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Welcome to the Ambulatory Care Apprenticeship (ACA)!

Overall Goals:
1. ACA provides a wonderful opportunity to use information learned in Practice of Medicine (POM) and other classes in a real world environment.
2. The ACA is the “clinical lab” where you will practice key clinical skills including: relating to and communicating with patients, obtaining comprehensive and focused medical histories, performing physical examinations, and introductory aspects of clinical reasoning/decision making. You will also learn about the systems and processes that impact patient care.
3. As the name “apprenticeship” implies, you will develop a close working relationship with your preceptor who will get to know you well over time, assisting in your longitudinal development as a clinician and professional.

Logistics:
1. You will visit your preceptor’s office 13 times during your first year (see schedule on the ACA page of the meded portal). This begins mid-October and will take place every other week (alternating with your POM small group) for the next 2 years. For MS1s, the session breakdown by quarter is as follows:
   a. Fall: 4
   b. Winter: 5
   c. Spring: 4
2. Sessions occur from, ~1pm to 5pm, with some flexibility as to the start and end times based on when you and your preceptor “brief” or “debrief” the afternoon.
3. During the first 1-2 sessions, you will largely observe the clinical care process.
4. After this brief period as an observer, you will be allowed to see 1-2 patients per session by yourself and perform focused histories and exams. Over the course of 2 years, the number of patients that you see (and the depth of your evaluations) will increase, commensurate with your growing abilities.
5. In the spring, you are expected to perform at least one “complete” history and physical exam.
6. At the end of each session, please use OASIS (https://meded-oasis.ucsd.edu/index.html) to document your attendance. This can be done as follows:
   a) After signing in, Under “Announcements” you will see You have Requirements Checklist items to complete. Click on the link.
b) For Session Sign-Offs, click on **Session Check-In**. Once you click on it, find the link for **Add Entry** and click on it.

c) Complete the entry and click **Submit** at the bottom of the screen. You will then go back to **Session Check-In**. Once you click on it, find the link for **Sign-Off** and click on it.
d) Now you will hand your device to your preceptor for sign off. They will enter their OASIS username and password. If they do not remember them, that is not a problem. We will send them an email for confirmation.
Missed Sessions

1. Students are expected to attend all assigned sessions.
2. Students **MUST** follow procedures for absences as detailed on the course web site. Students should contact the course coordinator Mr. Zatarain for any absences related to illness and contact both Mr. Zatarain AND Dean Kelly for any anticipated absences (due to travel, personal reasons, conferences, etc).

**Evaluations and Grades**

1. To pass ACA, students must attend all required sessions.
2. Your ACA preceptor will complete a summative evaluation at the end of the year.
3. At the end of the year, you will be asked to complete a formal evaluation of your ACA preceptor.
4. You will also evaluate the ACA experience as a whole. This information will be used to shape the course moving forward.

**Professional Attire**

For your ACA sessions, dress according to the standards that are exemplified by your faculty preceptor. Some preceptors are more formal (e.g. ties and dress shirts for the men) and other are less so (i.e., business casual). If you have doubts about what is appropriate, ask your preceptor – and always better to over dress for the initial sessions.
Equipment
At a minimum, you should always bring your stethoscope and wear your white coat with your UCSD ID badge. Most offices will have oto/ophthalmoscopes, blood pressure cuffs, tuning forks, reflex hammer, and other typical exam equipment (with some variation based on the specific site).

Optional educational opportunities:

1. Patient log: OASIS provides an opportunity to keep track of all the patient and clinical conditions that you see (in an anonymous way so that patient confidentiality is not compromised). Many students find it helpful to keep this log up to date, which can be a nice learning tool. To access this optional feature, sign on to OASIS as described above. The patient log can be accessed from this screen:
Expected variability in your experiences:
Each of your ACA experiences will be unique. Different clinical sites provide services for different patient populations and have access to differing levels of resources. In addition, your preceptors will each have their own style for providing care and integrating you into their practice. This means that you will each have opportunities and challenges that are unique to your sites. We encourage you to take advantage of all that the clinic has to offer and be willing to problem solve with your preceptor when challenges arise. In the event that you are confronted with a situation that you can’t address locally, please let the Clinical Foundations support staff and leadership group know as soon as possible so that we can provide additional assistance.
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ACA 1 - Fall Quarter – MS1 (4 sessions)

First Day of ACA
1. Get to know your preceptor: Where are they from? What’s their educational background? Path to medicine? Professional practice history? etc. Share your own story. This will be a long-term mentoring relationship and the more you get to know one another, the higher the likelihood that you will enjoy the process.
2. Get to know the other physicians in the office. They will sometimes stand in for your preceptor and are often eager to share interesting patients and events with you.
3. Get to know the staff of the office and understand their jobs and the role that they play in the operation of the clinic.
4. Understand patient flow through the office and how patients are checked in, where they wait, how the nurses interact with them and what happens after you and your preceptor leave the exam room.

For The Remaining Fall Sessions:
1. Observe why patients come to the office to see their doctor. This is usually for one of the following reasons:
   a. An acute problem
   b. Follow up of one or more chronic problem(s)
   c. A health maintenance visit
d. A new patient visit (for a comprehensive clinical intake)
e. A problem stemming largely from an emotional/behavioral issue

2. Observe whether this is a patient known to your preceptor or a first time visit for the patient. Note any differences in how your preceptor interacts or communicates with new vs. known patients. Note any other variables in how the communication goes between your preceptor and his/her patients.

