HEALTH SCRIBE

New Scribe Study Guide

Topic 1

Chart Components

The Medical Chart

Scribes accompany the physician into the patient's room and document the entire visit into the patient's medical record. Each chart has different sections for different types of information. Let's start by going over those sections.

Chief complaint: The reason the patient is being seen by a medical provider. The chief complaint can be an acute complaint, a follow up visit, a yearly physical exam, a hospital follow up or to establish care for the first time.
Examples: Abdominal pain, Headache, Hospital follow up after a stroke, Follow up appointment for hypertension

- Chief Complaint
- History of Present Illness
- Review of Systems
- Past Medical, Surgical, Social, and Family History
- Physical Exam
- Medical Decision Making/ Results
- Assessment/Treatment Plan

Every bit of information provided regarding a patient belongs in a specific section of the medical chart. Here we will discuss each section.

History of Present Illness (HPI): This section of the chart is used to expand and further describe the chief complaint. It is typically a long paragraph narrative which describes different characteristics of the chief complaint. This information is subjective and comes directly from the patient and/or their family.
Example: (here, our chief complaint is “chest pain”)
Mary Wallace is a 45 year old female who presents to the clinic with complaints of constant left-sided chest pain x 4 hours. Her pain is described as a heaviness and radiates into her left arm.

Review of Systems (ROS): This section of the chart is a list of body systems (cardiovascular, neurological, etc) with common symptoms of each body system (chest pain, numbness, etc). The physician will ask the patient if they have experienced specific symptoms. Scribes document which symptoms were asked and whether the patient has experienced that symptom or not. The ROS information is also subjective and comes from the patient and/or their family.

Past Medical, Surgical, Social, and Family History: This section of the chart is where we find the patient's medical history, surgical history, family history and social habits (drinking, smoking).
Medical History: Any long term diagnosed medical conditions a patient has. If the patient no longer has this problem we write "History of ***". If the patient is still being actively treated for this problem we do not include "History of ***" and we simply put the name of the condition.
Examples: Hypertension, Hyperlipidemia, GERD, History of Breast Cancer
Surgical History: Any surgeries that have been performed on the patient.
Examples: Hysterectomy (removal of the uterus), Cholecystectomy (removal of the gallbladder), Lumpectomy (removal of breast tissue), Prostatectomy (removal of part or all of the prostate)
Family History: Any long term diagnosed medical conditions for a patient's immediate family (Mother, Father, Grandparents and Siblings).
Examples: Father has a history of hypertension, Mother died of a myocardial infarction, Brother has diabetes
Social History: Any social habits affecting the patient's medical history. The most common asked are: Tobacco use, alcohol use, drug use, marital status, employment status, activity level (sedentary versus somewhat active with daily exercise)

Physical Examination: This section of the chart is where the scribe documents what the medical provider found when examining the patient. This section is another list of body systems, but here the scribe documents objective findings, not reported symptoms.
In each body system there are expected "normal" findings. For example, when listening to your lungs, the physician expects to hears "Clear lungs," but the physician may instead hear abnormal lung sounds like wheezing or rhonchi.

Medical Decision Making/Results:
- Labs: Labs are often ordered to measure different substances in the blood and urine.
- Imaging: Imaging studies such as x-rays, ultrasounds, CT scans and MRIs are ordered for different reasons we'll get into later.

Treatment Plan: This section of the chart is where the scribe records the diagnosis and treatment plan for the patient. The medical provider will discuss this plan with the patient while the scribe documents it into the chart.
Example:
Assessment:
1. Hypertension
2. Diabetes mellitus type II
3. Acute sinusitis
Plan:
1. Continue current medications for hypertension and diabetes.
2. Start Azithromycin 250 mg TID x 5 days for sinusitis.
3. Begin using Flonase, 2 sprays in each nostril twice a day for 5 days for acute sinusitis.
4. Use a humidifier at night while sleeping.
6. Follow up in 3 months.

