# Component III: Clinical

## Module A: Exam Room Procedures

## Topic 2 Patient Interview, History and Documentation

**Statement of Purpose**
To prepare the learner with basic knowledge and skills necessary to interview a patient and correctly complete appropriate sections of medical history forms.

**Student Learning Outcomes**
Upon completion of this topic, the learner will be able to:

1. Spell and define key terms.
2. List different sections of medical history and give examples of types of information included in each.
3. State the six C's of charting for writing an accurate patient history.
4. Utilize guidelines for conducting a patient interview.
5. Explain differences between a sign and a symptom. Give examples of each.
6. Explain chief complaint and present illness.
7. List the contents of a patient's chart.
8. Identify and describe types of formats used for documenting information into the medical record.
9. List general rules for medical record entry.

**Terminology**

1. Assessment
2. Chief complaint
3. Database
4. Demographic information
5. Family history (FH)
6. Head, eyes, ears, nose, throat (HEENT)
7. Hereditary
8. Last Menstrual Period (LMP)
9. Medical history
10. Over the counter (OTC)
11. Past Medical History (PMH)
12. Present illness (PI)
13. Problem, Implementation, Evaluation (PIE)
14. Problem Oriented Medical Record (POMR)
15. Review of Systems (ROS)
16. Signs
17. Social History (SH)
18. Source Oriented Medical Record (SOMR)
19. Subjective, Objective, Assessment, Plan, Evaluation (SOAPE)
20. Symptoms
21. Health Insurance Portability and Accountability Act (HIPAA)

**References**


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2. Dennerll, J.T., & Davis, P.E. (2010). *Medical Terminology: A Programmed Systems Approach (10th Ed.).* Clifton Park, NY: Delmar, Cengage Learning.
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4. Blesi, M., Wise, B.A., Kelley-Arney, C, (2012) *Medical Assisting Administrative and Clinical Competencies* (7th Ed.) Clifton Park, NY: Delmar, Cengage Learning.
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8. Proctor, D.B, Young-Adams, A.P. (2011). Kinn's The Medical Assistant: An Applied Learning Approach (11th Ed.). Philadelphia, PA: Saunders Elsevier.

**Websites**

1. www.osha.gov
2. www.cdc.gov
3. www.innerbody.com
4. www.epa.gov
5. www.mbc.ca.gov/allied/medical_assistants.html
6. www.jointcommision.org

| Content Outline/Theory Objectives | Suggested Learning Activities |
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| **Objective 1**<br>**Spell and define key terms.**<br>A. Review the terms listed in the terminology section.<br>B. Spell the listed terms accurately.<br>C. Pronounce the terms correctly.<br>D. Use the terms in their proper context. | A. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman and concentration.<br>B. Administer vocabulary pre-test and post-test.<br>C. Discuss learning gaps and plan for applying vocabulary. |
| **Objective 2**<br>**List different sections of medical history and give examples of types of information included in each.**<br>A. Demographic information<br>1. Patient's name.<br>2. Date of birth.<br>3. Address.<br>4. Home and work phone numbers.<br>5. Insurance carrier and policy number.<br>6. Gender.<br>7. Ethnicity.<br>B. Chief Complaint or present illness, purpose of the patient's visit<br>1. Gather as much information as possible and record concisely in the patient's own words.<br>C. Past history/Past medical history, summary of the patient's previous health<br>1. Allergies.<br>2. Immunizations.<br>3. Childhood diseases.<br>4. Current and past medication.<br>5. Previous illness.<br>6. Traumatic illnesses.<br>7. Surgeries.<br>8. Hospitalizations.<br>D. Family History, details about the patient's parents and siblings<br>1. Ask about parents and siblings general health and medical conditions.<br>2. Ask whether parents are deceased and ask the cause of death.<br>E. Social History, includes information about the patient's lifestyle<br>1. Occupation.<br>2. Education.<br>3. Use of tobacco and alcohol.<br>4. Sleeping habits.<br>5. Level of exercise.<br>6. Nutrition. | A. Lecture/Discussion<br>B. Assigned Readings<br>C. Provide samples of patient history forms. |

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| 7. Sexual activity.<br>8. Marital status.<br>9. Hobbies.<br>10. Entertainment preferences.<br>11. Last menstrual period (LMP).<br>12. Contraceptives.<br>13. Cultural and religious background.<br>F. Review of Systems (ROS), checklist and questions provide a guide to the patient's general health and to detect conditions other than those in the present illness<br>1. Head and neck.<br>2. Eyes.<br>3. Ears.<br>4. Mouth.<br>5. Nose.<br>6. Throat.<br>7. Respiratory.<br>8. Cardiovascular.<br>9. Digestive.<br>10. Urinary.<br>11. Genital-male.<br>12. Genital-female.<br>13. Obstetric history.<br>14. Musculoskeletal.<br>15. Neuromuscular.<br>16. Skin. | |
| **Objective 3**<br>**State the six C's of charting for writing an accurate patient history.**<br>A. Correctness, document patient's exact words; do not interpret what patient says.<br>B. Clarity, use medical terminology and precise descriptions.<br>C. Completeness, fill out forms completely.<br>D. Conciseness, be to the point and use approved abbreviations.<br>E. Chronological order, dates on all entries in the correct order, legal issue.<br>F. Confidentiality, follow HIPAA guidelines. | A. Lecture/Discussion<br>B. Assigned Readings |
| **Objective 4**<br>**Utilize guidelines for conducting a successful patient interview.**<br>A. Active listening, hearing the patient's message using active listening, concentration and understanding.<br>B. Restatement.<br>C. Reflection.<br>D. Clarification.<br>E. Nonverbal communication, be aware of nonverbal clues and body language<br>1. Position or body language. | A. Lecture/Discussion<br>B. Assigned Readings<br>C. Have students list the components of an interview.<br>D. Divide students in groups of three. Role play interviewing with one student taking notes to see if guidelines were followed. Roles |

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| 2. Touch.<br>3. Facial expressions.<br>4. Eye contact.<br>5. Personal space.<br>F. Use layman's terms to discuss symptoms and diseases.<br>G. Plan and research before interview<br>1. Review patient history.<br>2. Have general questions ready.<br>3. Ask patient's permission to ask questions.<br>H. Make the patient feel at ease<br>1. Build rapport.<br>2. Sit with patient.<br>I. Conduct interview in private without interruption<br>1. Do not rush.<br>2. Maintain eye contact.<br>3. Use patient's name.<br>J. Deal with sensitive topics with respect<br>1. Non-threatening.<br>2. Know when to stop interviewing.<br>K. Avoid making diagnosis or giving diagnostic opinion.<br>L. Summarize key points<br>1. Ask patient if they have questions.<br>2. Ask patient if they have additional information that should be added. | can then be switched. |
| **Objective 5**<br>**Explain differences between a sign and a symptom. Give examples of each.**<br>A. Signs are objective indications of disease or bodily dysfunction that can be perceived by others.<br>1. Rash.<br>2. Bleeding.<br>3. Cough.<br>4. Discharge.<br>5. Vital signs.<br>B. Symptoms are subjective indications of disease and changes in body as sensed by patient and not recognized by anyone else.<br>1. Pain.<br>2. Nausea.<br>3. Headache. | A. Lecture/Discussion<br>B. Assigned Readings |
| **Objective 6**<br>**Explain chief complaint and present illness.**<br>A. Chief complaint, description of symptoms that led patient to seek Physician care<br>1. Document in patient's chart; use patient's own words<br>a. Headache for two days.<br>b. Lifted and strained back.<br>B. Present illness, more specific account of chief complaint, chronological order of events | A. Lecture/Discussion<br>B. Assigned Readings |

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| 1. Onset.<br>2. Signs and symptoms.<br>3. Intensity.<br>4. Location.<br>5. Duration.<br>6. Precipitating factors.<br>7. Remedies.<br>8. Over the counter medications.<br>9. Prescription medications. | |
| **Objective 7**<br>**List the contents of a patient's medical record.**<br>A. Patient registration form.<br>B. Patient medical history form.<br>C. Test results<br>1. Laboratory.<br>2. Radiological.<br>3. Other information.<br>D. Records from other physicians or hospitals.<br>E. Physician diagnosis and treatment plan.<br>F. Operative reports.<br>G. Informed consent forms, signed by patient.<br>H. HIPAA and compliance forms.<br>I. Discharge summary forms from hospitalizations.<br>J. Correspondence with or about the patient. | A. Lecture/Discussion<br>B. Assigned Readings |
| f. Surgical reports<br>g. Correspondence.<br>h. Patient education.<br>B. Problem Oriented Medical Records (POMR)<br>1. Lists each patient problem at the beginning of the record and references each problem with a number throughout the record<br>a. Data base<br>1) Chief complaint.<br>2) Present illness.<br>3) Patient profile.<br>4) Review of systems.<br>5) Physical examination.<br>6) Laboratory reports.<br>b. Problem list<br>1) Social.<br>2) Demographic.<br>3) Medical.<br>4) Surgical.<br>c. Treatment plan<br>1) Management.<br>2) Additional consultations.<br>3) Therapist.<br>d. Progress notes<br>1) Structured.<br>2) According to institutional format, | A. Lecture/Discussion<br>B. Assigned Readings |

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| e.g. SOAPE.<br>C. Documentation forms<br>1. Progress notes.<br>2. Formats<br>a. Narrative – paragraph<br>1) What is wrong with patient?<br>2) What was done to help the patient?<br>3) Did treatment work?<br>b. SOAPE<br>1) Subjective component, what patient says, accurate quotes.<br>2) Objective component, what is observed about patient during assessment?<br>3) Assessment, phrase stating your impression of what is wrong with the patient.<br>4) Plan, list of interventions that have been done.<br>5) Evaluation, assessment of the patient's understanding of treatment.<br>c. PIE<br>1) Problem, statement of patient's problem.<br>2) Implementation, interventions provided.<br>3) Evaluation, how implementation affected the patient.<br>d. Focus<br>1) Focus.<br>2) Data.<br>3) Action.<br>4) Result.<br>e. Flow sheets, preprinted check list of most commonly asked questions.<br>f. Charting by Exception (CBE)<br>1) Only abnormal events are charted in narrative form.<br>2) Normal or expected findings are checked off in flow sheets.<br>g. Computerized charting utilizing "smart phrases." | |
| I. Use quotation marks for direct patient statements.<br>J. Document as soon as possible after completing a task.<br>K. Document missed appointments and your attempts to contact the patient by phone.<br>L. Document any telephone conversations with the patient in the chart.<br>M. If you have made an error, given the wrong medication, or performed an incorrect procedure, notify supervisor | A. Lecture/Discussion<br>B. Assigned Readings<br>C. Give students case studies and have them practice documentation in medical record. |

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| immediately, document it, and complete an incident report.<br>N. Never document for someone else and don't allow anyone else to document for you.<br>O. Do not share your password with anyone.<br>P. Never document false information.<br>Q. Never delete, erase, scribble over, or white-out in a medical record. This will be construed as tampering with a legal document.<br>1. Correct a written error according to institutional policy, e.g., draw a single line through the entry, initial it and write "error."<br>2. Document the correct information immediately adjacent to the lined-through information. | |