HEALTH CARE RECORDS (Ch. 2)
Medical Terminology

- Introduced early to put your med term knowledge to use → see practical application
- Format varies widely depending on facility, specialty, geography

I. History and Physical (H&P) → Fig. 2.1
A. History (Hₓ)
   - **symptoms** → subjectively reported by patient
     Ex.: headache, sleeplessness
   - **CC (chief complaint)**
     c/o (complains of)
   + other information listed on pp. 42-45
     * ROS = review of systems (correct on p. 45, wrong on p. 786)

B. Physical exam (PE, Pₓ) – Handout
   - **signs** → any **objective** evidence recorded by **practitioner**, based on direct observation or lab tests/procedures
     WDWN = well-developed & well-nourished
     WNL = within normal limits (we never looked?)

**IPPA**
- **Inspect** → visual
- **Palpate** → touch [masses, pain, texture, muscle tone]
- **Percussion** → tap & listen
- **Auscultation** → listen with stethoscope [heart, respiratory, bowel]

**Vital Signs** (VS, vs)
- **Respiration** (R) → ~14-17/min
- **Pulse** (P) → 60-80/min
- **Temperature** (T) → ~ 37° C
- **Blood Pressure** (BP) ~120/80 mm Hg (millimeters of mercury)

C. **Diagnosis** (Dₓ) – determination that a disease is present and identification or distinguishing one disease from another
   [May be recorded as **impression** (IMP) or **assessment** (A)]
   - etiology – study of the cause of a disease
     Ex.: pneumonia – viral or bacterial?
   - idiopathic – unknown cause
     Ex.: Crohn’s disease – chronic inflammation of intestinal lining

D. **Plan** (P)/recommendation/disposition
   May include **prognosis** – prediction of likely outcome; based on usual course & patient’s specifics
   Ex.: flu – healthy young adult vs. elderly nursing-home patient

Ch. 2 -- Page 1 of 4
II. Progress notes \(\rightarrow\) Fig. 2.2

S-O-A-P

Subjective (symptoms)
Objective (signs)
Assessment
Plan

III. Diagnostic imaging techniques

A. Ionizing \(\rightarrow\) uses radiation
   1. radiography: typical “X-ray”
      -- often involves using a contrast medium (barium, air, etc.)
      -- note that “radiograph” is preferred term for a “radiogram”
         [usually – graph is the machine, -gram is the record]
   2. computed (axial) tomography (CT, CAT scan)
      -- multiple X-rays, computer assembles into 3-D image
   3. nuclear medicine (radionuclide organ) imaging
      -- ingest or inject radioactive compounds (emit gamma rays)

B. Non-ionizing
   1. magnetic resonance imaging (MRI)
      -- uses magnetism and radio waves
      -- good for soft tissues
   2. sonography (ultrasound)
      -- uses “ultrasound” waves
      -- good for soft tissues

IV. Disease terms (pp. 64-65)

A. General
   • chronic – persisting for a long time
   • acute – short course, severe symptoms
   • syndrome \(\rightarrow\) collection of symptoms & signs that distinctly indicate a particular condition
     Ex.: AIDS – Acquired Immune Deficiency Syndrome (see medical dictionary)
     caused by HIV (Human Immunodeficiency Virus)
   • recurrent – same symptoms/signs return
     vs.
   • sequela – different symptoms/signs that typically result from previous condition
   • malaise – general feeling of discomfort/unease
     vs.
   • morbidity – sick/diseased state
     vs.
   • mortality – death/subject to death

B. Cancer
   neoplasm = tumor \(\rightarrow\) “swelling” (> 1-2 cm)
   -oma is typical suffix
   • benign – not cancer, restricted local growth
   • malignant = cancer, characterized by metastasis (spreading: cancer = crab)
V. Medical record abbreviations and symbols (p. 67-76)
- Medical shorthand to record all this info
  - Many based on Latin phrases

- Can lead to errors: Error Prone/Banned Abbreviations
  → see box p. 67 & p. 78-79 and Joint Commission “DO NOT USE” list (on website)

- Grouping into context will help you learn
  ✓ Medical care facilities
    PACU/PAR – postanesthetic care unit/postanesthetic recovery
  ✓ Patient care
    DO NOT USE: DC, D/C = discharge, discontinue?? [spell out]

  B = bilateral

  m = murmur

✓ Units of measure (metric & apothecary)
  dr = dram = 1/8 oz, NOT “drop”
  gr = grain (NOT “gram”) = 1/60 dram
  gt, gtt = drop/drops
  DO NOT USE: cc = cubic centimeters, use mL (milliliters) instead
  ➢ Note that metrics don’t use “s” to form plurals

✓ Routes of medication administration
  - by mouth
    • oral (p.o. = per os)
    • SL (sublingual = under tongue)
    • buccal (= cheek)

  - suppositories
    • PR = per rectum
    • PV = per vagina

  - parenteral (“alongside” + “intestine”) – non-GI route by injection
    • ID = intradermal
    • IM = intramuscular
    • IV = intravenous
    • DO NOT USE: SC, SQ, subQ = spell out subcut or subcutaneous

✓ Prescription
  q = “every” = qh = every hour
  or
  q = “four” → q.i.d. = 4 times/day
  but
  NEVER USE q.d/q.o.d. (every day/every other day) → spell out
VI. **Date and time** → chart p. 79
   Standard vs.
   Military[24hr] (don’t need a.m./p.m.)

VII. **Corrections** (Fig. 2.17)
   -- Never use white-out!
   -- Single line, initial & date