## CLINICAL SKILLS EVALUATION
## PATIENT NOTE

**HISTORY**: Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives) relevant to this patient's problem(s).

**PHYSICAL EXAMINATION**: Describe any positive and negative findings relevant to this patient's problem(s). Be careful to include *only* those parts of examination you performed in *this* encounter.

**DATA INTERPRETATION:** *Based on what you have learned from the history and physical examination*, list up to 3 diagnoses that might explain this patient's complaint(s). List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive or negative findings from the history and the physical examination (if present) that support each diagnosis. Lastly, list initial *diagnostic* studies (if any) you would order for each listed diagnosis (e.g. restricted physical exam maneuvers, laboratory tests, imaging, ECG, etc.).

**DIAGNOSIS #1:**

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| | |
| | |
| | |

(+) Click to add row(s)

**DIAGNOSIS #2:**

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| | |
| | |
| | |

(+) Click to add row(s)

**DIAGNOSIS #3:**

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| | |
| | |
| | |

(+) Click to add row(s)

| DIAGNOSTIC STUDIES |
|---|
| |
| |
| |

(+) Click to add row(s)

**CLINICAL SKILLS EVALUATION**
**PATIENT NOTE**

**HISTORY**: Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives) relevant to this patient's problem(s).

Ms. Bingham is a 24 yo woman who complains of worsening sore throat since yesterday morning. She has never had a similar problem in the past. She has no difficulty swallowing, but notes that swallowing makes the pain worse. Nothing makes it better. There is no SOB or sensation of choking or dysphagia. She has fatigue and has had some anorexia since the symptoms began. She has had some subjective fevers at home but has not taken her temperature. She has had no cough or rhinorrhea. There are no sick contacts at home or at work. She denies seasonal allergies and post-nasal drip.
ROS: No chest pain, cough, wheezing, abdominal pain, N/V, headache
PMHx: none
Meds: none
Allergies: none
PSHx: none
FHx: father with HTN
SHx: married with 2 children, No ETOH or drugs, monogamous with husband

**PHYSICAL EXAMINATION**: Describe any positive and negative findings relevant to this patient's problem(s). Be careful to include *only* those parts of examination you performed in *this* encounter.

She is in no acute distress, throat clear, abdomen soft, non-tender and without distension. There is no notable splenic or hepatic enlargement or tenderness.

**DATA INTERPRETATION:** *Based on wh[illegible]ou hav[illegible]* [illegible]hat might explain this patient's complaint(s) appropriate. Then, enter th[illegible] each diagnosis. Lastly, list [illegible] maneuvers, laboratory tests,

The physical exam description includes only a cursory examination of the throat. Providing more detail such as specific mention of erythema or exudate, and evaluation for regional lymphadenopathy, would result in a higher score. "No notable splenic or hepatic enlargement or tenderness" is an example of a negative finding.

**DIAGNOSIS #1:** Viral Pharyngitis

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| Sore throat | Tender submandibular lymph nodes |
| Subjective fever | |
| Fatigue | |
| Anorexia | |
| Pain with swallowing | |

Add a Row

Appropriate supporting information is drawn from the history and PE section above and used to support a likely diagnosis

**DIAGNOSIS #2:** Bacterial Pharyngitis

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| | |
| | |

Add a Row

Including a diagnosis without supporting information will result in a lower score even if the diagnosis is likely.

**DIAGNOSIS #3:**

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| | |
| | |

Add a Row

If only two diagnoses are likely based on the patient's presentation, do not list a third diagnosis.

| DIAGNOSTIC STUDIES |
|---|
| Throat Culture |
| Head/neck CT with Contrast |

Add a Row

"Head/neck CT with contrast" is overly aggressive and costly in this clinical scenario, and would result in a lower score.

**CLINICAL SKILLS EVALUATION**
**PATIENT NOTE**

**HISTORY**: Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives) relevant to this patient's problem(s).

75-y-o woman with sudden onset back pain last night while lifting turkey from oven.
-pain in midline, mid-thoracic
-sharp, stabbing in nature
-worse with movement or deep breath, better with re
-not improved with acetaminophen
-no symptoms in legs, no fever or chills
-had minor back pain in past that resolved on its own
-Post-menopausal due to hysterectomy at age 40, not on HRT
PMH: fracture of foot bone last year
Meds: acetaminophen for occasional headache and daily multivitamin

History can be presented in either narrative or listed format for full credit.

**PHYSICAL EXAMINATION:**
those parts of examination

The examinee has described the findings relevant to the back pain, and is not required to report a complete physical examination.

Well-nourished woman looks her age, alert and lucid; Appears in pain, especially with movements; point tenderness over T8; straight leg test negative; sensation intact on bilateral feet. No weakness of ankle, knee or hip musculature. Deep tendon reflexes 2+ at patella and ankle; P

**DATA INTERPRETATION:** *Based on what you have*
explain this patient's complaint(s). List your di
appropriate. Then, enter the positive or negative
each diagnosis. Lastly, list initial *diagnostic* studies (if a
maneuvers, laboratory tests, imaging, ECG, etc.).

"Pulled back muscle" is an inexact, non-medical term. The most likely diagnosis, vertebral fracture related to osteoporosis, has been overlooked, despite strong evidence from the history and physical examination. This will result in a lower score.

**DIAGNOSIS #1:** Pulled back muscle

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| Sudden onset back pain with lifting | ROM limited by pain |
| Pain worse with movement | |

Add a Row

**DIAGNOSIS #2:** Herniated disc/nerve root compression

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| Sudden onset back pain | ROM limited by pain |
| Occurred when lifting object | |
| Pain worse with movement | |

Few facts in the history and physical suggest this diagnosis, so it is appropriately listed lower than more likely diagnoses.

**DIAGNOSIS #3:** Epidural abscess

| HISTORY FINDING(S) | PHYSICAL EXAM FINDING(S) |
|---|---|
| Back pain | |
| | |

Add a Row

This diagnosis is poorly supported. Listing diagnoses that are not supported by the history will result in lower score.

| DIAGNOSTIC STUDIES |
|---|
| Imaging of back/spine |
| |

Add a Row