



Communication Guideline for Conducting Patient Interviews

Communication Style

- **Establish Eye Contact**
- **Avoid Medical Jargon**
 - Use plain language
- **Active or Attentive Listening**
 - Listen closely
 - Beware of the patient's emotional state
 - Use verbal and non-verbal skills
- **Guided Questioning**
 - Move from open-ended
 - EX: Can you tell me more about that?
 - Narrative
 - To a focused line of questioning
 - EX: Do you feel short of breath?
 - Yes/No
 - Ask a series of questions, ONE at a time
 - EX: Are you experiencing any of the following problems?
 - Offer multiple choices
 - Nausea
 - Vomiting
 - Diarrhea
 - Request clarification for ambiguity
 - EX: Feels like the “flu”, tell me exactly what you mean by that.
 - Encourage further narration by using *continuers*
 - Non-verbal responses such as postures and action
 - Nodding, leaning in, facial expressions
 - Verbal responses
 - Go on, I'm listening, tell me more
 - Use echoing/repetition
 - Mirror patient's posture, tone, and words to encourage expression of details and feelings
- **Empathetic Responses**
 - Recognize the patient's feelings
 - Elicit from the patient, do not assume
 - Respond with understanding and acceptance
 - Offer phrases such as “I understand”, “That sounds awful”, or “You seem upset.”
 - Use non-verbal expressions
 - Apply your hand to the patient's arm
 - Soften facial expressions
 - Offer a tissue
- **Summarize**
 - Briefly summarize the conversation
 - Demonstrate reflective listening skills
 - Organize clinical reasoning and convey your thoughts to engage

the patient collaboratively

- **Transition**
 - Alert the patient that you are changing topics
 - EX: What I'd like to discuss next is_____.
- **Partner**
 - Express desire to collaborate on the patient's care
 - Reassure the patient that you are committed to the partnership
 - FOLLOW THROUGH!
- **Validate**
 - Provide verbal support by legitimizing or validating patient's experience
 - EX: You have every right to feel that way.
- **Reassurance**
 - Avoid premature or false reassurance
 - Identify and accept the patient's feelings WITHOUT offering reassurance at that moment

Patient Empowerment

Patient-Provider relationship is hierarchical and unequal; trust is IMPERATIVE

- Evoke the patient's perspective
 - EX: How are you feeling about what is going on with you?
- Convey interest in the person, not just the problem
 - EX: What do you like to do for fun?
- Follow patient's lead
 - Ask follow-up or clarifying questions
- Elicit and validate emotional content
 - Use verbal and non-verbal skills
- Share information, especially at transition points
 - Summarize your thoughts and ask for feedback
- Make clinical reasoning transparent
 - Explain WHY you feel that way
- Reveal limits of your knowledge
 - Be vulnerable and clear about your lane
 - Explain the hand-off/referral process
 - Reinforce partnership and collaboration as a team moving forward

Use Understandable Language

APPROACH

- “Ask Me Three” (for patient)
 - What is my main problem?
 - What do I need to do?
 - Why is it important for me to do this?
- “Tell Them Three” (for provider)
 - The problem we are addressing today is _____.
 - I would like for you to do the following _____.
 - It is important because _____.
- Teach-Back Method
 - Chunk summaries of information, slowly, and consistently
 - Have patient convey the plan of care back to you, in their own words, and from their own perspective
 - Clarify misunderstandings or elicit more information
 - Use “Show Me” method to demonstrate understanding when prescribing new medicines or changing doses.
 - Use handouts, pictures, or draw images as a visual point of reference

Non-Stigmatizing Language

- Avoid language that is stigmatizing

EXAMPLE:

- **Instead of** labeling the patient as Schizophrenic
- Use people first language: A person diagnosed with schizophrenia

Nonverbal Communication

- Pay attention to eye contact, facial expressions, posture, shaking, nodding, head position, interpersonal distance, placement of arms and legs (crossed, etc.)
- Physical contact conveys empathy and helps the patient feel sense of control
- Mirror patient’s posture, tone, and words to encourage expression of details and feelings
- **See Empathetic Responses**

Sensitive Topic

APPROACH

- Be nonjudgmental
 - The goal is for YOU to learn from the patient.
 - Leave your beliefs, values, and bias outside the door, this is not about you, this is about your patient.
- Explain why you need this information
 - This will make people less apprehensive and more apt to share.
- Find opening questions and learn specific information needed for the assessment and plan
- Consciously acknowledge discomfort you are feeling
 - Denial will lead to avoidance of the topic all together

