

## **Charting Shortcuts**

Use these as a starting point to customize your notes or templates; change the negatives to positive as needed, delete the things you don't need, and watch your charting time get cut back drastically.

### **Subjective**

#### *Constitutional*

Patient presents with concern for \_\_\_\_\_. Denies: changes in appetite, fever, chills, sweats, weight change or fatigue. History significant for: \_\_\_\_\_.

#### *Head*

Patient denies any trauma, new lumps or masses, tenderness, rash or lesions.

#### *Eyes*

Patient denies vision changes (blur, diplopia), itch or discharge, excessive tearing or dryness. No photophobia. No history of cataracts, glaucoma. Patient does not wear glasses or contact lenses. Last eye exam: \_\_\_\_\_.

#### *Ears, Nose, Throat*

Patient denies hearing change, ear pain, discharge, vertigo; no suspicion of ear infection. Patient denies epistaxis, nasal and sinus congestion. Patient denies bleeding or swelling of gums, oral pain, sore throat,

or subjective voice change. Last dental exam: \_\_\_\_\_. Patient denies neck pain, lumps, swelling, or difficulty swallowing.

#### *Cardiac*

Patient denies chest pain, pressure, dizziness, nausea, SOB or weakness with exertion, palpitations. No numbness or tingling of extremities. No subjective edema, coldness of extremities, delayed wound healing. No history of murmurs, hypertension, MI.

#### *Respiratory*

Patient denies wheezing, shortness of breath, cough, hemoptysis. No history of asthma, COPD, bronchitis, pneumonia.

#### *Gastrointestinal*

Patient denies abdominal pain, change in bowel habits, constipation, diarrhea, nausea, vomiting, black/bloody or otherwise discolored stools. Patient denies dysphagia, heartburn. No previous history of hepatitis, gallstones, hemorrhoids.

#### *Genitourinary*

Patient denies difficult, burning, or pain with urination; denies nocturia, polyuria, hematuria. Patient denies urinary incontinence, suspicion of infection. No history of kidney or bladder stones.

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*Genital*

Patient denies discharge, genital sores, pain, or masses. Patient is sexually active; denies dyspareunia.

Patient uses contraception: \_\_\_\_\_. No history of sexually transmitted infection; no new sexual partners or recent unprotected intercourse. Last menstrual period: \_\_\_\_\_. Last OB/GYN exam: \_\_\_\_\_.

*Musculoskeletal*

Patient denies redness, swelling, warmth, pain, discomfort, limitations to range of motion, muscle cramps. No history of arthritis, fractures, sprains, joint replacement. Patient denies AM/PM joint stiffness.

*Skin*

Patient denies rash, pruritis, jaundice, bruising, lesions, delayed wound healing. Patient denies changes in hair, nails; no change to existing nevi. No history of skin cancer.

*Breasts*

Patient denies lumps, pain, nipple discharge, change in skin texture. Last mammogram: \_\_\_\_\_. Last clinical breast exam: \_\_\_\_\_. Patient performs self breast exams.

*Neuro*

Patient denies frequent or new headaches, seizures, vertigo. Patient denies subjective memory, gait, speech or coordination changes.

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### *Psych*

Patient denies suicidal, homicidal ideation. Patient denies depression, anxiety, change in sleep pattern.

Patient denies history of substance or alcohol abuse. No previous mental health diagnoses. No history of mental or physical abuse.

### *Endocrine*

Patient denies polydipsia, polyuria, polyphagia. No subjective heat or cold intolerance, or significant changes in energy level. Patient denies changes in hair, nails, skin.

### *Heme/Lymph*

Patient denies significant bruising, lymphadenopathy, axillary or groin tenderness. No history of blood disorders, transfusions, anemia, anticoagulation.

### *Allergy/Immunology*

Patient denies seasonal, food, medication allergies. Patient denies known immune disorders.

## **Objective**

### *General*

Patient is well appearing, well nourished, alert and oriented x3. Patient displays normal mood, affect.

### *Neurological*

Cranial nerves intact and symmetrical. EOM intact. PERRLA. Reflexes intact, normal, and symmetrical (SPECIFY LOCATION TESTED; SPECIFY #/5). Strength equal and symmetrical in all four extremities.