3. Observe how your preceptor elicits the history from each patient. How is the agenda set for each visit? How many issues are typically discussed?

4. Observe what parts of the physical examination are utilized for each patient’s specific problem(s). Reflect on why each element was performed.

5. Review the core aspects of history taking that you’ll learn about during fall quarter, including:
   a. History of Present Illness (HPI)
   b. Past Medical History (PMH), Past Surgical History (PSH)
   c. Medications prescribed and Medication Allergies
   d. Social history
   e. Substance use
   f. Sexual history
   g. Review of systems
   h. Intimate partner violence (for women)

6. Practice the Physical Exam (PE) skills that you will learn during the fall, including:
   a. Vital Signs
b. **Cardiovascular Exam**

c. **Pulmonary Exam**

d. **Abdominal Exam**

After each session, remember to ask your facilitator to sign off electronically on your attendance. You should complete 4 sessions preceptor by the end of fall quarter.
ACA 1 - Winter Quarter (5 Sessions)

Goals:
1. You should continue performing appropriate aspects of the history and physical on your own.
2. After seeing a patient, you will be expected to present him or her to your preceptor (either in the room or away from the patient). Specific presentation styles vary, so please discuss your preceptor’s preferences directly with them. A guide to oral presentation for outpatient clinics can be found at the Practical Guide to Clinical Medicine website in the section on Oral Presentations. Tips are also provided at the end of this guide.
3. After listening to the presentation, your preceptor will interact with the patient to verify the history and PE findings.
4. The number of patients that you see per session will vary with each preceptor (based on clinical flow and your level of skill development). This is something that you should discuss each session.
5. Set aside a few minutes at the end of each session and solicit feedback from your preceptor. Ask specifically about which aspects of the clinical encounter you’re doing well, and where they think you should spend additional time. Offer feedback about how things are going from your perspective.

New skills to Practice (based on what you’re leaning in POM winter quarter):
1. History taking
   a. Family history
b. Functional health assessment for older adults: Activities of Daily Living (ADLs), Independent Activities of Daily Living (IADLs)
c. HEADDSS (if you see kids)
d. Review of health maintenance
   i. Disease specific screening: e.g. breast, colon and cervical cancer
   ii. Vaccinations to prevent: influenza, HPV, pneumococcal infection, etc.

2. Physical Exam
   a. Head and Neck Exam
   b. Musculoskeletal Exam: With Focus on Knee and Shoulder
   c. Eye Exam
   d. Neuro Exam

3. Practice history and physical exam skills from the first quarter as well.

After each session, please remember to ask your facilitator to sign off electronically on your attendance. You should complete 5 sessions during winter quarter.
ACA 1- Spring Quarter (4 Sessions)

Goals:
1. Continue performing appropriate aspects of the history and physical on your own.
2. Continue to work on your oral presentations.
3. The number of patients that you see per session will vary with each preceptor. This is something that you should discuss every session.
4. Set aside a few minutes at the end of each session and solicit feedback from your preceptor. Ask specifically about which aspects of the clinical encounter you’re doing well, and where they think you should spend additional time. Offer feedback about how things are going from your perspective.
5. Note that the spring quarter ends with an Observed Structured Clinical Examination (OSCE), during which you’ll be expected to perform a complete history and physical and then write it up in standard format. Practicing your H&P skills during the spring quarter will help you prepare.

New skills to Practice (based on what you’re leaning in POM spring quarter):
   1. History taking
      a. Information sharing
      b. Observe (if possible) – communicating bad/difficult news
      c. Motivational interviewing
   2. Physical Exam
d. Female pelvic and breast (leaned on simulation tools). It’s unlikely that you will have a chance to practice these during ACA.

e. Practice all PE skills learned during fall and winter. These will be tested in the Spring OSCE. Use the checklists posted in the back of this book to guide your studying. Review pocket guides, lecture notes, on-line resources and text books in order to further develop your skills.

**Advanced Skills:**
You will almost certainly have an opportunity to watch your preceptor organize patient issues by problem as they formulate their assessments and plans. Discuss with your preceptor whether you can start to generate problem lists, each with an assessment and plan at the end of your patient encounters. While these are skills that will become more fully developed during the MS3 and 4 years, there is no reason why you can’t start working on them now.

After each session, please remember to ask your facilitator to sign off electronically on your attendance. You should complete 4 sessions during the spring.

Complete the evaluations of your ACA preceptor
Written Notes

There is a specific way in which physicians document their encounters with patients. This is how we organize our thoughts and create a reference document that summarizes the relevant history as well as our impressions and plans. While the precise format varies from physician to physician, standard notes contain many common elements. With the advent of the Electronic Health Record (EHRs), there are templates that help to remind you about which information to include and may even automatically import data that is stored elsewhere in the system (e.g. labs, medications, imaging reports, etc.). That said, before you fill your notes with large quantities of data, stop and consider the particular role that this information will have on patient care. If imaging or lab reports are available elsewhere in the system, it frequently makes more sense to highlight the key findings in your note, but then refer the reader to the lab or imaging tab for a more detailed report. This helps to keep the note succinct and uncluttered. Another pitfall to avoid is the “cutting and pasting” that occurs within EHRs. Other clinician’s histories should not be incorporated into your own notes. The goal of a note is to generate your own data and use this to derive a new impression and plan.

Over the course of your ACA experience, you may have the opportunity to write notes. Talk with your preceptor in order to determine when you can start contributing to the patient record and the format
that they would like you to follow. After writing a note, actively seek feedback so that you can learn and improve.

