

History And Physical Documentation

History and Physical Exam Documentation Manual: A Guide for Medical Students Entering Core Clinical Rotations:

Physical Examination for SurgeonsAn Aid to the MRCS OSCECambridge University Press

THE CLINICAL PICTUREBy Drs. Conwell & LehmanTick ... tick ... tick ... how many patients are waiting?As a health-care student or new practitioner, you work hard to refine your clinical skills, including the all-important history and physical (H&P) examination. You document your findings to help you diagnose your patient's problem and develop a treatment plan, and those records assist other health-care providers treating the patient. When care is holistic, integrated, and evidence-based, best-case practice requires careful documentation to increase good outcomes for patients. Meanwhile, the clock is ticking and more patients are waiting. THE CLINICAL PICTURE by Drs. Conwell & Lehman will help you improve your skill and efficiency in performing and documenting the initial H&P for patients presenting with neuromusculoskeletal conditions. Mastering the information in this concise and practical guide will: - Prepare you for board examinations that require knowledge in evaluating patients with neuromusculoskeletal conditions. - Improve your acumen and efficiency in acquiring and documenting complete information in a neuromusculoskeletal workup- Improve your ability to diagnose the majority of neurologic and musculoskeletal complaints of the neck, back, and extremities- Improve quality of care and patient outcomes in a patient-centered environment. The book includes illustrations to help you easily comprehend the material. Its three sections are History and Physical Examination, Narrative Report Writing, and Daily Record-Keeping. This comprehensive guide covers the following information: SECTION I thoroughly, yet succinctly, covers how to pull a comprehensive Medical History and report a detailed Physical Examination of the neuromusculoskeletal system. - Medical History This section includes an extensive Outline Guide for quick reference and a comprehensive Confidential Patient History Questionnaire form. You will learn how to obtain and use the valuable historical information by incorporating the following acronyms: HPI, PMH, OPQRST, PSFH, ADL, ROS, and much more. The history section covers all the steps required to collect a detailed history from the patient.- Physical ExaminationThe emphasis is placed on the individual parts of the medical exam including general appearance, vital signs, neurologic evaluation (screening for lesions of the Central and Peripheral Nervous System), and orthopedic evaluation (inspection, palpation, ROM, provocative tests, peripheral vascular screen, non-organic physical signs). Chapters cover in detail Impression/Diagnosis, Treatment Plan, Outcome Assessment Tools, indications for Diagnostic Tests, descriptions and significance of the most common orthopedic and neurologic tests, and the commonly used medical abbreviations. SECTION II, Narrative Report Writing, includes a complete Narrative Report Outline Guide for quick reference. You will learn how to: - Use the key components of the medical narrative- Integrate information from the physical exam into the narrative report- Use appropriate medical phrasing and a precise writing style for the narrative report. - Detailed sample narrative reports from different medical specialties will help you apply the information in this section. SECTION III, Daily Record Keeping, thoroughly discusses: - The S.O.A.P. Note method for documenting daily office visit findings- Documentation required for medical necessity of the treatment provided- Communications with other health care providers- The problem-oriented medical information system PROMIS - The definition of Evaluation & Management (E&M) service codes- This section includes numerous detailed Daily Office Note (SOAP note) examples with accompanying appropriate E&M codes.

