This document combines 3 documents for NUSC 532 Comprehensive Health Assessment for Advanced Practice Nursing

UNIVERSITY OF ILLINOIS AT CHICAGO
COLLEGE OF NURSING

Comprehensive Health Assessment Scoring Manual for the PHYSICAL EXAMINATION

Directions:

1. Each item is to be assessed and recorded on all patients unless exceptions are indicated. A patient's inability to cooperate or provide the necessary information should be reflected in the recording.
2. Any criteria delineated for an "adult" should be assessed and recorded in every patient who is 10 years of age or older.
3. Each element is graded as follows: 2 = completely and accurately assessed
   1 = partially and accurately assessed
   0 = assessment inadequate or inaccurate.
   Full credit will be given only if all of the assessment techniques of each item are performed accurately and completely.
4. Any items not observed by the evaluator will result in losing points in the "Performance" column. To avoid losing the same points in the "Recording" column, the student should indicate that the information was "not assessed," as would be appropriate in a clinical setting. Then, (although you would not do this in a clinical setting), follow the "not assessed" statement with a description [*in brackets*] of the information as if it had been obtained and were normal.

	Criteria	Performance	Recording
1.	Hands are washed before beginning the examination.	2 1 0	N/A
2.	Three (3) **blood pressure** measurements are taken in the standing and supine or seated positions. The third blood pressure is taken in one of these two positions in the opposite extremity. A cuff size appropriate for the patient's arm size should be used.	2 1 0	2 1 0
3.	The **pulse** is *timed* for at least 30 seconds.	2 1 0	2 1 0
4.	**Respirations** are *observed* for at least 30 seconds while looking at a watch.	2 1 0	2 1 0
5.	**Height, weight, and BMI** are recorded. (NOTE: For the graded evaluation of an adult patient this does not have to be demonstrated, but the information must be recorded.) **Child:** Head circumference is measured in any child two years of age or younger.	N/A	2 1 0
6.	**General** Survey: The patient record should contain a statement regarding the patient's age, race, sex; orientation to time, place, person; overall appearance, whether or not s/he is in distress; and the examiner's opinion regarding the patient's cognitive and emotional status.	N/A	2 1 0
7.	The patient's **general appearance** is deliberately *examined*.	2 1 0	2 1 0
8.	The entire **head and scalp** are *inspected*. Hair should be separated in at least three areas to note the condition of the scalp. **Child:** Fontanelles are *palpate*d on children two years of age and younger.	2 1 0	2 1 0
9.	**Sinus areas** are *palpated*. The **temporomandibular joint** is *palpated* while the patient opens and closes his/her mouth.	2 1 0	2 1 0
10.	**Cranial nerve five (CN V)** is tested by *palpating* the temporal and masseter muscles while patient clenches her/his teeth. **CN V** is further tested by *observing and palpating* the patient opening his/her jaw very wide, moving it side to side, and sticking it out, all against resistance	2 1 0	2 1 0
11.	**CN V** is further tested for light touch with a wisp of cotton (NOTE: Testing corneal reflex, "sharp/dull", and temperature sensation for the face are not required during the graded evaluation .)	2 1 0	2 1 0
12.	**CN VII** is tested by *observing* the presence and symmetry of patient's facial muscle movements (smiling, frowning, showing teeth, puffing out cheeks, raising eyebrows and resisting the examiner's attempt to open the eyes). (NOTE: The sensory function of CN VII, taste, does not have to be tested during the graded evaluation.)	2 1 0	2 1 0
13.	The **external structures of the eye** are *inspected*, including the lids, conjunctiva, sclera, cornea.	2 1 0	2 1 0
14.	**Visual acuity** (part of **CN II**) is tested. For purposes of grading, only near visual acuity must be tested by having patient (8 years of age or older) read newsprint or a small Snellen-equivalent chart. Patients wearing corrective lenses should be tested with lenses in place. Each eye is tested separately. (NOTE: Normally, distance vision is also tested using the standard Snellen or "E" chart.)	2 1 0	2 1 0

15.	**Visual fields** (part of **CN II**) are tested by confrontation.	2 1 0	2 1 0
16.	**The pupillary function (CN III, IV, VI) of each eye** is assessed separately for pupillary reactions to light. Testing is performed twice on each eye; each pupil is evaluated for its direct and consensual reaction to light. Pupils are also examined for accommodation (PERRLA).	2 1 0	2 1 0
17.	**CN III, IV, VI** are further tested by evaluating the extraocular movements (EOM) through the six cardinal fields of gaze.	2 1 0	2 1 0
18.	**CN III, IV, VI** are further tested by performing the cover-uncover test.	2 1 0	2 1 0
19.	**CN II** is further tested by *inspecting* the **fundi** with the ophthalmoscope using the appropriate eye and giving appropriate instructions to the patient. **Child under 6 years of age:** Assess for red reflex only.	2 1 0	2 1 0
20.	**Both outer ears** are deliberately and thoroughly *inspected* and *palpated*.	2 1 0	2 1 0
21.	**CN VIII** is tested using the screening hearing test (**whisper test**).	2 1 0	2 1 0
22.	**CN VIII** is also tested by performing the **Weber and Rinne tests** (not performed on children under 6 years of age).	2 1 0	2 1 0
23.	Using the otoscope in an appropriate and safe manner, **both ear canals** and **tympanic membranes** are *inspected*. **Child:** Mobility of the tympanic membrane is also tested.	2 1 0	2 1 0
24.	The **nose** is *inspected* with the light and speculum of an otoscope. The **patency** of the nose is also assessed by occluding each nostril. (Testing cranial nerve I, odor differentiation, is not required for grading.)	2 1 0	2 1 0
25.	The entire **oral cavity** is *inspected* with a tongue blade and a light source.	2 1 0	2 1 0
26.	**CN IX and CN X** are tested by having the patient swallow (which can be observed during the thyroid assessment) and by *observing* movement of the palate and uvula during phonation. A comment about the quality of the patient's **voice** should be recorded. (NOTE: Testing the gag reflex, which is unpleasant, does not need to be assessed during the graded evaluation, and is usually only tested if neurological impairment is suspected; the sense of taste on the posterior one third of the tongue does not need to be tested for the graded exam.)	2 1 0	2 1 0
27.	**CN XII** is assessed by *observing* the movement of the tongue laterally and medially. (NOTE: During the graded evaluation, specific assessment of lingual speech is not required for adults; however, the PE *record* must include a statement about the patient's ability to articulate.)	2 1 0	2 1 0
28.	The **thyroid gland** is *inspected* and *palpated* before and during swallowing. (NOTE: Ideally, the patient is provided a cup of water to facilitate swallowing during this part of the assessment.)	2 1 0	2 1 0
29.	The **range of motion of the cervical spine** is evaluated by having the patient put his/her chin on his chest, lift chin to ceiling, turn chin toward each shoulder, and touch each ear toward corresponding shoulder.	2 1 0	2 1 0
30.	**CN XI** is tested by having the patient shrug his/her shoulders against resistance and by turning his/her head against the examiner's hand bilaterally. (NOTE: *Observing* the sternocleidomastoid and trapezius muscles for equal size is also an assessment of CN XI, and can be done during the general examination of the patient's anterior neck and posterior thorax.)	2 1 0	2 1 0
31.	All **lymph nodes** in the head, posterior and anterior neck, and supraclavicular regions are *palpated*. The position of the trachea is palpated.	2 1 0	2 1 0
32.	The **carotid**s are *auscultated* bilaterally using the bell of the stethoscope while the patient is holding his breath. (NOTE: Normally, the thyroid is auscultated only if it is enlarged) (not performed on children).	2 1 0	2 1 0
33.	The entire **posterior thorax** is *inspected* and *palpated* bilaterally, including assessment of respiratory symmetry and excursion. **Tactile fremitus** is assessed bilaterally on the entire posterior and lateral areas of the thorax, using the proper part of the hands (not performed on children under 6 years of age).	2 1 0	2 1 0
34.	The **posterior thorax** is *percussed* bilaterally, including lateral areas, following the proper sequence (not performed on children under 6 years of age).	2 1 0	2 1 0
35.	The **costovertebral angle** is *percussed* bilaterally for tenderness using either the direct or indirect method (not performed on children).	2 1 0	2 1 0
36.	The entire **posterior thorax** is *auscultated* bilaterally, including lateral areas, following an appropriate sequence.	2 1 0	2 1 0

