

HPI template + quality checklist

A one-page drafting and pre-sign review aid for the history of present illness.

01

Source

02

Chronology

03

Modifiers

04

Function

05

Revised narrative

DRAFTING TEMPLATE

[Source] reports [current concern] beginning [onset or interval anchor]. Since then, [chronology and current course]. The problem is characterized by [relevant attributes] and is associated with [important positives and negatives]. [Measures tried] produced [reported response]. The current effect is [function or patient goal]. [Uncertainty or source limitation, if relevant].

12-point pre-sign review

Check against the encounter and authorized source.

- ☐ The reason for this encounter is identifiable in the first sentence.
- ☐ The information source is clear when someone other than the patient supplies material history.
- ☐ The chronology runs from onset or the prior encounter to the present.
- ☐ Relevant characteristics, context, modifiers, and associated symptoms appear only where useful.
- ☐ Important positives and negatives are attributed to the patient, caregiver, record, or observation.
- ☐ Change from baseline and response to prior treatment are described for follow-up.
- ☐ Functional effect and the patient goal are included when they affect the encounter.
- ☐ Uncertainty, conflicting accounts, and unmeasured information remain visible.
- ☐ The HPI excludes invented findings, premature diagnoses, and plan details presented as history.
- ☐ Copied or templated text was verified for this encounter and stale material was removed.
- ☐ Language is factual, professional, specific, and free of unnecessary judgment or stigma.
- ☐ The HPI agrees with the assessment, orders, medication changes, instructions, and follow-up.

Clinic configuration notes

Keep this section workflow-level and free of patient information.

Required source-attribution wording

Local HPI section conventions

Specialty-specific prompts

Verification owner and workflow