The ultimate guide to the evidence-based clinical encounter "This book is an excellent source of supported evidence that provides useful and clinically relevant information for the busy practitioner, student, resident, or educator who wants to hone skills of physical diagnosis. It provides a tool to improve patient care by using the history and physical examination items that have the most reliability and efficiency."--Annals of Internal Medicine "The evidence-based examination techniques put forth by Rational Clinical Examination is the sort that can be brought to bear on a daily basis – to save time, increase confidence in medical decisions, and help decrease unnecessary testing for conditions that do not require absolute diagnostic certainty. In the end, the whole of this book is greater than its parts and can serve as a worthy companion to a traditional manual of physical examination."--Baylor University Medical Center (BUMC)Proceedings 5 STAR DOODY'S REVIEW! "Physical diagnosis has been taught to every medical student but this evidence-based approach now shows us why, presenting one of medicine's most basic tenets in a new and challenging light. The format is extraordinary, taking previously published material and updating the pertinent evidence since the initial publication, affirming or questioning or refining the conclusions drawn from the data. "This is a book for everyone who has studied medicine and found themselves doubting what they have been taught over the years, not that they have been deluded, but that medical traditions have been unquestionably believed because there was no evidence to believe otherwise. The authors have uncovered the truth. "This extraordinary, one-of-a-kind book is a valuable addition to every medical library."--Doody's Review Service Completely updated with new literature analyses, here is a uniquely practical, clinically relevant approach to the use of evidence in the content of physical examination. Going far beyond the scope of traditional physical examination texts, this invaluable resource compiles and presents the evidence-based meanings of signs, symptoms, and results from physical examination maneuvers and other diagnostic studies. Page after page, you'll find a focus on actual clinical questions and presentations, making it an incomparably practical resource that you'll turn to again and again. Importantly, the high-yield content of The Rational Clinical Examination is significantly expanded and updated from the original JAMA articles, much of it published here for the first time. It all adds up to a definitive, ready-to-use clinical exam sourcebook that no student or clinician should be without. FEATURES Packed with updated, new, and previously unpublished information from the original JAMA articles Standardized template for every issue covered, including: Case Presentation; Why the Issue Is Clinically Important; Research and Statistical Methods Used to Find the Evidence Presented; The Sensitivity and Specificity of Each Key Result; Resolution of the Case Presentation; and the Clinical Bottom Line Completely updated with all-new literature searches and appraisals supplementing each chapter Full-color format with dynamic clinical illustrations and images Real-world focus on a specific clinical question in each chapter, reflecting the way clinicians approach the practice of evidence-based medicine More than 50 complete chapters on common and challenging clinical questions and patient presentations Also available: JAMAEvidence.com, a new interactive database for the best practice of evidence based medicine

An Aid to the MRCS OSCE

A Pocket Guide to Physical Examination and History Taking

Clinical Practice Guidelines for Midwifery & Women's Health

Clinical Methods

Documentation Guidelines for Evaluation and Management Services

A comprehensive single-volume text on clinical dermatology Featuring a strong focus on diagnosis and treatment, Clinical Dermatology is a concise yet thorough guide to 100 of the most common dermatologic conditions. This latest addition to the LANGE Clinical series is enriched by a full-color presentation and a logical, easy-to-use organization. More than 250 full-color illustrations Divided into three sections: Fundamentals of Diagnosis and Treatment, Common Skin Diseases, and Problem Based Dermatology (which includes cases) "Pearls" and "Pitfalls" throughout the text

Many Tests Address The Examination Component Of Health Assessment, But Do Not Cover The Diagnostic Reasoning Process That A Health Care Provider Must Go Through When Assessing An Actual Case. In The Second Edition Of Advanced Health Assessment And Diagnostic Reasoning, Authors Rhoads And Petersen Do Just That. By Including Each Step Of Health Assessment, They Demonstrate The Links Between Health History And Physical Examination, And Offer The Healthcare Provider With The Essential Data Needed To Formulate A Diagnosis And Treatment Plan. Furthermore, The Content In Advanced Health Assessment And Diagnostic Reasoning, Second Edition Is Accessible And Presented In A Way That Is Easy To Follow And Retain. Key Features & Benefits "Three Introductory Chapters Cover General Strategies For Health History Taking, Physical Examination, And Documentation, And The Remaining Chapters Cover Clinical Aspects Of Assessment, And Focus On Various Systemic Disorders (E.G., Gastrointestinal, Cardiovascular, Musculoskeletal), "Aspects Of The Health History Are Presented In Two Columns. The First Column Gives The Type Of Information That The Provider Should Obtain, And The Second Column Provides Specific Questions Or Information To Note And Gives Examples Of What Conditions The Findings May Indicate. "Aspects Of The Physical Examination Are Presented In Two Columns. The First Column Gives The Action, And The Second Column Lists Normal And Abnormal Findings, And Possible Diagnoses Associated With Those Findings. "Every Clinical Chapter Contains A "Differential Diagnosis Of Common Disorders" Table. This Table Summarizes Significant Findings In The History And Physical Exam And Gives Pertinent Diagnostic Tests For Common Disorders. "Every Clinical Chapter Also Includes "Assessment Of Special Populations." This Section Highlights Important Information On Assessing Pregnant, Neonatal, Pediatric, And Geriatric Patients. "Case Studies Recount A Patient'S History And Provide Sample Documentation Of The History And Physical Examination. The Sample Documentation Familiarizes Students With Proper And Complete Documentation And Use Of Forms, And Is Complete With A Final Assessment Finding Or Diagnosis.

