The Longitudinal Clinical Experience is an opportunity to provide the student with an exposure to an outpatient generalist's practice. The experience is intended to be an avenue to practice the history and physical exam skills taught in the FCM color group and expert sessions.

You will be assigned an M-2 Primary Care Preceptor and will meet with the preceptor for a total of **12 half-day sessions** during the year. Preceptors are located both in urban and rural settings. Some may be in large hospital practices and some in small private clinics. Primary care physicians see a wide variety of patients and patient problems. They represent the disciplines of Family Medicine, General Internal Medicine, and Medicine/Pediatrics.

During each half-day session, you will practice the components of the H&P, observe the clinical responsibilities of a primary care physician, observe the complexities of the medical office system, and correlate basic science knowledge with clinical medicine.

**General Goals and Objectives**

1. Understand and describe the breadth and depth of the generalist's practice content.
2. Correlate your education in the basic sciences with clinical practice.
3. Describe the clinical and intellectual challenges of the generalist’s practice.
4. Apply the clinical decision-making process in the community practice.
5. Practice history taking and physical examination skills, which are learned in the color group sessions in the community setting.
6. Understand the principles of disease prevention and health promotion for individuals, families and the community.
7. Articulate the pertinent community health problems unique to their preceptor site.

**Session Objectives:**

At each session there will be clear objectives for you to complete.

During the year, you will be exposed to a variety of primary care outpatient problems.

*LCE Visit Log*: You will keep track of the different patients and diagnosis you have encountered in your LCE visit log on Benware. This will also be reviewed with your color group faculty at subsequent color group sessions.
Assignments: You will have required write up assignments throughout the year. The majority will be SOAP notes (20 total) of patient encounters that need to be submitted in Benware after each visit. These will be discussed and reviewed by your preceptor as well as your color group faculty. You will also have 2 reflective writings that will be submitted at the end of each semester. Topics for the reflective pieces will be given to you by your color group faculty. These will also be submitted in Benware.

Submission of all SOAP notes and reflective writings will be required to pass the LCE portion of the FCM 2 course.

Evaluations:

Your preceptor will be expected to give you a mid term evaluation and final evaluation that will be discussed with your color group faculty. The preceptor will provide feedback of a direct patient encounter utilizing a Modified Mini-CEX Learner Rating Instrument. They will also give feedback for an oral presentation utilizing the oral presentation evaluation form. These will be included in your core faculty’s narrative evaluations.

If problems arise during any of your LCE sessions, you should contact the LCE coordinator immediately. The coordinator can discuss difficulties you encountered with the preceptor, arrange for an alternate if your preceptor is not available during one of the required sessions, and answer questions related to this experience.

Reference:
Adaptations from UIC-COM- Peoria ICM Handbook
VISIT 1/LCE1: Shadowing the preceptor/Professionalism

Visit needs to be completed by August 28
Student’s responsibility to email or call assigned preceptor before August 14 and schedule a time. If the student cannot reach the preceptor the student needs to contact LCE coordinator (Dr. Grace Park) by August 14

REQUIRED READING: Chapter 1 and 2

OBJECTIVES:

• Shadowing the preceptor
  • Observe for the following as you shadow your preceptor
    i. How does your preceptor introduce him/herself?
    ii. What is an opening question your preceptor asks to the patient?
    iii. What are ways you see your preceptor remove barriers to communication or ensure comfort for the patient?

• Professional expectations of the clinic will be reviewed

ASSIGNMENTS:

• Arrive promptly for clinic session, dressed in professional clothing with your white coat and stethoscope.
• Coordinate with your preceptor and the M2 calendar to set times for the rest of the fall and spring semester.
  i. These dates need to be submitted in LCE1 in Benware for approval
VISIT 2/LCE2: Meeting the Office Staff/Professionalism

Visit needs to be completed by September 15

REQUIRED READING: Chapter 1 and 2

OBJECTIVES:
- Understand the flow of the office and roles the different staff members have in patient care.
- Understanding the use of vital signs in the patient examination.
- Observation of patient-centered interviewing

ASSIGNMENTS:

Follow 2 patients as they go through the check-in process.
- Work with the receptionist as they check a patient in.
- Work with the medical assistant as they take the patient’s vital signs.
  1. Need to obtain at least 2 sets of vital signs
     a. One set of vital signs needs to be submitted by the student in LCE2 in Benware for approval

- Observe your preceptor as they interview the patient. Look for the 5 steps of the beginning of the interview: Obtaining a Patient-Centered HPI
  Step 1 – Set the stage for the interview
  Step 2 – Elicit chief complaint and set agenda
  Step 3 – Being the interview with non-focusing skills (open ended questions) to help the patient express him/herself
  Step 4 – Continue with focusing skills to learn 3 things from the patient (Symptom story, Personal Context, Emotional Context)

- Observe your preceptor as they transition to the Middle of the Interview (summary of what the patient shared/checking for accuracy)
- Observe your preceptor as they transition to the Clinician-Centered interviewing skills to obtain the rest of the history.
- Observe your preceptor as they summarize and end the interview.
VISIT 3/LCE3: Beginning of the Interview

Visit needs to be completed by October 3

REQUIRED READING: Chapter 3

OBJECTIVES:
- Student will see 2 patients on their own
- Focus for the student will be to obtain a patient-centered chief complaint and history of present illness

ASSIGNMENT:
- Student will obtain a chief complaint and HPI (patient-centered) and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.
- For physical exam student will perform Vital Signs and assessment of General Appearance
- Student will write patient encounter SOAP note for each patient
  i. Student will need to submit 2 patient encounter SOAP notes in LCE3 in Benware.

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

<table>
<thead>
<tr>
<th>TEMPLATE for LCE3 (delete rest of standard template)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.</td>
</tr>
<tr>
<td>History of Present Illness (HPI): Write a narrative description of the patient’s symptoms as obtained through the patient-centered interviewing phase. Begin with a brief description of the patient.</td>
</tr>
<tr>
<td>Physical Exam:</td>
</tr>
<tr>
<td>Vital Signs:</td>
</tr>
<tr>
<td>General Appearance:</td>
</tr>
<tr>
<td>Should’ve Section: What are things you should’ve asked or examined that you had missed?</td>
</tr>
</tbody>
</table>

KEY CONCEPTS:
What are Patient-Centered Chief Complaint and HPI?

Patients seek medical attention because of a specific concern. That main issue is the patient's chief complaint. This is usually established by an open-ended question, such as,
"What brought you in today?" or “What seems to be the matter?”

Other examples of initial questions used to elicit the chief complaint
- "What brings you into the hospital (office)?"
- "Tell me what has been bothering you."
- "What seems to be the matter?"

Elicit the Symptom Story: Using open-ended questions guide the patient to tell his/her story of the symptom.
  - Use skills of echoing what the patient said (Repeat patient’s words)
  - Requests – “Tell me more about it”
  - Summarizing/Paraphrasing

Elicit the Personal Concern: Expanding your understanding of the patient as a person

Elicit Emotional Context
  - Inquiring about impact: “How has this symptom affected your life?”
  - Eliciting beliefs/attribution: “What do you think is causing the problem?”
  - Demonstrating understanding through self-disclosure: “I think that if that happened to me I would feel upset.”

Triggers: Determining why the patient is seeking care at this precise time. “What made you decide to see me today for this symptoms?”
VISIT 4/LCE4: Beginning of the Interview
Obtaining a Clinician-Centered HPI/ Clinician-Centered Interviewing Phase

Visit needs to be completed by October 16

REQUIRED READING: Chapter 4

OBJECTIVES:

- Student will see 2 patients on their own
- Focus for the student will be to obtain a patient-centered chief complaint and full HPI

ASSIGNMENT:

- Student will obtain a chief complaint and full HPI and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.