Disclosing Serious News

SPIKES

- **Setting up the Interview**
 - Arrange for privacy
 - Involve significant others
 - Sit down
 - Make connection with patient
 - Manage time constraints and interruptions
- **Assessing the patient's Perception**
 - Uses Open-ended questions to create reasonable accurate picture of patients perceived medical situation
- **Obtaining the patient's Invitation**
 - How much does the patient want to know
 - At what LEVEL do they want to know?
- **Giving Knowledge and information to the patient**
 - Present information based on the assessed level of patient's understanding, compliance and wish to disclose
 - Start with a "warning shot"
 - Gauge the patient's verbal and non-verbal cues
 - Pause before proceeding
 - Avoid jargon
- **Addressing the patient's Emotions with Empathetic Responses**
 - Expect the first reaction to be an emotion
 - Prepare to acknowledge that emotion explicitly
- **Strategy and Summary**
 - Ensure patient understands information before discussing next steps.

"ASK-TELL-ASK"

- Patient centered
 - ASK: What is your current understanding of the situation?
 - TELL: Tell patient new information
 - ASK: Do you understand what we've just discussed?

Interprofessional Communication

Situation-Background-Assessment-Recommendation (SBAR)

- *Situation*
 - EX: "I am _____. I am calling because _____. I have a patient who is_____."
- *Background*
 - EX: "The patient was admitted on _____ because of_____."
- *Assessment*
 - EX: "I think this patient is likely having a _____."
- *Recommendation*
 - EX: Let's transfer_____. Let's monitor and then_____."



Approach

Set the agenda for your patient interview.

Patient-centered goals

Approach that follows patients' lead to understand their thoughts, ideas, concerns, and requests and evokes the personal context of the patient's symptoms and disease.

Provider-centered goals

Approach is symptom focused and concentrates on pathologic disease.



INTRODUCTION

Introduction

1. Hello, my name is _____. I am a _____ with _____ and I am going to _____.

- Introduce yourself
- Explain your role
- Explain how you will be involved in their care
- **BONUS:** Self-identify and disclose YOUR preferred pronouns.

Preference/Respect

2. How would you like to be addressed?

- **Identify Patient:**
 - A. Name
 - B. Date of birth
 - C. Age
 - D. Gender
 - i. Never ASSUME
 - ii. ASK how they would like to be addressed
 - iii. ASK what pronouns they prefer to use
 - E. Race
 - F. Others: Occupation, religion
 - G. Patient Reliability
 - H. Use of Interpreter

Chief Complaint Open-ended question #1

3. What would you like to discuss today? Or what brings you in today?

- Identify the chief complaint

Chief Complaint Open-ended question #2

4. Can you tell me more about that?

- Identify if more information is needed.
 - May not always be problem specific (EX: "I'm here for my yearly physical exam")

OPQRST	
<u>Onset (O)</u>	5. When did the symptoms first occur? Was it gradual or sudden? What was the patient doing when the symptoms occurred? <ul style="list-style-type: none"> Ask questions one at a time If the patient does not have any complaints, you should ask about the patient's perceived health status.
<u>Palliative Factors/Provocative Factors (P)</u>	6. What makes your symptoms better? What makes them worse? <ul style="list-style-type: none"> Ask questions one at a time "Better" EX: heat, ice, laying down, Tylenol, etc. "Worse" EX: walking up the stairs, lying flat, at night etc.
<u>Quality (Q)</u>	7. Can you describe _____? What does it feel like? <ul style="list-style-type: none"> Ask questions one at a time Clarify if needed EX: "Can you describe the pain?"
<u>Region/Radiation (R)</u>	8. Does it radiate or move anywhere? Where does the pain travel to? <ul style="list-style-type: none"> Identify location EX: up the arm, into the chest, etc.
<u>Severity (S)</u>	9. How severe are the symptoms? On a scale of 0-10, where 0 is none and 10 is the worst pain imaginable, how would you rate your pain? <ul style="list-style-type: none"> For pain-related symptoms: scale of 0-10 For non-pain related symptoms (such as fatigue): mild, moderate, or severe can be listed.
<u>Timing (T)</u>	10. Are the symptoms worse in the morning or at night? Are they episodic, constant, intermittent, or gradual? How long do the episodes/symptoms last? <ul style="list-style-type: none"> Ask questions one at a time Clarify if needed HOW long they last/WHEN they occur
<u>Previous Episodes</u>	11. Have you ever had these symptoms before? <ul style="list-style-type: none"> Clarify if needed WHAT symptoms/WHEN it happened/HOW MANY times