Dynamic, interactive videos depict the most commonly performed physical exam procedures for each body system. With these DVDs, you'll learn to apply concepts and develop critical thinking skills. 185 video clips with a running time of 2-4 minutes each. For each body system, videos include: Overview (rationale and purpose) Preparation (including equipment and patient teaching) Procedure (printable step-by-step procedure checklists) Follow-up care (including health promotion and patient teaching) Documentation (tips and techniques) 25 detailed 3-D animations depict what's happening inside the body. Critical thinking case studies let you apply your knowledge to simulated patients. A documentation form library allows you to practice recording history and physical information. 80 NCLEX® examination-style review questions let you reinforce your comprehension

Common Clinical Presentations in Dogs and Cats is a reliable resource and quick reference to essential information for diagnosing canine and feline patients, based on presenting complaints. The text takes a problem-oriented approach to recognizing common clinical conditions, and introduces diagnostic and treatment plans for companion animal practice. Equally useful for veterinary students and practicing clinicians, the book presents 78 chapters grouped by body system, for ease of access. Each chapter focuses on identifying the chief complaint, pinpointing possible diagnoses, and determining the clinical approach to patient care. The book is richly illustrated throughout with clinical photographs and line drawings that demonstrate the concepts presented. Common Clinical Presentations in Dogs and Cats is an essential reference that: • Gives clinicians fast access to essential details for approaching common case presentations in dogs and cats and forming a correct diagnosis • Presents information by clinical signs, organized by body system • Takes a standardized chapter format for ease of use • Includes color photographs and line drawings to illustrate the conditions discussed Written for small animal general practitioners and veterinary students, Common Clinical Presentations in Dogs and Cats is a patient-side reference that can help practitioners gain the knowledge and confidence to correctly diagnose a wide range of clinical presentations.

Clinical Care, Education, and Research

The Clinical Picture

The Rational Clinical Examination: Evidence-Based Clinical Diagnosis

Physical Therapy Documentation

Physical Examination and Health Assessment

In addition to reprinting the PDF of the CMS CoPs and Interpretive Guidelines, we include key Survey and Certification memos that CMS has issued to announced changes to the emergency preparedness final rule, fire and smoke door annual testing requirements, survey team composition and information of complaints, and legionella risk reduction. Fundamental Skills for Patient Care in Pharmacy Practice enables students and new pharmacists to master the skills associated with clinical care in either the inpatient or outpatient setting. In accessible steps, this valuable resource provides the tools for gaining medication histories from patients and counseling them on the most effective and safe manner to take medications. Each chapter explores the background and practice of a critical skill, tools that aid in its development and mastery, and tips for success. Students and pharmacists will come away with the knowledge to identify drug-related problems and formulate plans for solutions to these problems. Fundamental Skills for Patient Care in Pharmacy Practice prepares future pharmacists to communicate effectively in verbal and written formats with health professionals and special patient populations as they prepare and present SOAP notes, patient cases, and discharge counseling.

This guide to successful practices in observation medicine covers both clinical and administrative aspects for a multinational audience.

Complete & accurate documentation is one of the essential skills for a physical therapist. This book covers all the fundamentals & includes practice exercises & case studies throughout.

History and Physical Exam Documentation Manual: A Guide for Medical Students Entering Core Clinical Rotations

Macleod's Clinical Examination E-Book

History and Physical Patient Assessment Notebook

Common Clinical Presentations in Dogs and Cats

This notebook includes 40 templates to record a complete history and physical, assessment and plan. - Easily check boxes for review of systems and physical exam normals with room to write in additional findings. - Also includes sections for a differential diagnosis, assessment/plan, notes, and a checklist to record topics to look up later. - Great for medical students, PA students, and nursing students. - Your well organized notes will lead to perfect patient presentations. - Easily transfer your notes to the EMR after seeing the patient. Can also be used to record data for school patient logging. - The notebook is 5x8 inches and will fit in your white coat pocket.

