Writing a medical clerking

These notes should help you write a medical clerking in a patients notes.

History

Problem list

Often useful to start with a problem list, usually using patients own words, to create a list of one or two problems, e.g.: *1) Central chest pain; 2) Shortness of breath*

Background information

You may be tempted to write a story, organising this information in paragraphs, telling it as the patient told it. However, your task is to take the information you have acquired in the history and present it in an organised fashion.

If you look through patients notes, those that are the easiest to follow are usually those that are well organised and in bullet/note form. The way I would recommend setting this out, would be to follow on from your problem list, using these as subheadings, and then listing beneath the information you have gleaned. This is easily demonstrated using pain as the example, as you have 'socrates' to follow, which helps you to structure your answer. So for example:

Chest pain

- *Central chest tightness radiating to left arm*
- *Came on 1pm whilst digging in garden, lasting 1 hour*
- *Associated with sweatiness and nausea*
- *Worsened by any exertion, relieved by rest and GTN spray*
- *8/10 severity*

From the above, you can see all of the important information, in a few lines. This could have been written as a paragraph, but would be more difficult to skim through later. Also when presenting the history on a ward round, this is the format you should present the information, taking the salient points from the extensive history you have taken!

The same can be performed for any symptom the patient reports. You need to learn what information is important for each symptom.

Then you can add sentences below this with any additional information that is reported by the patient that does not fit into any of the main 'problems' mentioned, such as commenting on risk factors for the problems mentioned – e.g. smoking

Systems review

Regarding systems review, it is usual for this to be written here. Go through the other main systems and write important negatives. One important thing to note, is that for the symptoms reported, the systems review relevant should be mentioned whilst discussing the problem, not at the end of the background information section. For

example, in the above case, the CVS systems review should be noted earlier in the background information, not included in the 'systems review' section, which really is a screening for other system symptoms.

Patients perspective

You are taught to include this as a section in the clerking. Rarely will this be an independent section in a clerking written in patients notes, but would ideally be included. You should consider the patients ideas, concerns, expectations and feelings of what is happening and include this in the clerking.

Past medical/surgical history

Write as a list, ideally in chronological order, with dates, all that the patients mention. Make sure to ask specifically about surgical history, and ask about conditions related to the presenting complaint – such as hypertension, diabetes and hypercholesterolaemia in the case of cardiac sounding chest pain. Also ask about other important conditions such as diabetes, asthma etc.

Drug list

Write this as a list – including dose, route and frequency.
Ensure you write the allergy status at this point also

Family history

The easiest way to write this is if you have information about both parents and write it for example: *Mother – ischaemic heart disease, Father – colorectal carcinoma*. Any other important family history should also be noted. You can also construct a small family tree with the information annotated, this is more often done in the case of paediatric histories.

Social history

Put information regarding important social issues:

- occupation
- smoking
- alcohol intake
- living arrangements – especially for elderly patients this is of significant information and can allow discharge planning to begin at an early stage so it is important information to elicit: – who do they live with and the health of that person; is there anyone who is dependent upon the patient for care; who does shopping/cooking; do they have carers and how many times a day and what do they do; type of accommodation – any stairs.

Examination

General examination

This can include some basic statements that can be gained from looking at the patient from the end of the bed: such as does the patient look well/unwell; Also anything that doesn't fit in to any particular system: such as jaundice/clubbing/anaemia.

The remainder of the examination, I would dedicate space to each of the main systems as follows. All of this is important information that should be gained from a general examination of a patient:

Cardiovascular

- Pulse rate, rhythm and character
- Arterial blood pressure
- Capillary refill time
- Jugular venous pressure
- Apex beat position
- Heart sounds, any additional sounds and character of them
- Ankle swelling
- I would also include here any information about the fluid balance of patients for whom this is being monitored – i.e., urine output, drain/NG outputs
- (include any other positive findings from examination)

Respiratory

- Respiratory rate
- Oxygen saturations
- Tracheal position
- Chest expansion, percussion (dull/resonant), breath sounds (absent/bronchial/vesicular), vocal resonance
- Any additional sounds (crepitations/wheeze etc.)

Gastrointestinal

- (comment on peripheral stigmata of liver disease only if present)
- Draw any scars on diagram and label with procedure
- Abdominal distension
- Tenderness
- Masses palpable – and characterise if present e.g. soft etc.
- Organomegally – mention both if present or absent
- Bowel sounds
- DRE if indicated

This forms the basis for most examination annotation.

Neurological examination

In most medical clerkings, comments are made upon the neurological examination. It is common for this not to be formally examined if there is no indication of a neurological problem, which is fine. However, this should be written for example: 'formal neurological examination not performed but grossly in tact'. Any obvious abnormalities should be mentioned.

If there is a neurological component to the presenting complaint then a complete formal neurological examination should be written in the clerking:

Cranial nerves - go through each of the nerves I - XII commenting on findings

Peripheral neurology – use this format for both upper and lower limbs – usually easiest to create a table with columns for left and right.

- Tone – including clonus
- Power (x/5 for each of the muscle groups)
- Co-ordination
- Reflexes
- Sensation

Impression/Differential diagnosis

Here there should be a few possible diagnoses that might explain the findings.

Plan

It is best to write a comprehensive plan using a numbered list. For each point it is worthwhile adding a few words to explain your reasoning – particularly for specialised investigations/treatments. E.g., D-dimer – to exclude a PE.

Always start simple – e.g. analgesia, blood tests – specify which.

Identification

Always write your name in a legible manner, then sign and include a means of contact – i.e., your bleep number. This is of importance from both a medical and legal perspective, and it is important that all entries in notes are traceable to an individual.