multiple, chronic complaints who presents with a variation of his/her "usual" symptom complex. You will undoubtedly forget to ask certain questions, requiring a return visit to the patient's bedside to ask, "Just one more thing." Don't worry, this happens to everyone! You'll get more efficient with practice. Dealing With Your Own Discomfort: Many of you will feel uncomfortable with the patient interview. This process is, by its very nature, highly intrusive. The patient has been stripped, both literally and figuratively, of the layers that protect them from the physical and psychological probes of the outside world. Furthermore, in order to be successful, you must ask in-depth, intimate questions of a person with whom you essentially have no relationship. This is completely at odds with your normal day to day interactions. There is no way to proceed without asking questions, peering into the life of an otherwise complete stranger. This can, however, be done in a way that maintains respect for the patient's dignity and privacy. In fact, at this stage of your careers, you perhaps have an advantage over more experienced providers as you are hyper-aware that this is not a natural environment. Many physicians become immune to the sense that they are violating a patient's personal space and can thoughtlessly over step boundaries. Avoiding this is not an easy task. Listen and respond appropriately to the internal warnings that help to sculpt your normal interactions. How to Write a History of Present Illness (HPI) A History of Present Illness (HPI) is a crucial component of a patient’s medical record, providing a detailed account of their current symptoms, complaints, and medical concerns. Writing a comprehensive and accurate HPI requires attention to detail, effective communication skills, and a clear understanding of the patient’s medical history. In this article, we will guide you on how to write a thorough and informative HPI. Why is the History of Present Illness Important? The HPI is a vital component of a patient’s medical record, as it sets the stage for the diagnosis and treatment of their illness. A well-written HPI helps healthcare providers to: Understand the patient’s symptoms and concerns Identify potential underlying medical conditions Develop an effective treatment plan Monitor the patient’s progress and adjust treatment as needed How to Write a History of Present Illness Writing a comprehensive HPI involves several steps: Step 1: Gather Information Obtain a complete medical history: Review the patient’s medical record, including previous diagnoses, surgeries, and medications. Conduct a thorough physical examination: Note any abnormal findings or observations during the examination. Interview the patient: Ask open-ended questions to gather information about their symptoms, medical concerns, and previous illnesses. Step 2: Organize the Information Use a standard format: Use a standardized format for writing the HPI, such as the SOAP (Subjective, Objective, Assessment, Plan) note. Categorize the information: Group the information into categories, such as: Chief complaint: The patient’s primary reason for seeking medical attention. History of present illness: A detailed account of the patient’s current symptoms and medical concerns. Past medical history: A review of the patient’s previous illnesses, surgeries, and medical conditions. Medications: A list of the patient’s current medications, including dosages and frequencies. Step 3: Write the History of Present Illness Use clear and concise language: Avoid using medical jargon or technical terms that may be unfamiliar to non-medical professionals. Focus on the patient’s symptoms: Describe the patient’s symptoms in detail, including their duration, frequency, and severity. Include relevant medical information: Include any relevant medical information, such as laboratory test results or imaging studies. Example of a Written History of Present Illness Chief Complaint: The patient presents with a 3-day history of cough, fever, and difficulty breathing. History of Present Illness: The patient reports a sudden onset of symptoms, which began 3 days ago. The cough is productive of yellow sputum, and the patient experiences chest tightness and shortness of breath. The patient has also reported a low-grade fever (less than 100.4°F) and has been experiencing fatigue. Past Medical History: The patient has a history of asthma, which is well-controlled with inhalers. Medications: The patient is currently taking inhalers for asthma and antihistamines for allergies. Additional Tips Use bullet points: Use bullet points to summarize the patient’s symptoms, medical history, and medications. Include relevant vital signs: Include relevant vital signs, such as blood pressure, pulse, and temperature. Be thorough and detailed: Ensure that the HPI is thorough and detailed, covering all aspects of the patient’s symptoms and medical concerns. Conclusion Writing a comprehensive and accurate History of Present Illness requires attention to detail, effective communication skills, and a clear understanding of the patient’s medical history. By following the steps outlined in this article, you can ensure that your HPI is thorough, informative, and sets the stage for effective diagnosis and treatment of the patient’s illness. Table: Key Components of a History of Present Illness Component Description Chief Complaint The patient’s primary reason for seeking medical attention History of Present Illness A detailed account of the patient’s current symptoms and medical concerns Past Medical History A review of the patient’s previous illnesses, surgeries, and medical conditions Medications A list of the patient’s current medications, including dosages and frequencies Relevant Medical Information Any relevant medical information, such as laboratory test results or imaging studies References American Medical Association. (2019). Principles of the Medical Interview. World Health Organization. (2019). Standards for the Collection of Health Information. Note: This article is for educational purposes only and should