UNIVERSITY MEDICAL
& DENTAL COLLEGE

CFRC

Clinical Foundation Rotation Clerkship

MBBS YEAR 02

2026

Modular Integrated Curriculum

Department of Medical Education

Table of Contents

LIST OF ABBREVIATIONS

Abbreviations	Subjects
A	Anatomy
Ag	Aging
B	Biochemistry
BhS	Behavioral sciences
C	Civics
CM	Community Medicine
C-FRC	Clinical-Foundation Rotation Clerkship
CV	Cardiovascular
EnR	Endocrinology & Reproduction
ENT	Ear Nose Throat
F	Foundation
FM	Forensic Medicine
GIT	Gastrointestinal tract
GO	Gynecology and Obstetrics
HL	Hematopoietic & Lymphatic
HNSS	Head & Neck and Special Senses
IN	Inflammation
M	Medicine
MS	Musculoskeletal
NS	Neurosciences
O	Ophthalmology
Or	Orientation
P	Physiology
Pa	Pathology
Pe	Pediatrics
PERLs	Professionalism, Ethics, Research, Leadership
Ph	Pharmacology
Psy	Psychiatry
QI	Quran and Islamiyat
R	Renal
Ra	Radiology
Re	Respiratory
S	Surgery

PREAMBLE

The Aim of Medical training is to deliver the best possible patient care. This is not possible until medical students are holistically trained to deliver standardized patient care, with management and counselling skills.The competencies given by PMDC for a graduating physician include:

1. Skillful
2. Knowledgeable
3. Community Health Promoter
4. Critical Thinker
5. Professional
6. Scholar
7. Leader and Role Model

All the above cannot be accomplished without a robust Clinical clerkship program.

The purpose of this document is to provide an outline to the UHS clinical clerkship program which will serve as a vertically integrated module throughout the five years of medical college, transitioning from Clinical Foundation (CF) in the first two years to Clinical Rotations (CR) in the third and fourth year and finally to a complete clinical clerkship (CC) in final year of MBBS.

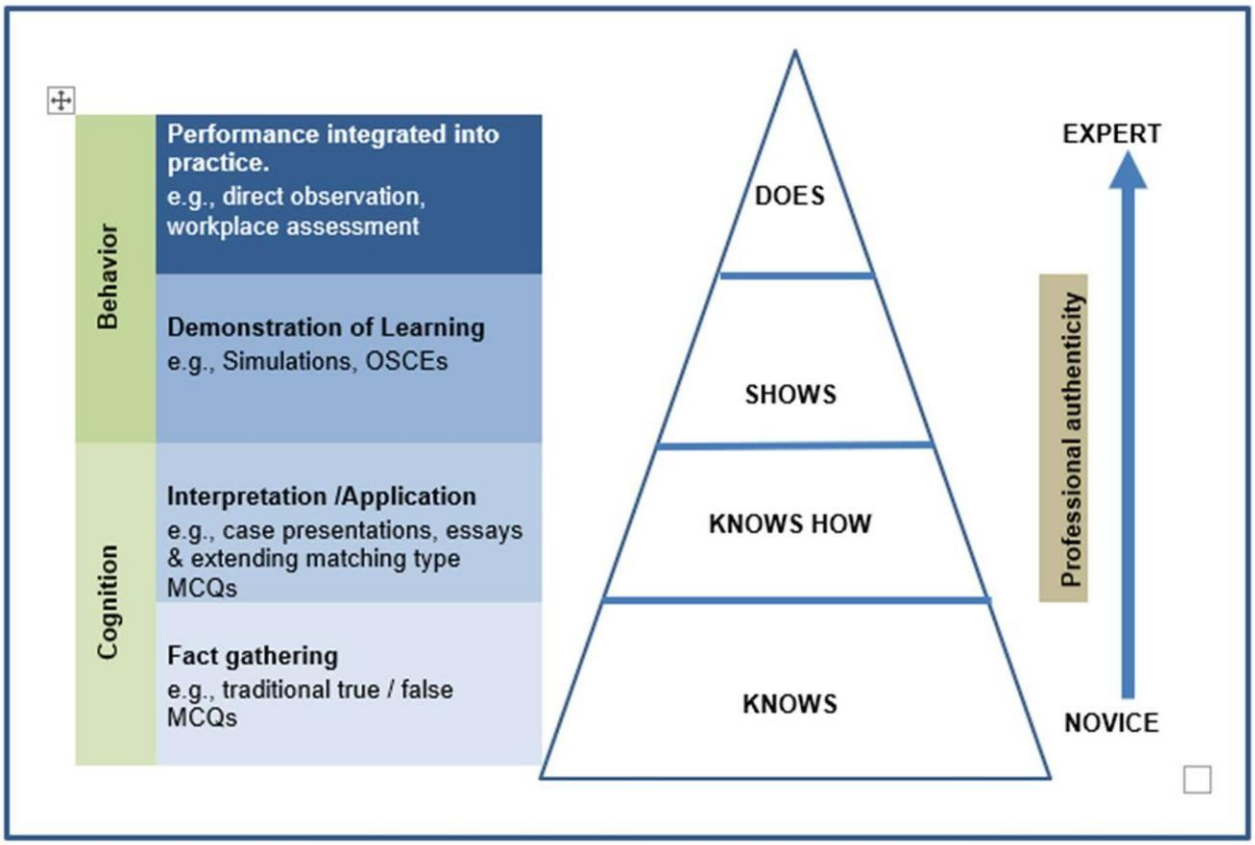
Keeping in view the 45 affiliated medical colleges under the umbrella of UHS, we have tried our best to devise a flexible program which colleges can tailor according to their capacities and resources. We are hopeful this innovative new step will lead to standardization of patient care for UHS lead colleges in the best possible way.

How to use this logbook:

- Each clinical skill has an entry in this logbook along with the checklist to be filled by the supervisor in the ward.
- Number of entries per skill is also mentioned in the modular study guides.
- The Clinical supervisor must tick all boxes deemed fulfilled and give feedback to the student regarding their performance.

MILLER'S PYRAMID

The basis to assess clinical skills is the Miller's pyramid. Different skills throughout the CFR-C module scale from Knows How (e.g., Interpretation of CXR) to does (administer IM injections etc.).




BLOCK-04

GIT AND NUTRITION-1 MODULE		
Objectives	**Skill**	**Miller's Pyramid Level Reflected**
Demonstrate steps of abdominal examination	Abdominal Examination	Shows
Demonstrate the procedure of shifting dullness	shifting dullness	Shows
Identify organs on X-ray abdomen	X-ray Abdomen	Shows
Assess dehydration in infant/young child and explain procedure of making home made ORS	Dehydration	Does

Place a "✓" in case box if step/task is performed satisfactorily, an **"X"** if it is not performed satisfactorily, or **N/O** if not observed.