Two common notes are described below:
- The SOAP note, which is used to document follow-up or acute care visits.
- The complete note, which is used for a new patient visit to document their entire medical history

**The SOAP Note**

**Key Elements:**

**Patient ID and chief complaint:** Patient name, age, sex, reason for visit

**Subjective Issues:**
Problem # 1
Problem # 2

**Objective data:**
VS and Exam

**Assessment and Plan:**
Problem # 1: Assessment → Plan
    Diagnostic studies to order
Problem # 2: Assessment → Plan
Diagnostic studies to order
Therapeutics
Follow-up

COMMENTS:
1) In a SOAP note for a focused visit the Problem title is equivalent to the “chief complaint” of a complete H&P. In both situations there can be more than one problem or chief complaint.
2) The Problem title should be either a diagnosis that generates symptoms or data that’s accrued by the patient (e.g. congestive heart failure, finger stick glucose readings for a patient with diabetes) OR a complaint (e.g. abdominal pain, shortness of breath etc.)
3) The “Subjective” of a SOAP note is equivalent to the HPI of the complete H&P and there should be one for each problem (just as there would be one HPI for each chief complaint in the H&P). Pertinent ROS are also included in the subjective.
4) In a SOAP note one usually omits historical features that aren’t relevant. These can be found by referring back in the record to the initial history and exam.
5) The Objective component refers to vital signs and physical exam findings.
6) “Assessment” comes in two forms:
- a *diagnosis* (e.g. Hypertension, Diabetes) + a status statement (e.g. worse, improved, stable, controlled), **OR**
- a *symptom or sign* (e.g. diarrhea, abdominal pain, heart murmur) + a *ddx* (differential dx.) with the *most* likely listed first
- There should **always** be a discussion which accompanies the assessment if the diagnosis is not fully defined. This is the space where you describe the differential as well as what you think is/are the most likely explanations.

7) “**Plans**” include *diagnostic* tests, *therapeutic* maneuvers (e.g. meds, patient education, physical therapy, etc.) and *disposition or follow up* for the patient (e.g. Dr. or pt. to call, email, fax or return in X days, weeks, months).

8) A review of medications (referred to as “med reconciliation”) is done at every visit and is often included in most notes.

9) Relevant labs and imaging results are also included.

**Sample Soap Note for a follow-up visit:**

**CC:** medication refill  
Ms. Y is a 61 year old woman with a history of hypothyroidism and HTN who presents today for a medication refill and follow up. Her last visit was 6 months ago and patient denies new concerns at this time.  
**HPI:**
#Hypothyroidism
The patient denies low energy, fatigue, weakness, constipation, forgetfulness, heat or cold intolerance. She does c/o some muscle and back pain but attributes that to her work. She is adherent to her levothyroxine 75 mcg that she takes in the morning 1 hour prior to eating. Last TSH was 1.27 on 7/23/2015.

#HTN
The patient states that her blood pressure is always "fine". She gets it checked at CVS and says that someone takes it for her and tells her that it's "normal." She has no headaches and mentions that she has been eating healthier and exercising more. For breakfast, she has fruit (usually a banana); for lunch, she starts with a smoothie then has a vegetable, a fruit, and a carb; for dinner, she usually drinks milk and doesn't eat food after 6pm. She reports no junk food such as candy, cookies or chips but does snack on cereal and nuts. She is adherent with hydrochlorothiazide 25 MG, 1/2 tablet per day. She has joined a gym and exercises for an hour 3 times a week.

**ROS:**
Endocrine: as her HPI
CV: denies SOB, CP, LEE, palpitations, HA

**Medications:**
levothyroxine 75 MCG, 1 tablet per day. Reports 100% adherence
hydrochlorothiazide 25 MG, 1/2 tablet per day. Reports 100% adherence
cholecalciferol Vitamin D 1000 unit, daily. Reports takes on “most days” but does occasionally forget

**Objective:**  
**Physical Exam:**  
VS BP 122/84 mmHg HR 76 Temp 98.9 RR 13 SpO2 99%  
General: Well developed and well nourished female. No acute distress  
HEENT: Oral mucous membranes are moist. Thyroid is non-palpable, no thyromegaly.  
CV: Regular rate and rhythm. No murmurs, rubs, or gallops.  
Lungs: Clear to auscultation bilaterally. No wheezing, rales, or rhonchi.  
Abdomen: Soft, non-tender, non-distended. NABS. No masses or organomegaly. Well healed suprapubic scar from past C-sections. No bruits.  
Extremities: No peripheral edema. Dorsalis pedis and posterior tibialis pulses intact.

**Relevant Labs:**  
A1c: 5.4 on 1/26/2015  
TSH: 1.27 on 7/23/2015  
Electrolytes: Normal on 1/26/2015.  
Lipids: normal 4/7/2015

**Assessment/Plan:** Ms. Y is a 61 year old woman with a history of hypothyroidism and HTN who presents today for a medication refill and follow up
#Hypothyroidism
Patient is clinically asymptomatic and well-controlled with her current medication regimen. Labs were drawn today for TSH
- F/U TSH with patient by phone when lab results return
- Continue levothyroxine 75 MCG, 1 tablet per day.

#HTN
Patient denies symptoms and is adherent with her current medication. BP today 122/84 patient reports her home BP readings are also “normal.” Her HTN is currently well controlled and meeting the treatment goal of BP <140/90 per JNC 8. Electrolytes normal on 1/26/2015 - labs were drawn today to repeat this.
- Advised patient to continue diet and exercise.
- BMP ordered to evaluate serum creatinine and electrolytes.
- Continue hydrochlorothiazide 25 mg, 1/2 tablet per day.

#Health maintenance and screening: Discussed the importance of HMS with the patient.
- She says that she will schedule Mammogram next month
- Up to date with flu shot, cervical CA, colon CA screenings, lipid and DM screening

Patient RTC in 3 months.
To Do:
- Review lab results of BMP and TSH.
- Review mammogram results.
- Refill medications.
Patient seen and discussed with Dr. W.

**Sample Note for a first visit (i.e. complete H&P):**

**CC:** Fatigue

**HPI:** Ms. B is a 56 y/o woman w/ a history of hypertension (HTN) and dyslipidemia who presents with a new complaint of fatigue. Patient is a new patient who moved to San Diego a year ago but had been receiving care for HTN at a clinic in Orange County. She reports that her last appointment with a PCP was about a year ago, immediately before she moved.

Patient reports she was in her usual state of health until about 4-6 months ago when she gradually noticed feeling tired. She does not recall a specific trigger or event associated with the onset of fatigue. She describes her fatigue as not having enough energy to do her usual activities. She states she was previously active with her work (as an administrative assistant for a hotel), family and several hobbies but over the past several months she has been feeling so tired that she cannot do her hobbies and struggles to keep up with work and her responsibilities at home. Patient denies any other associated
symptoms including weight changes, change in appetite, fevers, chills, night sweats, shortness of breath, melena, bright red blood per rectum and depression. She has tried to increase her caffeine intake and take a supplement from Herbalife that is for “energy” but states that she hasn’t noted any improvement. Patient states her fatigue is exacerbated by activity such as when she has to work overtime.

PMH
HTN: diagnosed ~ 5 years ago and on 1-2 BP medications since then with good control; no known heart attacks, strokes or other target organ damage.

Lipids: Pt states that 2 years ago she was told to take a cholesterol medication because she was “high risk” for heart disease. She states her cholesterol numbers are now “good.”

Past OB-Gyn History
Pt is G1P1 with a term delivery by C-Section for failure to progress

Pt had menopause at age 51 and denies any vaginal bleeding since then

PSH
Cholecystectomy: ~ 20 years ago, no complications

C-section x 1 in 1984
Hospitalization for trauma requiring blood transfusion and splenectomy in 1992 2/2 MVA

**Medications and OTC/Supplements:**

- HCTZ 25mg once a day
- Lisinopril 20mg once a day
- Atorvastatin 10mg once a day
- ASA 81 mg once a day
- Herbalife supplement for “energy”

**Allergies:**

- PCN causes hives

**Social History:**

Pt works as an administrative assistant for a hotel and she moved to San Diego because of her husband’s work. She is married and in a monogamous relationship. She is a former smoker who smoked a pack a day for 8 years but quit when she was pregnant 32 years ago. She was a former heavy drinker who currently drinks approximately 10 drinks per week (2-4 drinks 3 times per week). In the past she drank
daily, 2-3 drinks per day with heavy drinking (>5 drinks/day) every weekend. She reduced her alcohol intake about 10 years ago when her first grandchild was born at the request of her son. She has never used recreational drugs. She has one son who is 32 years old and 3 grandchildren who all live in Orange County.

**Family History:**

-Mom, alive in her 70’s w/ breast cancer, HTN

-Dad, alive in his 70’s w/ HTN, high cholesterol, had a MI in his 60’s, h/o “liver problems” and alcoholism

-Siblings: she is the youngest of her siblings, other siblings have HTN

**Health Maintenance Screening:**

-Pt had one mammogram 2 years ago that was wnl

-Pt had a PAP smear 2 years ago that was wnl; no h/o abnl

-Pt has never had colon cancer screening

-Pt is up to date on vaccines and had her last tetanus 7 years ago
Pt has been screened for HIV ~5 years ago by her previous PCP (neg)

She does not follow any specific diet or restrict her diet in any way

She walks for exercise 2-3 times per week for 30 minutes

ROS: As per HPI and below

General: Reports fatigue as in HPI above, but denies weight changes, fevers, chills, sweats, insomnia

Vision: Denies changes in vision, blurry or double vision, eye pain, eye discharge, or red eyes

Head and Neck: Denies sores or non-healing ulcers in or around the mouth, neck masses, changes in hearing, ear pain or discharge, nasal discharge or post nasal drip, vocal changes or hoarseness, dental pain, or sense of a lump when swallowing

Pulmonary: Denies shortness of breath at rest or with exertion, chest pain, cough, hemoptysis, wheezing, snoring or apnea
**Cardiovascular:** Denies chest pain, shortness of breath at rest or with exertion, orthopnea, paroxysmal nocturnal dyspnea, lower extremity edema, syncope, palpitations, claudication, lower extremity ulcers or wounds

**Gastrointestinal:** Denies heartburn, abdominal pain, difficulty or pain with swallowing, nausea, vomiting, diarrhea, constipation, bloating, jaundice, hematemesis, black stools, bright red blood per rectum

**Genito-urinary:** Denies hematuria, dysuria, nocturia, urinary frequency, urinary urgency, and incomplete voiding

**Heme-Onc:** Reports some easy bruising but no bleeding. Denies fevers, chills, night sweats, or new or growing lumps

**OB-Gyn:** Pt had menopause at age 51 and denies any vaginal bleeding since, no vaginal discharge

**Breast:** no breast masses or nipple discharge

**Neurological:** denies any changes in consciousness, weakness, numbness, burning pain, seizure activity, headache, dizziness

**Endocrine:** Denies any heat/cold intolerance, weight changes, polyuria, polydipsia, polyphagia
MSK: Pt reports some **diffuse large joint pain and occasional muscle aches.** Denies any joint swelling, redness.

Mental Health: Denies depression, anxiety, insomnia, memory problems or confusion

Skin and Hair: Denies hair loss, rashes, ulcers, non-healing wounds, itching

Physical Exam:

VS BP 122/84 mmHg HR 76 Temp 98.9 RR 13 SpO2 99% BMI 27.5

General: Well developed and well-nourished female. No acute distress

Skin: no rashes observed and only **mild bruises in b/l forearms and shins**

HEENT: Oral mucous membranes are moist and tonsils normal size. + **Conjunctival pallor.** No jaundice. Neck supple, no thyromegaly. No LAD

CV: Regular rate and rhythm. No murmurs, rubs, or gallops.

Lungs: Clear to auscultation bilaterally. No wheezing, rales, or rhonchi.
Abdomen: Soft, non-tender, non-distended. NABS. **mild hepatomegaly with liver edge palpated 4cm BCM.** No splenomegaly. Well healed suprapubic scar from past C-sections. No bruits.

Extremities: No peripheral edema. Dorsalis pedis and posterior tibialis pulses intact.

Labs: none available

A/P Ms. B is a 56 y/o woman w/ PMH of hypertension and dyslipidemia who presents with a new concern of 4-6 months of fatigue.

#Fatigue: Gradual onset of fatigue over the past 4-6 months is associated with only mild myalgias and joint pain as well as some easy bruising but history is otherwise negative. Physical exam is significant for mild hepatomegaly and conjunctival pallor only. Differential diagnosis for fatigue is broad and includes anemia, liver disease, kidney disease 2/2 HTN, possible side effect of medications, malignancy, hypothyroidism or OSA among other diagnoses. Other less likely causes could include depression though patient denies symptoms of depression, TB though no clear risk factors and no cough, diabetes given that patient is overweight but no other symptoms consistent with DM. Given conjunctival pallor and hepatomegaly, I am most concerned for anemia and/or liver disease though malignancy is also possible.
(e.g. hematologic, colon). As first step, will order CBC with differential, TSH, chem 7 (na, k, etc), lfts, HIV. Patient has risk factors for Hepatitis C including history of blood transfusion before 1992, age and alcohol so will check Hepatitis C antibody as well as Hepatitis B surface antigen. Will follow up with patient in one week with lab results.

#HTN: BP at goal today on HCTZ and Lisinopril. Will plan to continue current medications and check CMP for electrolytes and kidney function as above.

#Dyslipidemia: Previous lab results not available at today's visit but patient reports a history of dyslipidemia and statin use. Given myalgias and fatigue with check CK, CMP and fasting lipid panel with labs. Follow up with lab results in one week.

#HMS: Patient is overdue for a mammogram and for colon cancer screening and is at risk for both breast and colon cancer. Referred patient for mammogram and colon cancer screening today.
Follow up one week with lab results
**Brief Primer on Oral Presentations for ACA**

The goal of any oral presentation is to pass along the “right amount” of patient information to a specific audience in an efficient fashion. When done well, this enables the listener to quickly understand the patient’s issues and generate an appropriate plan of action. As with any skill, it can be learned, although this takes time and practice.

For the purposes of your ACA experience, we suggest that you discuss with your preceptor how they would like you to present patients. There is a lot of variation amongst physicians and it’s best to simply ask for their preferred style and content.

We’ve provided below some rough guidelines to help you get started. With time, practice and experience, this will become smoother and all of the elements will make more sense.

There are 3 main types of visits which commonly occur in an outpatient continuity clinic environment, each of which has its own presentation style and purpose. These include:

1. The patient who is coming for their first visit and is entirely new to the physician.
2. The patient who is returning for a scheduled follow-up visit.
3. The patient who is presenting with an acute problem
The Brand New Patient Who Presents to a Primary Care Clinic

Purpose of the presentation

- Organize the presenter (forces you to think things through)
- Accurately review all of the patient’s history as well as any new concerns that they might have.
- Identify health related problems that need additional evaluation and/or treatment
- Provide an opportunity for senior listeners to intervene and offer input

Duration: 5-8 min

Key features of the presentation

- **Reason for the visit:**
  - If this is truly their first visit, then one of the main reason is typically to “establish care” with a new doctor.
  - It might well include continuation of therapies and/or evaluations started elsewhere.
  - If the patient has other specific goals (medications, referrals, results review, etc.), then this should be stated as well.

  Note: There may not be a “chief complaint.”

- **Relevant acute/sub-acute history**
  - For a new patient, this is an opportunity to highlight the main issues that might be troubling/bothering them.
This can include chronic disorders (e.g. diabetes, congestive heart failure, etc.) which cause ongoing symptoms (shortness of breath) and/or generate daily data (finger stick glucoses) that should be discussed.

Sometimes, there are no specific areas that the patient wishes to discuss up-front.

- **Review of systems (ROS):** This is typically comprehensive, covering all organ systems. If the patient is known to have certain illnesses (e.g. diabetes), then the ROS should include the search for disorders with high prevalence (e.g. vascular disease). There should also be some consideration for including questions that are epidemiologically appropriate (i.e. based on age, sex and other risk factors).

- **Past Medical History (PMH):** All known medical conditions (in particular those requiring ongoing treatment) are listed, noting their duration and time of onset. If a condition is followed by a specialist or co-managed with other clinicians, this should be noted as well. If a problem was described in detail during the “acute” history, it doesn’t have to be re-stated here.

- **Past Surgical History (PSH):** All surgeries, along with year when they were performed

- **Medications and allergies:** All meds, including dosage, frequency and over-the-counter preparations. Allergies (and the type of reaction) should be described.

- **Social:** Work, hobbies, exposures.

- **Sexual activity** including partners, kids.

- **Smoking, Alcohol, other drug use:** including quantification of consumption, duration of use.

- **Family history:** Focus on heritable illness amongst first degree relatives.

- **Physical Exam:** Vital signs and relevant findings (or their absence).
– **Key labs, imaging:** If they’re available. Also when and where they were done.
– **Summary, assessment & plan(s)** presented by organ system and/or problems. As many systems/problems as is necessary to cover all of the active issues that are relevant to that clinic. This typically concludes with a “health care maintenance” section, which covers age, sex and risk factor appropriate vaccinations and screening tests.

**The Follow-up Visit**

**Purpose of the presentation**
Organize the presenter (forces you to think things through).
- Accurately review any relevant health care events that might have happened since the last visit.
- Identification of new symptoms and any health related issues that need additional evaluation and/or treatment
- Verification of medications, stability of healthy
- Provide an opportunity for listeners to intervene and offer input

**Duration**
5 min

**Key features of the presentation:**

– **Reason for the visit:** Follow up for whatever the patient’s main issues are, as well as stating when the last visit occurred
  *Note: There may well not be a “chief complaint,” as patients followed in continuity at any clinic may
simply be returning for a visit as directed by their doctor.

- **Events since the last visit:** This might include emergency room visits, input from other clinicians/specialists, changes in meds, new symptoms, etc.

- **Review of Systems (ROS):** Depth depends on patient’s risk factors and known illnesses. If the patient has diabetes, then an extensive vascular ROS would be done. On the other hand, if the patient is young and healthy, the ROS would be cursory.

- **PMH, PSH, Social, Family, Habits are typically OMITTED in the follow-up visit presentation.** This is because these facts are already known to the listener and actionable aspects have presumably been added to the problem list (presented at the end). That said, they can be restated if the patient has a new symptom or issue related to a historical problem.

- **MEDS:** Review these at every visit.

- **Physical exam:** Vital signs and pertinent findings (or absence thereof) are mentioned.

- **Lab and Imaging:** The reason why these were done should be mentioned and any key findings are mentioned, highlighting changes from baseline.

- **Assessment and Plan:** This is most clearly done by individually stating all of the conditions that are being addressed (e.g. hypertension, hypothyroidism, depression, etc.) followed by their specific plans. If a new or acute issue was identified during this visit, the diagnostic and therapeutic plan for that concern should be described.
The Focused Visit
Purpose of the presentation
Accurately review the historical events that lead the patient to make the appointment.
- Identification of risk factors and/or other underlying medical conditions that might affect the diagnostic or therapeutic approach to the new symptom or concern.
- Generate an appropriate assessment and plan
- Allow the listener(s) to comment

Duration
3-5 min

Key features of the presentation:

- **Reason for the visit**
- **History of Present illness:** Description of the sequence of symptoms and/or events that lead to the patient’s current condition.
- **Review of Systems:** To an appropriate depth that will allow the listener to grasp the full range of diagnostic possibilities that relate to the presenting problem.
- **PMH and PSH:** Stating only those elements that might relate to the presenting symptoms/issues.
- **MEDS**
- **PE:** Vital signs and key findings (or lack thereof)
- **Labs and imaging (if done)**
– **Assessment and Plan:** This is usually very focused and relates directly to the main presenting symptom(s) or issues.
Putting It All Together
Summary Check List – All Skills

How do you perform the examination in a way that is complete, makes sense and yet is not awkward or prolonged? Is it OK to mix together different areas of the exam or should each system be explored as a block? Answering these questions and putting together a smooth exam is quite challenging. There is no single right way to do this. Any approach should:

1. Cover all aspects of the examination such that you have a reasonable chance of identifying pathology that might be present.
2. Be readily reproducible, allowing you to perform the exam the same way, all the time.
3. Keep patient gymnastics to a minimum (i.e. limit the number of times that the patient has to get up and down).
4. Link together sections which, although disconnected physiologically, are connected spatially. For example, inspection and examination of the feet for edema and peripheral arterial disease is part of the cardiovascular exam, yet is described below following the exam of the abdomen.
5. Allow you to be efficient and perform the exam with an economy of movement (i.e. minimize the number of times that you pick up and put down instruments, move from one side of the patient to the other, etc.).

It will take time, thought and practice before you come up with a system that works for you. I encourage you to experiment while choreographing your own moves. It’s helpful to practice the “mental aspects” of the PE by writing down the components of the exam, in the order in which you plan to perform them. If you can write it from memory,
then you’re a step closer to gaining mastery of this material. The approach described below keeps the movement of the examiner to a minimum, limits the frequency with which the patient has to get up and down, and is reasonably logical, thorough and efficient. There is a lot of room for flexibility.

Recognize that when caring for patients, the exam is somewhat modularized, with physician performing selected aspects (e.g. cardiac, abdominal, pulmonary) to investigate particular symptoms. For example, the evaluation of a 20 year old with knee pain after an injury would be limited to a detailed lower extremity exam, as exploring other regions (e.g. heart, lung) in this situation would be very unlikely to reveal important information. Conversely, an older person with a chief complaint of “weakness” (a concern with many possible explanations) would require a comprehensive evaluation. Knowing which examination module(s) to apply in any situation takes practice and experience, something that you will gain in the coming years.

The checklist which follows includes all elements that would be part of a very comprehensive screening exam. Recognize that there are many additional maneuvers (not described here) which would be appropriate in specific clinical situations. You will learn these techniques (and the times when they should be performed) in the coming years. Pelvic, breast, male genital, rectal and detailed musculoskeletal/joint exams have been omitted.
**Vital Signs:**
- Wash Hands
- Ask patient to put on gown and sit
- General observation
- Measure pulse, both radial arteries
  - rate
  - rhythm
  - volume
- Measure respiratory rate
- Measure blood pressure
- Examine hands, fingers, nails

**Head, Neck and Eyes**
- Observation head, neck & scalp
- Palpation lymph node, parotid and salivary gland regions
- Observe external eye structures – lid, sclera, pupil

**Using the Ophthalmoscope** (done in specific clinical setting):
- Examine external eye structures (lids, sclera,
pupil, iris, conjunctiva)

- Check pupillary response to light – direct and consensual (CN 2 & 3)
- Red reflex
- Retinal exam – identifying:
  - Optic disc, arteries, veins, color of retina, and macular area.

- Ear: external and internal (otoscope)
- Nose: observation, nares/mucosa (otoscope)
- Oropharynx:
  - Inspect w/light from otoscope & tongue depressor → uvula, tonsils, tongue, mucosa
  - Inspect teeth & salivary gland ducts
  - Assess tongue movement (CN 12)
  - Assess “Ahh” & Gag reflex (CN 9, 10)
- Thyroid: Observation, palpation

**Pulmonary**

Observation and Inspection
☐ General observation of breathing, note if using accessory muscles/general respiratory effort
☐ Note shape of chest and spine

**Pulmonary (cont): Palpation**
☐ Assess chest excursion
☐ Assess for fremitus (“bag of tricks”)

**Percussion**
☐ Percuss posterior lung fields, top to bottom → comparing side to side
☐ Identify amount of diaphragmatic descent with inhalation
☐ Percuss right antero-lateral chest (middle lobe) and anterior lobes (bilateral)

**Auscultation**
☐ Listen w/diaphragm to posterior lung fields, top to bottom → comparing left w/right
☐ Listen to right middle lobe area
☐ Listen to anterior lung fields
☐ Listen over trachea
Cardiovascular:
- Drape appropriately
- Examiner stands on right side of patient’s body
- Patient lying with head of table elevated ~ 30°

Observation & Palpation
- Inspect precordium – visible PMI, other contours
- Palpation of RV and LV (heaves, thrills);
  Determination of PMI

Auscultation
- S1 and S2 in 4 valvular areas
  w/diaphragm; note rate, rhythm
- Try to identify physiologic splitting S2
- Assess for murmurs, characterize if present
- Assess for extra heart sounds (S3, S4)
  w/bell over LV

Carotid artery
- Palpation
- Auscultation

Internal Jugular Vein
- Measure jugular venous pressure
Abdomen
  □ Lay patient flat. Drape appropriately – allowing exposure of abdomen but not rest of body
  Observe & inspect abdomen
  □ Shape, scars, color, symmetry, protrusions
Auscultation
  □ Listen w/diaphragm to 4 quadrants
  □ Note quantity and quality of bowel sounds
  □ Listen for bruits centrally & over renal arteries

Abdomen (cont): Percussion
  □ Percuss all quadrants
  □ Percuss liver span
  □ Percuss area of spleen, stomach
Palpation
  □ Palpate all quadrants superficially
  □ Palpate all deeply
  □ Try to identify liver edge (w/inspiration)
  □ Palpate region of spleen – using 2 hands
  □ Palpate area of aorta
Lower Extremities (continuation of C/V)
Assess femoral area (you don’t have to do this on fellow students)
  □ Palpation for nodes
  □ Palpate femoral pulse
  □ Auscultation femoral artery (for bruits)
Assess knees (non-mechanical exam)
  □ color, swelling
  □ palpate popliteal artery pulse
Assess ankles/feet:
  □ Color
  □ Temperature
  □ Check cap refill
  □ Check for edema
Pulses
  □ Dorsalis pedis artery
  □ Posterior tibial artery

Neuro
□ Cranial Nerves – Covered (above) in eye, head & neck sections. However, it’s fine to practice as a separate “CN module” as well, including:
  □ CN 1 - assess smell
☐ CN 2 – visual acuity, visual fields
☐ CN 2 & 3 pupillary response to light
☐ CN 3, 4, & 6 – extra-ocular movements
☐ CN 5 sensory face & cornea; muscles mastication
☐ CN7 – facial expression; close eyes
☐ CN8 – hearing acuity
  ☐ If hearing loss, perform Weber & Rinne Tests 512 Hz fork (CN 8) (“bag of tricks”)
☐ CN 9 & 10 – gag, palate rise
☐ CN 11 – neck turn/shoulder shrug
☐ CN12 – tongue movement
☐ Motor testing (patient seated):
  ☐ muscle bulk of major groups (see below)
  ☐ tone of major groups (see below)

☐ Motor testing (cont):
  ☐ strength of major groups – shoulders, elbows, wrists, hand, hips, knees, ankle
☐ Sensory testing - in distal lower extremities:
□ pain
□ light touch
□ proprioception
□ vibration – 128 Hz tuning fork

□ Reflexes
□ achilles
□ patellar
□ brachioradialis
□ biceps
□ triceps
□ Babinski assessment

□ Coordination (finger→nose, heel→shin, rapid hand supination←→pronation, rapid alternating finger movements)

□ Gait, Romberg
□ Wash Hands
**History Taking Checklist**

1. **CC (chief concern):**
   What brings you in today?

