Appendix

Completeness criteria for history-taking and physical-examination notes

History

History item	Criteria for completeness (all of the following must be mentioned in the notes to mark the item 'complete')
Asking about chief complaint and duration	1. Chief complaint 2. Duration
Asking about associated symptoms	1. Positive symptoms 2. Important negatives (e.g. 'no associated shortness of breath' in case of chest pain without shortness of breath)
Asking about aggravating and relieving factors	1. Aggravating factors 2. Relieving factors
Previous episodes	- Yes or no? If yes: 1. How many? 2. When?
Asking about systemic review	1. Cardiovascular 2. Respiratory 3. CNS 4. Gastrointestinal 5. Genitourinary 6. Endocrine 7. Rheumatological 8. Haematological 9. Dermatological
Asking about allergies	1. Drug allergy 2. Food allergy
Asking about past medical history	- Does patient have established chronic diagnosis? If yes: 3. What is the disease? 4. Duration?
Asking about past surgical history	- Yes or no? If yes: 5. What type of surgery? 6. When?
Asking about social history	1. Smoking 2. Alcohol 3. Drug abuse 4. Occupation
Asking about family history	1. Similar disease in the family 2. Other chronic diseases in the family 3. Financial status In case of paediatrics patient only: 4. Who lives with the child and takes care of them?
Asking about medications	- Is the patient taking medications chronically? If yes: 1. What are the medications? 2. How long has the patient been taking them?

Asking about transfusion	- Yes or no? If yes: 1. How many times? 2. When? 3. Any complications?
Asking about perinatal history (antenatal, intranatal, and postnatal) (applies to paediatrics patients only)	Prenatal history: Is the baby premature? 1. Any prenatal baby complications? (e.g. bleeding, diseases, radiation) Intranatal history: 1. Apgar score 2. Spontaneous vaginal delivery or delivered by caesarean section? If delivered by caesarean section, what was the reason? Postnatal history: 1. Birth weight? 2. ICU admission/needed ventilation? Conditions, e.g. jaundice, cyanosis, disease?
Asking about nutritional history (applies to paediatrics patients only)	1. Formula fed, breastfed, or both? - If breastfed: a. Frequency? b. Duration? - If formula fed: c. Type of formula? d. Total daily intake? e. Frequency? f. Duration? 2. Age of introduction of solid food, and what kind of food was introduced? 3. Age of weaning 4. Type of diet: normal family diet or special diet?
Asking about immunisation (applies to paediatrics patients only)	- Has the child taken all vaccines for his or her age? If not, what is the reason?
Asking about developmental history (applies to paediatrics patients only)	1. Fine motor skills according to age 2. Gross motor skills according to age 3. Social according to age 4. Language and hearing according to age
Asking about menstrual history	1. Age of menarche 2. Last menstrual period 3. Regularity 4. Length 5. Quantity of discharge 6. Associated symptoms
Asking about sexual history	1. Dyspareunia 2. Post-coital bleeding 3. Sexually transmitted diseases
Asking about contraception history	1. Type 2. Duration 3. Any complications?
Asking about past gynaecological procedures history (applies to gynaecology patients only)	- Yes or no? If yes: 1. What type of procedure? (e.g. D&C, pap smear, pelvic ultrasound, colposcopy) 2. When?

Physical examination

Physical examination item	Criteria for completeness (all of the following must be mentioned in the notes to mark the item 'complete')
General examination	1. Appearance (well or ill) 2. Body built (cachectic or overweight?) 3. Abnormal discoloration (jaundice, pallor, or cyanosis) 4. Distress 5. Deformities 6. Vital signs
Heart examination	1. Inspection 2. Palpation 3. Auscultation
Nervous system examination	1. Mental status examination 2. Motor examination: a. Inspection b. Palpation c. Tone d. Power e. Reflexes Sensory, cerebellum, and cranial nerves examination are performed only in neurological cases
Respiratory examination	1. Inspection 2. Palpation 3. Percussion 4. Auscultation
Abdominal examination.	1. Inspection 2. Palpation 3. Percussion 4. Auscultation
Head and neck examination	1. Thyroid a. Inspection b. Palpation c. Auscultation 2. Lymph nodes in the head and neck a. Palpation
Musculoskeletal examination	1. Inspection 2. Palpation 3. Power 4. Special test depending on the joint
Lower limb examination (peripheral vascular examination)	1. Inspection 2. Palpation 3. Auscultation
Vaginal and pelvic examination	1. Inspection 2. Palpation and/or speculum exam
Breast examination	1. Inspection 2. Palpation

ENT examination	1. Ear a. Tympanic membrane b. External auditory canal 2. Nose a. Mucosa b. Turbinate c. Septum d. Secretions 3. Mouth a. Mucosa b. Teeth c. Hard and soft palate d. Tonsils e. Oropharynx
Ophthalmic examination	1. Pupil examination 2. Extraocular muscles movements 3. Anterior segment (anterior chamber, iris, and lens) 4. Fundal examination.

ICU: intensive care unit; D&C: dilation and curettage; ENT: ear, nose, and throat; CNS: central nervous system