The authors and reviewers have made every attempt to ensure the information in the Family Medicine Clinical Cards is correct – it is possible that errors may exist. Accordingly, the source references or other authorities should be consulted to aid in determining the assessment and management plan of patients. The Cards are not meant to replace customized patient assessment nor clinical judgment. They are meant to highlight key considerations in particular clinical scenarios, largely informed by relevant guidelines in effect at the time of publication. The authors cannot assume any liability for patient outcomes when these cards are used.

Canadian Family Medicine Clinical Card

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Major Health History

There is no single "major history" that is appropriate for all patients, as specific features on history, physical exam, and/or observed changes in the patient's condition can all influence the assessment.

Chief Concern

- critical to get enough detail/info so that you can picture the patient experiencing the illness/injury, including what happened just prior
- **clear description** of the problem – what/where/when/evolution
- **events associated** with the problem, including travel, new therapies, activities
- check for presence of **symptoms commonly associated** with the problem
  - ↳ symptoms from the same body system (see system history screen below)
  - ↳ symptoms that indicate serious progression of illness (eg. cognitive deterioration, weakness, inability to cope)
- other health providers seen and/or therapies to date
- patient/family **ideas** about the problem

PMHx

- **diagnosed** conditions (included brief confirmatory evidence as needed; seek detail on severity, eg. hospitalizations, ICU stay)
- any **undiagnosed** conditions that are being worked up and/or affect patient's wellness
- **previous** severe conditions (eg. meningitis, hospitalizations)
- **developmental** history (milestone achievement & conditions)

PSHx

- what, when, where, complications, outcome, further plans
- any reaction to anaesthesia

PREV

- immunization status (core + optionals)
- recent health screening status (eg. lipids, colon cancer screening)

Meds

- current **prescriptions** (confirm doses with patient/family +/- pharmacist)
- current **supplements** (eg. vitamins, herbals)
- **allergies** (** include what the reactions are)

Substance Use

- **tobacco** – type; determine approx. # pack-years of tobacco
- **alcohol** – determine # drink equivalents/wk; CAGE questionnaire as needed (C= need to cut down; A= angry; G= feels guilty; E= drinks eye-openers)
- **other drugs** (marijuana, cocaine, crack, heroin, stimulants, Rx drugs, etc.)
  - ↳ if +ve, consider asking how pt. acquires drugs (eg. sex trade, etc.)

Patient Context

- **family / relationships**
- **job or school**
- **income / resources** (including food/shelter)
- **beliefs / culture**
- **level of functioning**

Fam Hx

- focus on **immediate family** (parents/siblings/children)
  - conditions/events relevant to current illness
  - check for premature cardiovascular disease, cancer

consider pedigree/ genogram

System Symptom Screen

H/N – otalgia, sore throat, voice problems, dental problems
RESP – difficulty/rapid breathing, cough, wheeze, hemoptysis
CVS – chest pain/pressure/heaviness, palpitations, syncope/presyncope
GI – nausea, vomiting, diarrhea, abdominal pain, bleeding, melena
MSK – joint pain, stiffness, swelling
INTEG – rashes, lesions/moles
NEURO – headache, visual changes, weakness, sensory/neural changes
GU – sexual function, micturition [♂ erectile function, testicular masses]
[♀ LMP, menses, pelvic pain, ob hx]

Key reference: Stewart M, Belle Brown J, Weston W, McWhinney IR, McWilliam CL, Freeman TR. (2003). Patient-centred medicine: transforming the clinical method. 2nd Ed. Oxhon, UK. *Radcliffe Medical Press Ltd.*