MIDTERM

1. Comprehensive
    - New patients, identify or rule out physical causes related to patient concerns
2. Problem-focused assessments
    - Established patients, addresses focus or concerns, assesses symptoms specific to body system
3. Subjective
    - SELF, patient reports
4. Objective data
    - OBSERVED, physical assessment and labs
5. Creating the differential diagnosis
    - Using clinical reasoning to distinguish between two or more conditions that share similar S/S
6. Pertinent negatives
    - S/S that are NOT present that you would expect to find, weakens diagnosis
7. Pertinent positives
    - S/S that are present that you would expect to find, supports diagnosis
8. Principles of good documentation
    - Is the organization clear?
        A. Make the headings clear.
        B. Accent your organization with indentations and spacing.
        C. Arrange the HPI in chronological order, starting with the current episode, the filling in relevant background information.
    - Does the included information contribute directly to the Assessment?
        A. Spell out the supporting evidence, both positive and negative, or each problem or diagnosis. Make sure there is sufficient detail to support your differential diagnosis and plan.
    - Are pertinent negatives specifically described?
        A. Often portions of the history or examination suggest that an abnormality might exist or develop in that area. For example, for the pt with notable bruises, record the "pertinent negatives", such as the absence of injury or violence, familial bleeding disorders, or medications/nutritional deficits that might lead to bruising.
    - Are there overgeneralizations or omissions of important data?
        A. REMEMBER THAT ANY INFORMATION NOT RECORDED IS INFORMATION LOST.
    - Is there too much detail?
        A. Is there excess information or redundancy? Make your descriptions concise. You can omit unimportant structures even though you examined them, such as normal eyebrows and eyelashes.
        B. CONCENTRATE ON MAJOR NEGATIVE FINDINGS such as "no heart murmurs" rather than negative findings unrelated to the patient's complaints.
    - Is the written style succinct? Are phrases, short words, and abbreviations used appropriately? Is data unnecessarily repeated?

    A. Using words or brief phrases instead of whole sentences is common, but abbreviations and symbols should be used only if they are readily understood. Omit unnecessary words. Describe what you observed, not what you did.
- Are clear descriptions or images included whenever possible?
    A. To ensure accurate evaluations and future comparisons, describe findings fully. Use measurements in centimeters, not fruits, nuts or vegetables.
- Is the tone of the write up neutral and professional?
    A. It is important to be objective. Hostile or disapproving comments have no place in the patient's record. Never use inflammatory or demeaning words or punctuation.

9. Components of the medical history
    I. Initial information (Identifying patient information/source/reliability)
    II. Chief Complaint(s)
    III. History of Present Illness
    IV. Past Medical History
    V. Family History
    VI. Personal/Social History
    VII. Review of Systems (ROS)
10. Evaluation and management (E/M) codes
    - Codings ranging from 99202-99499 that represent a service by a provider in which the provider is evaluating or managing patients health
11. Evidence-based practice
    - Conscientious, judicious and reasonable use of modern, evidence in making decisions on an individual's care
12. PICOT question
    - Patient, intervention, comparison, outcome and time.
13. Application of sensitivity & specificity principles
    - Sensitivity refers to a test's ability to designate an individual with a disease as positive
    - Specificity refers to the ability of testing to recognize patients who do not have the disease.
14. Likelihood ratios in clinical practice
    - Positive: The likelihood the patient with the disease tests positive, compared to the likelihood that a patient without the disease tests positive
    - Negative: The likelihood the patient with the disease tests negative, compared to the likelihood that a patient without the disease tests negative
15. Diagnostic utility of radiology testing and categories of radiographic densities
    - Air- blackest on radiograph
    - Fat-darkest shade of grey
    - Soft tissues/fluid-light grey
    - Minerals-lightest shade of grey (absorbs most of x ray)
    - Metal- white (most dense & absorbs all x ray)
16. USPSTF guideline rating: United States preventive service task force.
    - Grade A- recommends this service, high certainty at the net benefits is substantial
        A. Offer or provide service