not be used as a substitute for professional medical advice. Your friends have asked us these questions - Check out the answers! This comprehensive HPI template helps general practitioners capture detailed patient histories, supporting preliminary assessments, diagnosis, and treatment planning. With Heidi, the AI medical scribe for all clinicians, you can instantly generate history of present illness records that:Capture detailed patient history, including symptom onset, severity, and impact on daily life. Identify key symptoms, modifying factors, and potential risk factors to narrow down possible diagnoses.Evaluate the likely diagnosis and recommend next steps for treatment and follow-up. View TemplateSee Sample PDFWhat is an HPI Template?A History of Present Illness (HPI) template is a structured format used to record the history of a patient’s current medical condition. The HPI details key elements such as the onset of the disease, duration, severity, and associated symptoms. HPI templates are essential for gathering and organizing the relevant history of a patient’s current illness. This helps ensure that no important details are missed, and treatment plans are well-informed to provide effective care. In this article, we’ll provide you with a step-by-step guide and practical tips on how to write an effective HPI, inform you about common HPI documentation mistakes and how you can fix them, and most importantly, provide customizable and AI-compatible HPI templates you can use for your medical practice. The Real-World Impact of Diligent HPI Template DocumentationHPI templates are critical for accurate diagnosis and timely care. A recent study estimated that around 80% of medical conditions can be correctly diagnosed by thorough HPI documentation. Additionally, it posits that digital tools can be used to improve doctors’ ability to obtain efficient and high-quality HPI documentation.A couple of years ago, 65-year-old Alexander Frank Patterson was misdiagnosed with an infection with atypical pneumonia, which caused confusion and hypoglycemia. In reality, he was suffering from bleeding from a duodenal ulcer with a large artery in its base. Six hours after arriving at the hospital, his condition worsened, and he was pronounced dead that evening. The coroner concluded that there had been a “premature diagnostic closure”, and that the failure of doctors to communicate key information between the care team members led to the fatal misdiagnosis.Ultimately, the hospital would be subject to medical documentation audits to ensure they meet the requirements of relevant National Safety and Quality Health Service (NSQHS) standards.This case underscores the importance of diligent and thorough HPI documentation for preventing diagnostic errors. How to Write an Effective HPI: Step-by-Step Guide with ExamplesWhile the template lays the groundwork, it’s ultimately up to healthcare providers to follow best practices to ensure effective HPI documentation. Below is our practical, step-by-step guide, along with some tips on how to fill out your HPI template:1. Start with the Chief Complaint (CC)Open with a clear, single-line summary of the patient’s reason for seeking care. This is the foundation of the HPI which will set the tone for the rest of the document.Example:Patient presents with severe chest pain lasting nearly 2 hours.2. Structure the HPI Using a Proven FrameworkUse the acronym SOCRATES to ensure you’re able to document a complete and organized narrative:S - Site: Where is the symptom?O - Onset: When did it start?C - Character: What does it feel like (e.g., sharp or dull pain)?R - Radiation: Does it spread to other areas?A - Associations: Are there other symptoms present?T - Timing/Time Course: How often does it occur? Has the pain changed over time?E - Exacerbating/Relieving Factors: What makes the symptom better or worse?S - Severity: How intense is the pain?Example - Note that the letters below in bold are only included for practice purposes, not in actual HPI documents:Central chest pain (S). Sudden onset while climbing stairs at home (O). Tight, crushing sensation (C), radiating to left arm and jaw (R). Reported shortness of breath, sweating, and nausea (A). Continuous for 2 hours without relief (T), and worsens with physical exertion and deep breathing; no relief with rest or antacids (E). Pain rated 8/10 (S). 3. Include Relevant Context and HistoryDetail any relevant past conditions, as well as current medications and allergies that can potentially complicate treatment plans. Additionally, include the patient’s family history to rule out genetic factors and hereditary conditions.Outline their social history and lifestyle factors like smoking, alcohol consumption, and the patient’s occupation, to rule out risk factors and other potential underlying cases. Example:Medical History - 45-year-old male with a history of hypertension and hyperlipidemia presents with sudden onset of chest pain radiating to the left arm. No previous cardiac arrests but reports of occasional heart palpitations. Medications - Lisinopril 10 mg daily for hypertension, and atorvastatin 20 mg daily for hyperlipidemia. Allergies - No known drug allergies. Family History - Father died of myocardial infarction at age 50, and mother has type 2 diabetes.Social History - Been smoking at least 1 pack of cigarettes daily for 20 years, and drinks alcohol occasionally. Works a high-stress office job. 4. Focus on Clarity and BrevityKeep your sentences short and precise, avoid medical jargon unless essential, and stick to a logical order; beginning with the onset before describing the progression. HPI notes are often used to inform emergency and admission notes so they must be able to give a complete picture of the patient’s situation in a few short sentences. Example:Sudden onset of sharp chest pain, radiating to the left arm and jaw. Continuous for 2 hours and no relief with rest or antacids. 