Note: some providers combine the assessment and plan to look like this (using the examples above):
1. Hypertension: Blood pressure is well controlled in the office today. Continue current medications.
2. Diabetes mellitus type II: Recent A1c is stable at 6.5%. Continue current medications.
3. Acute sinusitis: Start Azithromycin 250 mg TID x 5 days for sinusitis. Begin using Flonase, 2 sprays in each nostril twice a day for 5 days. Use a humidifier at night while sleeping.
4. Headache: Take Tylenol 250 mg every 12 hours as needed for your headache.

Follow up in 3 months.

Terms from this section to know/define for the quiz:

Chief complaint
HPI
ROS
ROS systems
Past medical history
Past surgical history
Past family history
Past social history
Physical exam
Difference between ROS and PE
Assessment/Plan

The following is a very basic example of a medical chart with a chief complaint of “chest pain”:

Chief complaint: Chest pain

HPI:
John Smith is a 52 year old male with history of asthma, hypothyroidism, and anxiety who presents to the clinic today with a complaint of central chest pain. He states the pain has been intermittent over the last 3 days and radiates into his left arm. He also reports associated shortness of breath over the last few weeks, even just walking to the mailbox to get his mail, as well as a cough. The pain is worsened with palpation of his chest. Last night, he took OTC Tylenol with some relief in pain.

Review of Systems (condensed):
Constitutional: No fevers or chills.
Cardiovascular: Positive for chest pain. No lower extremity edema, orthopnea, or palpitations.
Respiratory: Positive for dyspnea and cough.

Past Medical, Surgical, Social, and Family History:
Asthma, Hypothyroidism, Anxiety
Appendectomy
Rare alcohol use, non-smoker
Family history of CAD

Medications:
ProAir 4-6 puffs INH Q4-6H PRN
Synthroid 100mcg day

Physical Exam (condensed):
Vitals: O2: 99%, BP: 152/88 mmHg, HR: 78, Weight: 99 kg
Afebrile, In no apparent distress, Regular rate and rhythm, Normal breath sounds, Chest is tender to palpation, Normal bowel sounds, No edema

Assessment/Plan:
1. Chest pain - Order CXR and treadmill stress test. Order CBC, CMP, and troponin. Start ibuprofen Q4H PRN for pain.
2. Hypothyroidism - stable on current medications. Order TSH for reassessment of thyroid levels.
3. Asthma - could be contributing to current dyspnea. Compliance with inhaler was reiterated today.

Follow up after testing.

Topic 2

HPI Terminology

The History of Present Illness

The history of present illness is a paragraph of information from the patient and/or family, describing the chief complaint (why the patient came into the clinic to be seen). The patient is coming into the clinic with a complaint and symptoms they would like evaluated. The history of present illness section (HPI) will describe this acute complaint. The HPI does not always address an acute complaint, however - a patient can present to the clinic for routine management of chronic conditions.

The following is the most generic form of the HPI:
{NAME} is a {AGE} {GENDER} who presents to the clinic today for.....

David Jones is a 47 year old male who presents to the clinic today for.....

There are 8 elements used to thoroughly describe an acute complaint. Use the following pneumonic to remember them:

OLD CHARMS
Onset
Location
Duration
Character
Associated symptoms
Radiation
Modifying factors
Severity

Onset: When did the chief complaint begin?
- 3 days ago
- Yesterday

Location: Where is the chief complaint located?
- Right shoulder
- Left knee
- Right upper quadrant of the abdomen

Duration: How frequently is the chief complaint occurring?
- Constant
- Intermittent

Character: How does the patient describe the chief complaint?
- Sharp
- Stabbing
- Burning
- White
- Thick

Associated symptoms: Symptoms the patient has which are directly associated to the chief complaint
- Chief complaint: Abdominal pain
- Associated symptoms: Nausea, vomiting, fever

Radiation: Is the pain localized to one specific area or does it move into another area?
- Pain is located in the right low back and radiates into the right lower extremity.

Modifying factors: Anything that makes the chief complaint better or worse.
- Patient Took Tylenol with improvement in pain
- Pain is exacerbated by lying flat
- Pain is improved while sitting.