- For physical exam student will perform Vital Signs and assessment of General Appearance and Cardiovascular Examination

- Student will write patient encounter SOAP note for each patient
  i. Student will need to submit 2 patient encounter SOAP notes in LCE4 in Benware.

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

<table>
<thead>
<tr>
<th>TEMPLATE for LCE4 (delete rest of standard template)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.</td>
</tr>
<tr>
<td>History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.</td>
</tr>
<tr>
<td>Physical Exam:</td>
</tr>
<tr>
<td>Vital Signs:</td>
</tr>
<tr>
<td>General Appearance:</td>
</tr>
<tr>
<td>Cardiovascular:</td>
</tr>
</tbody>
</table>

Should’ve Section: What are things you should’ve asked or examined that you had missed?

KEY CONCEPTS:
What is a clinician-centered HPI?
Obtain a chronological description of the history of present illness (HPI)

1. OPQRST (describe the symptom that the patient has already brought up)
2. Ask about symptoms in the same organ system, as the chief complaint that patient has not brought up yet.
3. Think about what other organ systems that are around or associated with the one described in the HPI that could be the cause of the chief complaint.
   a. Ask about symptoms related to those organ systems

Use the 7 Descriptors of Symptoms (OPQRST) – Table 4-3 on page 70

O: Onset and chronology
   - “When does (did) it happen?”
   - “How long does it last?”
   - “How often does it happen?”

P: Position and radiation
   - “Where is it located?” (have the patient point with one finger)
   - “Does it travel anywhere?”

Q: Quality and Quantification
   - “What is it like?”
   - “How bad is it?”
   - “On a scale of 1 to 10, with 1 being no pain and 10 being the worst pain you can imagine, what number would you give your pain?”

R: Related symptoms
   - “Have you noticed anything else that occurs with it?”

S: Setting
   - “Are there any circumstances such as environment, social factors, activity, emotions that contribute to or precipitate the symptoms?”

T: Transforming factors
   - “What brings it on?”
   - “What makes it better?”
   - “What makes it worse?”
VISIT 5/LCE5: Middle of the Interview

Obtaining a Past Medical History

Visit needs to be completed by October 30

REQUIRED READING: Chapter 4

OBJECTIVES:

- Student will see 2 patients on their own
- Focus for the student will be to obtain a patient-centered chief complaint and full HPI and Past Medical History (PMH)

ASSIGNMENT:

- Student will obtain a chief complaint, full HPI, and PMH and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.
- For physical exam student will perform Vital Signs and assessment of General Appearance and Cardiovascular Examination and Pulmonary Examination
- Student will write patient encounter SOAP note for each patient
  1. **Student will need to submit 2 patient encounter SOAP notes in LCE5 in Benware.**

  **Benware Instructions:** Enter Case type, Primary Diagnosis and under Comments, the **SOAP NOTE**

  **TEMPLATE for LCE5 (delete rest of standard template)**

  Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

  History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.

  Past Medical History:

  Physical Exam:
  Vital Signs:
  General Appearance:
  Cardiovascular:
  Pulmonary:

  Should’ve Section: What are things you should’ve asked or examined that you had missed?
KEY CONCEPTS:

*What is a Past Medical History?*

The past medical history is a summary of the current and past illnesses, general state of health.

Components include general state of health and past illnesses.

Ask open-ended question first. “Do you have any other medical problems?”

Then ask more specific questions about the following:

- Childhood Illnesses
- Adult Illnesses/Diagnosis
- Past injuries/accidents/procedures/tests
- Past psychological problems
- Past hospitalizations – when and why
- Review immunizations during childhood and as an adult
- Inquire about status of age-appropriate preventive screening (i.e. Mammograms, colonoscopies, lab testings)
- Obtain female patient’s OB/Gyne history (Age of menarche or menopause, Number of pregnancies/complications or types of deliveries)

For any problem identified, note its time of onset, course of the disease, any special diagnostic testing, complications of the illness, etc.

