Reading Your Notes

Designed to help patients and families, this toolkit includes a variety of visit notes patients have shared with us, as well as brief descriptions about how they used the notes.

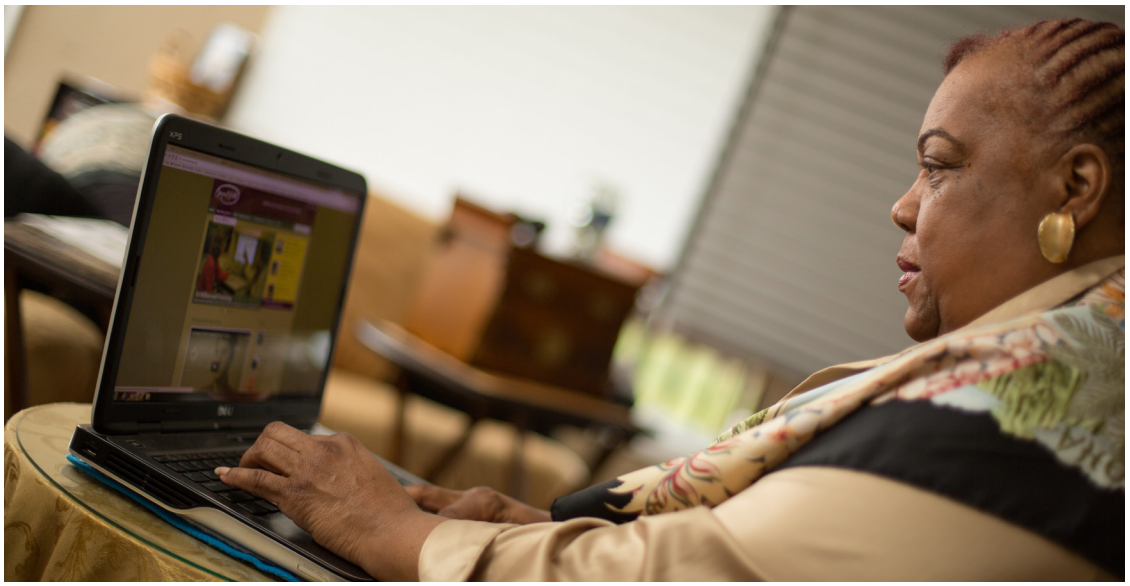
What Is a Note?

Your medical record contains a lot of information about you, including laboratory results, medication lists, visit summaries, and x-ray reports. The medical record also includes notes. These notes are different from other types of information in the record. They document the conversation you had with your doctor, nurse or other health care professional and contain a summary of the most important information discussed. The notes are the story of your health care, connecting the other elements of your medical record.

Notes can look quite different, depending on who writes them and depending on the kind of health care visit. Sometimes they are brief descriptions, other times they include a fuller account of the visit. These sample notes will give you a good idea of the kinds of information included in medical notes and why it might be helpful for you to access your own information between visits.

1. Orthopedic Visit Note

This patient visited an orthopedic specialist to talk about a hip replacement. In the note the doctor describes the visit and the patient's symptoms. The doctor also outlines some next steps for the patient, including follow up appointments. The patient used the note to remind himself about the appointments he needs to make. He also shared the note with a family member who helps with his care and saved the note in a file at home in case he wants to get a second opinion. **Read the sample Orthopedic visit note in the Appendix section of this document.**



2. Mental Health Progress Note

This patient has weekly therapy appointments with a social worker to talk about her feelings of depression and anxiety, which have become worse after a recent diagnosis of Parkinson's Disease. In the note, the therapist describes the patient's physical and mental health symptoms and outlines some of the coping strategies that were talked about in the therapy session. This patient was relieved to read that her therapist understands her condition. Parkinson's affects her memory, so being able to look back at the notes helps her remember what she's supposed to do between visits. Additionally, the patient was able to print the note and bring it to the doctor who prescribes her medications so that both members of her health care team are informed about her care. **Read the sample Mental Health progress note in the Appendix section of this document.**