Pertinent Symptoms

12. Have you experienced any other symptoms? Are you experiencing any of the following symptoms: _____, _____, and _____. (Chunk in 3's)

- See ROS List
- Identify positives and negatives
 - EX: Positive for nausea, fatigue, and chills
 - EX: Negative for fever, diarrhea, and vomiting

General

☐ Fatigue
☐ Weight change
☐ Fever
☐ Chills
☐ Night sweats

Genitourinary

☐ Urinary frequency
☐ Urine urgency
☐ Pain on urination
☐ Frequent urination at night
☐ Blood in urine
☐ Hx of kidney stones
☐ Flank pain
☐ STD hx
☐ Genital lesions
☐ Testicular mass or pain
☐ Decreased libido
☐ Loss of orgasms
☐ Erectile dysfunction
☐ Acute renal failure

Pulmonary

☐ Shortness of breath
☐ Cough
☐ Sputum production
☐ Chest pain or tightness
☐ Coughing blood
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Pneumonia hx
☐ TB hx
☐ Positive/Negative PPD hx
☐ Smoking hx
☐ Sleep study
☐ CPAP
☐ APAP
☐ BiPAP
☐ Nightmares
☐ Night terrors
☐ Parasomnia

Cardiovascular

☐ Chest pain
☐ Palpitations
☐ Tachycardia
☐ Shortness of breath at night
☐ Swollen ankles
☐ Leg cramps
☐ Phlebitis
☐ Hypertension
☐ Rheumatic heart disease hx
☐ Family hx of heart disease
☐ Stress test
☐ Echocardiogram
☐ Angiography
☐ Stent placement
☐ Congestive heart failure
☐ Cardiac ablation
☐ Fainting
☐ Paroxysmal nocturnal dyspnea

Musculoskeletal

☐ Joint pain
☐ Joint stiffness
☐ Joint swelling
☐ Muscle cramps
☐ Muscle wasting
☐ Muscle pain
☐ Hx of fractures
☐ Fibromyalgia
☐ Gout
☐ Lyme disease

HEENT

☐ Hearing loss
☐ Vertigo
☐ Bloody nose
☐ Hoarseness or voice change
☐ Ear pain
☐ Ear infection hx
☐ Sinus/Nasal infection or discharge
☐ Decreased auditory acuity
☐ Tinnitus
☐ Decreased visual acuity
☐ Dry mouth

Endocrine

☐ Hot or cold intolerance
☐ Thyroid problems
☐ Neck irradiation hx

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Vomiting blood
☐ Black tarry stools
☐ Pain on swallowing
☐ Heartburn
☐ Abdominal pain
☐ Abdominal swelling
☐ Jaundice
☐ Hepatitis hx
☐ Blood in stools
☐ Diarrhea
☐ Constipation
☐ Hernia
☐ Hemorrhoids
☐ Peptic ulcer disease
☐ Gallbladder disease
☐ Pancreatitis
☐ GI surgery
☐ Esophagogastroduodenoscopy
☐ Colonoscopy
☐ Hepatic ultrasound

Skin

☐ Mole
☐ Other lesion
☐ Pruritus
☐ Rash
☐ Bruises
☐ Contusions
☐ Lacerations
☐ Burns
☐ Skin cancer hx

Allergic/Immunologic

☐ Hay fever
☐ Lupus

Neurological

☐ Headache
☐ Migraines
☐ Unsteady while walking
☐ Incoordination
☐ Sense of spinning
☐ Gait problems
☐ Falls
☐ Loss of consciousness
☐ Seizures
☐ Head injuries
☐ Skull fracture
☐ Focal weakness
☐ Focal sensory change
☐ Stroke hx
☐ Chronic pain
☐ Brain imaging
☐ EEGs
☐ Coma
☐ Encephalitis
☐ Chronic fatigue syndrome

Hematopoietic

☐ Excessive bleeding
☐ Anemia
☐ Family history disorder
☐ Swollen lymph nodes

Gynecological

☐ Menopause
☐ Onset of menstruation
☐ Last menstrual period
☐ Description of last menstrual period
☐ Vaginal discharge or bleeding
☐ Pelvic pain
☐ Sexual dysfunction
☐ Breast mass
☐ Breast discharge
☐ Last breast exam
☐ Last mammogram
☐ Pregnancy hx
☐ Eclampsia/Pre-eclampsia
☐ Post-partum depression

