Evaluation of Student H&P **UNC Medicine Inpatient Clerkship**

Student Name: _____ Date Submitted: _____

When Dr. Klipstein evaluates an H&P, he will consider the following issues:

History of Present Illness	❑	Includes a chief complaint
	❑	Appropriate dimensions of cardinal symptom are listed (including location, severity, quality, setting, chronology, aggravating/alleviating, associated manifestations)
	❑	Chronological story begins at baseline state of health
	❑	Incorporates elements of PMH, FH, SH that are relevant to story (e.g. includes risk factors for CAD for patient with chest pain)
	❑	ROS questions pertinent to chief complaint are included in HPI (not in ROS section)
	❑	HPI reflects knowledge of differential diagnosis
	❑	HPI narrative flows smoothly, in a logical fashion
Past Medical History	❑	Includes sufficient detail (onset, complications, and therapy) for key diagnoses (e.g., Type 2 DM, on pills since 1995, mild neuropathy, no known retinopathy/nephropathy)
Medications	❑	Includes dose, route and frequency for each medication
	❑	Includes over the counter and herbal remedies
Allergies	❑	Includes nature of adverse reaction
Review of Systems	❑	Most systems are evaluated (e.g. Constitutional, HEENT, Respiratory, Cardiovasc, GI, GU, Neuro, Psych, Endocrine, Musculoskeletal, Hematologic/ Lymph, Skin)
	❑	Does not include PMH (ex. Cataracts or heart murmur belong in PMH, not ROS)
	❑	Does not repeat information already in HPI
	❑	Adequate depth (e.g. GI: no abdominal pain, bloating, nausea, vomiting, melena, hematochezia, change in color, caliber, consistency or frequency of stool)
Social History	❑	Occupation, marital status
	❑	Tobacco, EtOH, *and* substance abuse
	❑	Functional status, living situation
Family History	❑	State of health of parents, siblings, children
	❑	Extended family occurrence of CAD, DM, HTN and cancer
	❑	Age at diagnosis of important diseases, especially if premature onset (e.g. CAD in brother age 37, colon cancer in father age 42)
Physical Examination	❑	Includes areas relevant to the chief complaint (e.g. for patient with cirrhosis includes presence/absence of stigmata of liver disease, for patient with CHF in differential diagnosis includes presence/absence of JVD, crackles, murmur, gallops, liver size, edema, etc)
	❑	Does *not* include assessments/interpretations in PE section (e.g. describes "8x10cm oval area of warm, erythematous skin on medial aspect of left thigh" instead of "cellulitis on medial aspect of left thigh")

Physical Examination, continued	❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	Includes general description Includes vital signs (including O2 sats, orthostatics, and pain level when appropriate) Includes skin examination Includes lymph node survey (not limited to neck nodes only) Includes thyroid examination Respiratory includes more than "clear to auscultation" Cardiovascular includes assessment of neck veins, and distal pulses Abdominal examination includes measured liver span Includes rectal exam (or reasonable statement as to why not performed) Neurologic examination includes mental status, cranial nerves, strength, sensation, cerebellar function and reflexes
Laboratory and Other Studies	❑ ❑	Includes lab data appropriate for HPI Lab data adequately reported (e.g. includes intervals on EKG for patient with syncope)
Problem List	❑ ❑ ❑	Includes all active medical problems Includes significant abnormalities in physical examination and laboratory studies Includes health maintenance/screening issues when appropriate
Discussion/ Assessment And Plans	❑ ❑ ❑ ❑ ❑ ❑	Includes sentence summarizing key history, PE and laboratory data Discussion is specific to the patient, not a summary of textbook or review article Adequate differential diagnosis reviewed for major problems Evaluation/diagnostic strategy proposed (or reviewed if already performed) Management strategy discussed Reflects an understanding of the pathophysiology of the patient's illness
Style	❑ ❑ ❑	Legible Not laden with spelling or grammatical errors Uses medical abbreviations appropriately, does not coin own abbreviations

Comments: