EXAMPLE OF RECORDED HEALTH HISTORY

IDENTIFYING DATA: Name: John Paul Doe

The patient is a 32-year-old, white, divorced male who is an unemployed offset printer and lives at 1234 Surf Way, Marina Del Rey, California. The patient is self-referred, and has previously been cared for at Harbor General Hospital in Torrance, California. Source of information is from the patient, who attempted to be cooperative; however, was frequently vague about the nature and time of events.

CHIEF COMPLAINT: "Pain in the right side of the stomach for two days."

HISTORY OF PRESENT ILLNESS:

(Chronological Story)

The patient has been drinking one- to two-fifths vodka daily for approximately 14 years. Despite this, he has maintained regular employment until one year prior to admission. He has no prior history of delirium tremens, withdrawal seizures, pancreatitis or liver dysfunction. Seven years ago the patient was diagnosed as having a gastric ulcer at Harbor General Hospital, and he was treated on an outpatient basis with Maalox and prn Valium. The diagnosis was made by an upper GI, and endoscopy was not performed. Evidently subsequent upper GI x-rays showed healing of the ulcer. The patient has complained of slight to moderate gastric discomfort and food intolearance intermittently since that time. He is unable to relate the specific frequency or specific characteristics of the episodes of illness. He states that they are ususally accompanied by "hangovers". He generally experiences right upper quadrant discomfort associated with feelings of hunger, nausea, vomiting of mucus materizl 6 to 8 hours after drinking heavily. He drinks heavily (3- to 4-fifths of vodka) 3 or 4 days a week and states that symptoms occur approximately 2 times a week. His appetite generally has been good, he states, despite erratic meal patterns. Mr. Doe drinks 2 to 3 eight-ounce bottles of Maalox per week. His symptoms are relieved somewhat with the Maalox. He states that his bowel movements have been regular, formed and brown.

The day prior to admission, the patient awoke at approximately 7:00 a.m. and took several alcoholic drinks (approximately one cup). He had been drinking continuously the day and night before. After an hour he experienced nausea and vomiting of a yellowish vomitus. At 10:00 a.m. he walked to his friend's home two blocks away, and upon arriving experienced a sharp continuous non-radiating pain in his right upper abdominal area. The intensity was so severe that he felt he had to lay down. Change in position provided no relief, and taking a whole bottle of Maalox did not effect the pain which continued to increase in intensity over the next two hours. At approximately 2:00 p.m., he attempted to take food, but vomited again, and this time there were red streaks in greenish vomitus. The exact amout of the vomitus is unknown.

Throughout the remainder of the afternoon and early evening, the patient took four Valium 5 mg. over a period of approximately 12 hours. He obtained no relief, and the pain continued to be nagging and continuous. He was able to walk with no increase in the discomfort, but felt most comfortable lying down.

Mr. Doe took a sleeping pill at bedtime, but spent a fitful night, and the pain persisted with increased intensity. He took his temperature at midnight, and noted that he had a fever of 102° F. Mr. Doe rose at 9:00 a.m. and vomited approximately three cups of coffee-ground-appearing material. He then was brought by his friend to the UCLA emergency room where he was seen and admitted.

(Relevant Family History)

The only significant family history for a serious, persistant gastrointestinal disorder was a maternal uncle who was a heavy drinker and who died of stomach cancer at age 40.

PAST MEDICAL HISTORY, CHILDHOOD ILLNESS:

The patient assumes he had all childhood illnesses, including measles, mumps, chickenpox, but does not remember the dates. He denies a history or rheumatic fever or polio.

INJURIES: At age 9, the patient was hit in his right eye by a rock, and states that he has had a permanent decrease in vision in that eye since then. At age 18, the patient suffered a head injury from a blow with a blunt object and was unconscious for approximately 30 minutes. He required suturing of the head wound, but had no other evaluation and no neurological sequelae. At age 23, the patient had a stab wound in his left shoulder when he was attacked and robbed. He was sutured at an emergency room at Bellevue Hospital in New York. He had no follow-up except for removal of sutures and no sequelae.

MEDICAL HOSPITALIZATIONS: The patient had pneumonia at age 20 and was hospitalized at Bellevue Hospital for two weeks.

OPERATIONS: Age 8, tonsillectomy and adenoidectomy.

ALLERGIES: None known. Specifically denies allergies to penicillin or other drugs.

IMMUNIZATIONS: Unknown.

MEDICATIONS: Maalox p.r.n. for ulcer disease. Patient indicates that he uses 2-3 eight-ounce bottles per week. Valium 10 mg. tablets p.r.n. nervousness. Patient indicates he used 1-2 tablets per day. Sleeping pill p.r.n. The patient does not know the name or the dose of the pill, but indicates that it is a red tablet, and he takes one every night.

FAMILY HISTORY:

Maternal and paternal grandparents deceased; their age at death and cause of death is unknown. Patient's mother is age 52, alive and well. Father died at age 50 of an unknown cause. A brother died at age 20 of a drug overdose. A sister, age 27, is alive and well. He denies any family history of diabetes, blood disorders, arteriosclerosis, gout, obesity, coronary artery disease, tuberculosis, cancer, hypertension, epilepsy, kidney disease or allergic disorders. He has no children.

SOCIAL HISTORY:

The patient has been divorced from his wife for 8 years, and lives alone. He has no children and has no family in California. His mother lives in New York City. He has not seen her for 10 years. Patient has been employed as an offset printer since 1971, but has been unemployed for the past year because of difficulty maintaining the job with his intoxication and abseenteeism. Patient is on welfare assistance. Patient's only support systems are one male friend who lives approximately two blocks from his home and brought him to the hospital today. Patient finished high school but has not been to college. He was born in New York City and lived there until he moved to Los Angeles 10 years ago. He denies any military experience or foreign travel.

HABITS:

Patient smokes one pack of cigarettes per day, and has since he was age 14. His alcohol consumption is described in the history of present illness. He denies any use of narcotics or other recreational drugs. His description of his diet indicates that he frequently skips meals and often will make an evening meal off of hors d'oeuvres served at a bar.