Hx = History



<u>Medications</u>	13. Do you take any routine or maintenance medications? <ul style="list-style-type: none">• Identify all current prescription and over the counter (OTC) medications• Identify the reason for taking them• Clarify further
<u>Allergies</u>	14. Do you have any allergies to foods, drugs, or the environment? What is your <i>REACTION</i>? <ul style="list-style-type: none">• Ask questions one at a time• Ask about the patient’s reaction to each allergy listed

PAST HISTORY	
<u>Pertinent Past Medical History</u>	<p>15. Do you have any health problems or medical conditions I should be aware of?</p> <ul style="list-style-type: none"> • Ask about all childhood and adult illnesses. • Ask about FEMALE History: <ul style="list-style-type: none"> ○ <u>Menstrual History:</u> <ul style="list-style-type: none"> • First Day of Last Menstrual Period (FDLMP) or Last Menstrual Period (LMP) • If menopausal, ask about any hormone replacement therapy. • History of dysmenorrhea or other menstruation problems ○ <u>Birth Control Methods:</u> <ul style="list-style-type: none"> • Type and Frequency of use. ○ <u>Obstetric History:</u> <ul style="list-style-type: none"> • History of pregnancy and delivery (GxP_{FPAL})
<u>Pertinent Past Psychiatric History</u>	<p>16. Have you ever been treated for or diagnosed with any psychological issues in the past?</p> <ul style="list-style-type: none"> • See <i>Psychiatric Screening</i> including ROS list. • Ask about dates of diagnosis, hospitalizations, and treatments for psychiatric illnesses • Substance abuse treatments <ul style="list-style-type: none"> • <i>What type, last use, treatment programs</i> • Start with the most recent events and move back to earliest dates.
<u>Past Accidents/Injuries</u>	<p>17. Have you been in an accident or incurred any injuries recently? In the past?</p> <ul style="list-style-type: none"> • Clarify if needed. • Ask about age at the time of injury, treatments, causes, complications, and outcome. • Start with the most recent events and move back to earliest dates.
<u>Past Hospitalizations</u>	<p>18. Have you been hospitalized in the last 12 months? In the past?</p> <ul style="list-style-type: none"> • Clarify if needed. • Ask about the date, hospital, treatment, studies performed and outcomes for medical admissions. • Start with the most recent events and move back to earliest dates.



<u>Past Surgeries</u>	19. Have you had any surgeries in the last 12 months? In the past? <ul style="list-style-type: none">• Ask about all surgical procedures, date and hospital, surgeon, and any complications• Ask about blood type (if known) and any history of transfusions<ul style="list-style-type: none">○ incl dates and reactions to blood products• Start with the most recent events and move back to earliest dates.
<u>Immunizations</u>	20. Are you up to date on your immunizations? <ul style="list-style-type: none">• Ask whether the patient has had immunizations• Date of administration• Ask if patient has experienced any adverse reactions to immunizations
<u>Screening Tests</u>	21. Have you been screened for anything in the last 12 months? In the past? <ul style="list-style-type: none">• Ask about screening tests, dates and results that are appropriate to the patient's age, gender, and medical history.
<u>Pertinent Family History</u>	22. Does anyone in your family have any health problems? Any history of health problems? <ul style="list-style-type: none">• Ask about at least 3 generations (MGM, MGF, PGM, PGF, parents, siblings, and children)<ul style="list-style-type: none">○ <i>Include Familial Disease</i>

