ST. LUKE'S COLLEGE OF MEDICINE
William H. Quasha Memorial

COMPREHENSIVE CLINICAL EVALUATION

This guide will be useful for teaching and evaluating our students during patient encounters. Please take note that the standard techniques/procedures covered here are described in our main textbook Bates. Other techniques may be taught as additional skills as the students progress through time and experience.

This guide generally applies to all patient encounters. Other features of history taking and physical examination that are specifically applicable to certain groups of patients (e.g., pediatric, obstetric) may be included by the designated clinical department.

I. HISTORY

Initial Information

Date and Time of History

Identifying Data

- Should include the source of history or referral such as an accompanying relative or a medical record

Reliability

- this judgment reflects the quality of the information provided by the patient (usually made at the end of the interview)

Chief Complaint(s)

- stated as close as possible to the patient's (or informant's) own words

Present Illness

- complete, clear, and chronologic account of the problems that prompted the patient to seek care
- should include the onset of the problem, the setting in which it developed, its manifestation, and any treatment
- each principal symptom should be well-characterized, with the following attributes to describe it, namely (1) location; (2) quality; (3) quantity or severity; (4) timing, including onset, duration, and frequency; (5) the setting in which it occurs; (6) factors that have aggravated or relieved the symptom; and (7) associated manifestations
- must include "pertinent positives" and "pertinent negatives"
- should reveal the patient's response to his or her symptoms and what effect the illness has had on the patient's life
- if there is more than one problem or concern, these should also be narrated in the HPI meriting a full description
- others such as allergies, medications, as applicable

Past History

- any significant childhood illnesses
- should cover information relative to adult illnesses in each of four areas:
    - Medical: including significant childhood illnesses

    - Surgical: Dates, Indications and types of operations.
    - Obstetric/Gynecologic
    - Psychiatric
- other aspects of health maintenance, especially past immunizations and screening tests

Family History

- should include a review of conditions with familial tendencies and illnesses that are genetically transmitted

Personal and Social History

- should include concerns that are applicable to the patient and his condition (e.g. lifestyle habits and alternative health care practices)

Review of Systems

- with the aim to possibly uncover problems that the patient has overlooked, particularly in areas unrelated to the present illness
- The use of "See HPI" or non-contributory is discouraged

General
Skin
Head, Eyes, Ears, Nose, Throat
Neck
Breasts
Respiratory
Cardiovascular
Gastrointestinal
Peripheral Vascular
Urinary
Genital
Musculoskeletal
Psychiatric
Neurologic
Hematologic
Endocrine

II. THE PHYSICAL EXAMINATION

Preparing the patient

- measures that promote the patient's physical comfort and any adjustments needed in the environment of the interview
- selection of the appropriate sequence of examination.
- observation of standard and universal precautions, as applicable

General Survey

- includes the patient's general state of health and other observations such as posture, gait, affect and state of awareness, as applicable

Vital Signs

- application of proper techniques on obtaining vital signs, e.g., BP cuff placement, proper pulse determination
- including pain scale if necessary

Skin
Head, Eyes, Ears, Nose, Throat (HEENT)
Neck
Back

Thorax and Lungs

- application of proper technique of inspection, palpation, percussion and auscultation

Breast and Axillae

Cardiovascular System

- use of proper techniques of inspection, palpation and auscultation

Abdomen

- use of proper techniques of inspection, auscultation, percussion and palpation

Extremities

Nervous System

- Mental Status
- Cranial Nerves
- Motor System
- Sensory System
- Reflexes

Additional Examinations

- Application of additional examinations or measures as necessary e.g. fundoscopy, assessment of jugular venous pressure, genitourinary and rectal examination.

III. THE CASE WRITE-UP

The skill in making a case write-up develops through time and experience with patient encounters. This skill is valuable in helping the student organize his thoughts towards clinical reasoning and assessment. The following are parameters that may be used in evaluating the case write-up.

1. **Is the order clear?**
    - Presentation of the Present Illness should be in chronological order, starting with the current episode then filling in relevant background information.

2. **Do the data included contribute directly to the Assessment?**
    - All supporting evidence – both positive and negative – for every problem or diagnoses should be identified.
    - There should be sufficient detail to support the Assessment and Plan.

3. **Are pertinent negatives specifically described?**

4. **Is there too much detail?**
    - Excess repetition of information or redundancy should be avoided.
    - The report should not be a mere tabulation of the entire history and PE but a summary of the pertinent subjective and objective data. Picking out what is salient is according to the patient's case.

5. **Is the written style succinct? Are there excessive abbreviations?**
    - Records should be clear, legible and understandable.
    - Abbreviations and symbols should be used only if they are readily understood.
    - Narrative form of reporting in the case write-up is encouraged. However, students may do the tabulation as a guide for themselves.
    - The use of (+) "positive" or (-) "negative" when reporting is avoided. Instead, the use of present or absent (or no) is encouraged to avoid confusion.
    - Diagrams of abnormal findings may be included.

6. **Is the tone of the write-up neutral and professional?**
    - The report should be written in an objective manner avoiding hostile, moralizing, or disapproving comments.

IV. THE CASE DISCUSSION

The following is a series of steps that we may expect the student to develop in the case discussion of the patient encounter.

1. **Identification of abnormal findings.**
    - a summary of the patient's symptoms, signs observed during the physical examination and any laboratory reports available

2. **Approach to diagnosis may be done in one of 2 ways:**

    A. Localization of findings anatomically.
        - May localize signs and symptoms to a specific body region (e.g. throat) or organ system (e.g. musculoskeletal system)

    B. Interpretation of findings in terms of the probable process.
        a. may be a pathologic process involving diseases of a body structure (e.g.. inflammatory, infectious or neoplastic)
        b. Or derangements of biologic/physiologic functions (e.g. congestive heart failure)

    Note: Case discussions at the Second Year Level must revolve around the approach to diagnosis and the pathophysiologic processes behind it. This is the terminal competency that we expect from a Second Year student.

3. **Development of hypotheses about the nature of the patient's problem.**
    a. Selection of the most specific and critical findings to support the hypothesis.
    b. Matching of findings against all the conditions that can produce them.
    c. Elimination of the differential diagnosis that fail to explain the findings.

    Note: special attention should be placed to potentially life-threatening conditions to minimize the risk for missing conditions that may occur less frequently or are less probable but that, if present, would be particularly ominous ("the worst case scenario")

4. **Selection of the most likely diagnosis from among the conditions that might be responsible for the patient's clinical presentation.**

5. **Development of a plan.**
    - flows logically from the problems or diagnoses identified
    - range from tests to confirm or further evaluate a diagnosis to general plan of medical management and/or the need for surgical intervention