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Date Observed: _____

CHECKLIST FOR ABDOMINAL EXAMINATION **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES (Minimum 3 Entries)**		
STEP/TASK			
GETTING READY: 1. Has performed hand washing			
2. Introduces himself/herself to patient			
3. Explains Procedure and Asks for consent			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
THE PROCEDURE: **GENERAL EXAMINATION:** Examine the following features to check for any pathology related to the GIT: i. Facies ii. Body build iii. Posture iv. Color of skin v. Vital signs vi. Head vii. Neck			

viii. Upper limbs ix. Lower limbs x. Chest and heart xi. Spine **INSPECTION OF THE ABDOMEN:** 1. Position the patient in the supine position and drape the patient exposing only the areas needed for assessment. 2. Inspect the abdomen for shape/contour, symmetry, pigmentation/colour, lesions/scars, pulsation, and visible peristalsis 3. Examination was carried out in good light, looking from either end of the bed from the side, and finally tangentially 4. Looked for: i. shape (contour) ii. sub costal angle iii. epigastric pulsation iv. divarication of recti v. position of the umbilicus vi. hair distribution vii. skin(pigmentation, scars) viii. dilated veins ix. hernia orifices (ask pt to cough) x. visible movements xi. genitalia xii. back (all back exam at the end) 5. Type of breathing (ask the patient to take deep breath)			
PALPATION: 1. Stand by the right side of the patient 2. Relax the abdominal wall by asking the patient to flex his hip and knees, and ask him to open the mouth and breathe quietly in and out. 3. Make sure that his/her hand is warm 4. If a painful area or mass is present, palpate that area at the end.			

5. Started by light palpation (superficial palpation): i. Tenderness: Ask the patient to locate the site of tenderness. If he/she is not able to; ask them to take a deep breath or to cough. Elicit Rebound tenderness ii. Differentiate rigidity from guarding: rigidity is generally a sign of peritoneal irritation, it is present throughout the abdominal wall, the wall feels stiff and board like to touch. Guarding is a protective mechanism usually triggered by touch or patient's anticipation to pain. iii. (Swelling: If there is a swelling; - Ask the patient to contract his/her abdominal wall muscles by raising his/her head (to determine if it is intra or extra abdominal swelling) Notice the swelling mobility with respiration iv. Hernia orifices: Examine the anatomical sites of hernia for swelling and any expansile impulse with cough. Elicit deep palpation: i. Start Palpation of normal solid viscera (the liver, the spleen and the kidneys): **A. <u>Palpation of the liver:</u>** i. Place hand in the right iliac fossa, (hand may either rest transversely and flat at right angle to the linea semilunaris and parallel to the costal margin, or placed with fingers pointing towards the head of the patient). The other hand is placed in the loin. ii. Ask the patient to take a deep breath. iii. Keep hand still during inspiration and during expiration slide the hand a little nearer to the right costal margin. <u>When examining a hepatic swelling record:</u> i. The degree of enlargement in a fingerbreadth below the costal margin. ii. The character of the edge (sharp or rounded). iii. The surface (smooth or nodular) iv. The consistency (soft, firm, hard or heterogeneous)			

v. The presence of tenderness
vi. The degree of movement on respiration.

B. <u>Palpation of the spleen</u>

There are several clinical methods for the detection of an enlarged spleen:

a) <u>The standard method or bimanual examination:</u>

Start palpation from the right iliac fossa with the tips of the examining hand directed towards the left axilla. The left hand is placed over the lateral aspect of the left costal margin, exerting a certain amount of compression. Followed the rules of palpation moving toward the left hypochondrium until feeling the spleen.(If the spleen is not felt, lift the rib cage forwards as the patient inspired).

b) <u>The hooking method:</u>

If the spleen is not felt by the bimanual method, ask the patient to place the fist of the left hand under the lower ribs in order to push the spleen forward. Then stand on the left side of the patients head and place the fingers of both hands over the costal margin. The patient is instructed to take deep breath.

c) <u>The right lateral position</u>:

If the spleen is not felt by the ordinary method ask the patient to turn to his right side and palpate the spleen by insinuating hand below the costal margin and ask the patient to take deep breath till feeling the lower edge of the spleen .

d) <u>Dipping method:</u>

In the presence of tense ascites. Place hand in the left hypochondrium and push the abdominal wall downwards and wait for the return impulse to hand

C). <u>The kidneys:</u>

a) The right kidney is examined by the left hand behind the patient's right loin (between the last rib and the iliac crest) lift the loin and the kidney forward. Put the right hand on the right lumbar region just above the anterior superior iliac spine and as the patient to take deep breath. During expiration push the right hand deeply but gently

and keep it still during inspiration and repeat as patient takes his breath. b) The left kidney is examined by the same procedure on the left side by either standing on the patient's left side or by leaning across the patient, putting the right hand in the left loin and feeling the kidney with the left hand. **D). <u>Palpation for other abdominal swellings</u>:** Parietal swellings: Swellings of the anterior abdominal wall are differentiated from the intra-abdominal swellings by three signs: i. Relation to the costal margin. ii. Behavior on contraction of the abdomen. iii. Movement with respiration. ❖ If abdomen was tense, started percussion before palpation			
PERCUSSION: i. Percuss over the whole abdomen and particularly over any masses. ii. light percussion is necessary. iii. Start from resonant to dull in the midline **<u>A) Percussion of the liver (span of the liver):</u>** i. Determine the upper border of the liver by heavy percussion. (started from the 2nd intercostal space, opposite the sternocostal junction) ii. Percuss down along each interspace and when reaching the liver dullness of the upper border ask the patient to take a deep breath and hold it. Percuss again, and then asked him/her to exhale and re-percuss (tidal percussion). Percuss onto the abdomen until the liver dullness disappeared. iii. Mark the lower border of the liver. iv. Measure the distance between the upper and lower border in the right mid- clavicular line. **<u>B) Percussion of the spleen</u>:** The three methods for percussion of the spleen (a) <u>Percussion in the right lateral position.</u>			

Start at the lower border of pulmonary resonance in the posterior axillary line and carry down obliquely towards the lowest mid- anterior costal margin. (b) Percussion in the supine position: start from the right iliac fossa towards the left costal margin then continue to the mid axillary line. (c) Percussion of the Traube`s space: Area defined by the left sixth rib superiorly, the left midaxillary line laterally, and the left costal margin inferiorly. **C)Percussion of the kidney:** Percuss the renal angle.			
AUSCULTATION: i. Intestinal sounds ii. Bruits iii. Venous hum iv. Succussion splash **Examination of the back**: i. Ask the patient to sit ii. Inspect for any swellings, deformities or scars iii. Palpate for edema over the sacrum iv. Palpate for the tenderness in the renal angles, palpate for tenderness over vertebrae v. Auscultate the renal angles for bruit			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

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CHECKLIST FOR FLUID THRILL/SHIFTING DULLNESS **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES (Minimum 3 Entries)**		
STEP/TASK			
GETTING READY: 1. Washed hands/sanitized hands			
2. Explained procedure to the patient and take consent			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
The Procedure: 1. Percuss from the umbilical region to the patient's left flank. If dullness is noted, this may suggest the presence of ascitic fluid in the flank. 2. Whilst keeping your fingers over the area at which the percussion note became dull, ask the patient to roll onto their right side (towards you for stability). 3. Keep the patient on their right side for 30 seconds and then repeat percussion over the same area.			

4. If ascites is present, the area that was previously dull should now be resonant (i.e. the dullness has shifted).			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

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CHECKLIST FOR X-RAY ABDOMEN **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES (Minimum 2 Entries)**	
STEP/TASK		
Patient Information 1. Verify patient identification (name, date of birth).		
2. Confirm the date and time of the X-ray.		
SKILL/ACTIVITY PERFORMED SATISFACTORILY		
Technical Factors 1. Check the X-ray for proper exposure, focus, and positioning.		
2. Assess the image for any artifacts or technical errors.		
3. Ensure the correct orientation of the X-ray (anterior-posterior or posteroanterior view).		
SKILL/ACTIVITY PERFORMED SATISFACTORILY		
Procedure: 1. Identify and evaluate the integrity of the bony structures, including the spine, ribs, and pelvic bones.		
2. Assess the soft tissues, looking for any masses, swellings, or abnormalities.		

