

The Yale Way: New Patient Presentations

Presenting well is a fundamental skill. A succinct, cogent presentation allows colleagues to internalize patients' stories and improves diagnostic reasoning. Standard structures enable physicians to present from memory and allow listeners to anticipate details. Judgment determines how much detail to provide. The setting (bedside, morning report, grand rounds) and the nature of the patient's illness (simple problem vs. diagnostic mystery) influences the detail needed. Both too much and too little detail are problematic.

Presenting well takes practice. All physicians must master this skill and the ultimate goal is to make presentations that are concise, clinically effective, elegant, and interesting. Presentations should almost always be delivered in the following order:

1. Chief Concern
2. Source of Information
3. History of Present Illness
4. Past Medical History
5. Medications
6. Allergies and Medication Intolerances
7. Social History
8. Family History
9. Review of Systems
10. Physical Exam
11. Diagnostic Studies
12. Summary
13. Assessment
14. Plan

The following paragraphs describe each element of the presentation followed by examples and special considerations.

Chief Concern (aka the Chief Complaint, CC): The chief concern highlights the problem needing attention. Sometimes the patient's words can be used to structure the chief Concern, but this approach fails when patients cannot describe their problem (e.g., "change in mental status") or when the central problem is uncovered by the medical team (e.g., "hyponatremia"). Avoid irrelevant details (e.g., it may not matter that a patient with leg swelling previously had nephrolithiasis) but include key facts (e.g., that a patient with shortness of breath has COPD). Optimal chief concerns are succinct but include relevant details. The "Chief Complaint" is a more traditional term which many physicians find derogatory to the patient. For this reason, "Chief Concern" is preferred although both terminologies may be considered acceptable. Information about the patient's occupation, hobbies, or other compelling facts may be included if appropriate to foster the doctor-patient relationship and to make it easier for listeners to form a mental image of who the person is. When including such information, it

would be important to choose wisely to ensure that the information appropriately captures the essence of who the patient is and also reflects how the patient wants to be described (i.e., the characterization should be patient-centered). At the bedside, the patient's name should be used whereas the name should be deleted when confidentiality is required, for example in teaching conferences.

Examples:

- "Mr. Jones is a 47-year-old businessman with metabolic syndrome, presenting with two hours of substernal chest pressure radiating to the jaw"
- "Ms. Garcia is a 58-year-old woman visiting from Honduras, complaining of one month of fever, night sweats, weight loss, and hemoptysis"
- "The patient is a 73-year-old grandmother with recurrent urinary tract infections, brought in from her nursing home with fever and depressed mental status"
- "The patient is a 27-year-old man who manages an art gallery in downtown New Haven, presenting with two weeks of fever and shortness of breath."
- "Ms. Thomas is a 43-year-old woman with newly discovered metastatic cancer of unknown origin, transferred from Milford Hospital to begin chemotherapy."

Special considerations: In the ICU, the Chief Concern is expressed as a "Critical Care Chief Concern" to emphasize the problem requiring unit admission (e.g., "This is a 53 year old man undergoing treatment for leukemia, now transferring to the MICU with a temperature of 104 and severe hypoxemia requiring intubation"). Some identifiers (e.g., morbid obesity) may be selectively omitted during bedside rounds because they are self-evident or risk undermining the nascent doctor-patient relationship.

Source of information: the reliability of information provided is always open to scrutiny. Briefly state where the information comes from (e.g., the patient, family, prior medical records)

Example: "Information comes from the patient and records from Waterbury Hospital"

History of Present Illness (HPI): The history of present illness starts with a change in the patient's usual state of health, continues with key details that led to the patient coming to the hospital, includes critical findings in the ED that culminated in hospital admission and/or details the hospital course that led to transfer to your service. Time is described in units (e.g., months, weeks, days) prior to admission. Relevant details include symptoms (e.g., described with intensity, qualitative features, progression over time, aggravating and relieving factors, and associated findings), prior workup including diagnostic studies, previous diagnoses and treatments, and pertinent negatives. Pitfalls to avoid include listing unrelated details of the past medical history and review of systems, editorializing, deviating from the prescribed order, omitting events and key findings in the Emergency Department, and including details that belong later in the presentation (e.g., routine lab findings). Details typically described in subsequent sections may be included in the HPI if they directly relate to the patient's illness. For example, it is often helpful to present at the outset key features of the past medical history that impact the patient's usual state of health such as ESRD and poorly controlled diabetes. Similarly, the recent

acquisition of a pet bird (typically part of the social history) should be described in the HPI when a patient presents with fever, cough, and shortness of breath. In contrast, the bird should be relegated to the social history when a patient presents with a stroke. Finally, pertinent positive and negatives are not to be conflated with the review of systems (ROS), which has its own distinct section.