3. Chronic Disease Management Note

This patient has type-1 diabetes and at least two other chronic health conditions. She takes several medications and uses her notes regularly to help her manage her health. She remembered a time when a medication dose appeared to be incorrect when she went to pick it up at the pharmacy. She looked up her notes to remember what her doctor said and was able to get the dosage corrected. Additionally, the endocrinologist involved in her diabetes management is not located at the same hospital where she receives the rest of her care, but she's able to print the notes and share them. It's important to her that her entire health care team has access to the same information. The notes have helped her feel more like an expert in her own conditions, and she says despite her complicated medical life, she feels healthy. **Read the sample Chronic Disease Management note in the Appendix section of this document.**

4. Otolaryngology Pre-surgery Note

To prepare for surgery, this patient visited an otolaryngology (ear-nose-throat) specialist to determine if a breathing tube could be placed in her airway during surgery. The note summarizes the patient's medical history and describes the examination that was performed. The note contains some difficult medical terminology, for example, otorrhea and choanae. The patient said that she did not understand those words, but still liked having the note. She looked up some terms on the internet and wrote a list of questions in preparation for surgery. She was also able to share the note with her primary care doctor at a different institution. **Read the sample Otolaryngology note in the Appendix section of this document.**

Questions You Can Ask Yourself As You Read Your Notes

- Are the lists – medications, symptoms, health problems – accurate?
- Does the information in the note reflect what was discussed during the visit, and did my doctor and I leave the appointment with the same understanding?
- Is this information I might want to share with another member of my care team or my family?
- Is there anything I'm worried about that I want to clarify?
- Is there anything I don't understand? Could I use some help with medical terms, a diagnosis, or the treatment recommendations?
- Is there any information, like symptoms or family history, I forgot to share at my appointment?
- Are there any inaccuracies in my record that should be fixed?

Appendix 1 - Sample Orthopedic Visit Note

Initial - CCC

Note Date: 11/08/16
Signed by (ORTHOPEDIC SURGEON), MD, PHD on 11/11/16 at 3:32 pm Affiliation: HOSPITAL

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Active Medication list as of 11/08/16:
Medications - Prescription
FLUROSEMIDE – 20 mg daily
TYLENOL – OTC as needed

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This is a first office visit to my clinic by Mr. XXXX, a very pleasant 57-year-old male patient, who sustained in 1993, as the result of a ski accident, a pelvic fracture with vertical shear that has healed in about an inch vertical shortening. Nevertheless, Mr. XXXX has had a remarkably active life. He exercises and has been managing very well over the last few years until recently when he has developed some groin type pain, very reminiscent of arthritic symptoms. Films obtained today confirmed that finding with some bone-on-bone contact and significant posttraumatic hip osteoarthritis.

He actually has a remarkably good gait. He has overall good strength. He has pain along the groin. He has a little bit of anterior medial pain that may be muscular in nature and even though he has a leg length discrepancy, he walks a very normal gait on exam. His extremity appears to be sensory intact and well perfused. He reports the typical symptoms of pain on initiation of motion, winter pain and pain at end of the day.

Mr. XXXX's past medical history and intake sheet was reviewed. He has a past medical history that is not relevant to his musculoskeletal presentation and manages his pain with occasional Tylenol.

We had a long and frank conversation with Mr. XXXX. I have explained to him that given the nature of his hip he is at this point, based on the radiographic standpoint, certainly a candidate for hip arthroplasty. Though, he is 57 years old and I have explained to him that his hip if done at this age could potentially require revision before he is ready to become more sedentary at a later age. I explained to him that ultimately it is his choice, and it is not unreasonable to do a hip replacement at this point, but if he is comfortable and this condition is not severely affecting his lifestyle, he would benefit from waiting.

We recommend that Mr. XXXX have full length film taken to measure the leg length discrepancy and meet with an Orthotist to discuss a lift. Follow up with physical therapy for strength training is also recommended.

Overall, we had a nice conversation, and we will keep in touch with Mr. XXXX in the future. We spent half the time of this new 30-minute visit discussing and counseling regarding his findings, assessing his gait and counseling regarding the need for hip replacement.