3. Identify the presence and distribution of gas throughout the abdomen and bowel loops.		
4. Examine the diaphragm for any abnormalities, such as elevation or flattening.		
5. Evaluate the cardiac silhouette for size and shape.		
6. Identify abdominal organs: i. Liver: assess Assess the size, shape, and density of the liver ii. Spleen: Evaluate the size and contours of the spleen iii. Stomach: identify the gastric air bubble and its location iv. Pancreas: look for pancreatic shadow v. Kidneys: identify both kidneys, assess their size, shape and density vi. Bladder: check for presence of urine in bladder		
7. Small Bowel: Evaluate for normal loops and check for any signs of obstruction. 8. *Colon: Assess* the size and contour of the colon.		
9. Vascular structures: Aorta: evaluate the size and course of the abdominal aorta Inferior Vena cava: check the patency and size		
10. Muscles: examine abdominal wall muscles for symmetry and abnormalities. Fat: assess the distribution and amount of intraabdominal fat.		
11. Abnormalities: identify any abnormalities such as calcification, masses, abnormal densities.		
SKILL/ACTIVITY PERFORMED SATISFACTORILY		
Signatures of Supervisor		

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CHECKLIST FOR ORS FORMULATION AND DEHYDRATION ASSESSMENT **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES (Minimum 2 Entries)**	
STEP/TASK		
Introduction 1. Gain consent from parent / child for examination after explaining procedure		
2. Make sure hands are washed and warm		
SKILL/ACTIVITY PERFORMED SATISFACTORILY		
Procedure: 3. Ask about diarrhea/vomiting and any reduction in urine output		
4. Inquire about color of urine (darker indicates dehydration)		
5. Look for dry cracked lips, dry mouth		
6. Inspect eyes if they appear sunken (sign of dehydration)		
7. Notice if child is generally irritable/has an altered mental status		

8. Examine for absence of tears		
9. Check pulse (dehydration results in tachycardia)		
10. Skin pinch is assessed by pinching the skin of the abdomen between the thumb and forefinger without twisting. If the skin goes back in <1 second it is normal, if it takes more than that, dehydration is likely		
SKILL/ACTIVITY PERFORMED SATISFACTORILY		
Formulation of ORS at home 1. Counsel patient regarding rehydration		
2. Explain the procedure of adding 6 teaspoons levelled of sugar, ½ teaspoon of salt and exact 1 liter of water (Approx. 5 cups of 200 ml)		
3. Mix the ingredients well and make sure the salt and sugar amount are exact		
SKILL/ACTIVITY PERFORMED SATISFACTORILY		
Signatures of Supervisor		

RENAL MODULE		
Objectives	**Skill**	**Miller's Pyramid Level Reflected**
Detail the steps of urinary catheterization in females	*Catheterization	Knows how
Detail the steps of urinary catheterization in males	*Catheterization	Knows how

- These skills are at the 'Knows how' level of the miller's pyramid, meaning thereby that students need not perform them themselves but may develop a perception regarding them by observing performance/working on simulated patients/facilitation with video.

FEMALE CATHETERIZATION

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CHECKLIST FOR FEMALE CATHETERIZATION (Some of the following steps/tasks should be performed simultaneously.)	**(Minimum 1 Entry)**
1. Identification of patient	
2. Washed hands/ sanitized hands	
3. Preparation: gloves, in place, Foley catheter kit, extra pair of sterile gloves, Velcro™ catheter securement device to secure Foley catheter to leg, wastebasket, and light source	
SKILL/ACTIVITY DESCRIBED SATISFACTORILY	
4. Explain procedure to the patient and obtain consent, and explain the need of a chaperone (for male students)	
5. Assess for latex/iodine allergies, GYN surgeries, joint limitations for positioning, and any history of previous difficulties with catheterization.	
6. Position the female patient in a dorsal recumbent position. Uncover the patient, exposing the patient's groin, legs, and feet for positioning and sterile field (female = dorsal recumbent; may need assistance to position patient and help support legs). Drape the patient with a bath blanket, exposing only the necessary area for patient privacy.	
7. Create a sterile field on the over-the-bed table.	

8. Open the outer package wrapping. Remove the sterile wrapped box with the paper label facing upward to avoid spilling contents and place it on the bedside table or, if possible, between the patient's legs. Place the plastic package wrapping at the end of the bed or on the side of the bed near you, with the opening facing you or facing upwards for waste.	
9. Open the kit to create and position a sterile field: a. Open the first flap away from you. b. Open the second flap toward you. c. Open side flaps. d. Only touch within the outer 1" edge to position the sterile field on the table.	
10. Carefully remove the sterile drape from the kit. Touching only the outermost edges of the drape, unfold and place the touched side of drape closest to linen, under the patient. Vertically position the drape between the patient's legs to allow space for the sterile box and sterile tray.	
11. Wash your hands and apply sterile gloves.	
12. Empty the lubricant syringe or package into the plastic tray. Place the empty syringe/package on the sterile outer package.	
Simulate application of iodine/antimicrobial cleanser to cotton balls.	
13. Carefully remove the plastic catheter covering, while keeping the catheter in the sterile box. Attach the syringe filled with sterile water to the balloon port of the catheter; keep the catheter sterile.	
14. Lubricate the tip of the catheter by dipping it in lubricant and place it in the box while maintaining sterility.	
15. Tell the patient that you are going to clean the catheterization area and they will feel a cold sensation.	
16. With your nondominant hand, gently spread the labia minora and visualize the urinary meatus. Your nondominant hand will now be nonsterile. This hand must remain in place throughout the procedure.	

17. With your dominant hand, use an antiseptic swab or pick up a sterile antiseptic soaked cotton ball with plastic forceps to clean the labia minora farthest from you using a downward stroke, then discard the swab or cotton ball. Repeat for the labia minora closest to you. Use another antiseptic swab or antiseptic soaked cotton ball to clean the area between the labia minora. Discard the cotton ball after use into the plastic bag, not crossing the sterile field. Repeat for a total of three times using a new cotton ball each time. Discard the forceps in the plastic bag without touching the sterile gloved hand to the bag	
18. Pick up the catheter with your sterile dominant hand. Instruct the patient to take a deep breath and exhale or "bear down" as if to void, as you steadily insert the catheter maintaining sterility of the catheter until urine is noted.	
19. Once urine is noted, continue inserting the catheter 2-3″ farther." Do not force the catheter.	
20. With your dominant hand, inflate the retention balloon with the water- filled syringe to the level indicated on the balloon port of the catheter. With the plunger still pressed, remove the syringe and set it aside. Pull back on the catheter until resistance is met, confirming the balloon is in place.	
21. Remove your gloves and perform hand hygiene.	
22. Apply new gloves. Secure the catheter with securement device, allowing room as to not pull on the catheter.	
23. Place the drainage bag below the level of the bladder, attaching it to the bed frame.	
24. Remove your gloves and perform hand hygiene. Assist patient to a comfortable position.	
SKILL/ACTIVITY DESCRIBED SATISFACTORILY	
Signatures of Supervisor	