Example:

“The patient was in his usual state of health until one month prior to admission when he had an episode of mild substernal chest pressure while climbing a flight of stairs. The symptoms lasted for five minutes, did not radiate, and terminated spontaneously. There was no history of similar symptoms. At baseline he is sedentary and rarely exercises. He takes three medications for hypertension and smokes two packs of cigarettes daily. Symptoms recurred 2-3 times daily for the next three weeks, always with exercise and ending with rest. He did not seek medical attention because of the long hours he was working as a trial lawyer.

One week prior to admission the patient had an episode of more severe pressure while sitting at his desk. The discomfort radiated to the left jaw and arm and was associated with shortness of breath and diaphoresis. The symptoms lasted 15 minutes and resolved spontaneously. Similar episodes at rest recurred daily for the next week. He denied exacerbating or relieving factors and took antacids without relief. The symptoms was unaffected by deep breathing or changes in position. He denied palpitations, lightheadedness, cough, fever, rashes, or recent trauma.

At 5AM on the morning of admission, the patient awoke from sleep with severe substernal chest pressure radiating to the left jaw and arm, profuse diaphoresis, shortness of breath, and lightheadedness. He woke his wife who immediately called 911. An ambulance brought him to the Emergency Department where he had an initial heart rate of 120 bpm, respiratory rate 24 bpm, a blood pressure of 160/100, and an oxygen saturation of 84% on RA. An EKG showed 3mm ST segment elevations in V1-V4 and a CXR showed an enlarged heart and pulmonary vascular redistribution. He was immediately given aspirin, sublingual nitroglycerin, furosemide, and supplemental oxygen with prompt resolution of his symptoms, output of 1 liter of urine, improvement in his oxygenation, and normalization of his EKG. He was started on intravenous unfractionated heparin and admitted to the CCU for further evaluation and management.”

Past Medical History (PMH): The past medical history lists active and resolved medical problems and surgeries. In contrast to what is often taught, we encourage inclusion of substance use disorders here and not in the Social History below. The detail required varies, depending on current activity and relevance to the current presentation. For example, when presenting a patient with pneumonia who has a history of COPD, it helps to describe severity, need for hospitalizations, and use of supplemental oxygen. In contrast, the same patient admitted for gout may not warrant such a detailed pulmonary history. Diseases described by patients but not confirmed by objective data should be considered uncertain (e.g., “asthma,” “celiac disease,” “rheumatoid arthritis”). Relevant pertinent negatives should be included here. For example, when describing a patient with HIV, it helps to indicate whether or not she’s had opportunistic infections or common related disorders such as Hepatitis C. For past surgeries,

include the approximate date and indication for the operation. Historic details already presented in the CC and HPI should not be repeated here. The chart note will almost always include more detail than that presented orally. The PMH is a great place to name the physicians responsible for the patient's longitudinal care.

Example (for a patient admitted with substernal chest pain and possible unstable angina):

- Well-controlled hypertension, s/p stent placement for right-sided renal artery stenosis 5 years previously
- Well-controlled hyperlipidemia
- Mild intermittent asthma managed by Dr. Smith.
- Chronic kidney disease (baseline Creatinine 2.4) managed by Dr. Thomas.
- S/p cholecystectomy 20 years previously
- S/P appendectomy 45 years previously
- No history of DM, myocardial infarction, CHF
- No history of tobacco use, excess alcohol intake, or recreational drug use

Medications (Meds): The detail provided depends on relevance. For example, when a patient is admitted for an asthma flare, all respiratory medications, dosing, and presumed adherence should be included. In contrast, when a patient with well-controlled asthma is admitted with cholecystitis, it would be sufficient to simply list the asthma medications. Over the counter drugs and supplements should be included here. When the list of medications is long, it may help to note this and indicate that additional detail can be provided if the team is interested. The list of medications is generally best organized by disease process rather than in an alphabetical or other arbitrary order. It may also help to include pertinent negatives if a patient is not taking a medication commonly used for his condition (e.g., a patient with coronary artery disease who is not taking aspirin). For most medications, the route can be omitted for brevity when self-evident. It may be helpful to state whether or not medicine reconciliation has been performed. Generic names are generally preferred.