Sensation intact. Hearing intact to spoken words at conversational volume.

*Dermatological*

Skin color and turgor normal for ethnicity, age. No obvious rashes, scaling, broken skin, unusual bruising, prominent lesions noted. No discoloration or deformities of nails. Texture and distribution of hair within normal limits.

*Head, Eyes, Ears, Nose, Throat*

Head is normocephalic, atraumatic, with no visible or palpable masses noted. No obvious depressions, scarring noted. Visual acuity grossly intact (with glasses/contacts), extraocular movements grossly intact, fields of vision grossly intact; conjugate gaze. Conjunctiva clear bilaterally; no discharge or redness present. PERRLA. Funduscopic exam within normal limits bilaterally. No exudate, no hemorrhage noted. External auditory canals patent bilaterally, no excessive cerumen noted; tympanic membranes translucent and mobile bilaterally. No mid-ear effusion noted. Hearing grossly intact to spoken words at conversational volume. No lesions or mucosal inflammation noted in bilateral nares; septum grossly midline. No swelling of turbinates noted; no obvious discharge. No frontal or maxillary sinus tenderness to palpation. Oropharynx within normal limits; free of lesions, erythema, obvious/significant caries or abnormal dentition, obvious gingival inflammation; mucous membranes moist. No tonsillar hypertrophy or exudate noted. Neck is supple with grossly normal ROM. No bruit, adenopathy, JVD noted. No obvious hypertrophy or tenderness of thyroid to palpation. Non-nodular.

*Cardiac*

Regular rate and rhythm; S1, S2 present. No murmur, rub, click, gallop noted. No PMI displacement noted. Pulses present and symmetrical in bilateral extremities. No visible swelling of extremities, no pitting edema.

*Respiratory*

Lungs clear to auscultation in all fields bilaterally. No inspiratory or expiratory wheezes noted. No rales, crackles, rhonchi noted on auscultation. Patient speaks in full, complete sentences without limitation.

*Breast*

Breasts are symmetrical. No dimples, retractions, skin changes noted. No masses appreciated. No nipple abnormalities or discharge on exam. No tenderness to palpation. Axillary and clavicular nodes nontender, nonrigid, not enlarged or fixed.

*Abdominal*

Bowel sounds present in all four quadrants. No tenderness to palpation. No masses appreciated; no organomegaly noted. No hernia. Patient ascends/descends exam table without limitation or significant effort.

*Rectal*

Sphincter tone normal. No internal or external hemorrhoids noted. No palpable masses. No blood noted in rectal vault.

*Gynecological*

Patient in supine position. Vulva and vagina normal; no erythema, abnormal discharge, lesions. Cervix normal, nondilated; no discharge, no lesions, not friable, no cervical motion tenderness. No obvious prolapse of bladder or uterus. No adnexal masses or tenderness to palpation. Rectal tone normal; no hemorrhoids appreciated.

*Genitourinary*

Penis is circumcised and free of lesions. Urethra midline; no discharge, no erythema. Cremasteric reflex present bilaterally; no swelling, varicocele, hydrocele noted. Digital rectal exam within normal limits; prostate is non-tender, non-nodular. No inguinal hernia.

*Musculoskeletal*

No obvious misalignment, asymmetry, defects, or obvious swelling noted. No crepitation or effusion appreciated on exam; no tenderness in joints on palpation. Gait and ROM grossly within normal limits; normal muscle bulk and tone. Reflexes symmetrical bilaterally (#/5, location) and grossly within normal limits; strength equal bilaterally in upper and lower extremities.

*Back*

No abnormal curvature or tenderness noted; ROM grossly within normal limits. No CVA tenderness.

*Extremities*

No amputations or deformities present. No significant varicosities, cyanosis, or edema; peripheral pulses present and symmetrical bilaterally.

*Psych*

Alert and oriented to person, place, time. Intact recent and remote memory; judgment, insight, and affect grossly within normal limits. No anxiety, depression, suicidal ideation or homicidal ideation.

*Foot*

Pulses present bilaterally in dorsalis pedis, posterior tibialis locations. No abnormally thickened nails, broken skin, significant dry skin, significant erythema, calluses present. Monofilament test positive in all locations.