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CHECKLIST FOR MALE CATHETHERIZATION **(Some of the following steps/tasks should be performed simultaneously.)**	**(Minimum 1 Entry)**
1. Identification of patient	
2. Collect the equipment required for the procedure and place it within reach on the clean trolley. Check the expiry date on the catheter, sterile water, normal saline and lidocaine gel. Ensure a clinical waste bin is placed nearby	
SKILL/ACTIVITY OBSERVED AND DESCRIBED SATISFACTORILY	
1. Wash hands	
2. Introduce yourself to the patient, explain the procedure and take consent	
3. Explain the need for a chaperone (for female students)	
4. Setup up the sterile field by first removing the outer packaging from the catheter pack and then opening the catheter pack from the corners without touching the inner surface of the field.	
5. Using aseptic non-touch technique (ANTT) empty the catheter, lidocaine gel syringe, sterile water syringe and sterile gloves onto the field.	
6. Pour the 0.9% sodium chloride solution over the cotton balls which should already be located within the gallipot of the catheter pack	
7. With the patient lying supine, ensure the bed is at an appropriate height for you to comfortably carry out the procedure	
8. Wash your hands again and don a pair of sterile gloves	
9. Ask your chaperone to remove the sheet covering the patient's genitals to allow you to maintain sterility	
10. Place a sterile absorbent pad underneath the patient's genital region,	

ensuring you maintain sterility	
11. With your dominant hand pick up a cotton ball and use a single stroke moving away from the urethral meatus to clean an area of the glans. Dispose of the first cotton ball into the clinical waste bin and continue to repeat this process with a new cotton ball each time until all areas of the glans have been cleaned	
12. Discard your used gloves, wash your hands again and don a new pair of sterile gloves	
13. Place the sterile drape over the patient's penis, positioned such that the penis remains visible through the central aperture of the drape. Some drapes come with a hole already present for this purpose, whereas others will require you to create one	
14. Place the sterile urine collection bowl below the penis but on top of the sterile drape	
15. Warn the patient that the anesthetic gel might initially sting, but then should quickly cause things to become numb with your dominant hand place the nozzle of the syringe of anaesthetic gel into the urethral meatus. Empty the entire 10mls of anaesthetic gel into the urethra at a slow but steady pace . Continue to hold to the penis in the vertical position to ensure the gel remains within the urethra and allow 3 to 5 minutes for the lidocaine gel to reach its maximum effect	
16. Pick up the catheter which should be on your sterile field in its wrapper. Remove the tear-away portion of the wrapper near the catheter tip, making sure not to touch the catheter. Clean away any urine spillage or excess lubricating gel and cover the patient with the sheet. Dispose of your equipment into a clinical waste bin 46 Provide the patient with privacy to get dressed	
17. Hold the penis again using sterile gauze with your non-dominant hand	
18. Warn the patient you are about to insert the catheter. Insert the exposed catheter tip into the urethral meatus using your dominant 'clean hand'	
19. Advance the catheter slowly whilst gradually removing more of the wrapper to expose more of the catheter. You should continue to advance the catheter until it is fully inserted into the penis	
20. Once the catheter is fully inserted, inflate the catheter balloon with the 10ml syringe of sterile water to secure it within the bladder	
21. Once the balloon is fully inflated, remove the syringe and gently withdraw the catheter until resistance is noted, confirming the catheter is held securely within the bladder	
22. Attach the catheter bag tubing to the end of the catheter securely. Position the catheter bag below the level of the patient to facilitate effective drainage of urine	
23. Clean away any urine spillage or excess lubricating gel and cover the patient with the sheet Dispose of your equipment into a clinical waste bin. Provide the patient with privacy to get dressed	

24. Dispose of your equipment into a clinical waste bin. 25. Provide the patient with privacy to get dressed	
SKILL/ACTIVITY PERFORMED SATISFACTORILY	
Signatures of Supervisor	


BLOCK-05

ENDOCRINOLOGY & REPRODUCTION-1 MODULE		
Objectives	**Skill**	**Miller's Pyramid Level Reflected**
Examination of the thyroid gland	Thyroid examination	Shows
Examination for Acromegaly	Examination for acromegaly	Shows
Measurement of blood glucose levels	Blood sugar measurement	Shows
Suturing	Suturing	*Knows how

- These skills are at the 'Knows how' level of the miller's pyramid, meaning thereby that students need not perform them themselves but may develop a perception regarding them by observing performance/working on simulated patients/facilitation with videos.

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CHECKLIST FOR THYROID EXAMINATION **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES** **(Minimum 3 Entries)**		
STEP/TASK			
GETTING READY:			
1. Wash your hands and don PPE if appropriate			
2. Introduce yourself to the patient including your name and role			
3. Gain consent to proceed with the examination			
4. Ask the patient to sit on a chair for the assessment			
5. Adequately expose the patient's neck and upper sternum			
6. Ask if the patient has any pain before proceeding			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
THE PROCEDURE:			
7. Inspect the patient whilst at rest, looking for clinical signs suggestive of underlying pathology			
8. Inspect the patient's face for clinical signs suggestive of thyroid pathology (dry skin, excessive sweating, eyebrow loss)			
9. Inspect the patient's eyes for evidence of lid retraction, inflammation and exophthalmos			
10. Assess for eye movement abnormalities			

11. Assess for lid lag			
12. Inspect the midline of the neck for evidence of thyroid enlargement, lumps or scars			
13. Ask the patient to protrude their tongue and repeat inspection			
14. Palpate the patient's thyroid gland assessing size, symmetry and consistency. Also note any masses present in the thyroid tissue.			
15. Ask the patient to protrude their tongue whilst you palpate			
16. Palpate local lymph nodes to assess for lymphadenopathy			
17. Inspect for tracheal deviation			
18. Percuss downwards from the sternal notch for evidence of retrosternal dullness			
19. Auscultate each lobe of the thyroid for a bruit			
20. Thank the patient			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

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CHECKLIST FOR ACROMEGALY **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES** **(Minimum 3 Entries)**		
STEP/TASK			
THE PROCEDURE:			
1. Wash your hands and gain consent from the patient			
2. Ask the patient if he/she has any pain in any region			
3. Perform a brief general inspection of the patient, looking for clinical signs suggestive of acromegaly such as: a. Facial features: coarse features, such as prominent supraorbital ridges and prognathism, may be indicative of acromegaly.			
4. Hands and feet: may be enlarged.			

5. Skin: may display thickening in the hands and face and excess sweating or oiliness in acromegaly.
6. Posture: patients with acromegaly can present with signs of osteoarthritis, especially in the weight-bearing joints (knees and hips).
7. Hair growth: hirsutism in women and hypertrichosis may occur.
8. Skin tags: acromegaly can cause an increase in the number of skin tags.
9. Gait: acromegaly can cause a rolling gait or varus deformity.
10. Clothes: clothes or jewellery may appear tight if significant weight gain has occurred.

11. Hands:

    Inspect for:

    a. Enlargement: grossly increased size of the hands may be assessed by comparing your hands to the patient are, accounting for natural size differences.
    b. Wasting: thenar wasting can indicate untreated carpal tunnel syndrome.
    c. Scars: carpal tunnel release scar may indicate previous median nerve compression.
    d. Skin changes: skin thickening and excess sweating can occur in acromegaly.
    e. Finger pricks: finger prick marks on the tips of the fingers may indicate diabetes, which is linked to acromegaly
    f. Palpation
    g. Assess for thickening of the patient's skin by pinching the skin overlaying the third metacarpophalangeal joint. This can be compared with your own hand's skin to detect any differences.