Example (for a patient admitted with DKA):

- Lantus insulin 25 units every morning (no short acting insulin prior to meals due to past hypoglycemia)
- Lisinopril 10 mg once daily
- Allopurinol, indomethacin, and colchicine for gout (when gout is not central to the patient's admission)
- Coenzyme Q

Allergies and Medication Intolerance: The detail provided depends on the relevance. Serious or life threatening allergies should be described in detail. Medications that are poorly tolerated can be described here with a description of the intolerance. It may be important to note that, lacking documentation, a reported allergy may or may not be accurate.

Example:

- Penicillin: anaphylactic shock
- Ibuprofen: gastric upset
- Sulfa: reaction unknown but told by a physician never to take sulfas again

Social History: Knowing the patient's social history may be key to understanding the current illness (e.g., unemployed and unable to pay for medications) and provides key information when planning discharge and follow up. Depending on the particular case, the social history should include sexual history, travel history, current and past employment, military service, hobbies, pets, details of the home situation, the ability to perform ADLs and IADLs, and immigration status. The Social History offers presenters the opportunity to share special and interesting facts about the patient to share with the team (e.g., Mr. Smith used to play nose tackle for the Green Bay Packers). It falls to the presenter's judgment to include or withhold details, depending on the relevance. For example, the fact that a works on a farm may be relevant when presenting a patient with possible hypersensitivity pneumonitis, but the fact that the patient emigrated from Italy 35 years ago may not be. For older adults, ability to perform ADLs and iADLs should be included. Features of the social history that directly relate to the present illness should be included in the HPI (e.g., a patient presenting with fever after a trip to Cambodia).

Example (for a patient presenting with a fever of unknown origin):

- The patient works as a home health aide
- The patient served in the first Gulf War, where he was exposed to burning oil fires
- The patient lives in an apartment in New Haven with her husband, six-month-old son, and mother-in-law. There are no pets and there has been no exposure to animals.
- The patient immigrated from Ecuador two years previously
- The patient is able to feed himself and use the toilet independently but needs help with toileting and, shopping, and managing his checkbook.

Family History: The family history assumes more or less relevance, depending on the patient's age and the likelihood that reciting the family history will foster understanding of the patient's illness. For example, an extensive family history of rheumatologic disorders should be described in a 23 year-old-woman presenting with a malar rash and joint pain. Such details would not be relevant when a 90-year-old grandmother presents with a UTI.

Example (for a 45-year-old man presenting with renal failure):

- His mother, maternal uncle, and grandmother all had polycystic kidney disease
- His maternal aunt died of a subarachnoid hemorrhage
- His father, his father's side of the family, and a brother and sister are alive and well

Example (for an 87-year-old woman presenting from a nursing home with fever and vomiting):

- "The family history is non-contributory"

Review of Systems (ROS): The Review of Systems is used to uncover disorders that might not have been elicited elsewhere and is particularly helpful for health screening. In general, problems that are directly relevant to the patient's HPI should be described in the HPI, even if elicited when going over the ROS with the patient. If presented in the HPI, these facts should not be repeated when describing the ROS. For example, the discovery that a patient presenting with severe aortic stenosis has had multiple episodes of syncope belongs in the HPI, not the ROS. In contrast, the ROS may reveal that this patient snores loudly at night and has excessive daytime somnolence. In general, when presenting the ROS, only positive findings should be included. The presenter can note that the rest of the ROS was negative while recognizing that some listeners may request additional detail. Problems identified in the ROS need to be addressed in the assessment and plan below.

Example (for a patient admitted with a COPD flare): "The ROS was positive for mild headaches in the late afternoons, which respond to acetaminophen. The patient has not had the Pneumovax. The rest of the ROS was negative in detail."

Physical Exam: The degree of detail included in the physical exam varies with the setting, time available, and the patient's particular problem. Similar to the rest of the presentation, a more detailed physical exam may be documented in the medical record than is described verbally. More detail is needed when the exam findings pertain to the patient's problem, while less detail may be provided elsewhere. When time is limited, details may be eliminated from the presentation although speakers may be asked to elaborate. For example, it may be sufficient to say that the mental status exam was normal when a patient is admitted for a septic elbow. However, more detail is crucial for patients admitted with an altered mental status. Physical exams should always be presented in the same order with the general appearance, followed by vital signs, followed by a top to bottom description. By convention, some parts of the exam are almost always included (vital signs, heart, lungs, etc.) whereas some parts may be omitted if irrelevant (e.g., presence or absence of epitrochlear lymph nodes). When presenting patients at the bedside, self-evident details (e.g., the patient is an elderly man) can be omitted. Findings should not be interpreted here- just give the facts and save the assessment for the appropriate section to follow.