A concise and highly visual guide to postgraduate physical examination for the MRCS exam, from an expert panel of surgeons.

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy![®] 5th Edition. Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read, bulleted format NEWdiscussion of the necessary documentation process outside of charting—Informed consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don'ts of charting – a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient's health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts – a quick summary of each chapter's content Advice from the experts – seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans "Nurse Joy" and "Jake" – expert insights on the nursing process and problem-solving That's a wrap! – a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Doshier Memorial Hospital in Southport, North Carolina.

Learn facility-based coding by actually working with codes. ICD-10-CM/PCS Coding: Theory and Practice provides an in-depth understanding of in-patient diagnosis and procedure coding to those who are just learning to code, as well as to experienced professionals who need to solidify and expand their knowledge. Featuring basic coding principles, clear examples, and challenging exercises, this text helps explain why coding is necessary for reimbursement, the basics of the health record, and rules, guidelines, and functions of ICD-10-CM/PCS coding. UPDATED ICD-10 codes and coding guidelines revisions ensure students have the most up-to-date information available.

30-day access to TruCode[®] encoder on the Evolve companion website provides students realistic practice with using an encoder. UPDATED codes for Pancreatitis, Diabetic Retinopathy, Fractures, GIST Tumors, Hypertension and Myocardial Infarctions. ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting provide fast, easy access instruction on proper application of codes. Coverage of both common and complex procedures prepares students for inpatient procedural coding using ICD-10-PCS. Numerous and varied examples and exercises within each chapter break chapters into manageable segments and help students gauge learning while reinforcing important concepts Illustrations and examples of key diseases help in understanding how commonly encountered conditions relate to ICD-10-CM coding. Strong coverage of medical records provides a context for coding and familiarizes students with documents they will encounter on the job. Illustrated, full-color design emphasizes important content such as anatomy and physiology and visually reinforces key concepts.

Advanced Health Assessment and Diagnostic Reasoning

Sapira's Art & Science of Bedside Diagnosis

Documentation of the History and Physical Evolution of Hermitage Farm, Centreville, Maryland

An Interprofessional Approach

H&P Medical Student Pocketbook; Patient Documentation Notebook for Clinical Rotations and Clerkships; Notebook for Medical Students, PA Students, Nursing Students; 40 Templates; 5 X 8 In

Understand the when, why, and how! Here's your guide to developing the skills you need to master the increasing complex challenges of documenting patient care. Step by step, a straightforward 'how-to' approach teaches you how to write SOAP notes, document patient care in office and hospital settings, and write prescriptions. You'll find a wealth of examples, exercises, and instructions that make every point clear and easy to understand.

Develop the skills you need to effectively and efficiently document patient care for children and adults in clinical and hospital settings. This handy guide uses sample notes, writing exercises, and EMR activities to make each concept crystal clear, including how to document history and physical exams and write SOAP notes and prescriptions. Primary care medicine is the new frontier in medicine. Every nation in the world has recognized the necessity to deliver personal and primary care to its people. This includes first-contact care, care based in a positive and caring personal relationship, care by a single healthcare pro vider for the majority of the patient's problems, coordination of all care by the patient's personal provider, advocacy for the patient by the provider, the provision of preventive care and psychosocial care, as well as care for episodes of acute and chronic illness. These facets of care work most effectively when they are embedded in a coherent integrated approach. The support for primary care derived from several significant trends. First, technologically based care costs have rocketed beyond reason or availability, occurring in the face of exploding populations and diminish ing real resources in many parts of the world, even in the wealthier nations. Simultaneously, the primary care disciplines-general internal medicine and pediatrics and family medicine-have matured significantly.