PSYCHOSOCIAL HISTORY- Narrative

<p><u>Ethnic Lineage/ Cultural Beliefs</u></p>	<p>23. Tell me about things that are important to you. What should I know, that would help us work together on your health? Are there any beliefs, values, or practices you would like incorporated in your treatment and care today?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask how patients identify themselves and any information related to their background and their personal care.
<p><u>Support Systems</u></p>	<p>24. Do you have a support system? Who is part of that system?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about family/friends and quality of relationships, community involvement, religious/spiritual/cultural affiliation <ul style="list-style-type: none"> ○ HOW beliefs might affect their medical care
<p><u>Sexual History</u></p>	<p>25. Are you currently sexually active? Are you monogamous? How many partners do you have? Any new partners recently? How many lifetime partners have you had? Do you use contraceptives? Have you ever had any STD's or STI's?</p> <ul style="list-style-type: none"> • See <i>SENSITIVE TOPIC</i> • <i>Reserve judgment</i> • Ask questions one at a time • Ask about sexual orientation, number and gender of partners, nature of intercourse (vaginal, oral, anal), methods of birth control, and STI prevention.
<p><u>Home Situation/Significant Others</u></p>	<p>26. What is your current home situation? Are you single, married, in a relationship, etc.? Do you have any children? Do you have any obstacles to accessibility? Do you feel safe at home?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about marital status and children, living situation, home configuration (flights of stairs, access to bathroom, etc. if relevant), and whether they feel safe at home (any domestic violence/abuse). • <i>BONUS: Offer resources.</i>
<p><u>Occupational History</u></p>	<p>27. What do you currently do for a living? Sedentary or Active? What have you done in the past? Any exposure to hazards in the workplace? Any workplace injuries current or past?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about past and present jobs and exposure to physical, environmental, or occupational hazards. Include any injury or issue related to the workplace.



	<ul style="list-style-type: none"> Start with most recent events and move back to earliest dates.
<u>Financial Situation</u>	<p>28. Do you currently have health insurance? How are you paying for your care today?</p> <ul style="list-style-type: none"> Ask questions one at a time Ask if they are insured or uninsured. If uninsured, inquire about self-pay. <i>BONUS: Offer resources</i>
<u>Education</u>	<p>29. What is the highest level of education completed? What language do you prefer to communicate in? Do you speak, read, or write in any other languages? Do you need an interpreter?</p> <ul style="list-style-type: none"> Ask questions one at a time Ask what the highest grade/degree is completed or career training Ask about other languages spoken, which is the preferred method to communicate in, and if an interpreter is necessary.
<u>Military History/Other Life Events</u>	<p>30. Do you currently serve in the military? Which branch/service? Are you a veteran? Do you have any service-related injuries or disabilities? Have you experienced any injuries or disabilities due to a natural disaster, mass event, or other related life event?</p> <ul style="list-style-type: none"> Ask questions one at a time Ask whether they are active duty, reserve, or a veteran, location and length of deployment, and service-related history of injury or trauma. <ul style="list-style-type: none"> THANK THEM FOR THEIR SERVICE! Ask about history, injury, or trauma inflicted by natural disaster or other life experience.
<u>Travel</u>	<p>31. Have you traveled anywhere recently? In the last 12 months?</p> <ul style="list-style-type: none"> Ask about foreign and domestic travel, date, and location.
<u>Sick Contacts</u>	<p>32. Have you been in contact with anyone who is or has been sick recently?</p> <ul style="list-style-type: none"> Ask about any recent contact, type of illness (if known), and location.

<u>Daily Life</u>	<p>33. What does a typical day look like for you? Can you describe a typical day for me?</p> <ul style="list-style-type: none"> • Ask what a “typical day” of activities look like from wake to bedtime. • Clarify if needed
<u>Sleep</u>	<p>34. How are you sleeping? How many hours of sleep is normal for you? Do you wake up feeling refreshed? Any problems sleeping? How many pillows do you use?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about the number of hours of sleep per night, whether they feel refreshed, or have issues with sleep <u>including</u> early awakening, difficulty falling asleep, staying asleep, snoring, or daytime tiredness.
<u>Exercise and Leisure Activities</u>	<p>35. What do you like to do for exercise? How often do you exercise? What hobbies do you have? What do you do for mental health? What type of recreational activities do you enjoy?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about type and frequency of exercise, any hobbies, recreational activities, and mental health care.
<u>Effect of Illness</u>	<p>36. How is this affecting you? How is this affecting your daily life? You should document patients’ perception of any chronic illness they have and how it affects their daily life and perception of well-being.</p> <ul style="list-style-type: none"> • Ask questions one at a time • <i>USE EMPATHETIC STATEMENTS</i> • Allow patient to narrate
<u>Safety Measures</u>	<p>37. Do you feel safe in your home? Do you wear a seat belt? Do you wear bicycle or motorcycle helmets? Do you wear sunblock? Do you have functional and working smoke and carbon monoxide detectors in your home? Do you own a gun(s)? If so, are they locked up?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about the frequency of use of the following items: seat belts, helmets, sunblock, smoke and carbon monoxide detectors, and gun safety.

PSYCHOSOCIAL HISTORY- List

<u>Diet</u>	<p>38. What does your typical diet look like? Any dietary restrictions? Any recent changes to your diet or concerns with certain foods? Any current or history of eating disorders such as anorexia nervosa or bulimia? Any difficulty eating or swallowing foods?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask what the patients' typical diet consists of, any dietary restrictions, eating disorders, and difficulties with certain foods. Focus on areas of concern relevant to your patient. • Consider the patient's current diagnosis and past medical history when obtaining the diet history.
<u>Tobacco</u>	<p>39. Do you currently use tobacco products? Do you smoke cigarettes, use e-cigs, or vape products? Do you use chewing tobacco or any other type of product? How much? How long?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about the type (cigarettes, pipe, chewing), amount, and duration of use.
<u>Alcohol (ETOH)</u>	<p>40. Do you drink alcohol? What type? How much? How often?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about current intake, and history of abuse (type, amount, frequency, duration of use, and last use).
<u>Illicit Drugs</u>	<p>41. Do you use any type of illicit or "street" drug? Do you use any type of recreational drug? Do you use any other type of substances? What type? How much? How often? How used?</p> <ul style="list-style-type: none"> • Ask questions one at a time • Ask about type of drug, route of administration, amount per day, duration of use, and last use. <ul style="list-style-type: none"> ○ List past and present use.

CLOSING

<u>Clarification</u>	<p>42. Is there anything else you would like to share about the problem? Do you have any other questions or concerns at this time?</p> <ul style="list-style-type: none"> Make sure your patient has the opportunity to share any other pertinent information or ask any clarifying questions.
<u>Diagnosis</u>	<p>43. Based on your history and current symptoms, I believe you have or are experiencing/exhibiting/etc. _____.</p> <ul style="list-style-type: none"> Make sure you are clear about your diagnosis/diagnoses and do not use excessive medical jargon.
<u>Diagnostics</u>	<p>44. To confirm my diagnosis/diagnoses, I would like to order the following diagnostics: _____.</p> <ul style="list-style-type: none"> Make sure you are clear about which labs, images, or tests you plan to order and why you are ordering them. (EX: CBC, TSH, X-Ray, CT scan, etc.)
<u>Therapeutics</u>	<p>45. What I would like to do next is provide you with a treatment plan. I would like to do the following: _____.</p> <ul style="list-style-type: none"> Make sure you are clear about medications, treatments, therapies, procedures, lifestyle changes, referrals, etc. <i>including</i> frequency, dose, route, and side effects.
<u>Education</u>	<p>46. It is important that you understand the diagnosis/diagnoses so I would like to provide you with the following information and resources: _____.</p> <ul style="list-style-type: none"> Make sure you provide adequate information regarding your diagnosis/diagnoses: what it is, how it will be treated, what lifestyle changes to make, what medications to take, etc. (EX: <i>Continue the Diet and lifestyle modifications we discussed in addition to starting medication.</i>)
<u>Follow-up</u>	<p>47. I would like follow-up with you in ____ weeks. If you have any questions or any issues arise during that time, please call the office.</p> <ul style="list-style-type: none"> Make sure you are clear about when to return and why.
<u>Closing</u>	<p>48. Thank you for coming in, please let us know if there is anything else we can do to help you. Take care.</p>

REVIEW OF SYSTEMS (ROS)

Remember, the ROS pertains to SYMPTOMS which have developed in the past 6 months.

If the patient has a positive response, explore the same factors as HPI (OPQRST and associated symptoms).

General <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight change <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats Genitourinary <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urine urgency <input type="checkbox"/> Pain on urination <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Blood in urine <input type="checkbox"/> Hx of kidney stones <input type="checkbox"/> Flank pain <input type="checkbox"/> STD hx <input type="checkbox"/> Genital lesions <input type="checkbox"/> Testicular mass or pain <input type="checkbox"/> Decreased libido <input type="checkbox"/> Loss of orgasms <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Acute renal failure Pulmonary <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Sputum production <input type="checkbox"/> Chest pain or tightness <input type="checkbox"/> Coughing blood <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia hx <input type="checkbox"/> TB hx <input type="checkbox"/> Positive/Negative PPD hx <input type="checkbox"/> Smoking hx <input type="checkbox"/> Sleep study <input type="checkbox"/> CPAP <input type="checkbox"/> APAP <input type="checkbox"/> BiPAP <input type="checkbox"/> Nightmares <input type="checkbox"/> Night terrors <input type="checkbox"/> Parasomnia	Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Tachycardia <input type="checkbox"/> Shortness of breath at night <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Leg cramps <input type="checkbox"/> Phlebitis <input type="checkbox"/> Hypertension <input type="checkbox"/> Rheumatic heart disease hx <input type="checkbox"/> Family hx of heart disease <input type="checkbox"/> Stress test <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Angiography <input type="checkbox"/> Stent placement <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Cardiac ablation <input type="checkbox"/> Fainting <input type="checkbox"/> Paroxysmal nocturnal dyspnea Musculoskeletal <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle wasting <input type="checkbox"/> Muscle pain <input type="checkbox"/> Hx of fractures <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gout <input type="checkbox"/> Lyme disease HEENT <input type="checkbox"/> Hearing loss <input type="checkbox"/> Vertigo <input type="checkbox"/> Bloody nose <input type="checkbox"/> Hoarseness or voice change <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear infection hx <input type="checkbox"/> Sinus/Nasal infection or discharge <input type="checkbox"/> Decreased auditory acuity <input type="checkbox"/> Tinnitus <input type="checkbox"/> Decreased visual acuity <input type="checkbox"/> Dry mouth	Endocrine <input type="checkbox"/> Hot or cold Intolerance <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Neck Irradiation hx Gastrointestinal <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Black tarry stools <input type="checkbox"/> Pain on swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal swelling <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis hx <input type="checkbox"/> Blood in stools <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Peptic ulcer disease <input type="checkbox"/> Gallbladder disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> GI surgery <input type="checkbox"/> Esophagogastroduodenoscopy <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Hepatic ultrasound Skin <input type="checkbox"/> Mole <input type="checkbox"/> Other lesion <input type="checkbox"/> Pruritus <input type="checkbox"/> Rash <input type="checkbox"/> Bruises <input type="checkbox"/> Contusions <input type="checkbox"/> Lacerations <input type="checkbox"/> Burns <input type="checkbox"/> Skin cancer hx Allergic/Immunologic <input type="checkbox"/> Hay fever <input type="checkbox"/> Lupus	Neurological <input type="checkbox"/> Headache <input type="checkbox"/> Migraines <input type="checkbox"/> Unsteady while walking <input type="checkbox"/> Incoordination <input type="checkbox"/> Sense of spinning <input type="checkbox"/> Gait problems <input type="checkbox"/> Falls <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Seizures <input type="checkbox"/> Head injuries <input type="checkbox"/> Skull fracture <input type="checkbox"/> Focal weakness <input type="checkbox"/> Focal sensory change <input type="checkbox"/> Stroke hx <input type="checkbox"/> Chronic pain <input type="checkbox"/> Brain imaging <input type="checkbox"/> EEGs <input type="checkbox"/> Coma <input type="checkbox"/> Encephalitis <input type="checkbox"/> Chronic fatigue syndrome Hematopoietic <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Anemia <input type="checkbox"/> Family history disorder <input type="checkbox"/> Swollen lymph nodes Gynecological <input type="checkbox"/> Menopause <input type="checkbox"/> Onset of menstruation <input type="checkbox"/> Last menstrual period <input type="checkbox"/> Description of last menstrual period <input type="checkbox"/> Vaginal discharge or bleeding <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Breast mass <input type="checkbox"/> Breast discharge <input type="checkbox"/> Last breast exam <input type="checkbox"/> Last mammogram <input type="checkbox"/> Pregnancy hx <input type="checkbox"/> Eclampsia/Pre-eclampsia <input type="checkbox"/> Post-partum depression
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Hx = History

PSYCHIATRIC SCREENING

DEPRESSION

Do you ever feel down, hopeless, or helpless? Have little interest or pleasure in doing things? Do you feel bad about yourself? Do you have trouble concentrating?

ROS: Do you have trouble sleeping, staying asleep, or sleeping too much? Do you feel tired or have little energy? Have you noticed an increase or decrease in appetite?

SUICIDAL/HOMICIDAL IDEATION: Do you ever have thoughts of harming or killing yourself? Do you have a plan? Do you ever have thoughts of harming or killing others? Do you have a plan? Do you have access to guns?

ANXIETY

Do you experience intense anxiety or worry and find it difficult to control? Does your mind race constantly? Do you have repetitive and persistent thoughts that are upsetting and unwanted? Do you experience strong fear that you cannot control? Do you avoid places or social situations? Do you engage in repetitive behaviors to manage your worry?

ROS: Does worry or anxiety cause you to feel fatigued or irritable? Does it interfere with your ability to concentrate or sleep? Does the fear cause you to have shortness of breath, chest pains, a pounding heart, sweating, shaking, nausea, dizziness, or fear of dying?

BIPOLAR MANIA

At times, do you speak or talk much faster than normal? At times, have you been much more active or do many more things than usual? At times, do you feel excessively irritable? At times, are you much more interested in sex than usual? At times, have you engaged in risky or foolish behaviors such as: excessive spending, gambling, sexual promiscuity, or drug addiction? Did this behavior cause any legal difficulties? At times, and for no apparent reason, do you sometimes feel very hostile or angry? At times, do you feel great interest in being around others and times when you want to be left alone? At times, are you very emotional and other times when you are very happy?

ROS: At times, do you feel you got much less sleep and found you really didn't miss it? At times, do you have more energy than normal?

BORDERLINE PERSONALITY

Do you ever experience extreme or inappropriate emotional reactions (strong feelings for others- positive or negative)? Do you engage in risky or foolish behaviors such as: excessive spending, gambling, sexual promiscuity, or drug addiction? Did this behavior cause any legal difficulties? Do you have a history of unstable relationships? Do you experience frequent mood swings? Do you feel overly self-confident? Do you find it difficult to experience empathy for others? Do you feel abandoned or rejected? Often, do you feel isolated from others or find yourself bored? At times, and for no apparent reason, do you sometimes feel very hostile or angry? Do you find yourself moving from job to job?

SUICIDAL/HOMICIDAL IDEATION: Do you ever have thoughts of harming or killing yourself? Do you have a plan? Do you ever have thoughts of harming or killing others? Do you have a plan? Do you have access to guns?

PSYCHOSIS/SCHIZOPHRENIA

Do you see things or hear voices (hallucinations)? Is someone/something conspiring by giving you orders or telling you to do things (delusions)? Do you have trouble organizing thoughts or information? Do you ever feel down, hopeless, or helpless? Do you experience intense anxiety or worry and find it difficult to control? Do you feel isolated from others? Do you lack motivation?

ROS: incoherent or nonsense speech. Sudden movements or behavior that is inappropriate for the situation. Do you have trouble sleeping?

NEUROCOGNITIVE

What is the month? What is the day? What is the year? What is the date? What is the season? What city are you in? What state are you in? What county are you in? What is the name of the building you are in? What floor/room number are you in? What is the name of the state capital? What is the name of the current president? I am going to give you 3 words, and I want you to remember them for later: pen, ball, and dog. Read some directions, close your eyes, and follow them. Spell WORLD forwards. Spell WORLD backwards. Subtract 7 from 100 and keep subtracting 7. Repeat the phrase, “No ifs, ands or buts.” Follow a 3-stage command. Identify 2 objects in the room. Repeat the 3 words from before. Write a sentence. Draw a clock or pentagon.

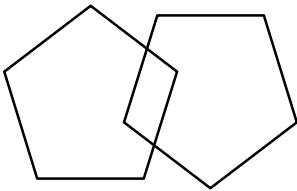
See Mini Mental Exam on the next page.



The Mini-Mental State Exam

Patient _____ Examiner _____ Date _____

Maximum	Score	
		Orientation
5	()	What is the (year) (season) (date) (day) (month)?
5	()	Where are we (state) (county) (town) (hospital) (floor)?
		Registration
3	()	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____
		Attention and Calculation
5	()	Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively, spell "world" backward.
		Recall
3	()	Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		Language
2	()	Name a pencil and watch.
1	()	Repeat the following "No ifs, ands, or buts"
3	()	Follow a 3-stage command: "Take a paper in your hand, fold it in half, and put it on the floor."
1	()	Read and obey the following: CLOSE YOUR EYES
1	()	Write a sentence.
1	()	Copy the design shown.



_____ Total Score
ASSESS level of consciousness along a continuum _____
Alert Drowsy Stupor Coma

"MINI-MENTAL STATE." A PRACTICAL METHOD FOR GRADING THE COGNITIVE STATE OF PATIENTS FOR THE CLINICIAN.
Journal of Psychiatric Research, 12(3):189-198, 1975. Used with permission.



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