Gathering Subjective & Objective Information

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Fundamental question

- What patient-specific information do I need to provide pharmaceutical care?
- What is the most reliable & efficient way to get it?
- How will I organize & store the information to facilitate identification & resolution of drug-related problems?

Patient-specific information Part 1

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Past Medical History (PMH)
  - including allergies, surgery, immunization
- Demographics (age, gender, pregnancy)

Patient-specific information Part 1

- Social history (SHx)
  - Diet, exercise; tobacco, alcohol
  - Employment, family / living situation, travel
  - Health beliefs & practices
- Medication history
  - Drugs, dose, frequency, efficacy, safety & cost
  - Prescription, OTC, Herbal, other

Patient-specific information Part 2

- Physical examination
  - Vital signs, review of systems
- Laboratory
  - Hematology, Chemistry, Coagulation, liver function tests, endocrine, drug levels et al
- Other (imaging, pathology, microbiology)

What information is <u>needed</u>

- Should be driven by delivery of pharmaceutical care.
- Gather more information than you think you need until more experienced.
- Learn to focus on what is essential
- Always ask yourself “why do I need this information”.
  - How does it relate to their drug therapy
  - What will you do with the information

Sources of information Part 1

- The patient!
  - May be subjective / not reproducible / unreliable
  - Depends heavily on communication skills
    - Theirs - recall, vocabulary, mental status
    - Yours – interview techniques, empathy etc.
  - Absolutely essential to find out “what is really going on” and set foundation for effective interventions
    - Patients intelligence, behaviors, beliefs, biases etc

Sources of information Part 1

- Family and caregivers
  - Must respect patient’s right to privacy
    - Cancer, HIV, Pregnancy etc.
  - Reliability?
    - May be only / best source
    - May not have patient’s best interest at heart
  - Consider potentially less reliable than other sources

Sources of information Part 1

- In hospital or clinic
  - Past medical records
  - Current records (admission history & physical)
    - Consider source’s reliability
      - Medical student vs intern vs attending
    - Height & weight almost always wrong – ask patient
    - Reliable but should be confirmed whenever possible
    - Still may often need to be supplemented for pharmaceutical care

Gathering information from patients

- The interview: how & what
  - How
    - Privacy, respect, purpose relationship
    - Language (vocabulary) including body language
    - Open-ended & non-judgmental
  - What
    - Purpose of the interview
      - From patient and your point of view
      - Information to be gathered

Other sources of information

- Medication history – depends on setting
  - Ambulatory
    - Refill history (make sure you know all their pharmacies)
    - Pill counts
  - Inpatient
    - Medication administration record (paper or electronic)
      - Dose dispensed vs doses given

Specific questions for patients

- CC:
  - What can I do for you today? How are you doing? What brings you to the pharmacy/clinic / hospital?
- HPI:
  - How were you feeling before you came to the pharmacy? What were your symptoms and for how long? What made them better or worse?

Specific questions for patients

- PMH:
  - What current or past medical issues have you had? How are / where you treated?
  - What medication allergies or adverse reactions have you had? Exactly what happened? How were you treated? What medication have you taken without problems?

Specific questions for patients

- Demographics
  - What year where you born?
  - If female and question is relevant
    - How many pregnancies and how many live births
    - Are you pregnant or breastfeeding now?
    - Is there potential for you to become pregnant?
  - What is your current height & weight? When did you last check? Has this changed in the past few months? Was any change intentional?

Specific questions for patients

- Social history
  - Be specific but open ended and non-judgmental
    - Do you use tobacco products and if so, how much (i.e. packs of cigarettes) would you smoke in a week?
    - What would you eat in a typical day & when?
    - Who do you live with? How do you get to the clinic?
    - Has the cost of medication ever prevented you from being able to take it?
    - Do you get medical care from outside the doctor's office?

Specific questions for patients

- Medication history
  - Current prescribed & non-prescribed medication
  - Past medication use
    - Drug name
    - Purpose / symptoms
    - Dosage
    - Duration
    - Beneficial & adverse effects
    - Reason for discontinuation (if applicable)

Specific questions for patients

- Prime questions
  - What were you told this medication is for? What symptoms is it supposed to help? What is it supposed to do?
  - How were you told to take the medication? What does three times a day mean for you? What did your doctor say to do when you miss a dose?
  - What were you told to expect? What good effects are you supposed to notice? What bad effects did the doctor say to watch for? What should you do if a bad reaction happens?

Specific questions for patients

- Some questions to ask yourself
  - What is your patients level of understanding of his/her illness, drug therapies etc. (health literacy)
  - What concerns or barriers does your patient have in general or about medical conditions & drug therapies (including side effects, costs etc.)
  - What are the patient's expectations and goals? Are they realistic and acheivable

Sources of information Part 2

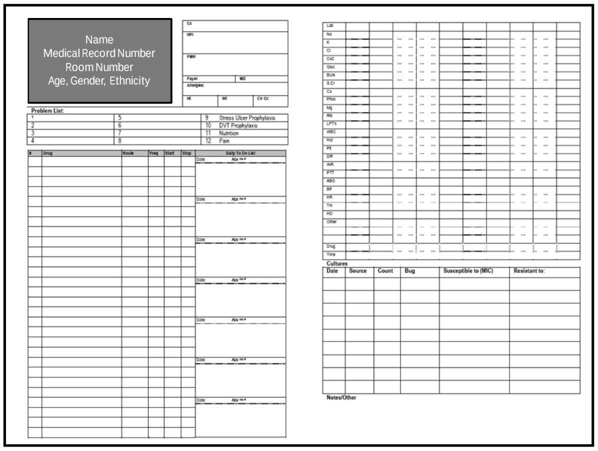
- Physical examination / Review of systems & other objective evaluations
  - Typically done by physicians & other healthcare professionals
  - Documented in medical chart (History & Physical)
    - May not all be in one place
      - Vital signs vs physical examination vs laboratory vs radiology
      - Often requires lots of digging, systematic approach
    - Focus on gathering what you need for drug therapy!

Sources of information Part 2

- Pharmacists' role in H & P
- Focused on drug therapy goals / measures
  - History
    - Anticoagulation: Blood in stool?
  - Physical examination
    - Blood pressure for hypertension
  - Laboratory
    - Blood glucose for diabetes
    - INR for anticoagulation

Putting it all together

- Pharmacist database & documentation
  - Practice setting specific
  - Condensed version of medical record
  - Focused on drug therapy
  - Often uses a SOAP format
  - Facilitates systematic presentation and analysis

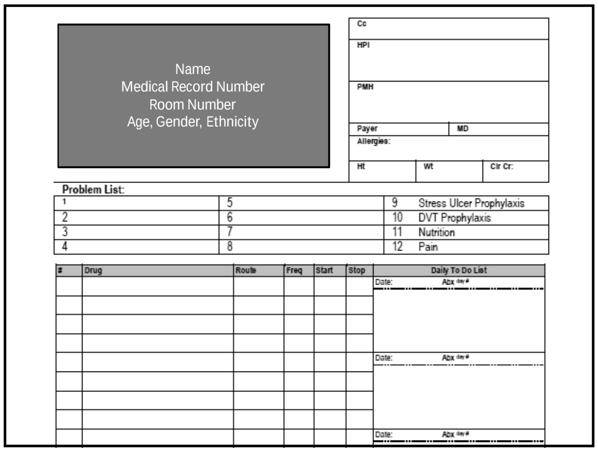


Name
Medical Record Number
Room Number
Age, Gender, Ethnicity

Cultures

Date	Source	Count	Bug	Susceptible to (MIC)	Resistant to:

Notes/Other



Name
Medical Record Number
Room Number
Age, Gender, Ethnicity

Cc

HPI

PMH

Payer | MD

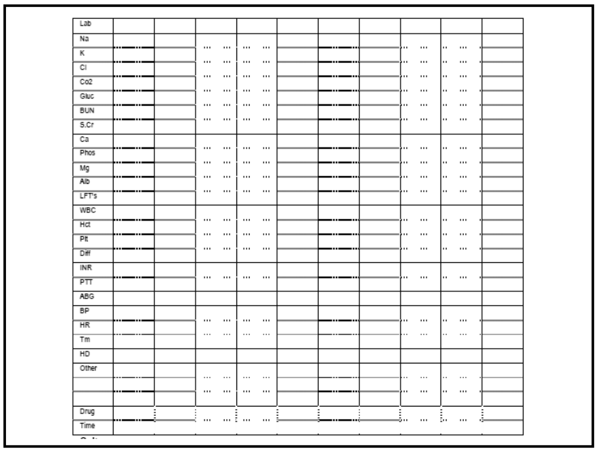
Allergies:

Ht | Wt | Clr Cr:

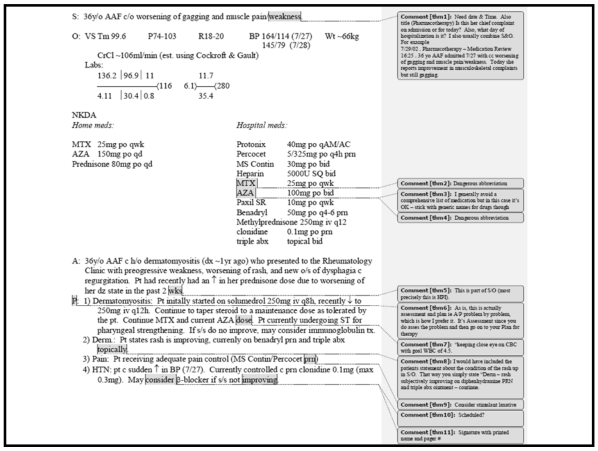
Problem List:

1	5	9 Stress Ulcer Prophylaxis
2	6	10 DVT Prophylaxis
3	7	11 Nutrition
4	8	12 Pain

#	Drug	Route	Freq	Start	Stop	Daily To Do List
						Date: Abx day #
						Date: Abx day #
						Date: Abx day #



Lab										
Na										
K										
Cl										
Co2										
Gluc										
BUN										
S.Cr										
Ca										
Phos										
Mg										
Alb										
LFT's										
WBC										
Hct										
Plt										
Diff										
INR										
PTT										
ABG										
BP										
HR										
Tm										
HD										
Other										
Drug										
Time										



S: 36y/o AAF c/o worsening of gagging and muscle pain/weakness

O: VS Tm 99.6 P74-103 R18-20 BP 164/114 (7/27) Wt ~66kg
145/79 (7/28)
CrCl ~106ml/min (est. using Cockroft & Gault)
Labs:
136.2 | 96.9 | 11 11.7
——————〈116 6.1〉——〈280
4.11 | 30.4 | 0.8 35.4

NKDA

Home meds:

MTX	25mg po qwk
AZA	150mg po qd
Prednisone	80mg po qd

Hospital meds:

Protonix	40mg po qAM/AC
Percocet	5/325mg po q4h prn
MS Contin	30mg po bid
Heparin	5000U SQ bid
MTX	25mg po qwk
AZA	100mg po bid
Paxil SR	10mg po qwk
Benadryl	50mg po q4-6 prn
Methylprednisone	250mg iv q12
clonidine	0.1mg po prn
triple abx	topical bid

A: 36y/o AAF c h/o dermatomyositis (dx ~1yr ago) who presented to the Rheumatology Clinic with preogressive weakness, worsening of rash, and new o/s of dysphagia c regurgitation. Pt had recently had an ↑ in her prednisone dose due to worsening of her dz state in the past 2 wks.

P: 1) Dermatomyositis: Pt initally started on solumedrol 250mg iv q8h, recently ↓ to 250mg iv q12h. Continue to taper steroid to a maintenance dose as tolerated by the pt. Continue MTX and current AZA dose. Pt currently undergoing ST for pharyngeal strengthening. If s/s do no improve, may consider immunoglobulin tx.
2) Derm.: Pt states rash is improving, currenly on benadryl prn and triple abx topically.
3) Pain: Pt receiving adequate pain control (MS Contin/Percocet prn)
4) HTN: pt c sudden ↑ in BP (7/27). Currently controlled c prn clonidine 0.1mg (max 0.3mg). May consider β-blocker if s/s not improving.

Comment [thm1]: Need date & Time. Also title (Pharmacotherapy) Is this her chief complaint on admission or for today? Also, what day of hospitalization is it? I also usually combine S&O. For example
7/29/02 . Pharmacotherapy – Medication Review
16:25 . 36 yo AAF admitted 7/27 with cc worsening of gagging and muscle pain/weakness. Today she reports improvement in musculoskeletal complaints but still gagging.

Comment [thm2]: Dangerous abbreviation

Comment [thm3]: I generally avoid a comprehensive list of medication but in this case it's OK – stick with generic names for drugs though

Comment [thm4]: Dangerous abbreviation

Comment [thm5]: This is part of S/O (most precisely this is HPI).

Comment [thm6]: As is, this is actually assessment and plan ie A/P problem by problem, which is how I prefer it. It's Assessment since you do asses the problem and then go on to your Plan for therapy

Comment [thm7]: "keeping close eye on CBC with goal WBC of 4.5.

Comment [thm8]: I would have included the patients statement about the condition of the rash up in S/O. That way you simply state "Derm – rash subjectively improving on diphenhydramine PRN and triple abx ointment – continue.

Comment [thm9]: Consider stimulant laxative

Comment [thm10]: Scheduled?

Comment [thm11]: Signature with printed name and pager #