(ORTHOPEDIC SURGEON), MD

eScription document:

Appendix 2 - sample Mental Health progress note

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Progress - CCC

Note Date: 10/27/16
Signed by (CLINICAL SOCIAL WORKER), LICSW on 10/27/16 at 3:28 pm
Affiliation: MEDICAL CENTER

SOCIAL WORK - AMBULATORY SERVICES
Progress Note

CLINICAL DATA: (Relevant Subjective and Objective Information including session length and #; mental status including SI/HI.)
45 minute solution focused psychotherapy
Problems addressed:
adj to illness
family strain
Focus today is stressful relationship w/sister who provides financial support in many arenas for pt. Pt feels sister doesn't appreciate her perspective around the financial dependency. Pt views sister as often very critical and unkind. It triggers for pt feelings she had growing up w/mother who could also exhibit these behaviors. Pt comes from appointment earlier with Dr. S. Per her report, recent MRI showed stability in terms of new lesions, but some abnormalities "that explain my cognitive problems" which is some relief for her. She has been referred to a neuropsychologist and she hopes tha can provide some help w/her organizational problems.
She now volunteers regularly with a local agency in her home town. She is upset by strife with her 15 yo dtr who is critical of pt's behavior and cognitive problems.

MSE: Pt late for session (she had an earlier appointment she had forgotten about when she scheduled with me). She is casually dressed and engages actively in session w/full range of affect. Mood again this visit is somewhat discouraged and irritable in discussion about tension w/her sister. She feels interactions w/her teenaged children is more difficult; esp w/dtr. Pt continues to meet regularly w/community psychiatrist who manages her meds. She has ongoing challenges w/paperwork and organizational tasks. She's been referred to a neuropsychologist. As above, she gets pleasure from activity in volunteer role where she feels valued and smart. Insight and judgment are good. She makes good use of sessions and feedback.
CLINICAL ASSESSMENT: (Brief summary of pertinent information

relative to problems listed. Note additional problems or changes in rationale of treatment.)
Patient w/Parkinson's, psychosocial stressors and related mood problems. She actively uses sessions and feedback. Regular meetings can be challenged by her organizational problems resulting in lateness or cancelled appts.
PLAN:
May f/u
explore dynamics between pt and sister
collaborate w/neuropsychologist around referral

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Appendix 3 - sample Chronic Disease Management note

Progress - CCC
Note Date:11/17/16
Signed by (RHEUMATOLOGIST), MD on 11/21/16 at 11:00 am Affiliation: MEDICAL CENTER

Vital Signs sheet entries for 11/17/16: BP: 123/74. Heart Rate: 83. Weight: 173 (With Clothes). BMI: 26.9. Pain Score: 0.
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Active Medication list as of 11/17/16:

Medications - Prescription
FLUOCINOLONE - fluocinolone 0.01 % topical cream. Apply to affected area twice a day Use for up to 2 weeks as needed for flares.
HYDROXYCHLOROQUINE - hydroxychloroquine 200 mg tablet. One tablet(s) by mouth daily
INSULIN LISPRO [HUMALOG] - Humalog 100 unit/mL subcutaneous cartridge. Insulin pump - (Prescribed by Other Provider)
LEVOTHYROXINE - levothyroxine 75 mcg tablet. 1 tablet(s) by mouth qam
LOSARTAN - losartan 50 mg tablet. 1 tablet(s) by mouth once a day am
ROSUVASTATIN [CRESTOR] - Crestor 40 mg tablet. 1 tablet(s) by mouth q pm - (Prescribed by Other Provider)

Medications - OTC
ASPIRIN [ENTERIC COATED ASPIRIN] - Enteric Coated Aspirin 81 mg tablet, delayed release. 1 Tablet(s) by mouth once a day - (OTC)
CETIRIZINE - cetirizine 10 mg tablet. One tablet(s) by mouth a day as needed - (Prescribed by Other Provider; Dose adjustment - no new Rx)
CHOLECALCIFEROL (VITAMIN D3) - cholecalciferol (vitamin D3) 2,000 unit capsule. 1 capsule(s) by mouth once a day - (OTC)
LACTOBACILLUS COMBINATION NO.4 [PROBIOTIC] - Dosage uncertain - (OTC)
MULTIVITAMIN - multivitamin tablet. 1 Tablet(s) by mouth once a day - (OTC)
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HISTORY OF PRESENT ILLNESS: I saw Ms. XXXXX in the Rheumatology Clinic in a follow-up appointment. Ms. XXXXX is a 57-year-old patient with the following problems:

1. Hypocomplementemic urticarial vasculitis. Presented with hives since early 2012, a skin biopsy was consistent with vasculitis. Her laboratory reported negative serology for HBV, HCV, ANCA, dsDNA, Ro, La, Sm, RNP, normal C1 inhibitor, C4 3, and

C2 <1.3, CU index 13.5 (<10.0). Initiated colchicine on 08/2012 increased up to 1.2 mg, and discontinued on 09/2012 due to failure and diarrhea. Initiated prednisone 15 mg on 08/22/12, and Plaquenil on 09/17/2012 after her ophthalmologist found no contraindication. By 10/2012, had improved and prednisone was tapered. By 12/2012 hand only few transient lesions, on 2.5 mg of prednisone and Plaquenil. By 02/2013 had discontinued the prednisone. On 04/2013 had no lesions, Plaquenil was reduced to 200 mg improvement was maintained. The patient was last seen on September 2015 with only scattered few transient short-lived lesions and normal C4. My impression was that the patient was in remission on 200 mg of Plaquenil, no evidence of internal organ involvement. Treatment was not modified.

2. Neuropathy. The patient reported paresthesia on right foot, hypoesthesia, and sensation of numbness, unilateral. Considering that diabetic mellitus will cause mostly a bilateral polyneuropathy, an EMG was requested to investigate the possibility of a mononeuritis multiplex.

3. Plaquenil monitoring. The patient had scheduled an ophthalmologic exam in December.

3. Reactive airway disease & OSA. On 07/2014, reported episodes of shortness of breath and fatigue. There were no abnormalities on exam, chest x-ray showed no cardiopulmonary disease. Pulmonary function tests and a CT scan of the chest were normal. This ruled out the possibility that her shortness of breath could be related to lung involvement from the HUV. Evaluated in Pulmonary on 09/2014, diagnosed reactive airway disease and prescribed inhaled steroids. A sleep study 10/22/14, that showed severe obstructive sleep apnea. Initiated CPAP in 01/2015.

4. Left middle DIP mucous cyst. If in the future represents a painful problem, it can be injected or surgically remove it.
5. Plantar fasciitis. The patient was advised to do exercises.
6. Status post right carpal tunnel syndrome.
7. Diabetes mellitus.
8. ID prophylaxis. Pneumovax 2001 at Joslin; negative HBV/HCV on 08/2012.

Since the last visit, the patient has had on November 24 an electromyography that showed abnormalities, a dedicated electromyography for upper extremities was recommended and was done on January 29.

Since the last visit, the patient developed a right fourth finger flexor tendonitis, for which she had a surgical release on May 11, 2016.

Ms. XXXXX presented today to the clinic stating that she is recovering uneventfully for the operation of the tendon. She reports that she has had only occasional urticarial lesions that may last for hours or at the most one day. She continues taking Plaquenil and reports no side effects.

The patient reports that she continues having a sensation of numbness on the lateral aspect of the right foot that is very persistent and on occasions the sensation ascends to the leg. These symptoms started around May 2015 after a 5-mile walk.

The patient reports that she has intermittent variable intensity numbness on the hands, sometimes is more predominant in the ulnar aspect, sometimes involves the entire hand, but is not severe. She has occasional sensation of numbness on the right triceps area. The patient reports that she used to have more symptoms related to neuropathy in arms, but since she had the C-spine surgery they improved substantially. The patient denies having weakness in either upper or lower extremities.

REVIEW OF SYSTEMS: Otherwise negative.

PAST MEDICAL HISTORY:
1. Insulin-dependent diabetes mellitus.
2. Hashimoto's thyroiditis.
3. Herpes zoster.
4. Hyperlipidemia.
5. Hypertension.
6. Low back pain.
7. Chronic urticaria.
8. Whiplash.

PAST SURGICAL HISTORY:
1. Right shoulder rotator cuff tendinopathy. Labral tear. Right shoulder arthroscopic subacromial decompression. Debridement of labral tear 03/2204.
2. Left shoulder impingement with partial rotator cuff tear. Left shoulder arthroscopic sub acromial decompression. Debridement of partial rotator cuff tear 05/2001.
3. Anterior cervical diskectomy C5-C6, C6-C7. 05/2009 Anterior cervical interbody reconstruction with biomechanical device C5-C6 and C6-C7.

Anterior cervical arthrodesis C5-C6, C6-C7.
Anterior cervical plate instrumentation C5, C6, C7.
Application of local autograft for fusion augmentation.
Globus Providence anterior cervical plate with screw fixation, 28 mm plate, 12-mm screws.
DePuy Spine VG-2 interbody biomechanical device: lordotic, 5/7 mm x2.
4. Right carpal tunnel release 07/2010.
5. Tenosynovectomy, left posterior tibial tendon; arthrotomy 05/1993
6. synovectomy, left ankle 05/1993. Right ring finger A1 pulley release and synovectomy.

SOCIAL HISTORY: The patient does not smoke, has two drinks a week. No recreational drug use. Has not received transfusions. A program manager at a local hospital. Single with no children.

PHYSICAL EXAMINATION:
GENERAL: The patient was alert, oriented, in no acute distress.
HEENT: No alopecia. Pupils equal, round and reactive, extraocular muscles intact. Conjunctivae pink. Mouth moist, no oropharyngeal lesions.
NECK: Supple, no adenopathy, no thyromegaly, no bruits.
LUNGS: Clear to auscultation.
HEART: Regular rate and rhythm, normal S1 and S2, no murmurs.
ABDOMEN: Soft, non-tender, no hepatosplenomegaly.
EXTREMITIES: No cyanosis, no edema, distal pulses 2+.
NEUROLOGIC: Intact cranial nerves II through XII. Motor power 5/5 proximal and distal. Sensory intact to touch and vibration in upper extremities, a sensation of hypoesthesia in the lateral aspect of the right foot, reduction of vibration perception on the right foot.
MUSCULOSKELETAL: No swollen or tender joints.
SKIN: No inflammatory lesions.

LABORATORY DATA: Joslin, December 1, 2015, BUN 10, creatinine 0.5, ALT 19, AST 20, albumin 4.4, alkaline phosphatase 69.

EMG, November 24, 2015. Impression: Abnormal study. There is electrophysiologic evidence for a chronic generalized predominantly sensory axonal polyneuropathy. The absence of a left tibial motor response and right radial sensory response may be suggestive of the diagnosis of underlying mononeuropathy multiplex.

EMG, February 29, 2016. Impression: Abnormal study. There is

evidence for a mild left median neuropathy at the left wrist as in carpal tunnel syndrome. The data is also suggestive of mild cervical radiculopathies affecting C7-8 myotomes bilaterally. Compared to the previous study performed on November 24, 2015, the electrophysiologic data continue to demonstrate a generalized polyneuropathy affecting sensory greater than motor fibers. The abnormalities seen in this study, however, are more demyelinating as opposed to axonal in nature. The previous absent right radial response was able to be elicited. There were no clear asymmetries, focal finding to suggest mononeuritis multiplex.

ASSESSMENT AND PLAN: A 57-year-old patient with the following problems:

1. Hypocomplementemic urticarial vasculitis. The patient has been in treatment with Plaquenil 200 mg; that has resulted in excellent control of the urticarial vasculitis, as the patient has had only a few scattered and transient lesions. Her C4 has recovered to more normal levels and the patient has not presented with nephropathy or other internal organ involvement. I have advised to continue with 200 mg of Plaquenil.