- Current Medications (dosage and route)
  - inquire about OTC and herbal supplements

- Allergies (clarify if allergy or intolerance)
  - Identify the specific type of reaction
    - Environmental
    - Medications
    - Foods
Visit needs to be completed by November 20

REQUIRED READING: Chapter 5

OBJECTIVES:

- Student will see 2 patients on their own
- Focus for the student will be to obtain a patient-centered chief complaint and full HPI, PMH, and Social History (SH)

ASSIGNMENT:

- Student will obtain a chief complaint, full HPI, PMH, and SH and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.
- For physical exam student will perform Vital Signs and assessment of General Appearance and Cardiovascular Examination and Pulmonary Examination and Breast/Pelvic (if applicable)
- Student will write patient encounter SOAP note for each patient
  - Student will need to submit 2 patient encounter SOAP notes in LCE6 in Benware.

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

**TEMPLATE for LCE6 (delete rest of standard template)**

Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.

Past Medical History:

Social History: Write as a descriptive narrative, not bullet points.

Physical Exam:
Vital Signs:
General Appearance:
Cardiovascular:
Pulmonary:
Breast/Pelvic (if applicable)
KEY CONCEPTS:

*What is a social history?*

The social history provides insight into the individual's values, attitudes, habits, and support systems.

Components: See Table 5-5, page 109 for details

- Occupation
- Diet/Physical Activity
- Functional Status
- Safety
- Exposures (pets, travel, illness, STI)
- Substance use
- Personal
  - Living arrangements “Who do you live with at home?”
  - Sexuality (orientation, practices, difficulty)
  - Intimate partner violence/abuse “Do you feel safe?”
  - Life stress
  - Mood
  - Spirituality/Religion
  - Cultural Identity/Background
- Health Screening/May have been covered in PMH
- Health Literacy/Educational background
VISIT 7/LCE7: Mid-Term Evaluation/Professionalism

Visit needs to be completed by December 11

REQUIRED READING: To be determined

OBJECTIVES:
- Mid-term Evaluations and Feedback for patient interviewing
- Student to spend time with office manager, social worker, or caseworker to discuss patient access obstacles (topic is subject to change).

ASSIGNMENT:
Spend time with the office manager or social worker in the clinic.
  i. Ask about patient access
     1. What are obstacles?
     2. What are potential solutions?
     3. Write a 1 page reflective paper on the obstacles that patients encounter for access to their provider in your specific clinic and how you feel that the solutions implemented may or may not work in the greater healthcare context.

See one patient with your preceptor and have them fill out the Mini-CEX evaluation
- Spend time with your preceptor going over your evaluation.
- Reflective paper needs to be submitted in LCE7 in Benware for approval
- Mini-CEX evaluation needs to be submitted to Kate Kress (this will be done by your preceptor)
VISIT 8/LCE8: Middle of the Interview

Obtaining a Family History

Visit needs to be completed by January 29

REQUIRED READING: Chapter 5

OBJECTIVES:
- Student will see 2 patients on their own
- Focus for the student will be to obtain a patient-centered chief complaint and full HPI, PMH, SH, and Family Medical History (FMH)

ASSIGNMENT:
- Student will obtain a chief complaint, full HPI, PMH, SH, and FMH and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.
- For physical exam student will perform Vital Signs and assessment of General Appearance and Cardiovascular Examination and Pulmonary Examination, Abdominal Examination, and Breast/Pelvic/MSK/Male GU (if applicable)
- Student will write patient encounter SOAP note for each patient
  i.  **Student will need to submit 2 patient encounter SOAP notes in LCE8 in Benware.**

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

**TEMPLATE for LCE8 (delete rest of standard template)**

Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.

