**NURSING NOTE**

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| **Section** | **Details** |
| **Subjective** | **Chief Complaint (CC):** Brief statement of the patient’s main concern or reason for the visit. Example: “I have been experiencing a persistent cough for the last two weeks.”**History of Present Illness (HPI):** A detailed description of the patient’s symptoms, onset, duration, severity, context, modifying factors, and associated signs and symptoms. Example: Patient reports a dry, non-productive cough that started gradually two weeks ago. The cough is worse at night, and there is no relief with over-the-counter cough suppressants. The patient denies fever, chills, chest pain, or shortness of breath.**Past Medical History (PMH):** Summary of the patient’s relevant medical history, including chronic conditions, surgeries, allergies, and medications. Example: Asthma, seasonal allergies; Appendectomy (2018); Allergic to penicillin; Currently taking montelukast 10 mg daily and fluticasone/salmeterol inhaler.**Social History (SH):** Information about the patient’s lifestyle, occupation, and living situation. Example: Non-smoker, occasional alcohol use, works as a teacher, lives with spouse and two children.**Family History (FH):** Relevant health information about the patient’s immediate family. Example: Mother with asthma, father with hypertension, sibling with type 2 diabetes. |
| **Objective** | **Vital Signs:** Blood pressure, heart rate, respiratory rate, temperature, and oxygen saturation. Example: BP 120/80 mmHg, HR 75 bpm, RR 18 breaths/min, Temp 98.6°F (37°C), SpO2 98% on room air.**Physical Exam:** Documentation of the physical examination, focusing on the relevant body systems. Example: General appearance: Patient is alert and oriented, in no apparent distress. HEENT: Pupils equal, round, and reactive to light. Nasal mucosa is erythematous and swollen. No discharge. Throat is clear without exudate. Lungs: Clear to auscultation bilaterally, no wheezing or crackles. Heart: Regular rate and rhythm, no murmurs. Skin: No rashes or lesions. |
| **Assessment** | **Diagnosis/Problem List:** List of the patient’s current medical problems, including any new diagnoses made during the visit. Example: 1. Acute bronchitis 2. Asthma, stable 3. Seasonal allergies**Supporting Data:** Brief summary of the subjective and objective data that support the assessment. Example: Persistent dry cough, no fever or other signs of infection, clear lung sounds, and history of asthma and seasonal allergies. |
| **Plan** | **Diagnostic Tests:** Any additional tests or imaging needed to further evaluate the patient’s condition. Example: Chest X-ray to rule out pneumonia.**Treatment:** Medications, interventions, or referrals to address the patient’s problems. Example: Prescribe guaifenesin and dextromethorphan syrup for cough, encourage increased fluid intake, and recommend a follow-up appointment in one week if symptoms do not improve.**Patient Education:** Information provided to the patient about their condition, medications, and self-care. Example: Review proper inhaler technique, discuss triggers for asthma, and explain the importance of consistent allergy medication use |