Mastering each aspect of the patient interview and physical exam is fundamental to medical education, resulting in more accurate diagnostic skills, more effective patient management, and better patient outcomes! Dr. Swartz's Textbook of Physical Diagnosis is a highly respected reference in this critical area, offering a compassionate, humanistic approach to the art and science of interviewing and physical examination. From cover to cover, you'll learn how your interpersonal awareness is just as important in physical diagnosis as your level of skill - and why clinical competence in this area is essential for physicians, nurse practitioners, physician assistants, and all members of the healthcare profession. Explores how cultural differences can influence communication, diet, family relationships, and health practices and beliefs - which may affect your approach to a patient's treatment. Features hundreds of high-quality color images, an easy-to-use design, and detailed descriptions of practical techniques throughout. Offers clear, easy-to-understand explanations of interviewing and examination techniques, clinical presentations, pathophysiology, complementary and alternative medicine, and physical diagnosis standards and tests. All chapters completely reviewed and revised. Features a new chapter on deconstructing racism and bias in clinical medicine. Provides expanded coverage of the musculoskeletal system with more specialty examinations of joints. Emphasizes precision, accuracy, and critical thinking in clinical assessment. Highlights clinical ethics and professionalism. Includes more than 6 hours of in-depth video, featuring step-by-step key aspects of the physical examination for adults, toddlers, and newborns, important interviewing scenarios, and audio of heart and lung sounds. Enhanced eBook version included with purchase. Your enhanced eBook allows you to access all of the text, figures, and references from the book on a variety of devices.

Fundamental Skills for Patient Care in Pharmacy Practice

Mosby's Nursing Video Skills: Physical Examination and Health Assessment

Handbook of Clinical Diagnostics

Nursing Documentation Made Incredibly Easy

Seidel's Guide to Physical Examination - E-Book

Pocket-sized text offers detailed guidance on developing and refining history and physical examination skills for 28 medical specialties. Provides in-depth, ready-to-use questions covering all key potential health issues. Sample write-ups after each chapter are also included.

Getting the right diagnosis is a key aspect of health care - it provides an explanation of a patient's health problem and informs subsequent health care decisions. The diagnostic process is a complex, collaborative activity that involves clinical reasoning and information gathering to determine a patient's health problem. According to Improving Diagnosis in Health Care, diagnostic errors-inaccurate or delayed diagnoses-persist throughout all settings of care and continue to harm an unacceptable number of patients. It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Diagnostic errors may cause harm to patients by preventing or delaying appropriate treatment, providing unnecessary or harmful treatment, or resulting in psychological or financial repercussions. The committee concluded that improving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative. Improving Diagnosis in Health Care, a continuation of the landmark Institute of Medicine reports To Err Is Human (2000) and Crossing the Quality Chasm (2001), finds that diagnosis-and, in particular, the occurrence of diagnostic errors-has been largely unappreciated in efforts to improve the quality and safety of health care. Without a dedicated focus on improving diagnosis, diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity. Just as the diagnostic process is a collaborative activity, improving diagnosis will require collaboration and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policy makers. The recommendations of Improving Diagnosis in Health Care contribute to the growing momentum for change in this crucial area of health care quality and safety.

Today, an increasing number of healthcare professionals (including nurses, midwives and members of many allied professions) have to conduct the vital first stage in a patient's journey - taking a clinical history and conducting an effective physical examination. This book offers clear, practical guidance on the fundamentals of clinical examination for any practitioner who wishes to understand their patient's specific needs and to plan appropriate care. Recognising that readers will come from a diverse range of clinical backgrounds and roles, the opening chapter (on consultation and the skills needed to take an accurate clinical history) underpins the systems-based approach. This, combined with the use of case study examples, allows healthcare professionals to focus on the principles of examining the system or systems that are most relevant to their specific area of practice. The book also includes a helpful glossary and list of abbreviations. The authors come from the same diverse range of professions for whom the book has been written, and their wealth of knowledge and experience enables them to understand the challenges facing today's healthcare professionals. Contents include: Consultation and clinical history-taking skills Respiratory assessment Cardiovascular assessment Gastrointestinal assessment Neurological assessment Genitourinary assessment Musculoskeletal assessment Obstetric assessment Mental health assessment Perioperative assessment

Dynamic, interactive videos depict the most commonly performed physical exam procedures for each body system. With these DVDs, you'll learn to apply concepts and develop critical thinking skills. 185 video clips with a running time of 2-4 minutes each. For each body system, videos include: Overview (rationale and purpose) Preparation (including equipment and patient teaching) Procedure (printable step-by-step procedure checklists) Follow-up care (including health promotion and patient teaching) Documentation (tips and techniques) 25 detailed 3-D animations depict what's happening inside the body. Critical thinking case studies let you apply your knowledge to simulated patients. A documentation form library allows you to practice recording history and physical information. 80