12. Axillae: Whilst supporting the patient's arm, inspect each axilla for the following: a. Acanthosis nigricans: darkening (hyperpigmentation) and thickening (hyperkeratosis) of the axillary skin which can be benign (most commonly in dark-skinned individuals) or associated with insulin resistance (e.g., type 2 diabetes mellitus) as a complication of acromegaly. b. Hypertrichosis: increased hair growth can occur as a result of the effects of growth hormone.			
13. Palpate for thyroid gland			
14. Look for raised JVP			
15. Face: a. General features: b. Inspect the general appearance face for coarse features associated with acromegaly: c. Frontal bossing: a prominent or protruding brow can occur with excess GH. d. Large nose, ears, and lower lip: aspects of soft-tissue overgrowth. e. Prognathism: overgrowth of the jaw can lead to a mandibular protrusion			
16. Mouth: Inspect the inside of the mouth for the following: a. Macroglossia: tongue enlargement may cause the tongue to appear large for the mouth or even cause visible partial airway obstruction in extreme cases. b. Wide spaced teeth: growth of the soft palate may cause interdental separation of the lower jaw. c. Prognathism: overgrowth of the jaw may only be discernible on closer inspection.			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

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Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Date Observed: _____

CHECKLIST FOR EXAMINATION OF BLOOD GLUCOSE LEVELS **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES** **(Minimum 3 Entries)**		
STEP/TASK			
THE PROCEDURE:			
1. Explain the procedure to the patient and get a verbal consent to proceed.			
2. Gather the relevant equipment and place in a clean tray: i. Non-sterile gloves ii. Blood glucose reader (a.k.a. glucometer): calibrate using calibration fluid if required. iii. Spring-loaded lancet: to obtain the blood sample. iv. Testing strips: make sure the expiry date is valid. v. Gauze vi. Tape			
3. Ensure the patient's finger is cleaned prior to measuring capillary blood glucose: i. It's important that the skin over the site being tested has been cleaned, as substances on the skin can affect the accuracy of capillary blood glucose results (e.g. substances containing sugar). ii. Ask the patient to wash their own hands or alternatively you can clean the site with an alcohol swab (70% isopropyl).			

iii. Make sure the skin over the testing site has dried completely before performing capillary blood glucose measurement.			
4. Turn on the capillary blood glucose monitor and ensure it is calibrated.			
5. Load a test strip into the glucose monitor.			
6. Don a pair of non-sterile gloves.			
7. Pick up the lancet and carefully remove the protective cap.			
8. Prick the side of the patient's finger with the lancet and gently squeeze the finger from proximal to distal to produce a droplet of blood. Some guides advise cleaning away the first drop of blood, however, there is no evidence that this significantly impacts the reliability of blood glucose results.			
9. Gently touch the tip of the test strip against the droplet of blood to allow it to be absorbed into the strip.			
10. Apply gauze or cotton wool to the puncture site to stop the bleeding and ask the patient to maintain pressure over the site			
11. Safely dispose of the lancet into a sharps bin.			
12. Dispose of the test strip and the cotton wool/gauze into a clinical waste bin. If the patient's finger is still bleeding, keep the cotton wool or gauze in place and secure with some tape.			
POST PROCEDURE:			
1. 'Wash your hands, thank the patient'			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

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CHECKLIST FOR SIMPLE INTERRUPTED SUTURE (Some of the following steps/tasks should be performed simultaneously.)	**CASES (Minimum 2 Entries)**		
STEP/TASK			
EQUIPMENT: Collect a procedure trolley, and clean the top surface using an alcohol surface disinfectant wipe. Next obtain a plastic tray, and clean it in a similar manner. You will then need to collect a number of items. For cleaning: i. A pair of non-sterile gloves. ii. Five 10mL sachets of 0.9% sodium chloride (saline) solution. iii. Gauze. For anaesthesia: i. A pair of sterile gloves. ii. Alcohol wipe (2% chlorhexidine in 70% alcohol). iii. 20mL 1% lidocaine solution (with or without adrenaline. iv. Drawing up needle (≤18 gauge). v. Subcutaneous needle (25-27 gauge) and syringe (20mL). vi. Sharps bin. For suturing: i. Suture pack (containing needle holder, scissors, toothed forceps, non-toothed forceps). ii. A pair of sterile gloves. iii. Suture material. iv. Sterile drape. v. Sharps bin.			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			

THE PROCEDURE: i. Explain the procedure to the patient and take consent			
Inspection: ii. Assess the size and depth of the wound as well as the state of its border. Inspect for any pus inside which may suggest infection. Ensure that there are no foreign bodies present, such as glass. Finally, check the surrounding skin for any bruising or erythema which may suggest a cellulitis infection.			
Cleaning iii. To clean the wound, take the gauze and soak it in saline solution. Carefully wipe the area starting from the centre of the wound and continuing outwards.			
Anaesthesia iv. Before injecting the anaesthetic, confirm with the patient that they have had no previous reactions to local anaesthetic. Once this has been confirmed, clean the surrounding area using an alcohol wipe. Whilst waiting for the skin to dry, draw up the lidocaine solution into the syringe. a) Once ready to inject, switch the needle on the syringe and don some sterile gloves. Using proper technique, inject 2mL of lidocaine solution subcutaneously into the surrounding skin. After doing so, manoeuvre the needle and continue to inject small amounts of anaesthetic such that all of the surrounding skin is anaesthetised. For medium to large wounds, you will need to withdraw the needle and reinject at another area.			
v. Wash and dry both your hands and the distal third of your forearms and then put the sterile gloves on using correct sterile technique. Allow the anaesthesia at least 5 minutes to work.			
vi. Carefully position the part of the body with the wound and apply the sterile drape over it. At this point, explain to the patient that it is very important for them to keep still and not touch anything on the sterile field to avoid contamination.			
a) Using the toothed forceps, pinch the sides of the wound to test for numbness, and ask the patient whether they can feel any pain. Be sure to warn the patient before you do this. The patient may be able to feel a sense of pressure but should not feel any pain.			

vii. Use the forceps to position the needle in the needle holder so that the needle holder is two-thirds of the way up from the tip of the needle.			
viii. Hold the needle holder in your dominant hand and the toothed forceps in the other. Starting from the middle of the wound, use the forceps to pull the skin up on the wound side closest to your dominant hand. Insert the needle into the skin on the same side at a 90° angle, at least 5mm from the wound edge.			
ix. Push the needle through the skin, supinating your forearm to follow the curvature of the needle as you do so. Remove the needle from the needle holder and pull the needle through that side of the wound using the forceps. a) Position the needle back into the needle holder and insert it into the dermis of the other side of the wound, around 5mm below the skin surface. Again, supinate your wrist such that the needle emerges to the skin surface. Pull the needle through such that only 15cm of thread remains on the other side.			
x. To secure the suture in place, you will need to tie a surgical knot. This is achieved by tying three smaller "throw" knots.			
xi. 1st throw: Hold the needle holder directly above and parallel to the wound. Wrap the longer end of the thread around the needle holder twice in a clockwise direction and then use the tip of the needle holder to grasp the shorter end of the thread and pull in opposite directions, tying the first throw.			
xii. 2nd throw: Once again wrap the longer end of the thread around the needle holder, however this time, do so only once and in an anticlockwise direction. Then, as before, use the tip of the needle holder to grasp the shorter end of the thread. Pull the suture material through, tying another throw.			
xiii. 3rd throw: Tie this throw in a clockwise direction in a similar manner to the 1st. However, only wrap the thread once around the needle holder.			
xiv. Once you have completed the three throws, you should have a strong surgical knot. Try to position the knot on one side of the wound. Next, cut both ends of the suture such that there is 5mm of thread on either side. This is so that it is easy to identify the suture. Insert more sutures as required about 5-10mm apart.			
xv. Once you are finished, dispose of the needle in the sharps bin.			

xvi. Press lightly on the sides of the wound to stop any bleeding. Once satisfied, remove the drape and your gloves. Arrange for the wound to be dressed using a non-adherent dressing.			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

HEAD AND NECK, SPECIAL SENSES MODULE		
Objectives	**Skill**	**Miller's Pyramid Level Reflected**
Examination of the nose	Nasal examination	Shows
Examination of neck lumps	Neck lump examination	Shows

- These skills are at the 'Knows how' level of the miller's pyramid, meaning thereby that students need not perform them themselves but may develop a perception regarding them by observing performance/working on simulated patients/facilitation with videos.

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Date Observed: _____

CHECKLIST FOR EXAMINATION OF THE NOSE **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES** **(Minimum 3 Entries)**		
STEP/TASK			
THE PROCEDURE: 1. Explain the procedure to the patient and get a verbal consent to proceed.			
Inspection: 2. Inspect the external surface of the nose from the front, side and behind the patient to identify any abnormalities. 3. Skin changes: I. Inspect for skin lesions: i. Basal cell carcinoma: pearly lesions with telangiectasia and rolled edges. ii. Squamous cell carcinoma: scaly lesions, sometimes with associated ulceration and hyperpigmentation. iii. Keratoacanthoma: raised lesions with a core of scaly keratin.			

II. Deformity i. Inspect for any deviation in the nasal bones or cartilage suggestive of a fracture. This is best performed by standing behind the patient with their head tilted slightly backwards.			
III. Palpation: i. Warn the patient that you will be applying some pressure to their nose and ask them to let you know if they experience any pain.			
4. Palpate the nasal bones assessing: i. Alignment ii. Tenderness iii. Irregularity (suggestive of fracture)			
5. Palpate the nasal cartilage assessing: i. Alignment ii. Tenderness			
6. Palpate the infraorbital ridges and assess eye movement if there is a history of trauma to screen for an orbital blowout fracture**.**			
*An orbital blowout fracture is a fracture of the orbital floor or medial wall resulting from blunt trauma to the eye socket (e.g., tennis ball). Typical findings on clinical examination include infraorbital tenderness, epistaxis and restricted eye movement (usually on vertical gaze).			
7. The correct method for using a nasal speculum is slightly counter-intuitive, however, it does allow the best visualization of the nasal mucosa: i. Insert your index finger into the bend of the speculum and support it above with the thumb. ii. The middle and ring fingers are used to manipulate the prongs of the speculum. iii. You will be aiming to look at the gap between these two fingers.			

iv. Press the prongs of the speculum together to allow them to be placed within the nostril and then reduce your grip on the speculum to widen the prongs until an optimal view of the nasal cavity is achieved. a) Nasal vestibule: inspect for inflammation, ulceration or oedema affecting the nasal mucosa. b) Nasal septum: note any polyps, deviation, perforation, haematoma, superficial vessels or areas of cautery. c) Inferior turbinates: note any asymmetry, inflammation or polyps.			
8. Place a cold shiny surface, such as a metal tongue depressor under the nose.			
9. Observe for misting of the metal surface as the patient breathes and compare the misting pattern of the two nostrils.			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

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CHECKLIST FOR EXAMINATION OF NECK LUMPS **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES** **(minimum 2 entries)**		
STEP/TASK			
THE PROCEDURE:			
1. Explain the procedure to the patient and get a verbal consent to proceed.			
2. Inspect the patient, looking for clinical signs suggestive of underlying pathology: i. Scars: may indicate previous neck surgery (e.g. thyroidectomy, lymph node biopsy/excision, radiotherapy related scarring). ii. Cachexia: ongoing muscle loss that is not entirely reversed with nutritional supplementation. Cachexia is commonly associated with underlying malignancy. iii. Hoarse voice: caused by compression of the larynx due to thyroid gland enlargement (e.g. thyroid malignancy). iv. Dyspnoea or stridor: may indicate compression of the upper respiratory tract by a neck mass. v. Behaviour: anxiety and hyperactivity are associated with hyperthyroidism (due to sympathetic overactivity). Hypothyroidism is more likely to be associated with low mood. vi. Clothing: may be inappropriate for the current temperature. Patients with hyperthyroidism suffer from heat intolerance whilst patients with hypothyroidism experience cold intolerance. vii. Exophthalmos: bulging of the eye anteriorly out of the orbit associated with Graves' disease.			

3. Ask the patient to point out the neck lump's location if relevant. i. Inspect the neck lump from the front and side, noting its location (e.g. anterior triangle, posterior triangle, midline).			
4. If a midline mass is identified during the initial inspection, perform some further assessments to try and further narrow the differential diagnosis. <u>Swallowing</u> Ask the patient to swallow some water and observe the movement of the mass: i. Thyroid gland masses (e.g. a goitre) and thyroglossal cysts typically move upwards with swallowing. ii. Lymph nodes will typically move very little with swallowing. iii. An invasive thyroid malignancy may not move with swallowing if tethered to surrounding tissue. <u>Tongue protrusion</u> Ask the patient to protrude their tongue: i. Thyroglossal cysts will move upwards noticeably during tongue protrusion. ii. Thyroid gland masses and lymph nodes will not move during tongue protrusion. <u>Further Assessment</u> i. If you identify a midline neck lump or systemic signs indicative of thyroid disease, ask the examiner if a full thyroid status examination should be performed.			
5. Palpate the neck lump assessing the following: i. Site: assess the lump's location in relation to other anatomical structures (e.g. anterior triangle, posterior triangle, midline). ii. Size: assess the size of the lump. iii. Shape: assess the lump's borders to determine if they feel regular or irregular.			

iv. Consistency: determine if the lump feels soft (e.g. cyst), hard (e.g. malignancy) or rubbery (e.g. lymph node). v. Mobility: assess if the lump feels mobile or is tethered to other local structures. Asking the patient to turn their head as you palpate, the mass can reveal if it is tethered to the underlying muscle (e.g. malignant tumour). vi. Fluctuance: hold the lump by its sides and then apply pressure to the centre of the mass with another finger. If the mass is fluid-filled (e.g. cyst) then you should feel the sides bulging outwards. vii. Temperature: increased warmth may suggest an inflammatory or infective cause (e.g. infected epidermoid cyst). viii. Overlying skin changes: note any overlying skin changes such as erythema (e.g. inflammatory/infective aetiology) or a punctum (a pore in the epidermis indicative of an underlying epidermoid cyst). ix. Pulsatility: suggests vascular origin (e.g. carotid body tumour, aneurysm). x. Tenderness: may indicate infective and/or inflammatory aetiology (e.g. ruptured epidermoid cyst, infected cyst). Other characteristics of the lump may include: i. Transillumination: apply a light source to the lump, if it is illuminated it suggests the lump is fluid-filled (e.g. cystic hygroma). ii. Vascular bruit: auscultate the lump to listen for a bruit suggestive of vascular aetiology (e.g. carotid artery aneurysm). 6. Assess cervical lymph nodes and thyroid gland as explained in previous checklists			
7. Assess the submandibular gland if a swelling is found in that area. Each submandibular gland can be palpated inferior and posterior to the body of the mandible. Move inwards from the inferior border of the mandible near its angle with the patient's head tilted forward. To assess the gland thoroughly, you should perform bimanual palpation with one gloved finger palpating the floor of the mouth whilst the other palpates externally underneath the mandible**.** ❖ Submandibular gland swellings are usually singular, whereas lymphadenopathy typically involves multiple nodes). Salivary duct calculi are relatively common and may be felt as a firm mass within the gland.			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			


BLOCK-06

NEUROSCIENCES-1 MODULE		
Objectives	**Skill**	**Miller's Pyramid Level Reflected**
Assess Glasgow Coma Scale	GCS	Shows
Interpretation of Normal CT brain	CT scan interpretation	Knows how

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CHECKLIST FOR GLASGOW COMA SCALE **(Some of the following steps/tasks should be performed simultaneously)**	**CASES** **(Minimum 3 Entries)**		
STEP/TASK			
THE PROCEDURE: The Glasgow Coma Scale (GCS) allows healthcare professionals to consistently evaluate the level of consciousness of a patient. It is commonly used in the context of head trauma, but it is also useful in a wide variety of other non-trauma related settings. Regular assessment of a patient's GCS can identify early signs of deterioration. There are three aspects of behaviour that are independently measured as part of an assessment of a patient's GCS **–** motor responsiveness**,** verbal performance and eye-opening**.** The highest response from each category elicited by the healthcare professional is scored on the chart. The highest possible score is 15 (fully conscious) and the lowest possible score is 3 (coma or dead).			

1. Eye Opening:

To assess eye response, initially observe if the patient is opening their eyes spontaneously.

i. If the patient is opening their eyes spontaneously, your assessment of this behaviour is complete, with the patient scoring 4 points. You would then move on to assessing verbal response, as shown in the next section. If, however, the patient is not opening their eyes spontaneously, you need to work through the following steps until a response is obtained.

ii. If the patient doesn't open their eyes spontaneously, you need to speak to the patient *"Hey Mrs Smith, are you ok?"*

iii. If the patient's eyes open in response to the sound of your voice, they score 3 points.

iv. If the patient doesn't open their eyes in response to sound, you need to move on to assessing eye-opening to pain.

v. There are different ways of assessing response to pain, but the most common are:

   a. Applying pressure to one of the patient's fingertips
   b. Squeezing one of the patient's trapezius muscles (known as a trapezius squeeze)
   c. Applying pressure to the patient's supraorbital notch
   d. If the patient's eyes open in response to a painful stimulus, they score 2 points.

   e. If the patient does not open their eyes to a painful stimulus, they score 1 point.

   f. If the patient cannot open their eyes for some reason (e.g., oedema, trauma, dressings), you should document that eye response could not be assessed (NT).

2. Verbal responses:

i. If the patient is able to answer your questions appropriately, the assessment of verbal response is complete, with the patient scoring 5 points.

ii. If the patient is able to reply, but their responses don't seem quite right (e.g. they don't know where they are, or what the date is), this

would be classed as confused conversation and they would score 4 points.

iii. Sometimes confusion can be quite subtle, so pay close attention to their responses.

iv. If the patient responds with seemingly random words that are completely unrelated to the question you asked, this would be classed as inappropriate words and they would score 3 points.

v. If the patient is making sounds, rather than speaking words (e.g., groans) then this would be classed as incomprehensible sounds, with the patient scoring 2 points.

vi. If the patient has no response to your questions, they would score 1 point.

vii. If the patient is intubated or has other factors interfering with their ability to communicate verbally, their response cannot be tested, and for this, you would write NT (not testable).

3. Motor Response:

i. The final part of the GCS assessment involves assessing a patient's motor response.

ii. You should score the patient based on the highest scoring response you were able to elicit in any single limb (e.g., if they were unable to move their right arm, but able to obey commands with their left arm, they'd receive a score of 6 points).

iii. Ask the patient to perform a two-part request (e.g. "Lift your right arm off the bed and make a fist.").

    a. If they are able to follow this command correctly, they would score 6 points and the assessment would be over.

iv. This assessment involves applying a painful stimulus and observing the patient for a response.

There are different ways of assessing response to pain, but the most common are:

a. Squeezing one of the patient's trapezius muscles (known as a trapezius squeeze)

b. Applying pressure to the patient's supraorbital notch

If the patient makes attempts to reach towards the site at which you are applying a painful stimulus (e.g. head, neck) and brings their hand above their clavicle, this would be classed as localising to pain, with the patient scoring 5 points.

This is another possible response to a painful stimulus, which involves the patient trying to withdraw from the pain (e.g. the patient tries to pull their arm away from you when applying a painful stimulus to their fingertip).

This response is also referred to as a "normal flexion response" as the patient typically flexes their arm rapidly at their elbow to move away from the painful stimulus.

It differs from the "abnormal flexion response to pain" shown below due to the absence of the other features mentioned (e.g., internal rotation of the shoulder, pronation of the forearm, wrist flexion).

Withdrawal to pain scores 4 points on the Glasgow Coma Scale.

Abnormal flexion to a painful stimulus typically involves adduction of the arm, internal rotation of the shoulder, flexion of the elbow, pronation of the forearm and wrist flexion (known as decorticate posturing).

Decorticate posturing indicates that there may be significant damage to areas including the cerebral hemispheres, the internal capsule, and the thalamus.

Abnormal extension to a painful stimulus is also known as decerebrate posturing.

In decerebrate posturing, the head is extended, with the arms and legs also extended and internally rotated.

The patient appears rigid with their teeth clenched.

The signs can be on just one side of the body or on both sides (the signs may only be present in the upper limbs).

Decerebrate posturing indicates brain stem damage. It is exhibited by people with lesions or compression in the midbrain and lesions in the cerebellum.

Progression from decorticate posturing to decerebrate posturing is often indicative of uncal (transtentorial) or tonsilar brain herniation (often referred to as coning).

The complete absence of a motor response to a painful stimulus scores 1 point. If the patient is unable to provide a motor response (e.g., paralysis), this should be documented as not testable (NT).			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			

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CHECKLIST FOR INTERPRETATION OF CT BRAIN **(Some of the following steps/tasks should be performed simultaneously)**	**CASES** **(Minimum 2 Entries)**	
STEP/TASK		
THE PROCEDURE: 1. Orientation and Windowing: a. Check the patient's information, including name, age, and date. b. Confirm that the images are properly oriented (anterior is at the top, and the left side corresponds to the patient's right side). c. Adjust window settings to optimize visualization of soft tissues and bone. 2. Overall Assessment: a. Begin by observing the overall appearance of the brain for symmetry and any obvious abnormalities. b. Look for signs of mass effect, midline shift, or other gross abnormalities. 3. Ventricles: a. Assess the size and symmetry of the lateral ventricles. b. Look for any signs of ventricular enlargement or obstruction. 4. Sulci and Gyri: a. Evaluate the sulci and gyri for normal patterns and symmetry. b. Ensure there are no signs of cortical atrophy or abnormal folding. 5. Cisterns and Cisternal Spaces:		

a. Examine the major cisterns (e.g., suprasellar cistern, ambient cistern) for appearance. b. normal Check for any compression or effacement of cisternal spaces.		
6. Basal Ganglia and Thalamus: a. Evaluate the basal ganglia (caudate nucleus, putamen, and globus pallidus) and thalamus for symmetry and density. b. Look for any signs of calcification or hemorrhage		
7. Brainstem: a. Assess the midbrain, pons, and medulla for normal anatomy. b. Look for any signs of midline shift or compression.		
8. Pineal Gland: a. Check the size and symmetry of the pineal gland. b. Assess for calcification, which is a common finding.		
9. Fourth Ventricle: a. Evaluate the size and symmetry of the fourth ventricle. b. Look for any signs of obstruction or enlargement.		
10. Subarachnoid Spaces: a. Assess the subarachnoid spaces for normal distribution and density of cerebrospinal fluid (CSF). b. Check for signs of subarachnoid hemorrhage.		
11. Skull and Scalp: a. Inspect the skull for fractures, abnormalities, or signs of trauma b. Assess the scalp for any soft tissue swelling or abnormalities.		
12. Sinuses and Mastoids: a. Check the paranasal sinuses and mastoid air cells for normal aeration. b. Look for signs of sinusitis or mastoiditis.		
13. Blood Vessels: a. Evaluate major intracranial blood vessels for patency and any signs of vascular abnormalities. b. Look for signs of intracranial hemorrhage. 14. Soft Tissue Structures: a. Soft tissue structures, including the eyes and extraocular muscles, for any abnormalities.		
SKILL/ACTIVITY PERFORMED SATISFACTORILY		
Signatures of Supervisor		

INFLAMMATION MODULE		
Objectives	**Skill**	**Miller's Pyramid Level Reflected**
Learn how to do history taking	History Taking	Shows

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Date Observed: _____

CHECKLIST FOR HISTORY TAKING **(Some of the following steps/tasks should be performed simultaneously.)**	**CASES** **(Minimum 3 Entries)**		
STEP/TASK			
INTRODUCTION (WIIPP) 1. Wash your hands 2. **I**ntroduce yourself: give your name and your job (e.g. Dr. Louise Gooch, ward doctor) 3. Identity: confirm you're speaking to the correct patient (name and date of birth) 4. Permission: confirm the reason for seeing the patient ("I'm going to ask you some questions about your cough, is that OK?") **P**ositioning: patient sitting in chair approximately a metre away from you. Ensure you are sitting at the same level as them and ideally not behind a desk.			
PRESENTING COMPLAINT 1. Ask the patient to describe their problem using open questions (e.g. "What's brought you into hospital today?") 2. The presenting complaint should be expressed in the patient's own words (e.g. "I have a tightness in my chest.") 3. Do not interrupt the patient's first few sentences if possible 4. Try to elicit the patient's ideas, concerns and expectations (ICE) e.g. "I'm worried I might have cancer." or "I think I need some antibiotics."			

HISTORY OF PRESENTING COMPLAINT 1. Ask the patient further questions about the presenting complaint 2. A useful mnemonic for pain is “SOCRATES“ i. Site ii. Onset iii. Character iv. Radiation v. Alleviating factors vi. Timing vii. Exacerbating factors viii. Severity (1-10)			

PAST MEDICAL HISTORY

1. Ask the patient about all previous medical problems.
2. They may know these medical problems very well or they may forget some. Top ensure none are missed ask about these important conditions specifically (mnemonic: “MJTHREADS Ca”)

    i. Myocardiac infarction
    ii. Jaundice
    iii. Tuberculosis
    iv. Hypertension
    v. Rheumatic fever
    vi. Epilepsy
    vii. Asthma
    viii. Diabetes
    ix. Stroke
    x. Cancer (and treatment if so)

3. If the patient is unsure of their medical problems, ask them further clarifying questions, for example “What do you usually visit your doctor for?”. Remember you can add to past medical history if any of the medication later mentioned don’t match the medical problems listed.
4. Risk factors

    i. As part of medical history ask about specific risk factors related to their presenting complaint.
    ii. For example, if the patient presents with what maybe a myocardial infarction, you should ask about associated risk factors such as:

        a. Smoking, cholesterol, diabetes, hypertension, family history of ischemic heart disease.

5. Clarification of past medical history

    i. Some medical conditions require clarification of the severity. For example:

        a. COPD

    i. Ask about when the patient was diagnosed, their current and previous treatments, whether they have ever required noninvasive ventilation (“a tight-fitting face mask”), whether they have been to intensive care

        b. Myocardial infarction

ii. Ask about angina, previous heart attacks, any previous angiograms (“a wire put into your heart from your leg or from your arm”), previous stenting c. Diabetes iii. Duration of diagnosis, current management including insulin and usual control of diabetes i.e. well- or poorly-controlled			

DRUG HISTORY 1. All medications that they take for each medication ask them to specify: i. Dose, frequency, route and compliance (i.e whether they regularly take these medication). ii. If they take medication weekly ask what day of the week they take it. iii. If they take a medication with a variable dosing (e.g. Warfarin) ask what their current dosing regimen is 2. Recreational drugs 3. Intravenous drug use (current or previous) 4. Over the counter (OTC) medications			
ALLERGIES 1. Does the patient have any allergies? i. If allergic to medications, clarify the type of medication and the exact reaction to that medication. ii. Specifically ask about whether there's been a history of anaphylaxis e.g. "throat swelling, trouble breathing or puffy face"			
FAMILY HISTORY 1. Ask the patient about any family diseases relevant to the presenting complaints (e.g. if the patient has presented with chest pain, ask about family history of heart attacks). 2. Enquire about the patient's parents and sibling and, if they were deceased below 65, the cause of death i. If relevant and a pattern has emerged from previous history sketch a short family tree			

SOCIAL HISTORY

3. Alcohol intake
4. Tobacco use
    i. Quantify the number of pack years (number of packs of 20 cigarettes smoked per day multiplied by the number of years smoking)
5. Employment history
    i. Particularly relevant with exposure to certain pathogens e.g. asbestos, where you need to ask whether they have *ever* been exposed to any dusts
6. Home situation
    i. House or bungalow
    ii. Any carers
    iii. Activities of daily living (ability to wash, dress and cook)
    iv. Mobility, and immobility aids
    v. Social/family support
    vi. Do they think they're managing?
7. Travel history
8. Further social history maybe required depending on the type of presenting complaint for example:
    vii. Respiratory presenting complaint
        a. Ask about pets, dust exposure, asbestos, exposure to the farms, exposure to birds or if there are any hobbies
    viii. Infectious to disease related
        b. Ask for a full travel history including all occasions exposure to water, exposure to foreign food, tuberculosis risk factors, HIV risk factors, recent immunisations

SYSTEMS REVIEW 1. Run through a full list of symptoms from major systems: 2. Cardiovascular: chest pain, palpitations, peripheral oedema, paroxysmal nocturnal dyspnoea (PND), orthopnoea 3. Respiratory: Cough, shortness of breath (and exercise tolerance), haemoptysis, sputum production, wheeze 4. Gastrointestinal: Abdominal pain, dysphagia, heartburn, vomiting, haematemesis, diarrhea, constipation, rectal bleeding 5. Genitourinary: Dysuria, discharge, lower urinary tract symptoms 6. Neurological: Numbness, weakness, tingling, blackouts, visual change 7. Psychiatric: Depression, anxiety 8. General review: Weight loss, appetite change, lumps or bumps (nodes), rashes, joint pain			
SUMMARY 1. Provide a short summary of the history including: a. Name and age of the patient, presenting complaint, relevant medical history 2. Give a differential diagnosis 3. Explain a brief investigation and management plan			
SKILL/ACTIVITY PERFORMED SATISFACTORILY			
Signatures of Supervisor			