37.	The entire **anterior thorax** is *palpated* bilaterally. **Infant:** The **clavicles** are *palpated*. **Tactile fremitus** is assessed bilaterally on the entire anterior chest, including apical areas, using the proper part of the hands (not performed on children under 6 years of age).	2 1 0	2 1 0
38.	The **anterior thorax** is *percussed* bilaterally, including apical areas, following an appropriate sequence (not performed on children under 6 years of age).	2 1 0	2 1 0
39.	The **anterior thorax** is *auscultated* bilaterally, including apical areas, following an appropriate sequence.	2 1 0	2 1 0
40.	The **breasts** are *inspected* with the patient assuming the four (4) major positions (arms at sides, arms pressing in at waist, arms overhead, patient leaning forward). **Adult Male/Child:** not applicable.	2 1 0 or N/A	2 1 0 or N/A
41.	With the patient in sitting position, the **entire axilla, the chest wall below the axilla, and the upper arm** are *palpated* bilaterally with passive abduction of the arm to assess for nodes or masses. (NOTE: This procedure is performed on males and children.)	2 1 0	2 1 0
42.	**Cardiac sounds** are *auscultated* in the five anatomical areas using the diaphragm and bell of the stethoscope while the patient is in a sitting position. The base of the heart is again auscultated with the diaphragm while the patient is leaning forward and exhaling completely.	2 1 0	2 1 0
43.	The **neck veins** are *inspected* with the patient at a 30-45 degree angle using tangential lighting; evidence of jugular venous distention must be measured with a straightedge and ruler (not applicable to children).	2 1 0	2 1 0
44.	With the patient in a supine position, the total **precordial area** is deliberately *inspected* and *palpated* for heaves, thrills, and location of the apical impulse.	2 1 0	2 1 0
45.	**Cardiac sounds** are *auscultated* in the five anatomical areas using the diaphragm and bell of the stethoscope with the patient supine. With the patient rolled partly onto his/her left side, the apex of the heart is again auscultated with the bell.	2 1 0	2 1 0
46.	The entire **breast including areolar and nipple** areas is *palpated* bilaterally with the patient in a supine position, arm raised over the head. (NOTE: This procedure is also performed on male patients. For children, a general palpation of the breast area is sufficient.)	2 1 0	2 1 0
47.	Bilateral **pulses** are *palpated,* simultaneously when possible. **Inguinal nodes** are also palpated. **Adult:** Assessment must include brachial, radial, femoral, popliteal, posterior tibial, and dorsalis pedis pulses. **Child:** Assessment includes only the radial, brachial, and femoral pulses.	2 1 0	2 1 0
48.	The entire **abdomen** is deliberately *inspected*. (NOTE: Use of tangential lighting is advised if the patient has an abdominal complaint.)	2 1 0	2 1 0
49.	The **abdomen** is *auscultated* with the diaphragm of the stethoscope. The aorta, renal arteries, and femoral arteries are *auscultated* with the bell.	2 1 0	2 1 0
50.	The **entire abdomen** is *percussed*.	2 1 0	2 1 0
51.	Light and deep *palpation* of the **entire abdomen** is performed.	2 1 0	2 1 0
52.	The **liver, spleen, and kidneys** are *palpated*.	2 1 0	2 1 0
53.	**Fingernails** and **toenails** are deliberately *inspected*.	2 1 0	2 1 0
54.	**Edema** is estimated in the lower extremities using firm *palpation*.	2 1 0	2 1 0
55.	The **strength** of 3 muscle groups in the **upper extremities** and 3 muscles groups in the **lower extremities** is assessed.	2 1 0	2 1 0
56.	**Adult:** The **deep tendon reflexes** (biceps, triceps, patellar and achilles) and Babinski reflex are evaluated bilaterally. Children under 6 can be tested prn; the examiner's finger may be used instead of a reflex hammer on very small children.	2 1 0	2 1 0
57.	During the grading evaluation, patients are usually ambulatory, so no specific assessment is necessary if it is apparent that the patient has adequate **range of motion in all extremities**. However, a statement that the patient exhibited full ROM of all extremities must be recorded. (NOTE: In other situations, if the patient has a defect or is bedridden, ROM must be assessed directly specific to upper and lower extremities.) **Child**: The child who is not yet walking is assessed for congenital hip disorders.	N/A	2 1 0
58.	The **spine** is *inspected* with the patient attempting to touch his toes with his hands, with legs straight, in a standing position.	2 1 0	2 1 0
59.	The **barefoot gait** of the patient is *observed*.	2 1 0	2 1 0

