STRUCTURED OBSERVATION OF APPROACH TO THE PATIENT AND MEDICAL HISTORY-TAKING SKILLS
Student_____ Faculty Observer_____

Patient's Chief Complaint
S I X S = Satisfactory, I = Needs Improvement, X = Not Observed

Introduction
Address the patient and introduce self and role

History of Present Illness
Begin with an open-ended question/statement to elicit the patient's Chief Complaint
Use open-ended techniques to encourage the patient's story of the present illness
Brief summary to ensure understanding
Transitional statement to doctor-centered questions
Further develop the patient's complaint (onset, anatomical position, quality, radiation, related symptoms, relieving or worsening factors, severity, timing, understanding, past evaluation or treatment of the symptom)
Impact on functional status (physical, emotional, interpersonal, task-related)
Empathic response to the emotional impact (name, understand, respect, support)
Additional pertinent positives and negatives elicited to support differential diagnosis:
Pertinent PMH_____
_____
Pertinent risk factors (FH, habits, exposures)_____
_____
Pertinent ROS_____
_____

Past Medical History
General state of health
Past illnesses
Injuries
Hospitalizations
Surgery
OB/GYN
Psychiatric
Medications
Allergies
Immunizations

Family History
Age and health status of grandparents
Age and health of parents
Age and health of siblings
Age and health of children
Any family hx of DM, HBP, CVA, MI, CA

Social History
Age
Occupational history
Education
Living situation
Support systems
Stress
Sexual history
Spiritual , cultural, and health beliefs and values
Diet
Exercise
Smoking, EtoH, drugs
Safety (domestic violence/abuse, seatbelt, guns)

Review of Systems
General
HEENT
Skin
Endo
Respiratory
CV
GI
GU/Sexual
Musculoskeletal

Neurological
Hematologic
Endocrine

Closure
Summarize

ASSESSMENT OF APPROACH TO THE PATIENT AND AND MEDICAL HISTORY-TAKING SKILLS

O S I O = Outstanding, S = Satisfactory, I = Needs Improvement

Demonstrates respect for the patient by introducing himself or herself and explaining the steps of the history and physical examination.
Attends to patient privacy and comfort.
Clearly demonstrates a patient-centered approach (open-ended questions, silence, facilitating verbal and nonverbal communication, emotion seeking and handling, interest in patient beliefs and values).
Develops a rapport with the patient.
Demonstrates an appropriate balance of patient-centered and doctor-centered interviewing techniques.
Fully develops the patient's complaint.
Asks how the illness affects the patient's physical, emotional, and interpersonal function.
Demonstrates empathy for the patient.
Purposefully elicits the pertinent positives and negatives of the differential diagnosis.
Logically organized.
Summarizes to ensure understanding.