Severity: How severe is the chief complaint?
- Mild, moderate, severe, Scale 1-10
- Patient's abdominal pain is currently a 5/10, but was a 8/10 this morning while driving.

<u>Example:</u>
Maggie Smith is a 75 year old female who presents to the clinic today with nasal congestion which began 3 days ago. She reports green and yellow drainage. Her symptoms are constant and worse at night. She took OTC Mucinex with some relief.

Chief complaint: Nasal congestion
Onset: 3 days ago
Character: Green and yellow drainage
Duration: Constant
Modifying factor: Worse at night. Some relief with Mucinex.

Variations of the HPI

There are several types of patients being seen:
- An acute complaint (sore throat, chest pain, etc)
- Follow-up (regular follow-up, testing results, etc)
- Follow-up after being hospitalized
- New patient/establish care

Follow-up visit

Once a patient has established care with the clinic, they have routine visits scheduled in advance. Patients who have chronic, long term illnesses follow up in the clinic every 3 months. Other, healthier patients, are only seen every 6 months.

The history of present illness (HPI) will describe any new symptoms, changes to their medications, changes to their lifestyle and go over any recent specialist visits or tests such as labs. A follow-up visit is like an update on their life since they were last seen in the clinic.

Example:
Maggie Jones is a 75 year old female who presents to the clinic today for a 3 month follow up visit for hypertension, hyperlipidemia and diabetes.
Overall Maggie is doing very well. She states her blood pressure has been stable. She denies any chest pain or palpitations.
Maggie has been compliant with her simvastatin. Her lipid panel from 1/23/16 was within normal ranges.
Maggie states her fasting blood sugars have been stable, around 110 each morning.

Hospital follow-up

If a patient is hospitalized for any period of time, once discharged home (sent home) they are recommended to follow up with their family medicine physician.

During this follow up visit the physician will review the medications to determine if any need to be adjusted, provide any referrals to a specialist if needed and ensure the patient is continuing to improve and do well at home.

The HPI will describe the hospital visit including why the patient was hospitalized, any labs or imaging that was done and any treatments and medications given. The HPI will then discuss how the patient has been doing since being discharged.

Example:
Maggie Jones is a 75 year old female who presents to the clinic today after being hospitalized at HonorHealth Deer Valley Center on 1/24. She presented with abdominal pain and a CT of the abdomen showed acute diverticulitis. She was discharged home on Flagyl. Overall she reports feeling much better and states her pain has resolved. She has been compliant with her medications.

New patient

New patients often come into the clinic to establish care. They typically have never seen a primary care physician or they have moved or changed insurance plans, requiring them to see a new primary care physician.

The HPI will describe any complaints they have, any medications they're taking and address any needs such as labs or referrals.

Example:
Martin Jones is a 57 year old female who presents to the clinic today to establish care. She was previously seen by Dr. Joshua Jones, but her insurance changed. She has a history of hypertension and normally takes Lisinopril, but she states she ran out. She also has a history of GERD and normally takes Pantoprazole, but states she ran out. She states that she overall feels well and is only here today to establish care.

Important Phrasing Tips

The role of the scribe is to not only document information into the patient chart, but document it WELL - as if the doctor wrote it him/herself. It is very important you translate information from layman's terms into correct medical terminology. Here are examples to keep in mind:

"The pain in my belly started yesterday."	He reports abdominal pain which began yesterday.
"I took Tums and it didn't help"	Patient took Tums with no relief in his symptoms.
"I have low back pain, but I always have that"	He notes chronic lower back pain, unchanged from baseline.
"My sister has the same cold"	Positive sick contact with sister who has similar symptoms.
"If I try to eat or drink anything, I throw it back up"	The vomiting is exacerbated by PO intake.