NCLEX examination-style review questions let you reinforce your comprehension

Admission Assessment Exam Review E-Book

The Medical Interview

Resolving Ethical Dilemmas

The CMS Hospital Conditions of Participation and Interpretive Guidelines

History and Examination

30-day access to TruCode[®] Encoder Essentials gives you experience with using an encoder, plus access to additional encoder practice exercises on the Evolve website. ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting provide fast, easy access to instructions on proper application of codes. Coverage of both common and complex procedures prepares you for inpatient procedural coding using ICD-10-PCS. Numerous and varied examples and exercises within each chapter break the material into manageable segments and help reinforce important concepts. Illustrations and examples of key diseases help in understanding how commonly encountered conditions relate to ICD-10-CM coding. Strong coverage of medical records provides a context for coding and familiarizes you with documents you will encounter on the job. Illustrated, full-color design emphasizes important content such as anatomy and physiology and visually reinforces key concepts. Evolve website offers online access to additional practice exercises, coding guidelines, answer keys, coding updates, and more.

Passing the HESI Admission Assessment Exam is the first step on the journey to becoming a successful healthcare professional. Be prepared to pass the exam with the most up-to-date HESI Admission Assessment Exam Review, 5th Edition! From the testing experts at HESI, this user-friendly guide walks you through the topics and question types found on admission exams, including: math, reading comprehension, vocabulary, grammar, biology, chemistry, anatomy and physiology, and physics. The guide includes hundreds of sample questions as well as step-by-step explanations, illustrations, and comprehensive practice exams to help you review various subject areas and improve test-taking skills. Plus, the pre-test and post-test help identify your specific weak areas so study time can be focused where it 's needed most. HESI Hints boxes offer valuable test-taking tips, as well as rationales, suggestions, examples, and reminders for specific topics. Step-by-step explanations and sample problems in the math section show you how to work through each and know how to answer. Sample questions in all sections prepare you for the questions you will find on the A2 Exam. A 25-question pre-test at the beginning of the text helps assess your areas of strength and weakness before using the text. A 50-question comprehensive post-test at the back of the text includes rationales for correct and incorrect answers. Easy-to-read format with consistent section features (introduction, key terms, chapter outline, and a bulleted summary) help you organize your review time and understand the information. NEW! Updated, thoroughly reviewed content helps you prepare to pass the HESI Admission Assessment Exam. NEW! Comprehensive practice exams with over 200 questions on the Evolve companion site help you become familiar with the types of test questions.

Now in its Fifth Edition, this respected reference helps readers tackle the common and often challenging ethical issues that affect patient care. The book begins with a concise discussion of clinical ethics that provides the background information essential to understanding key ethical issues. Readers then explore a wide range of real-world ethical dilemmas, each accompanied by expert guidance on salient issues and how to approach them. The book 's two-color design improves retention of material for visual learners. An accompanying website lets readers access the full text, along with features designed to reinforce understanding and test knowledge. New to the Fifth Edition: This edition includes new discussions of ethical issues as they relate to clinical practice guidelines and evidence-based medicine, electronic medical records, genetic testing, and opioid prescription. The book also includes an increased focus on ethical issues in advanced practice care. Real-world case studies, more highlight pages relating clinical ethics to emergency medicine, oncology, palliative care, and family medicine. Also new are discussions of quality improvement and use of advance care planning rather than advance directives.