5. End with a Summary and Next StepsConclude the HPI documentation with a concise summary of the key details, and include any working diagnosis or planned testing. A well-written summary improves handoffs and communication between healthcare providers for a quicker, more accurate diagnosis.Example:Patient presents with acute chest pain radiating to left arm, onset 2 hours ago. Suspected myocardial infarction. Will order ECG and troponin test. Here’s a free HPI example in PDF and Google Doc form.Download PDF | Copy Google DocWhile HPI documentation is critical for helping doctors in emergencies, they are also time-consuming and error-prone when written manually. Fortunately, an AI-powered solution is now available to ensure fast, accurate, and thorough HPI documentations for doctors everywhere. 77% of My Emergency Doctor’s (MED) clinicians immediately adopted Heidi within the first three weeks of its rollout, cutting their average documentation and reporting time from 2 hours to just 20 minutes. “Heidi is easy to work with, the training required is minimal. And seeing a professional medical summary created after a consult with a patient, which filters out all the unnecessary details and includes clear plans and patient instructions... is a game changer.” - Tatiana Lowe, Medical Director and FACEM at MEDEasily Complete HPI Templates with HeidiHeidi is our state-of-the-art AI medical scribe designed to help healthcare providers complete HPI templates in real-time. With your patient’s permission, simply hit record and let Heidi work as you go. Here’s how Heidi helps you complete your HPI documentation:Transcribe – Open Heidi on your computer or mobile device and press Start so Heidi can capture your conversation in the background. For information that you don’t want to verbalize, you can type them under context notes to be considered later. Customize – After the session, simply select your preferred HPI template and watch as Heidi perfectly transcribes the details of your conversation and context notes in the appropriate format!Transform – After generating your completed HPI templates, you can ask Heidi to give additional documentation including physical exam notes and treatment plans as needed. Heidi complies with jurisdiction-specific regulations, ensuring data localization for customers in Australia, Canada, the United States, the United Kingdom, and beyond. Read more about our compliance here.Try for FreeFree History of Present Illness (HPI) TemplatesHistory of Presenting Complaint TemplateThis HPI template is a comprehensive digital tool used by general practitioners to document relevant medical histories in patient visits. It captures key points including the onset, duration, and characteristics of the patient’s current condition along with associated symptoms. View TemplateHPI Medical Example TemplateThis template with an HPI section is designed for emergency medicine specialists. It captures critical patient information including past medical history, habits, medications, and a detailed history of present illness to inform emergency care plans. View TemplateEmergency Medicine HPI TemplateThis emergency admission template, which includes an HPI section is designed to outline essential patient information during an emergency admission. It covers the reason for presentation, relevant medical history, review of systems, and management en route, among others. View TemplateFAQs About HPI TemplatesWhat’s the difference between HPI and ROS?HPI focuses on the information regarding the patient’s current complaint, while review of systems (ROS) performs a broader review of the patient’s bodily systems. The latter aims to uncover additional issues and symptoms even if they’re not directly related to the current complaint. How can poor HPI template documentation lead to misdiagnosis or delayed care?Low-quality HPI notes can result in overlooked details critical to forming an accurate diagnosis. For example, if the clinician fails to take note whether the patient’s chest pain radiates to other parts of their body, a myocardial infarction could be overlooked. This could lead to dangerous delays in treatment. Can I tailor Heidi’s HPI templates to my patients’ needs?Yes! Heidi’s AI-enabled HPI templates can be easily tailored to fit specific patient conditions. We’ve designed Heidi to be highly-intuitive so you can adopt the system and improve your existing process right away. Review our guide on note customization and document management to get started. To determine what to include in the History of Present Illness (HPI), keep these questions in mind. Location – Where is the pain? Where is the problem? Ex. back pain, nasal congestion Quality – Please describe your symptoms (Action words) Ex. sharp or shooting pain, dry cough Severity – What is the patient’s level of discomfort or pain? Ex. extremely nauseated, moderate pain Duration – How long has the patient had this problem? Ex. onset two weeks ago Timing – How long does it last? When does this problem happen? What time of day does this problem occur? Ex. worse in the mornings, occurs constantly Context – How or what happened? What is going on? Ex. Dizzy upon standing, worse after exercise Modifying factors – What has the patient taken or done for relief? Ex. No relief from OTC meds, improves with rest Associated signs and symptoms – This can be positive or negative. Ex. a chief complaint of nausea may be accompanied by associated symptoms of vomiting and diarrhea, no fever Remember: Listing three of the patient’s chronic problems, along with the status, could be considered a comprehensive HPI. Ex. Diabetes Mellitus, stable on current insulin CHF, worse since last visit due to weather Osteoarthritis, improved with increase in RX The question “Who” can be used to add to the complexity in the Medical Decision Making (MDM) in the amount and complexity of data to be reviewed. Simply put, who is giving the history? This must be documented in the note. Ex. History was given by mom/dad History was given by patient’s daughter/son History was given by patient’s spouse Remember: To reach a comprehensive HPI, you need at least four of the eight elements, listed above. History of Present Illness: The Who, What, When, Where was last modified: June 19th, 2017 by Katreece Tate