VERBAL PATIENT PRESENTATIONS:
A PRACTICAL GUIDE FOR MEDICAL STUDENTS

Lia Pierson Bruner, MD
Assistant Professor, Department of Family Medicine
Augusta University/University of Georgia Medical Partnership

In the hospital and clinic, medical student verbal patient presentations convey important information to the team. Time is of the essence, so concise and logical presentations of the relevant information will set you apart. The overall format for the verbal presentation is similar to the written note, but is usually more concise—aim for 3-5 minutes for a full initial presentation. Without written headings, you will need to provide oral signposts to orient your listeners to the parts of your presentation. I have included some suggestions for sign-posting and phrasing below in italics. Being able to select the pertinent information and present it in an efficient manner takes organization and practice, but it is a skill that can be learned. What follows is a practical guide for verbal presentations to the healthcare team. Presenting to your team in front of your patient has some extra nuances that will not be addressed here in detail. This guide reflects my preferences as a family medicine physician. There are many ways to present, so you will need to be ready to adjust to the preferences of your attending physicians throughout medical school.

VERBAL PRESENTATION GUIDE

CHIEF CONCERN

Start with a sentence that includes the patient's name or initial(s), age, and any critical pieces of information from the past medical, family, or social histories and the chief concern in the patient's own words.

"*Mr. M. is a 55-year-old construction worker with a history of gout who presents with a chief concern of 'my foot is killing me.'"*

HISTORY OF PRESENT ILLNESS

After the chief concern sentence, go right into the history of present illness (HPI), without a signpost for this section.

"Mr. M. was in his usual state of health until 5 days prior to this visit when he noticed___" Then go on to describe the concern using as many of the typical components of the HPI as apply in telling the patient's story (location, quality, timing, severity, setting, aggravating/alleviating factors, associated symptoms, etc.).

For the associated symptoms, don't forget to include the pertinent negatives from the review of systems that will help with differential diagnosis, such as no fevers, etc.

Try to combine the components to make it complete, but concise. *"He describes the pain as a constant, 8/10, stabbing pain in his great toe that radiates to his forefoot. It is aggravated by movement and walking and improved with rest and 600 mg ibuprofen. He does report dropping a heavy object on his foot at work yesterday."*

Finish the HPI out with any other highly relevant parts from the past medical (risk factors for the relevant problem), family history (history of similar issues), and social history.

"His last gout flare was 8 months ago, and he reports eating fried shrimp and drinking 6 beers the night before the pain started."

PAST MEDICAL HISTORY

You can be selective with the past medical history. Only give the chronic medical conditions, hospitalizations, and surgeries that may relate directly to the current issue or are major medical problems or procedures that may inform your differential diagnosis (e.g. medical problems: diabetes, chronic renal disease, HIV, etc.; surgeries: coronary artery bypass graft, splenectomy, etc.). If you aren't sure about the relevance of a condition, it is better to list it than leave it out. If there are none, you can say past medical history is *"non-contributory."*

*"**Past medical history** is significant for___"*

*"Relevant **hospitalizations** include ___"*

*"**Surgical procedures** include ___"*

*"**Medications** include ___"* Give the full list of prescription medications with doses as well as over-the-counter drugs, supplements/herbs, and home remedies.

*"**Allergies** include___"* List allergies to drugs and foods along with the type of reaction. If there are no allergies, you can simply say *"Mr. M. has no known drug or food allergies."*

FAMILY HISTORY

Similar to the past medical history, the family history should contain primarily the things that may shed light on the active problem.

*"**Family history** is significant for____"*

SOCIAL HISTORY

The social history should concentrate on stressors and supports that may be contributing to or alleviating the current problem (occupation, living situation, social support or lack thereof, etc.), lifestyle factors that also may contribute (tobacco, alcohol, drugs, exercise level, diet, sleep, sexual history), and any beliefs that may impact care. The social history may also contain self-identified race/ethnicity/heritage if relevant.

*"**Social history** is remarkable for___"*

REVIEW OF SYSTEMS

The pertinent positives and negatives from the review of systems that relate to the chief concern should already be in the HPI. Only add extra issues here if they are active problems for the patient. That said, you need to have your full review of systems ready in case there are questions about systems you do not list in your presentation.