Terms from this section to know/define for the quiz:

Onset
Location
Duration
Character
Associated Symptoms
Radiation
Modifying Factors
Severity
Follow up visit
Hospital follow up visit
New patient visit
Examples of correct/improved phrasing

Topic 3

ROS Terminology

The Review of Systems

The review of systems is a list of body systems arranged by body system with common symptoms of each system. A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. The body systems are as follows:

- Constitutional
- Eyes
- ENT (Ears, Nose, and Throat)
- Heme/Lymph (Hematologic/ Lymphatic)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Neurological
- Integumentary
- Allergy/Immunology
- Endocrine
- Psychiatric

Here we delve deeper into specific terminology within each ROS body system:

All terms on this page are fair game for the quiz!

Constitutional: Constitutional is the overall body.
Common symptoms include:
Fever, chills, night sweats, changes in weight, generalized weakness and malaise.

Eyes: Refers to any symptoms affecting the eyes, eyeballs or vision. Common symptoms include:
Vision changes, floaters, eye redness or discharge and eye pain.

ENT (Ears, Nose, and Throat): Refers to any symptoms affecting the ears, nose, and throat. Common symptoms include:
Headache, ear pain, throat pain, nasal discharge, sinus congestion, dysphagia and hoarseness.

Heme/Lymph (Hematologic/Lymphatic): Refers to any symptoms related to the Hematologic and Lymphatic body systems. Common symptoms include:
Swollen glands, easy bruising, bleeding problems.

Cardiovascular: Refers to symptoms related to the heart and circulatory system. Common symptoms include:
Chest pain, palpitations, Paroxysmal Nocturnal Dyspnea (PND), Orthopnea, Cyanosis, Edema, Shortness of breath on exertion

Respiratory: Refers to symptoms related to breathing and the lungs. Common symptoms include:
Dyspnea, wheezing, shortness of breath, cough, sputum, hemoptysis

Gastrointestinal: Refers to symptoms related to digestion, along the gastrointestinal tract from the mouth to the rectum. Common symptoms include:
Abdominal pain, nausea, vomiting, diarrhea, constipation, heartburn, bloody or black stool.

Genitourinary: Refers to symptoms related to the genital and urinary organs, from the kidneys to the urethra. Common symptoms include:
Dysuria, nocturia, urine frequency, incontinence, blood in the urine, pelvic pain or testicular pain and swelling.

Musculoskeletal: Refers to symptoms related to the bones and muscles. Common symptoms include:
Joint pain, joint stiffness, joint swelling, joint redness, muscle weakness, myalgias

Neurological: Refers to symptoms related to the nerves and nervous systems. Common symptoms include:
Numbness, tingling, tremor, changes in gait, dizziness, seizures and syncope

Integumentary: Refers to symptoms related to the skin. Common symptoms include:
Lesions, rash, ulceration, itching, jaundice

Allergy/Immunology: Refers to symptoms related to the immune system. Common symptoms include:
Sneezing, hives, recurrent infections

Endocrine: Refers to symptoms related to the endocrine system. Common symptoms include:
Fatigue, hair loss, polydipsia, polyuria

Psychiatric: Refers to symptoms related to mental health. Common symptoms include:
Depression, anxiety, suicidal ideations

Topic 4

Physical Exam Findings

The Physical Exam

The physical exam throughout medicine is the process of evaluating objective findings through the use of observation, palpation, percussion, and auscultation. The information obtained will be thoughtfully integrated with the patient's history and pathophysiology. The same body systems as the ROS are evaluated:

- Constitutional
- Eyes
- ENT (Ears, Nose, and Throat)
- Heme/Lymph (Hematologic/ Lymphatic)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Neurological
- Integumentary
- Allergy/Immunology
- Endocrine
- Psychiatric

Here we delve deeper into specific terminology within each PE body system:

Constitutional: Any findings on the patient's general appearance.
Normal finding: General appearance is normal.
Other things you may document: Cachectic. Febrile. Obese

Eyes: Any findings on the patient's eyes.
Normal finding: PERRLA, EOM intact, and conjunctiva and sclera clear.
Other findings you may document: Conjunctiva is red in the right eye. Left pupil is fixed.

Head, Ears, Nose, Mouth and Throat: Any findings on the patient's head, ears, nose, mouth and throat.
Normal findings: TM's and canals clear bilaterally, nasal mucosa clear, throat clear, no neck masses
Other findings you may document: Cerumen in the right external canal. Left TM is erythematous and bulging. Oral pharynx is erythematous with white exudate.

Lymphatic: Findings relating to the patient's lymphatic system.
Normal findings: No lymphadenopathy or tenderness
Other things you may document: Tender anterior cervical lymphadenopathy.

Cardiovascular: Findings relating to the patient's heart and circulatory system.
Normal findings: Rate and rhythm normal, no murmurs, gallops or rubs. Color pink, no cyanosis.
Other things you may document: Tachycardic rate. Irregular rhythm. 2+ pitting edema of the bilateral lower extremities.

Pulmonary: Findings relating to the patient's breathing and lungs.
Normal findings: Lungs clear, breath sounds are equal. No respiratory distress.
Other things you may document: Expiratory wheezing. Rales in the bilateral bases. Rhonchi in the left lower lung.

Abdomen/GI: Findings relating to the patient's abdominal region.
Normal findings: Abdomen is flat, soft, normoactive bowel sounds. No tenderness, rebound or guarding. No organomegaly or masses.
Other things you may document: Tenderness in the RUQ. Hypoactive bowel sounds. Hepatosplenomegaly.

Genitourinary: Findings relating to the patient's genital and urinary organs.
Normal findings: Only performed when there is a complaint in this region or a male patient here for a complete physical exam. We would document: Normal prostate.
Other things you may document: Grade II prostate, no nodules.

Neurological: Findings relating to the patient's neurological system.
Normal findings: No abnormalities in sensation. No abnormalities in gait or coordination. Motor exam normal.
Other things you may document: Reflexes present and symmetric. Cranial nerves intact. Strength in 3/5 in the left upper extremity and 5/5 in the right upper extremity.

Musculoskeletal: Findings relating to the patient's bones and muscles.
Normal findings: No back/neck tenderness or muscle spasticity. No joint tenderness, edema, or diminished range of motion. No lower extremity edema.
Other things you may document: Tenderness in the paraspinal region of the lumbar spine. No midline tenderness.

Skin: Findings relating to the patient's skin.
Normal findings: No abnormal rashes, lesions or ulcerations. No lacerations, abrasions or contusions. Normal turgor.
Other things you may document: 2 x 3 cm area of erythema, warmth and fluctuance to the left lateral arm.

Terms from this section to know/define for the quiz:

Febrile
PERRLA
EOM
Conjunctiva
Tympanic membrane (TM)
Oral mucosa
Lymphadenopathy
Murmur
Cyanosis
Erythema
Exudate
Tachycardia
Bradycardia
Tachypnea
Edema
Wheezing
Rales
Rhonchi
Gait
Lesion
Laceration
Abrasion

How are the review of systems and the physical exam different?

ROS = subjective; reported by the patient
PE = objective; measurable findings

Information reported by the patient does *not* belong in the PE, and findings dictated by physician do *not* belong in the ROS!

Topic 5

Common Labs, Radiology, and Medications

The following sections will outline the most common labs, radiology, and medications ordered by physicians across all specialties.

All bolded terms are fair game for the quiz

The following are the most common labs ordered by physicians across all specialties. It is very important you know each one and their components in order to be a well-informed scribe. Do not worry about learning the normal ranges, since that is more complicated than it needs to be right now.

Complete Blood Count (CBC): A CBC measures several components of your blood. This can test for anemia (low blood levels), infection, and leukemia.

WBC (White Blood Cell Count)
- Elevated WBC = Leukocytosis
- Low WBC = Leukopenia

Hb (Hemoglobin)
- Low Hb = Anemia

Hct (Hematocrit)
- Low Hct = Anemia

Plt (Platelets)
- Low Plts = Thrombocytopenia. Significance: Prone to bleeding

Lipid Panel: A lipid panel measures the cholesterol in your body, good and bad.