Seidel's Guide to Physical Examination 9th Edition offers a uniquely interprofessional, patient-centered, lifespan approach to physical examination and health assessment. This new edition features an increased focus on patient safety, clinical reasoning, and evidence-based practice, along with an emphasis on the development of good communication skills and effective hands-on examination techniques. Each core chapter is organized into four sections – Anatomy and Physiology, Review of Related History, Examination and Findings, and Abnormalities – with lifespan content integrated into each area. Written by an author team comprised of advance practice nurses and physicians with specialties in the care of adults, older adults, and children, this one-of-a-kind textbook addresses health assessment and physical examination for a wide variety of disciplines. UNIQUE! Interprofessional, interdisciplinary approach, written by two advanced practice nurses and three physicians, with expertise in both pediatric and adult-geriatric health. UPDATED! Infectious outbreak content addresses the growing problem of global infectious disease outbreaks such as Zika and Ebola and the need for infection precautions. UNIQUE! Cross-references to Dains et al Advanced Health Assessment & Clinical Diagnosis in Primary Care help you take "the next step" in your clinical reasoning abilities and provides a more seamless user experience. UNIQUE! Compassionate, patient-centered approach emphasizes developing good communication skills, use of effective hands-on examination techniques, and reliance on clinical reasoning and clinical decision-making. Integrated lifespan content includes separate sections in each chapter on Infants and Children, Adolescents, Pregnant Women, and Older Adults. NEW! Emphasis on clinical reasoning provides insights and clinical expertise to help you develop clinical judgment skills. NEW! Enhanced emphasis on patient safety and healthcare quality, particularly as it relates to sports participation. NEW! Content on documentation has been updated with a stronger focus on electronic charting (EHR/EMR). NEW! Enhanced social inclusiveness and patient-centeredness incorporates LGBTQ+ patients and providers, with special a emphasis on cultural competency, history-taking, and special considerations for examination of the breasts, female and male genitalia, reproductive health, thyroid, and anus/rectum/prostate. NEW! Telemedicine, virtual consults, and video interpreters content added to the Growth, Measurement, and Nutrition chapter. NEW! Improved readability with a clear, straightforward, and easy-to-understand writing style. NEW! Updated drawing, and photographs enhance visual appeal and clarify anatomical content and exam techniques.

H&P Pocketcard Set

Textbook of Respiratory Medicine

26 Clinical Cases Reviewed for Internal Medicine, Surgery, Pediatrics, Psychiatry, and Obstetrics & Gynecology.

Textbook of Physical Diagnosis

Bates' Nursing Guide to Physical Examination and History Taking

The book covers basic theories, basic knowledge and basic skills on clinical diagnosis, basic requirements for doctors' ethical conduct, clinical reasoning and documentation of medical records during the process of making a diagnosis. It consists of six parts, including 'Symptoms', 'History Taking', 'Physical Examination', 'Supplementary Examination', 'Common Clinical Diagnosis Techniques', and 'Diagnostic Process and Clinical Reasoning'. A vocabulary index is included for easy reference at the end of the book. This book is compiled by authors of 14 Chinese medical schools and universities, whose years of experience in clinical diagnostics, rich overseas learning and working experiences. This book is included in the first round of English textbooks series for clinical medicine major of China's higher medical colleges; and is among "13th Five-Year" planning textbooks of National Health Commission of the People's Republic of China. It is also an ideal textbook for MBBS (Bachelor of Medicine and Bachelor of Surgery) student It is a co-publication book with People's Medical Publishing House (PMPH). The ISBN of PMPH version in China is 978-7-117-23852-6.

This handbook describes the diagnostic process clearly and logically, aiding medical students and others who wish to improve their diagnostic performance and to learn more about the diagnostic process. History and Physical Examination: A Common Sense Approach provides a comprehensive, accessible foundation to the crucial patient care skill of clinical history taking and 'head-to-toe' clinical examination. Through full color illustrations, patient photographs, and video examples, this valuable resource highlights a logical, step-by-step approach to gain clinical competency. The authoritative content is divided into three sections to build and develop students' practical skills: History Flows, which provide context and practice through clinical scenario work, to logically develop differential diagnoses; Physical Examination Flows, which focus on comprehensive and consistent exams by using the human body as a map; and finally, Comprehensive Flows, which enable the student to apply their history taking and examination tools together to develop a differential diagnosis and a treatment plan—all under the real-world pressure of a time-sensitive office visit. Each section features "Clinical Case Practice" for students to interact and apply the clinical concepts and to prepare for actual practice. By moving beyond discrete symptoms, History and Physical Examination: A Common Sense Approach prepares students not only for practical boards, but for delivering humanistic care in real-world patient encounters.

Essential reading for beginning and experienced clinicians alike, Sapira's Art & Science of Bedside Diagnosis, Fifth Edition, discusses the patient interview and the physical examination in an engaging, storytelling style. Tried and true methods are described in step-by-step detail, and include clinical pearls, vignettes, practical clinical experiences, personal history, explanations of the physiologic significance of findings, and extensive discussions of evidence-based medicine. It's a useful guide for learning and reinforcing effective bedside diagnosis techniques at all levels and stages of clinical practice.