NOTE: By the time a child reaches age 6, the neurologic assessment is essentially the same as for the adult patient. <u>For children under age 6</u>, consult the Mosby pocket companion regarding adapting the neurologic examination according to various age groups.

		Performance	Recording
60.	The patient's ability to **walk on his/her heels, toes, and heel-to-toe** is *observed*.	2 1 0	2 1 0
61.	**Adult: Neurosensory loss** is assessed on all extremities using a circular pattern around both wrists and both ankles, sampling for specific dermatomes.	2 1 0	2 1 0
62.	**Cerebellar function** is *observed* in both upper and lower extremities bilaterally. Only <u>one</u> test (either rapid alternating movements, or thumb-to-finger, or finger-to-finger, or finger-to-nose) is required for **upper extremities**. Heel-to-shin test is performed for **lower extremities**.	2 1 0	2 1 0
63.	**Adult: Vibratory sense**, <u>including cessation</u>, is evaluated distally in all extremities (two fingers of both hands and two toes of both feet).	2 1 0	2 1 0
64.	**Proprioception** is also assessed by performing **bilateral position sense testing** in both upper and lower extremities (two fingers of both hands, two toes of both feet).	2 1 0	2 1 0
65.	**Proprioception** is *observed* by performing the **Romberg test**.	2 1 0	2 1 0
66.	The **skin** is <u>deliberately</u> *inspected* throughout the examination.	2 1 0	2 1 0

<u>OBSERVED PROFESSIONAL BEHAVIORS</u>:

67.	Performance: Provided for privacy/appropriate draping. Recording: Identifying information obscured or deleted.	2 1 0	2 1 0
68.	Provided directions/explanations for patient.	2 1 0	N/A
69.	Organized/integrated exam with minimal position changes.	2 1 0	N/A
70.	Made notes of findings to be included in subsequent documentation (e.g., vital signs, ruler measurements, etc.)	2 1 0	N/A
71.	Dressed and behaved in a professional manner.	2 1 0	N/A

<u>GRADE CALCULATION</u>: *Total possible points = Number of total items listed minus those deemed "not applicable" given the particular patient or setting.*

<u>Performance</u>: Total possible points ___________; Number of correct items __________; Percent achieved ____________.
(Male = 134 points; Female = 136 points; Child = 126 points minimum if ≥ 6 years; adjust points as indicated for a younger child.)

<u>Recording</u>: Total possible points __________; Number of correct items ___________; Percent achieved _____________.
(Male = 130 points; Female = 132 points; Child = 122 points minimum if ≥ 6 years; adjust points as indicated for a younger child.)

COMMENTS:

NUSC 532, Comprehensive Health Assessment for Advanced Practice Nursing, is an ***advanced*** health assessment course that has the prerequisite of an undergraduate health assessment course or its equivalent. Therefore, it is assumed that those students who register for this course have already learned the basic skills of taking a complete health history and performing a complete physical examination. These basic skills are not covered in any detail in this course, nor are instructions regarding using oto/opthalmoscope or other equipment provided. The thrust of NUSC 532 is to cover higher-level assessment skills (e.g. performing complete male and female genitourinary examinations, identifying abnormal heart sounds, identifying potential differential diagnoses, appropriately conducting episodic encounters, etc.). Students are expected to demonstrate mastery of the basic components of a complete history and physical, including the appropriate documentation, early in the semester of the course.