Past Medical History:

Social History: Write as a descriptive narrative, not bullet points.

Family Medical History: May do as a genogram or as bullet points

Physical Exam:

Vital Signs:
General Appearance:
Cardiovascular:
Pulmonary:
Abdomen:
Breast/Pelvic (if applicable)
Male GU (if applicable)
MSK (if applicable)

Should’ve Section: What are things you should’ve asked or examined that you had missed?

KEY CONCEPTS:

*What is a Family History?*

A Family History is very important because many medical problems have a genetic component.

It is never appropriate to state, “Family history was non-contributory”

Start with a General Inquiry. Begin with a screening open-ended question. “Tell me about any illnesses or other problems that run in your family.”

Inquire about age and health (or cause of death) of first-degree relatives. “How is your father’s health?” “Mother’s health?” Ect.

Then list specific diseases that tend to run in families. (See Table 5-6, page 123 for details)
VISIT 9/LCE9: Middle of the Interview

Obtaining a Review of Systems

Visit needs to be completed by February 12

REQUIRED READING: Chapter 5

OBJECTIVES:

- Student will see 2 patients on their own
- Focus for the student will be to obtain a patient-centered chief complaint and full HPI, PMH, SH, FMH, and Review of Systems (ROS)
- Students will write notes in timed format (10 minutes)

ASSIGNMENT:

- Student will obtain a full history and focused physical and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.
- Focused physical applicable to differential diagnosis
- Student should be able to give at least 3 differential diagnosis (or involved organ systems) and support their reasoning.
- Student will write patient encounter SOAP note for each patient (timed 10 minutes)
  1. **Student will need to submit 2 patient encounter SOAP notes in LCE9 in Benware.**

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the **SOAP NOTE**

**TEMPLATE for LCE9**

Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.

Past Medical History (PMH)

Social History (SH): Write as a descriptive narrative, not bullet points.

Family History (FH): May do as a genogram or as bullet points

Review of Systems (ROS):
Organ System approach
List all positives and negatives
List all the positives first then the negatives

Avoid
"No problems with heart"
"Negative ROS"
"All Normal"

Repeat notations
Use "see HPI"

Physical Exam:
Vital Signs:
General Appearance:
Cardiovascular:
Pulmonary:
Breast/Pelvic (if applicable):
Abdomen:
Male GU (if applicable)
MSK: (if applicable)
Integument: (if applicable)

Differential Diagnosis:
Differential Diagnosis: What are the top 3 possibilities? Can be based by actual diagnosis or organ system involvement. What in the history and physical supports each possibility and what makes the possibility less likely?
1. +/-
2. +/-
3. +/-

Should’ve Section: What are things you should’ve asked or examined that you had missed?

KEY CONCEPTS:
What is a Review of Systems?
Table 4-1, page 65-67 for full ROS questions

The ROS is a structured series of questions covering all aspects of the patient's health status. It is utilized in the HPI as a means of obtaining pertinent positives and negatives, at the end of the history to avoid omissions, and as a mechanism for discovery of an unrecognized illness.

The ROS involves mainly symptoms not diagnoses. It is not necessary to repeat items covered in another area of the history. During this course, you will be expected to ask all questions within the ROS. As you become more familiar with the process and advance in your career, you may elect to ask key questions under each heading and only ask the detailed questions when a positive response occurs to a key item. For example, you may ask a general question, "Have you had any problems with your eyes?" If the response is
negative, you can move on to the next set of questions. If the response is positive, further specific questions should be asked. This is referred to as **branching**. Branching can lead to omissions if the patient needs prompting to recall a specific issue.

*Each positive answer needs to be developed fully (as a mini HPI)*. All of the pertinent information should be obtained on that response, before another system is addressed.

**Overview**
- Comprehensive review
- Head-to-toe evaluation

**Purpose**
- Identify the status of each organ system
  - Past
  - Present
  - Identify co-existing illness
- A double check for omissions in the HPI
- A list of questions, which can be used in the HPI

Includes positives and negatives

**Utilization (When do you use the ROS?)**
- During the HPI
  - Use components related to the Chief Complaint (patient-centered open-ended interviewing phase)
  - Use during clinician-centered closed-ended interviewing phase
    - Late in the interview
    - Identify omissions
- As a separate subsection of the Medical History
  - Comprehensive list of questions
  - Exhaustive search for other problems
    - Utilize most of the questions [see ROS list later in this text]
- **General Concepts**
  - Move from general to specific
  - Initial use of open-ended questions
  - Avoid leading questions
  - Avoid a long stream of yes/no questions
  - Avoid medical jargon
  - Avoid repeat questions
    - Those that fall in multiple categories
    - Those asked during the HPI
  - Don't dwell on ancient history
    - Symptoms that were resolved years ago
    - Focus the patient's time frame
  - Develop each positive response to its fullest
    - PQRST [see HPI]
    - Associated symptoms
  - Can be performed during the physical exam
    - Saves time
- But may be confusing as
  - difficult to remember
  - patient may have more difficulty answering
  - May create concern on the patient's part
    - it may draw concern when there is no specific worry on your part
- The patient with a positive review of systems
  - Definition
    - The patient answers yes to nearly everything
  - Solution
    - Emphasize severity
    - Limit time frame
    - Reduce items to bare minimum

Branching Method
Definition: Broad question with follow-up questions for positive responses
Examples
- “Have you had any problems with your eyes?”
  - Yes
    - “What kind of problems?”
    - Problems with vision, diplopia, flashing lights, photophobia, increased or decreased tearing, etc...
  - No
    - Move on with other systems
- Benefits of branching questions
  a. Saves time if there is no problem
- Risk of branching
  - Missing data
Visit needs to be completed by February 26

REQUIRED READING: Chapter 6

OBJECTIVES:
- Student will see 2 patients on their own
- Focus for the student will be to obtain a full history and focused examination and present to the preceptor clearly and concisely
- Focus will for student to give at least 3 developing differential diagnosis or involved organ systems and explain their reasoning
- Students will write notes in timed format (10 minutes)

ASSIGNMENT:
- Student will obtain a full history and focused physical and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.
- Focused physical applicable to differential diagnosis
- Student should be able to give at least 3 differential diagnosis (or involved organ systems) and support their reasoning.
- Student will write patient encounter SOAP note for each patient (timed 10 minutes)
  i. Student will need to submit 2 patient encounter SOAP notes in LCE10 in Benware.

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

**TEMPLATE for LCE10**

Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.

Past Medical History (PMH)

Social History (SH): Write as a descriptive narrative, not bullet points.

Family History (FH): May do as a genogram or as bullet points
Review of Systems (ROS):
Organ System approach
List all positives and negatives
List all the positives first then the negatives
Avoid
"No problems with heart"
"Negative ROS"
"All Normal"
Repeat notations
Use "see HPI"

Physical Exam:
Vital Signs:
General Appearance:
Cardiovascular:
Pulmonary:
Breast/Pelvic (if applicable):
Abdomen:
Male GU (if applicable)
MSK: (if applicable)
Integument: (if applicable)

Differential Diagnosis:
Differential Diagnosis: What are the top 3 possibilities? Can be based by actual diagnosis or organ system involvement. What in the history and physical supports each possibility and what makes the possibility less likely?
1. +/-
2. +/-
3. +/-

Should’ve Section: What are things you should’ve asked or examined that you had missed?

KEY CONCEPTS:
How to end an interview?
Oran the patient to the end of the interview and ask for permission to begin discussion. For example, “We have about 5 minutes left; I’d like to share my thoughts about what may be causing your symptoms and then discuss where to go from here. Is that all right with you?”

Bringing the patient into the discussion and asking permission gives patients more receptivity to your thoughts on their symptoms/condition.
VISIT 11/LCE11: Clinical Reasoning

Visit needs to be completed by March 11

REQUIRED READING: To be determined

OBJECTIVES:

• Student will see 2 patients on their own
• Focus for the student will be to obtain a full history and focused examination and present to the preceptor clearly and concisely
• Focus will for student to give at least 3 developing differential diagnosis or involved organ systems and explain their reasoning
• Students will write notes in timed format (10 minutes)

ASSIGNMENT:

• Student will obtain a full history and focused physical and then will step out and present to the preceptor and then return with the preceptor to watch the rest of the interview.

• Focused physical applicable to differential diagnosis

• Student should be able to give at least 3 differential diagnosis (or involved organ systems) and support their reasoning.

• Student will write patient encounter SOAP note for each patient (timed 10 minutes)
  
  i. **Student will need to submit 2 patient encounter SOAP notes in LCE11 in Benware.**

  Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the **SOAP NOTE**

  **TEMPLATE for LCE11**

  Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

  History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.

  Past Medical History (PMH)

  Social History (SH): Write as a descriptive narrative, not bullet points.

  Family History (FH): May do as a genogram or as bullet points
Review of Systems (ROS):
Organ System approach
   List all positives and negatives
   List all the positives first then the negatives
Avoid
   "No problems with heart"
   "Negative ROS"
   "All Normal"
Repeat notations
   Use "see HPI"

Physical Exam:
Vital Signs:
General Appearance:
Cardiovascular:
Pulmonary:
Breast/Pelvic (if applicable):
Abdomen:
Male GU (if applicable)
MSK: (if applicable)
Integument: (if applicable)

Differential Diagnosis:
Differential Diagnosis: What are the top 3 possibilities? Can be based by actual
diagnosis or organ system involvement. What in the history and physical supports each
possibility and what makes the possibility less likely?

1. +/-
2. +/-
3. +/-

   Should’ve Section: What are things you should’ve asked or examined that you
had missed?
Visit 12: End of the Year Evaluation/Clinical Reasoning

Visit needs to be completed by March 30

OBJECTIVES:

• End of the Year Evaluations and Feedback for patient interviewing and oral presentation skills

ASSIGNMENT:

• Student will see one patient with the preceptor and complete a full history and focused physical examination and preceptor will fill out the Mini-CEX evaluation (preceptor will submit this form to Kate Kress after giving feedback to the student)

• Student will see another patient on their own and obtain a full history and focused examination. The student will present the patient to the preceptor and the preceptor will evaluate the student’s oral presentation skills using the oral presentation form. (preceptor will submit this form to Kate Kress after giving feedback to the student)

• Student will write a patient encounter note in 10 minutes (timed) for each patient

Student will need to have 2 Patient Encounters SOAP Notes submitted in LCE12 in Benware for approval. Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

**TEMPLATE for LCE12:**

Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained.

Past Medical History (PMH)

Social History (SH): Write as a descriptive narrative, not bullet points.

Family History (FH): May do as a genogram or as bullet points

Review of Systems (ROS):

Organ System approach
List all positives and negatives  
List all the positives first then the negatives

Avoid
"No problems with heart"
"Negative ROS"
"All Normal"

Repeat notations
Use "see HPI"

Physical Exam:
Vital Signs:
General Appearance:
Cardiovascular:
Pulmonary:
Breast/Pelvic (if applicable):
Abdomen:
Male GU (if applicable)
MSK: (if applicable)
Integument: (if applicable)

Differential Diagnosis:
Differential Diagnosis: What are the top 3 possibilities? Can be based by actual
diagnosis or organ system involvement. What in the history and physical supports each
possibility and what makes the possibility less likely?

1. +/-
2. +/-
3. +/-

Should’ve Section: What are things you should’ve asked or examined that you
had missed?

- Reflective paper needs to be submitted in LCE12 in Benware for
approval. (topic to be determined)