ICD-10-CM/PCS Coding: Theory and Practice, 2023/2024 Edition - E-Book

Improving Diagnosis in Health Care

Clinical Examination Skills for Healthcare Professionals

Observation Medicine

From Examination to Outcome

Clinical Practice Guidelines for Midwifery & Women's Health, Fifth Edition is an accessible and easy-to-use quick reference guide for midwives and women's healthcare providers. Completely updated and revised to reflect the changing clinical environment, it offers current evidence-based practice, updated approaches, and opportunities for midwifery leadership in every practice setting. Also included are integrative, alternative, and complementary therapies. The Fifth Edition examines the transition to the use of ICD-10 codes, women's health policy and advocacy, risk assessment and decision-making in practice, and inspiring truth in midwifery care. New clinical practice guidelines include health promotion and primary care practice, such as promoting restorative sleep, optimizing oral health, promoting a healthy weight, and caring for the woman with a substance abuse disorder.

In this text "structure and function information is streamlined, health history is symptom and interview-focused, nursing documentation examples are included, data analysis is covered in end-of-chapter summary sections, health promotion is streamlined with a focus on follow-up and teaching at the end of the chapters. "--Publisher.

A guide to the techniques and analysis of clinical data. Each of the seventeen sections begins with a drawing and biographical sketch of a seminal contributor to the discipline. After an introduction and historical survey of clinical methods, the next fifteen sections are organized by body system. Each contains clinical data items from the history, physical examination, and laboratory investigations that are generally included in a comprehensive patient evaluation. Annotation copyrighted by Book News, Inc., Portland, OR

This classic textbook sets out clearly and concisely how to evaluate symptoms and elicit relevant physical signs. It describes the practical skills which every clinician must acquire and develop in order to evolve diagnostic procedures and management strategies and plans. 'Highly Commended' in the 2006 and 2010 BMA Medical Book Competitions, this Thirteenth Edition contains over 500 clinical photographs and diagrams to illustrate the text, with new topics added to make the book even more comprehensive. This Thirteenth Edition has four sections: History taking and general examination. System examination covering symptoms and signs. Examination in special situations including babies & children and the critically ill. How to pass an OSCE. Included on the Student Consult site are the specially-recorded videos demonstrating many of the clinical examination routines described in the main text. The book starts with a general overview section on history taking and the general examination that provide the framework on which to hang the detail. The systematic examination section documents clearly the relevant history, examination and special investigations as well as giving advice on their significance. The third section covers examination in specific situations and emphasises an integrated and structured approach to these patients. A final section spells out how to demonstrate the techniques learned in the book in an OSCE. Macleod's is closely linked to its sister publication, Davidson's Principles & Practice of Medicine, which complements the information in this text. Available with full online access on Student Consult and ancillary videos demonstrating key clinical examination routines following the format laid out in the book. There are two new chapters on examination in specific situations: The frail elderly and the adult with fever A new section explicitly spells out how to demonstrate the techniques learned in the book in an OSCE and other formative and summative examinations. Over 50 new text boxes highlight the evidence-base for the examination techniques discussed. An Advisory Board of students, junior doctors, and representatives from the nursing, ambulance, Primary Care and academic communities from six countries has made detailed comments and critically appraised the entire book. The text has been substantially rewritten with more on medically unexplained symptoms in the History Taking chapter and extended coverage of diabetes mellitus in the Endocrine System chapter. Integrated with the online text are clinical examination videos of trained professionals performing many of the examination routines described in the book with an accompanying commentary by the Editor, Professor Colin Robertson Two new videos show how the Glasgow Coma Scale should be performed in clinical situations, demonstrating the correct techniques and also common pitfalls in using the GCS.

History and Physical Examination: A Common Sense Approach

ICD-10-CM/PCS Coding: Theory and Practice, 2019/2020 Edition E-Book

The Clinician's Complete Guide To: Neuromusculoskeletal Evaluation, Initial Consultation and Narrative Report, S. O. A. P. Charting and Documentation

Clinical Dermatology