Students who require some refresher of basic techniques are invited to view parts or all of the complete physical assessment series of videotapes available in the Library of Health Sciences in Chicago or through faculty in your region. However, if your undergraduate health assessment course was taken more than 5 years ago, you are advised to take another basic course prior to enrolling in NUSC 532. If you utilize complete health assessment skills in your clinical practice, you may contact the course coordinator to discuss whether a refresher course is necessary.

Equipment necessary for a complete physical examination may not be provided by the College of Nursing. Check with your faculty regarding the availability of the following equipment: reflex hammer, penlight, and two tuning forks (one of 500 Hz or higher and one of 400 Hz or lower), blood pressure cuff, and a near vision chart. Oto/opthalmoscopes are available for use in the nursing lab. All students are required to purchase their own stethoscope.

11-14-06 Sefton

Comprehensive Health Assessment Scoring Manual for the **HISTORY**

DIRECTIONS: READ CAREFULLY

1. Each item is to be assessed and recorded on all patients unless exceptions are indicated. A patient's inability to cooperate or provide the necessary information should be reflected in the recording.
2. Any criteria delineated for an "adult" should be assessed and recorded in every patient who is 10 years of age or older.
3. To ensure confidentiality, pseudonyms should be used in recordings submitted for evaluation. Gathering the biographical information (item #2) does not need to be included on the videotaped history, but it must be recorded in the write-up.)
4. Each element is graded as follows: 2 = completely and accurately assessed
1 = partially and accurately assessed
0 = assessment inadequate or inaccurate.
5. Any information not heard on the videotape will result in losing points in the "Performance" column. To avoid losing the same point in the "Recording" column, the student should indicate that the information was "not assessed," as would be appropriate in a clinical setting. Then, on this graded history recording [but not in a clinical setting], follow the "not assessed" comment with a description [*in brackets*] of the information as if it had been obtained and were normal.

Criteria		Performance	Recording
Introduction			
1.	The student introduces her/himself, clarifies how the patient wishes to be addressed, inquires about the patient's familiarity with nurse practitioners, and *briefly explains the NP role*.	2 1 0	N/A

Identifying Information / Biographical Data

		Performance	Recording
2.	Identifying information regarding name, address, phone, age, sex, race, usual source of health care. *(Adult: Include data regarding marital status, usual occupation, present occupation).* Identification of person providing information and her/his apparent reliability as a historian.	N/A	2 1 0
Chief Complaint / Reason for Seeking Care			
3.	The reason the patient has sought care. The response is usually recorded in quotation marks using the patient's own words and is no more than one sentence.	2 1 0	2 1 0

Present Health Status / History of Present Illness

A summary of the patient's overall health status, including:

		Performance	Recording
4.	Reason for last examination (episodic or complete) and its approximate date.	2 1 0	2 1 0
5.	Brief summary of significant past or chronic illnesses, including those of a psychiatric nature, that may have current or future implications. Must include the onset / duration of the illness and a brief description of its treatment. The most salient points of the illness are recorded here; however, if information on the diagnosis and treatment of the illness is complicated, it can be discussed more fully under the appropriate review of systems section.	2 1 0	2 1 0
6.	Any concerns relating to the patient's health or well-being or potential disability.	2 1 0	2 1 0

Past Health / Past Medical History

Immunizations and Communicable Illnesses

		Performance	Recording
7.	**Adult**: Immunizations if known. Date of last Td booster and PPD results. History of influenza, pneumonia and hepatitis B vaccines. **Child:** Dates of immunizations, PPD results and influenza vaccine.	2 1 0	2 1 0
8.	Recent exposure to any communicable disease (e.g. Hep. B, TB).	2 1 0	2 1 0

Allergies / Drug Reactions

		Performance	Recording
9.	Presence of allergies to seasonal and other environmental factors, food, and drugs; specifically address allergy to penicillin and latex. If a patient reports an allergy, note the allergen and the nature of the reaction.	2 1 0	2 1 0

