

## Outpatient History & Physical (H&P) Presentation and Note Template

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### Chief Complaint/Concern

[Insert chief complaint/concern, ideally in the patient's own words – use quotation marks when possible]

### History of Present Illness

[Insert ID statement + version of chief complaint, this time using medical terminology]  
[Include OLDCAART, pertinent positive ROS, pertinent negative ROS, pertinent past medical history, pertinent family history, pertinent social history]

### ER Course

[Include vitals upon arrival to the ER, relevant exam, testing, and management]

### Past Medical History

Other past medical history includes [insert past medical history NOT mentioned in HPI]

[Insert all past medical history, including and past medical history mentioned in the HPI]

### Past Surgical History

Includes [insert list of surgeries and approximate dates]

### Medications

[List medications (grouped by INDICATION) in the following order – name, dose, route, frequency. If patient is not taking it/taking it differently than prescribed, please note that]

### Allergies

Patient is allergic to [insert drug and food allergies and reaction that occurs]

### Family History

Family history includes [Insert relative's relation to patient and their diagnosed medical conditions only if it pertains to the patient's chief complaint/HPI]

[Insert relative's relation to patient and their diagnosed medical conditions]

### Social History

[Insert smoking, alcohol, drug use not covered in HPI. Provide sense of home and work environment. If relevant to chief complaint, include sexual history, travel history, pets, and occupational exposures.]

[Insert full HEEADSSS assessment]

### Exam

[Insert vitals range since admission and most recent vitals]

[Insert pertinent positive and negative exam findings]

### Labs

[Insert pertinent labs and relevant trends]

### Imaging

[Insert pertinent imaging dates, modalities, and results]

### Other studies

[Insert pertinent EKG, microbiology, pathology results]

### Assessment and Plan

[Insert assessment here - the one-liner that also includes an ASSESSMENT of what you think is going on with the patient]

# [Insert problem, chronicity, trajectory]: Differential diagnosis includes [insert differential from MOST to LEAST likely]. [Explanation for each differential and why they are more or less likely].

- [Diagnostic interventions (includes more exam maneuvers, labs, imaging, inpatient consultation, some procedures)]

- [Therapeutic interventions (includes mediations, some procedures, outpatient consultations)]

- [Patient counseling - examples: patient encouraged to hydrate, avoid salty foods, etc.]

- [Contingency planning - example: return to clinic if "X" symptom worsens]

# [Insert each active problem with above template. Organize them from most to least active]

Chronic/Resolved:

# [Insert problem, chronicity]: Continue [insert ongoing management]

# [Insert problem, resolved]: [Insert brief explanation of why it happened and how it resolved]

# [Insert each chronic or resolved problem with above templates]

# Healthcare maintenance: [Include cancer screening, surveillance testing, vaccinations, goals of care discussions]

# Code status: [Insert code status here if discussed with patient]

# Emergency contact: [Insert name of emergency contact and relation to patient and contact number]

Return to clinic in [Insert estimate follow-up window (e.g., one week, two months, etc.) and specific items to follow up on]

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**Blue and purple are your script**

**Blue text should always be included in the oral presentation**

**Red text should always be included in the written note**

**Purple text should always be included in the oral presentation AND written note**

[Items in brackets are the parts that you need to fill out]

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