2. Neuropathy. The patient has diabetes mellitus and I suspected that will have polyneuropathy. She has cervical spondylosis status post-surgery, her electromyography showed evidence of cervical radiculopathy. There is also evidence of left carpal tunnel syndrome. The electromyography in upper extremities is not consistent with mono neuritis multiplex; there is absence of the left tibial motor response with an axonal neuropathy. The electromyography in upper extremities is more consistent with demyelinating polyneuropathy, it would be expected that the diabetic neuropathy could be more axonal. Considering these two findings, the question is whether at least the left tibial motor response could be related to vasculitis, and whether the patient has a demyelinating neuropathy independent to the neuropathy secondary to DM, cervical radiculopathy and carpal tunnel. I have advised the patient to have an evaluation in Neurology to further advice on the nature of these abnormalities. If it is concluded that they could be of an immune nature or indeed vasculitic, her treatment will be modified. The patient was in agreement.

3. Plaquenil monitoring, last ophthalmologic exam August 2016.

I am planning to see Ms. XXXXX in six months or before if treatment for neuropathy is necessary.

(RHEUMATOLOGIST), MD

Cc: PRIMARY CARE DOCTOR, MD

Appendix 4 - sample Otolaryngology note

Dear Dr. XXXXXX:

Your patient R was seen today in Otolaryngology consultation as part of an airway clearance prior to upcoming sclerotherapy.

HISTORY OF PRESENT ILLNESS: R is a 51 year old female who presents to today's clinic visit due to history of cervicofacial venous malformation. R has involvement in the right cheek and submandibular regions with extension towards the floor of the mouth based on imaging. R previously has received care in Chicago. She has had four prior sclerotherapies, most recently in 2009. R reports that she tolerated these procedures well to her recollection. She did not require prolonged intubation following the procedures. In general R has no difficulty breathing. She is able to be active without distress. She sleeps well without snoring or apneic concerns. She is able to eat and drink without concerns for dysphagia.
R has recently been evaluated by Dr. XXXXX in the Vascular Anomalies Center. They are planning to perform sclerotherapy at our institution next week.

REVIEW OF SYSTEMS: Has been reviewed with R via the sheet provided to her at clinic check in encompassing 14 systems and is otherwise negative.

PAST MEDICAL HISTORY: left-sided cervicofacial venous malformation.

PAST SURGICAL HISTORY: Sclerotherapy, most recently 2009.

MEDICATIONS: None.

ALLERGIES: No known drug allergies

SOCIAL HISTORY: R does not smoke and is not exposed to those who do.

PHYSICAL EXAMINATION: Pulse 58 beats per minute, oxygen saturation 100% on room air. Temperature 36.8 degrees C. She is not in any pain. R is seated comfortably in the examination chair. She is breathing comfortably and quietly without stridor or stertor. There is venous malformation involving the left cheek and submandibular regions. Bilateral tympanic membranes and external auditory canals are clear. There is no effusion or otorrhea noted. Nasal passages are patent anteriorly. Septum is midline. Intraoral examination reveals symmetrical palate elevation. Uvula is midline. Tonsils are small. Tongue mobility is normal. Floor of mouth is soft. Dentition is in good repair. There is no evidence of any venous malformation within the oral cavity. Neck examination is otherwise normal with the exception of mild submandibular fullness.

PROCEDURE: A flexible nasal endoscopy and laryngoscopy was performed at today's clinic as part of her airway evaluation. On examination, she was found to have patent nares and septum was midline. Choanae is patent. She has normal nasopharynx, normal hypopharynx, and normal laryngeal examination. There is normal vocal cord function bilaterally. There is no evidence of any venous malformation on flexible endoscopy.

IMPRESSION: Venous malformation.

RECOMMENDATIONS: Dr. XXXXXXXX and I reviewed our findings with R. R has venous malformation

involving the left cervicofacial region. There is no obvious involvement within the oral cavity or the hypopharynx or laryngeal regions. We will contact Dr. XXXXX with our findings. We do feel that she is safe to proceed with her sclerotherapy next week. Precautions have already been made as to tentatively admit her to the ICU postoperatively.

Thank you for allowing us to participate in her care.

Sincerely,

Otolaryngologist
Department of Otolaryngology
HOSPITAL

I provided direct supervision for this service. In conjunciton with the physician assistant, I examined the patient and discussed the case. I agree with the findings and plan as documented in her note.

Otolaryngologist, DMD, MD
Department of Otolaryngology
HOSPITAL