Hospitalizations / Surgeries

10.	Information regarding past hospitalizations/surgeries/invasive procedures, dates, and any sequelae, including emergency department visits.	2	1	0	2	1	0

Injuries

11.	Accidents, injuries, and harmful ingestions; the nature and outcomes of each event.	2	1	0	2	1	0

Medications

12.	All types of medications taken on a regular or PRN basis, including both prescribed and over-the-counter drugs, as well as the use of vitamin supplements and home/herbal remedies.	2	1	0	2	1	0
13.	Use of complementary and alternative therapies, including massage, acupuncture, traditional oriental medicine, homeopathy, chiropractic, magnets, therapeutic touch, Qi Gong, meditation, hypnosis, imagery, prayer, or special diet or vitamin therapies.	2	1	0	2	1	0

Perinatal history

These items apply only to patients under 5 years of age. For grading purposes, six points are added to the total possible points:

a.	Whether the pregnancy for this child was planned; when the mother first sought prenatal care, if she experienced any of the following during the pregnancy: infections, rubella, amount of weight gain, bleeding, convulsions, diabetes, hypertension; whether she used alcohol, tobacco, or medications during pregnancy.	2	1	0	2	1	0
b.	Place of birth, length of gestation, length and difficulty of labor, type of delivery, complications during delivery, birth weight.	2	1	0	2	1	0
c.	Whether the patient experienced any of the following problems as a newborn: cyanosis, jaundice, convulsions, congenital abnormalities; difficulty with feeding; when the patient was discharged from the nursery.	2	1	0	2	1	0

Family History

Family Tree

14.	**Adult:** The age, health status/cause of death of grandparents, parents, siblings, aunts, uncles and children are obtained. Information on the health of a spouse is also obtained to identify potential health-related stresses in the family. Data are recorded as a family tree (pedigree). **Child:** Age, health status/cause of death of grandparents, parents, siblings, aunts, and uncles. Data are recorded as a family tree (pedigree).	2	1	0	2	1	0

Illnesses of a Familial Nature

15.	The presence of any of the following illnesses in any family member: allergies, asthma, arthritis, high blood pressure, heart disease, stroke and other peripheral vascular diseases, diabetes, cancer, cystic fibrosis, gastrointestinal disease, gout, kidney disorders, sickle cell (all patients), thyroid disease, blood disorders, obesity, vision/hearing problems genetic/congenital disease ("birth defects"), sudden infant death, neurological problems including seizure disorders, emotional problems, learning disabilities, mental retardation, drug/ETOH abuse. Also explore whether the patient is concerned about any illnesses of a family nature.	2	1	0	2	1	0

Personal and Social History

Family Relationships

16.	Nature of and satisfaction with living arrangements and relationships with family members (spouse, children, parents, in-laws, siblings, etc.), including those who live and do not live with patient.	2	1	0	2	1	0

Occupational History

17.	**Adult:** Work history (all jobs past and present), including any job changes necessitated by health problems, and occupational risks, including exposure to violence. NOTE: Nurses especially need to be asked about the variety of settings in which they have worked during their careers. **Child:** Parent's occupation; adolescent: employment.	2	1	0	2	1	0

Economic Status

18.	Perception of the adequacy of the patient's/family's financial resources, including insurance coverage for primary and inpatient care.	2	1	0	2	1	0

Educational Level

19.	**Adult:** Years of education completed, including vocational education. **School aged child/adolescent:** School progress including grade, type of school, special interests, behavior in school, and how behavior problems are handled by parents and other authority figures.	2	1	0	2	1	0

Habits

20.	The current and past use, including amount and frequency, of alcohol, tobacco, caffeine-containing beverages, and recreational drugs. **Child:** The parent is asked about the presence of bed wetting, thumb sucking, nail biting, temper tantrums, and how parents and others involved with the family deal with these problems (e.g., forms of discipline or other methods used).	2	1	0	2	1	0

Sleep Patterns

21.	Sleep patterns, including number of hours and disturbances. **Child:** In addition to above, naps, and nightmares.	2	1	0	2	1	0

Activities / Exercise / Leisure Patterns

22.	The regularity, frequency, duration, and type of aerobic and anaerobic exercise. **Child:** Types of recreational activities.	2	1	0	2	1	0