*"**Review of systems** reveals ___"*

If there are no other symptoms, you can say *"**Review of systems** did not reveal other pertinent positives or negatives besides those presented in the HPI."*

PHYSICAL EXAMINATION

For verbal presentations, you will give the general appearance and vitals, but then typically only the positive findings and the pertinent negatives in detail. You should mention each category, but if normal and not obviously related to the problem, you can say those systems are *"unremarkable"* or *"within normal limits."* This is only for verbal, not written presentations (where you need to document all of your findings in detail). It can be helpful to highlight abnormalities as you go (e.g. "*heart rate elevated at 112")*. Below, I have adapted a normal complete physical exam to show what the detailed parts of your normal physical exam presentation might sound like.

*"On **physical exam**, Mr. M. is a slim man who is alert, healthy-appearing, and well-groomed.*

***Vitals signs** include T 98.6, RR 16, HR 80, BP 130/80, BMI 23.*

Skin color good without jaundice. No atypical nevi, rashes, petechiae, or ecchymoses.

Scalp without lesions. Head normocephalic and atraumatic.

Conjunctivae pink without erythema or discharge. No scleral icterus. Extraocular movements intact. Pupils equal, round, and reactive to light and accommodation. Visual acuity by near card 20/20 OD and OS. Visual fields full to confrontation. Fundi with sharp disc margins and no AV nicking, hemorrhages, or exudates.

Hearing intact to finger rub bilaterally. Pinnae symmetric without lesions or deformities. Canals clear. Tympanic membranes pearly grey with good light reflexes bilaterally.

Nasal mucosa pink without lesions or polyps. Septum midline. No sinus tenderness.

Oral mucosa pink and moist without lesions. Good dentition. Tonsils not enlarged. Pharynx without exudates or lesions.

Trachea midline. Neck supple. No thyroid enlargement, tenderness, or nodules.

No cervical, supraclavicular, axillary, or inguinal lymphadenopathy (specify more or less sites as applicable).

Breathing non-labored. Thorax symmetric with good expansion. Lungs clear to auscultation and resonant to percussion. No wheezes, crackles, or rhonchi.

JVP 6 cm. Carotids brisk bilaterally without bruits. Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. Apical impulse non-displaced. Brachial, radial, femoral, dorsalis pedis, and posterior tibial pulses 2+ and symmetric.

Breasts symmetric. No skin lesions, masses, or nipple discharge.

Abdomen flat without scars or hernias. Bowel sounds present. No abdominal or femoral bruits. Soft, non-distended, and non-tender. No masses or hepatosplenomegaly. No costovertebral angle tenderness.

(Female) External genitalia without erythema or swelling. No vulvar, vaginal, or cervical lesions. No vaginal or cervical discharge. Cervix pink without erythema. Uterus not enlarged. No cervical motion tenderness. No adnexal masses or tenderness.

(Male) Circumcised (or uncircumcised) male. No genital skin lesions or penile discharge. No scrotal swelling, testicular masses, or inguinal hernias.

Normal rectal sphincter tone. No rectal masses. Brown stool tests negative for occult blood. (Prostate not enlarged and without nodules.)

No cyanosis, clubbing, or edema. No varicosities or stasis changes.

Good range of motion in joints (specify which ones) *without evidence of swelling or deformity.*

He/She is relaxed and cooperative with "good" mood (insert what patient reports for mood) *and full affect. Oriented to person, place, and time. Speech with normal rate and content. Thought process coherent.*

Cranial nerves II-XII intact.

Good muscle bulk and tone. Strength 5/5 bilaterally for grip, biceps/triceps, quads/hamstrings, and ankle flexion/extension (specify which muscles/joints checked if more or less are applicable).

Sensation intact to light touch, pain, position, and vibration (specify modalities and locations).

Rapid alternating movements, finger-to-nose, and heel-to-shin intact.

Reflexes 2+ and symmetric with plantar reflexes downgoing.

Gait intact. Romberg negative."

TESTING

Testing includes any lab results, imaging studies, etc. that are available and relevant. It is helpful to highlight abnormal tests as well as give the absolute values. You can often group normal tests together unless there has been a change within the normal range that is clinically significant (e.g. creatinine increased from 0.7 to 1.2 in a short period of time).

*"Relevant **testing** shows the WBC is elevated at 14, but the rest of the CBC and CMP are within reference ranges."*

ASSESSMENT (SUMMARY AND DIFFERENTIAL)

The assessment is the main place where you show your understanding of what is going on with your patient. Start with one line summing up why the patient presented for care. This time use the medical term rather than the patient's words (e.g. right MTP joint pain rather than "my food is killing me"). If there is any doubt about the diagnosis, please list a differential and a brief discussion of which diagnosis is the most likely. If there are any relevant clinical decision rules, diagnostic criteria, or prognostic scales or stages, apply them to your patient here.

*"**In summary**, this is a 55-year-old man with a history of gout who presents with right MTP joint pain after significant alcohol use and possible trauma at work. The differential diagnosis includes gout, arthritis, and contusion/fracture. Gout is most likely given the location, past history of gout, and the alcohol precipitant. However, given his occupation and possible trauma, we need to rule-out fracture."*

PLAN

Describe your daily plan for the patient in the hospital or your overall plan for a patient in the outpatient setting. If there are multiple problems, it is usually easier to do the assessment and plan for a given problem before moving on to the next problem. You can present these by problem (foot pain, diabetes) or by system (musculoskeletal, endocrine). Start with active problems and note if they are stable, improving, or worsening before stating your plan. The plan should include:

- Tests or additional history needed for diagnosis or prognosis—labs, imaging, PHQ-9, etc.
- Referrals/consults—medical specialists, physical/occupational/speech therapy, social work, etc.
- Treatment and prevention
    - Lifestyle recommendations—cut down on alcohol, increase exercise, etc.
    - Medications—prescriptions, over-the-counter medications, and immunizations
- Patient education
    - Disease process and risks of untreated disease
    - How medications work, dose and instructions, and potential side effects
    - Importance of following the treatment regimen including lifestyle changes
    - Emergency room precautions or reasons to call or return sooner than planned (clinic)
- Disposition plan (hospital) or follow-up plan (clinic)

"The plan for Mr. M's right MTP pain is to:

- *Obtain an x-ray to rule out fracture.*
- *Check renal function and start an appropriate empiric acute gout treatment based on his estimated GFR.*
- *Counsel on gout and lifestyle changes to prevent gout flares.*
- *Consider starting a prophylactic medication for gout once the acute flare has resolved.*
- *Gather more history on Mr. M.'s alcohol use to calculate an AUDIT score. Discuss the importance of weaning off alcohol (but not stopping abruptly) and offer a referral depending on his AUDIT score and preferences.*
- *He is to return for follow up in 1 week or sooner if his condition worsens.*

Always ask what questions your listeners have when you finish.

HELPFUL TIPS FOR A GREAT VERBAL PATIENT PRESENTATION

1. **Know the expectations.** The best way to exceed expectations is to know what the expectations are before you present. Other students or residents may be able to tell you what the attending likes in terms of length, level of detail, etc. If there are no residents or students, you should ask your attending for their preferences, because these can vary dramatically between specialties and attendings.

2. **Engage your audience.** Speak clearly, crisply, and loud enough to be heard without straining. Use notes, if needed, but be sure to keep good eye contact.

3. **Remember the listener.** Unlike the written record, your listeners only have one chance to grasp the important facts. Organize with signposts to orient the listener. Be brief. Don't repeat things in multiple places and be selective about what you present.

4. **Craft the history of present illness.** This is one of the most important parts of any presentation. Tell the story logically, and remember to include pertinent facts from the past medical, family, and social histories and the review of systems.

5. **Separate multiple problems.** If the patient has several active problems, try to complete all of the history about one problem before moving to the next problem rather than skipping back and forth. This also applies to the assessment and plan.

6. **Synthesize your information.** Don't just recite the facts. By highlighting the points you view as relevant, try to make an argument in favor of a diagnosis. A strong summary statement at the end of the objective data with a brief discussion of the differential is a good way to show your team that you are thinking.

7. **Keep it patient-centered.** The point of verbal presentations is to quickly convey the information the team needs to take good care of the patient, so make sure that your patient is at the heart of everything you do. Use language that is empathetic, kind, and non-judgmental. Know your biases and work to counteract them. Also be sure that your patient's preferences and constraints are incorporated into the plan.

8. **Advocate for your patient.** Be sure to include at least a few sentences about who this patient is as a person in the introduction, social history, or both. Your enthusiasm and energy can make the patient come alive in the listener's mind and may lead to better care.

9. **Change the format for bedside presentations.** Refer to the patient as "Mr./Ms. last name or however they prefer rather than "he/she" or "the patient." Include them in the presentation and make sure you ask them to speak up if they hear anything that isn't correct. Before you present in front of visitors, be sure you know their relationship to the patient and whether the patient wants them present. You can also leave out information that can be gathered from looking at the patient (general appearance, sex, body habitus, etc.).

10. **Practice!!** Presentations go much more smoothly if you have run through them at least once out loud. Ask your fellow students to listen and give you feedback before you present to the team. You know this patient well, so relax and tell their story!