TC (Total Cholesterol)
LDL - “bad” cholesterol
HDL - “good” cholesterol
Tri (Triglycerides)

Basic Metabolic Panel (BMP): A BMP measures your sugar (glucose) level, electrolyte and fluid balance, and kidney function.

Na - Sodium
K - Potassium
- Low (Hypokalemia) = May be due to diuretics

BUN - Blood Urea Nitrogen
Creat - Creatinine = measure of kidney function
Gluc - Glucose = measure of blood sugar
HCO3- -Bicarbonate
Cl- -Chloride

Comprehensive Metabolic Panel (CMP): All the labs from the BMP, PLUS:

Liver Function Tests (LFTs):
• Total Protein / Albumin
• Total bilirubin
• AST (SGOT)
• ALT (SGPT)
• Alk Phos

Hemoglobin A1c (HbA1c): Shows how well your diabetes is being controlled by providing an average of your blood sugar control over the past 2 to 3 months.

4% and 5.6% = No Diabetes
5.7% and 6.4% = Pre-Diabetic
6.5% or higher = Diabetes

Coagulation Studies: for patients on Coumadin, a blood thinner aka anticoagulant

• PT
• INR = should be between 2.5-3 or 2-3
• PTT

Thyroid Labs: tests for hypothyroidism

• TSH
• Free T3
• Free T4

Urinalysis (UA), significant components:
Nitrites
Leukocyte esterase
If present, means possible urinary tract infection (UTI)

The following are the most common diagnostic studies/imaging ordered by physicians across all specialties. It is very important you know each one in order to be a well-informed scribe.

X-Ray
Based on density. Used primarily to evaluate bones and some disease processes in soft tissue.

DEXA Scan or Bone Density Scan
An enhanced form of x-ray technology that is used to measure bone loss. Used to diagnose and determine the degree of osteopenia/ osteoporosis.

CT Scans
Special X-ray tests that produce cross-sectional images of the body using X-rays and a computer. Can be with or without contrast which is a special dye injected into the veins to outline organs and tissues.

Magnetic resonance imaging (MRI)
A diagnostic technique that uses magnetic fields and radio waves to produce a detailed image of the body's soft tissues and bones.

Ultrasound (US)
An imaging method which uses high frequency sound waves to generate real-time images/video as opposed to a "snap shot" like an X-Ray or CT. Ultrasound is used to visualize muscles, tendons, and many internal organs, to capture their size, structure and any pathological lesions.

Electrocardiogram (EKG)
Interpretation of the electrical activity of the heart over a period of time, as detected by electrodes attached to the outer surface of the skin and recorded by a device external to the body. Often ordered on pre-operation authorization patients.

The following is a basic guide to medication classes and shorthand of medication information.

Analgesics
Medications that relieve the symptoms of pain

Narcotics
Opioid pain relievers, They are very addicting and sometimes taken too often by patients. This is a controlled substance and needs a printed prescription

Antacids
Medications that relieve the symptoms of indigestion and heart burn

Antibiotics
Used to treat bacterial infections

Anticoagulants
Blood thinners; A class of drugs that work to prevent the coagulation of blood

Antidepressants
Medications used to treat depression

Anxiolytic
Medications used to treat anxiety

Diuretics
"Water" pill

Routes of Administration
PO: medication is taken by mouth or "per os"

IM: intramuscular. Medications are given as an injection into the muscle tissue. Vaccinations are given IM

IV: intravenous. Medications are administered straight into the vein

Medication Frequency
QD: once a day

BID: twice a day (Think "Bi" as in 2, like Bilateral)

TID: three times a day (Think "tri" as in 3, like triple)

QID: four times a day (Think "quarter" as in 4)

Q6H: every 6 hours

Q8H: every 8 hours

QHS: at bedtime

QAM: in the morning

Don’t forget to memorize the terms in the Quizlet!

If you remember one thing, remember this: Scribes must take it upon themselves to succeed. That means studying and having the initiative to learn. We can tell the difference between those who have studied and who haven’t - as well as those who are dedicated to this journey into medicine and those who aren’t!