Example (a patient admitted to the MICU with a GI bleed): "The patient was a fatigued, worried-appearing, elderly man, lying in bed. The Temperature was 98.5°F, Heart Rate 110 and regular, Respiratory Rate 22, Blood Pressure 94/55, oxygen saturation 98% on RA. The skin was pale without rashes. The HEENT exam was notable for conjunctival pallor, an NG tube in the left nares, and dry mucous membranes. The lips were without telangiectasias. No JVD was visible. There was no cervical or supraclavicular lymphadenopathy. The heart exam was notable for a regular tachycardia, a II/VI early systolic murmur without radiation, heard best at the LUSB without gallops or rubs. The lungs were clear to auscultation and percussion. The abdomen was non-distended with normal active bowel sounds and was mildly tender in the midepigastrium without rebound or guarding. There was no organomegaly. Pulses were 2+ throughout except for being 1+ in the dorsalis pedis bilaterally. The extremities were without clubbing, cyanosis or edema. Two 18 gauge IVs were present, one in each arm bilaterally. The rectal exam showed normal tone, no masses, and black, grossly heme positive stool. The patient was

alert and oriented to name, place, and year. The remainder of the exam, including a full neurological and GU exam, was unremarkable.

Diagnostic Studies: Depending on the setting, time available, and relevance, study data may be presented with varying detail. Studies presented here are those obtained as part of your workup for the current admission. Do not repeat results described previously in the HPI or PMH. For example, when you present a patient with CHF who had an echocardiogram three months previously, include the results in the HPI or PMH as appropriate. In contrast, when you present a patient with shortness of breath for whom you obtained an echocardiogram, you should give the results here. When abnormal findings are reported, reference should be made to past values. Diagnostic studies should always be presented in the same order (if done): blood work (CBC, coagulation studies, chemistries, other blood work), followed by the urinalysis, microbiological studies, EKG, and imaging. For stable patients, you may be asked to present just the abnormal results. In complex patients, especially in the ICU, it is often better to just recite all the findings, including those that are normal. For abnormal and evolving findings, note the change (e.g., “the patient’s creatinine is 1.8, up from a baseline of 0.9”). Irrelevant and duplicative details should be omitted- for example, it is not necessary to give the PT when the INR has been presented. Do not interpret the results here- interpretations belong in the assessment, to be presented later.

Example (a patient admitted with renal failure): “The CBC revealed a normal WBC and platelets but a hemoglobin and hematocrit of 10 and 30, which were at her baseline. The MCV was 83 with a normal RDW. The sodium was 140, potassium 5.5 (up from 4.0 last week), chloride 110, bicarbonate 14 (down from 18 last week, anion gap 16), BUN and Creatinine 92 and 5.6 respectively (up from 45 and 4.2 last week). The calcium, magnesium, and phosphate were 8.2, 2.2, and 5.4, respectively). The urinalysis showed a specific gravity 1.20, 3+ protein, and no active sediment, including no cells or casts. The EKG showed normal sinus rhythm at 88, axis 60°, normal intervals, and no signs of ischemia. There was specifically no peaking of the T-waves or widening of the QRS complex. The chest radiograph showed enlargement of the cardiac silhouette and small bilateral pleural effusions, unchanged from one month earlier. A stat retroperitoneal ultrasound showed small kidneys, 8.8 cm on the left and 8.6 cm on the right, without hydronephrosis and unchanged from previously.”

Summary: A concise summary focuses the listener, synthesizes important details, and highlights the key issues needing the team’s attention. A good summary is crucial when admitting complicated patients. Effective summaries include sufficient detail but generally remain short- no more than 2-3 sentences. Longer summaries may be necessary for more complex stories, but the goal should still be to highlight key points. Good summaries should be conceptual and coherent. Pitfalls include repeating yourself and failure to edit less important facts (e.g., a sodium of 134 in a patient with asthma).

Examples:

“In summary this is a 45-year-old man with a history of hypertension, hyperlipidemia, and diabetes, presenting with two hours of substernal chest pain unresponsive to nitroglycerin, an EKG showing 3 mm inferior ST segment elevations, and an elevated troponin.”

“In summary, this is a 35-year-old woman with HIV, non-adherent on ART, presenting with 10 days of fever, worsening shortness of breath, an oxygen saturation of 84% on room air, diffuse bilateral crackles and egophony on lung exam, and bilateral patchy consolidation on chest x-ray.”

Assessment: The Assessment is arguably the most important part of the oral presentation and your opportunity to demonstrate your diagnostic reasoning skills. A common error is to reiterate data here. Effective assessments connect key features of the history, physical exam, and diagnostic studies with the most likely diagnoses. It is useful to state explicitly that “diagnostic considerations include...” or “the differential diagnosis includes...” followed by an assessment of the relative likelihood of the different possibilities. It helps to briefly state why certain diagnoses are unlikely and finish with those that warrant attention. Unreasonable diagnoses should not be mentioned unless prompted.