Typical Day

23.	Patient's description of the events in a usual day of her/his life, summarized in chronological sequence from the time the patient arises until s/he retires at night.	2	1	0	2	1	0

Daily Intake Patterns / Nutritional Data

24.	Description of the past twenty-four hour food and fluid intake, recorded in the sequence the meals and snacks were eaten. A statement as to whether the past 24 hours intake is typical for the patient is also obtained. Number of restaurant meals eaten per week or any special dietary practices. **Child < 3 years old:** In addition to the above, whether child was breast or bottle fed, juice intake, when solid food was introduced, and the age at which the child was feeding self and using utensils.	2	1	0	2	1	0

Coping and Stress Management

25.	**Adult:** Amount and nature of stress in patient's life and her/his methods of coping, including whether s/he has sought outside help to deal with problems (e.g., from mental health professionals, clergy). **Child:** Concerns over bullying, anxiety, school problems.	2	1	0	2	1	0

Exposure to Violence

26.	Have you or any of your family or friends witnessed or been exposed to violence or abuse?	2	1	0	2	1	0

Developmental Status / Life Satisfaction

27. **Adult/Adolescent:** Patient's perception of whether s/he has accomplished what s/he had hoped at this stage in life *(the patient's assessment of meeting developmental milestones)*. **Child:** Questions should be applicable to age of child. Focus on gross/fine motor and speech/language development for younger children. Older children should have school performance assessed. — 2 1 0 2 1 0

2 1 0 2 1 0

Safety

28. Use of safety measures, such as seat belt, car seat, bicycle helmets, etc. should be noted. Presence of functioning smoke and CO alarms, guns in the household, etc. should also be assessed.

Environmental Data

29. Current or past exposure to health hazards (including crime, violence, pollution, second hand smoke, lead, radon, etc.) of home, work, and community environment. Source of water and its quality/safety.
Child < 6 years old: Date and results of last lead level assessment. — 2 1 0 2 1 0

Cultural Influences on Illness, Therapy and Health Practices

30. Religious affiliations and ethnic/cultural beliefs or traditions, their importance to the patient, and any influences they might have on how providers care for the patient. — 2 1 0 2 1 0

Review of Systems

Constitutional Symptoms

31. Fever, chills, malaise, fatigue, night sweats, weight (current, average, preferred, change). — 2 1 0 2 1 0

Skin / Nails

32. The condition of and/or any changes in skin, moles, and nails, and frequency of use of sunscreen. — 2 1 0 2 1 0

Hair / Scalp

33. Condition of and/or changes in the scalp or in the quality or distribution of hair. — 2 1 0 2 1 0

Eyes

34. Use of eye glasses, date of last eye examination, history of visual disturbances, halo lights, wandering or lazy eye, glaucoma, cataracts, or eye infections. — 2 1 0 2 1 0

Ears

35. Hearing loss, pain, discharge, tinnitus, vertigo, or use of hearing aids.
Child: In addition to the above: history of Otitis media including number, treatment and sequela. — 2 1 0 2 1 0

Nose / Sinuses

36. Sinus pain or infections, epistaxis, frequent colds and/or frequent rhinorrhea. — 2 1 0 2 1 0

Oral Cavity / Throat

37.	Date of last dental exam, missing teeth, prosthetic devices, dental problems, bleeding gums, brushing and flossing habits, oral lesions, sore throat, strep throat, difficulty swallowing, voice change or hoarseness. **Child:** In addition to the above: age of eruption of deciduous and permanent teeth, tooth brushing habits and nighttime bottle use (if appropriate).	2 1 0	2 1 0
	<u>Neck / Nodes</u>		
38.	Stiffness, decreased ROM, or swelling of the neck, or lumps or tenderness in the neck.	2 1 0	2 1 0