2. **History of Present Illness**
   *(OLD CARTS)*- Listed here in order of OLDCARTS, but would encourage you to obtain the history in the order that feels natural for the presenting concern
   
   **O – Onset**
   When did the symptom(s) begin?
   What were you doing when it started?

   **L – Location**
   Where is the problem located?
   Can you point to where it hurts?
   Does it migrate or radiate?
**D – Duration (chronology)**
How did the events unfold from the onset of the problem?
How often does it occur?
Is it constant or intermittent?

**C – Characteristics (quality, quantity, severity)**
How would you describe the symptom? What does it feel like?
How severe is it? (1-10 scale OR mild/moderate/severe)

**A - Aggravating and Alleviating Factors**
What makes it worse?
What makes it better?
Is there anything you do that makes it start and/or stop?

**R - Related symptoms**
Are there any other symptoms or any other problems that you’re noticing?
Are there symptoms that occurred preceding, or following the primary symptom?
(See the “Review of Systems” section.)

**T – Treatment**
Have you tried taking anything for this symptom such prescription or over the counter medicine?
Have you tried any homemade remedies?
Have there been prior treatments for similar symptoms?

S – Significance (patient perspective)
What do you think this is? What do you think has caused this?
How does this affect your life?
Does this have an impact on your ability to live/work?
What are your concerns and/or fears about what you are experiencing?

3. Past Medical History:
If follow-up visit, confirm relevant history and any changes since last visit.
Childhood Illnesses?
Adult Illnesses and chronic conditions?
Obstetric/gynecological history?
Psychiatric illnesses?
History of hospitalizations?
History of trauma?

4. Past Surgical History:
Operation type? Year?

5. Medications:
Confirm every visit.
What medications do you take? Do you take exactly as directed?
Do you take any over the counter medications or supplements?

6. Allergies:
If follow-up visit, confirm if any changes.
Do you have any known allergies to medications? If yes, what type of reaction?

7. Family Medical History:
If follow-up visit, confirm if any changes.
Do any major health problems run in your family? If yes, type and age of onset?
Who has these problems and how are they related to you?

8. Social History:
If follow-up visit, confirm if any changes. There may be overlap of this section with Health Maintenance Screen.
What is your occupation?
Who do you live with?
Tobacco use: Method of use? How many packs per day? For how many years?
Alcohol use: What type? How many drinks? How often?
Other illicit drug use: If so, what type? Method of use? Frequency?
Sexual History? (extent of questions will vary based on clinical scenario and risk)
Intimate Partner Violence (screen all women of child-bearing age, ask others whom you are concerned about)

9. Health Maintenance Screen:
*Usually completed comprehensively during establish care or annual visit. There can be overlap of this section with Social History.*
Tell me about your diet.
Tell me about your exercise/activity level.
Are you up to date with your immunizations?
Are you up to date with cancer screening?

10. Review of Systems (ROS)
*These are examples of possible ROS questions though there are many more. Pertinent ROS depends on presenting concern and your goals for eliciting ROS.*

General: Changes in weight, Fatigue, Difficulty sleeping, Aches and pains, Fever, Chills, Sweats.

Head: Vision/hearing problems, Headaches, Nasal discharge, Tooth Pain, Sore throat

Cardiovascular: Chest pain/pressure, Shortness of breath, Edema, Irregular/rapid heart beat, palpitations.
Pulmonary: Difficulty breathing, Chest pain, Cough, Wheezing, Snoring/sleep apnea.

Gastrointestinal: Heartburn, Abdominal pain, Nausea or vomiting, Jaundice, Black/tarry/bloody stools, Constipation or diarrhea.

Genito-Urinary: Problems with urination, Blood in urine, Burning or pain with urination, Incontinence, Urgency/Frequency, Incomplete Emptying.

Musculoskeletal: Joint pain, Joint Stiffness, Muscle Cramps, Muscle Weakness

Heme/Lymphatic: Abnormal Bleeding, Abnormal Bruising, Swollen nodes

OB/GYN: Menstrual History, Sweats, Vaginal Discharge

Neurological: Numbness, Weakness, Dizziness, Tremor

Mental Health: Depressed mood, Insomnia, Anxiety

**11. Communication Skills Reminders**

- Use open ended questions to begin the interview
- Use paraphrasing or summary to check understanding of patient’s story
- Avoid jargon, use appropriate language based on health literacy
• Avoid making judgemental statements
• Elicit, express understanding, and validate patient’s emotions
• Express respect for the patient’s situation
• Express willingness to support or partner with the patient
• Active Listening Skills:
  ➢ Allow patient to complete sentences and provide adequate time for patient to think of response
  ➢ Discern patient’s verbal and nonverbal cues
  ➢ Use appropriate nonverbal behavior to elicit further elaboration, convey concern, understanding, interest, empathy