Example:

“In this middle-aged patient with acute fever, chest pain, shortness of breath, hypoxemia, and cough, the differential diagnosis includes pneumonia, asthma, pulmonary embolism, and CHF. CHF is unlikely given the patient’s normal cardiac function and low BNP. Pulmonary embolism is also unlikely given the absence of risk factors and the consolidation on chest x-ray. Despite a history of asthma, the absence of wheezing argues against this being a flare. Finally, given the right middle lobe infiltrate, crackles, egophony, and rusty sputum, pneumonia would tie this case together best. Given the absence of a smoking history, pneumococcus is the most likely organism. Atypical organisms such as mycoplasma, chlamydia, and legionella are possible but epidemiologically less likely. Our specific plan is as follows:”

Plan: The plan should be presented as specifically as possible so that listeners know exactly what is to be done diagnostically and therapeutically. In some settings, such as the ICU, the plan is traditionally organized by system (e.g., Hemodynamic, Pulmonary, Renal, ID, etc.) whereas in other settings, especially on the floor, the plan is best organized by problem (pneumonia, hypertension, diabetes, etc.). In the ICU, plans often change rapidly and a complete presentation of the plan, leaving out no details, is generally required. In contrast, for stable floor patients, it may be acceptable to focus on active issues and leave out issues that are chronic and stable (e.g., discuss the switch from IV to oral antibiotics but leave out the fact that statins for chronic hyperlipidemia will be continued). All new abnormalities identified in the history, physical, and diagnostic studies must be addressed. Plans should be presented in the following order: a brief summary of clinical reasoning, followed by diagnostic and specific treatment plans, including code status if relevant.

Example (ICU, system-based)

1. “Hemodynamic: the patient’s shock is most likely secondary to sepsis leading to inadequate preload and vasodilation. Cardiogenic shock is still possible given the EKG changes and needs to

be excluded. Our plan is to 1) order an echocardiogram to evaluate LV function, 2) check a central venous oxygen saturation, and 3) look for evidence of pulse pressure variation on the A-line waveform. Pending the results of these studies, we will bolus the patient with 1L of LR over the next 20 minutes, aiming to increase the mean arterial pressure to 65 mmHg. If the MAP remains below 65 mmHg, we will start norepinephrine to increase vasomotor tone.”

2. Continue with other systems...

Example (Floor, problem-based)

1. “Urinary tract infection: given the chronic indwelling Foley catheter in this nursing home patient and past culture results, we are worried about resistant gram negatives. Our plan is to 1) check the results of blood and urine cultures, 2) remove the Foley catheter and switch to straight catheterizations every six hours, and 3) treat with piperacillin-tazobactam and gentamicin until cultures return. If she fails to improve over the next 48 hours on appropriate antibiotics, we will obtain a retroperitoneal ultrasound of the kidneys to check for hydronephrosis and consult urology if the results are abnormal.”
2. Continue with other problems...

Special Considerations

1. An abbreviated presentation will be required for different settings such as hold overs and transfers from the ICU. In these cases, a brief summary of the hospital course and the clinical reasoning of prior teams should lead into your physical assessment, studies, assessment, and plan
2. For patients being presented for the first time on the day following admission, the initial assessment and plan will precede a description of the overnight course, followed by a follow up physical exam, summary of subsequent studies, assessment, and plan. It is important to separate initial and subsequent findings to avoid confusion. For example, it would be very confusing to admit a patient with a GI bleed and give the post transfusion hematocrit before sharing the fact that the hematocrit was low and transfusion was required.
3. For special settings such as morning report the Chiefs may ask for a slight modification of your presentation for teaching purposes (e.g., leave out a key finding in the ED so the residents can figure it out). In doing so, you or the Chiefs will generally be asked to state that some information is being left out for teaching purposes.
4. For bedside rounds, particularly when other members of the team know the story, an abbreviated presentation may be requested and the language used will have to be chosen carefully to reflect the patient’s presence (e.g., “copious sputum production” and a “right lower lobe infiltrate” may evolve into saying “the patient was coughing up a lot of mucus: and “x-ray showed a pneumonia in the bottom of the right lung”). If jargon cannot be avoided, you should let the patient know that you will translate to their satisfaction before leaving the room.
5. The written presentation will inevitably contain more detail than the oral presentation which must be concise while incorporating key facts.