Breast / Axilla

39.	Swelling of glands under the arms, the presence of a lump or soreness in the breast, or discharge from the nipple (asked of men as well as women). **Adult/Adolescent female:** In addition to above, frequency of BSE, whether or not the patient breast-fed her children and for how long. Frequency of mammography and the date of the last test. (NOTE: While mammography is more critical for women over the age of 35, all women at least 21 years of age or older should be asked if they ever had a mammogram and what they know about mammography guidelines.)	2 1 0	2 1 0
	<u>Chest / Respiratory</u>		
40.	Cough, sputum production, shortness of breath, wheezing, history of asthma, pneumonia, bronchitis, emphysema.	2 1 0	2 1 0
	<u>Cardiovascular</u>		
41.	Heart problems, hypertension, chest pain, heart murmurs, rheumatic fever, exercise intolerance, palpitations, edema, claudication, and information regarding cholesterol levels. **Child:** Information regarding cyanosis, congenital heart disease, fatigue, tiring with feeding or heart murmurs.	2 1 0	2 1 0
	<u>Gastrointestinal</u>		
42.	Information regarding abdominal pain, food intolerance, nausea or vomiting, diarrhea or constipation, bowel patterns (including if patient must strain to have a BM), rectal bleeding, swelling of the glands in the groin, history of peptic ulcer, gall bladder disease, or soiling.	2 1 0	2 1 0

Urinary

43.	Dysuria, flank pain, hematuria, frequency, incontinence (stress or otherwise), nocturia, infections (sexually transmitted, urinary) or discharge (penile, vaginal). **Male Child:** If circumcised, any problems with procedure. If uncircumcised, hygiene measures and retractability of foreskin. Presence of hypospadias, epispadias, undescended testicles, scrotal swelling with crying or bowel movement.	2 1 0	2 1 0

Reproductive

44.	**Adult/Adolescent Female:** Complete menstrual history (LMP, whether LMP was typical, age of menarche, cycle, flow, cramping, premenstrual symptoms), obstetrical (including G,P,A; vaginal vs. cesarean delivery, complications), fertility desires/problems, contraceptive history, Pap smear history (dates and results of most recent and all previous). **Adult/Adolescent Male:** Patient's knowledge of and frequency of performance of testicular examination, fertility desires/problems, date of last prostate exam.	2 1 0	2 1 0

Sexual History

45.	Sexual activity with men, women, or both. Number of current & lifetime partners. Use of condoms, foam, and other contraceptives. Whether current sexual activity is enjoyable for patient and partner. Based on patient's apparent risk, may need to inquire re: oral, anal, vaginal practices.	2 1 0	2 1 0

Musculoskeletal

No.	Item	Performance	Recording
46.	Pain or stiffness in joints or back, limitation in ROM, impaired gait, swelling or weakness. **Older adult or disabled patient:** History of or fear of falling. Ability to perform ADLs (e.g., dressing, toileting, ambulation, shopping, meal preparation, need for assistive devices or caretaker assistance).	2 1 0	2 1 0

Neurological

No.	Item	Performance	Recording
47.	History of head injury, loss of consciousness, loss of coordination, dizziness, numbness, tingling, seizures, tremors, headaches, impaired cognitive functioning, memory impairment, irritability, or mood swings.	2 1 0	2 1 0

Hematopoietic / Endocrine

No.	Item	Performance	Recording
48.	Anemia, sickle cell trait (asked of all patients), bleeding tendency, history of blood transfusions, thyroid problems, unusual sensitivity to hot or cold environments, polyuria, polyphagia, or polydypsia.	2 1 0	2 1 0

Quality of overall encounter with patient and documentation

No.	Item	Performance	Recording
49.	**Performance:** Evaluator's opinion that the encounter was conducted in an efficient yet caring manner, including student's ability to relate to patient's educational level, mental status, and demeanor. **Recording:** Evaluator's opinion that documentation was accurate, thorough, yet concisely written.	2 1 0	2 1 0

GRADE CALCULATION

Performance*:*

Total possible points ________; Number of correct items _________; Percent achieved ____________.

Possible points: well adult = 96 points; child < 5 years old, add 6 points to total.

Recording*:*

Total possible points ________; Number of correct items _________; Percent achieved ____________.

Possible points: well adult = 96 points; child < 5 years old, add 6 points to total.

COMMENTS: