Purpose:

The purpose of this paper is to understand the importance of accurate medical record documentation to record pertinent facts, findings, and observations about a patient’s health history including past and present illnesses, examinations, tests, treatments, and outcomes.

Directions:

1. Review and critique the comprehensive H&P below and thoroughly answer the questions that follow in complete sentences and paragraphs using APA format. Please provide the question prior to your response.

1. Does this document meet the CMS guidelines for documentation of a comprehensive history and physical? Why or why not? Be specific.

2. Critically analyze the H&P and list any errors. Identify the strengths of the H&P.

3. Did any questions come to mind that you are unable to answer after reading the H&P?

4. Are the conditions listed in the assessment section reasonably supported by the history? Why or why not? Explain your rationale.

5. Did you identify other differential diagnoses or conditions that should be included in the assessment? If so, list them.

6. List the ICD-10 code for each of the following (go to [CMS.gov](https://www.cms.gov/) and search for the ICD-10 Codes):

 Moderate persistent asthma with (acute) exacerbation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pneumonia, unspecified organism:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Essential (primary) hypertension: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hyperlipidemia, unspecified \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Obesity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Is it appropriate to include the ICD-10 code for pneumonia when billing for this visit? Why or why not?

8. Is the plan reasonable based on the assessments listed? Why or why not?

9. List 3 patient education strategies relevant to the case study including specific medication teaching. Include references.

10. List health promotion recommendations from AHRQ according to age/gender/conditions. Cite your references.

1. Use current APA format to style your paper and to cite your sources. Your source(s) should be integrated into the paragraphs. Use internal citations pointing to evidence in the literature and supporting your ideas. Include a title page and a reference page listing the sources you used.
2. Keep in mind the requirements set forth in the 1997 Guidelines of Documentation for Evaluation and Management by CMS. Visit [CMS.gov,](https://www.cms.gov/) and then search "1997 Guidelines of Documentation for Evaluation and Management" for information that should be included in a medical record.
3. **Your paper should be 3-4 pages not including the title and reference pages. A minimum of 2 sources, not including your texts, must be incorporated into your paper.**

**A comprehensive H&P for patient Anne Smith is shown. Ms. Smith is a new patient presenting to an internal medicine office-based practice. Carly Sanders, an experienced nurse practitioner, authored the H&P.**

Patient Name: Anne Smith                                      Age: 55

Date of Visit:    2-14-2016                                       Gender: Female

Information Source: Patient, reliable source, face-to-face office visit

**Subjective:**

**Chief Complaint:** Follow up after Emergency Department visit

**History of Present Illness:** Reports were seen in the Emergency Department approximately 2 weeks ago and was treated for bronchitis with an unknown antibiotic that she has now finished. Was prescribed a refill of an Albuterol MDI as well. Pt continues to report cough and shortness of breath with exertion. Cough and shortness of breath have not improved since last Emergency Room visit. Cough reported as dry and present day and night without provocation. Has been using Albuterol MDI 4–5 times per day with slight relief of shortness of breath symptoms. Pt reports multiple diagnoses of bronchitis last year and has been using Albuterol MDI multiple times daily for the past 6 months or more.

**PMH:** Hypertension. Bronchitis. Hyperlipidemia. Obesity.

**Medications:** HTCZ 25mg BID. Albuterol MDI q4h PRN. Simvastatin 20mg daily. OTC Aleve 1–2 tabs PRN headaches.

**Allergies:** Codeine. Shellfish.

**Family History:** Mother and Father with CV disease. Son with asthma. Daughter with hypertension. Denies family history of DM. Mother diagnosed with breast cancer at age 40, died at 44.

**Social History:** Retired from clerical work. Widowed. Lives with adult children and assists with watching grandchildren. Denies tobacco use, ETOH use, drug use.

**Review of Systems:**

*GENERAL:* Reports good sleep but decreased energy levels. Denies fever.

*CV:* (-) palpitations. (-) CP. (-) swelling.

*PULM:* (+) SOB with exertion. (+) wheezing. (+) dry cough. (-) hemoptysis.

            *ENT:* (-) rhinorrhea. (-) sinus pain/pressure. (-) ear pain/pressure. (-) sore throat.

**Objective:**

**CV:** RRR, no murmur.

**Pulm:** Posterior inspiratory wheezes bilaterally in all lobes. No rales/rhonchi/crackles. No consolidation present with percussion. Equal rise and fall of chest. No accessory muscle use.

**Ears:** Bilat TM pearly white, canals clear, no discharge, no external ear tenderness.

**Nose:** Nasal mucosa pink, moist. No discharge present. No sinus pressure pain.

**Throat/Neck:** Oral mucosa pink/moist. Tonsils grade 1 without exudate. No lymphadenopathy.

**General:** Obese caucasian female. Affect appropriate. Appears very anxious. Appropriately dressed. No obvious deformity.

**VS:** Temp97.8, Pulse 72 RR 22, BP 140/90, BMI 32

**Assessment:**

1**.** Moderate persistent asthma with (acute) exacerbation

2. Pneumonia, unspecified organism

3. Essential (primary) hypertension

4. Hyperlipidemia, unspecified

5. Obesity

**Plan:**

**Dx Plan:** None

**Tx Plan:** Rx: Qvar 40mcg/spray 2 puffs BID. Rx: Albuterol MDI 1-2puffs q4h PRN wheezing. Rx: Inhalation Spacer Device. Refill HTCZ 25mg PO BID #30 with 2 refills.

Refill Simvastatin 20mg PO QD #30 with 2 refills.