

DEPARTMENT OF PEDIATRICS AND HUMAN DEVELOPMENT  
MICHIGAN STATE UNIVERSITY – COLLEGE OF HUMAN MEDICINE

**EVALUATION OF THE FORMAL WRITTEN H&Ps**

**2009-2010**

Student: \_\_\_\_\_

Course Name: Pediatrics

Community: F G K L S U

Clerkship Dates: \_\_\_\_\_

Semester: FI FII SI SII SSI SSII

Course #600 Section # 1 2 3 4 5 6

Credits: 12

Date of Formal Written H&P #1: \_\_\_\_\_

Clerkship Director: \_\_\_\_\_

Date of Formal Written H&P #2: \_\_\_\_\_

Based on your review of the Formal Written H&Ps, please evaluate the above named student by placing the appropriate number in the corresponding blank for each category.

RATING SCALE:

- NE = Not Evaluated  
1 = Unacceptable  
2 = Below Expectations  
3 = Average  
4 = Very Good  
5 = Outstanding

#1 #2

**1. MASTER PROBLEM LIST**

- A Write-up of a Level 4 or above includes all the following
- all of active and most resolved and potential problems listed
  - problem labels neither too general nor too specific for available data
  - problems kept sufficiently separate to allow adequate differential diagnosis
  - includes dates of onset and termination as well as date recorded for all problems

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**2. IDENTIFYING DATA AND HISTORY OF THE MAJOR ACTIVE PROBLEM(S)**

- A Write-up of a Level 4 or above includes all the following
- characterized the chief complaint, in the patient's own words or informant's
  - identifies patient by initials, age, gender and any other significance identified such as race, ethnicity, chronic health conditions
  - succinctly summarized circumstances leading to admission (for hospitalized patients) or to visit (for office patients)
  - indicated source of information and gave assessment of the reliability of the informant
  - described onset of the symptom of problem, and gave chronological account of events since that time
  - provided complete description of each symptom (eg PPQRST)
  - presented pertinent positives or negatives related to diagnostic hypotheses and/or ROS
  - explored psychosocial context of the problem, including parents//patient's explanations, expectations and impact of illness
  - includes pertinent past, family and social history

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**3. PAST MEDICAL HISTORY**

- A Write-up of a Level 4 or above includes all the following
- covered allergies and current medications described important past medical events as appropriate: childhood illnesses, operations, accidents/injuries, hospitalizations, travel and other exposures
  - mentioned stable or lower priority problems not covered in HMAP

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**4. MOTHER'S PREGNANCY HISTORY AND PATIENT'S BIRTH HISTORY**

- A Write-up of a Level 4 or above includes all the following
- covered mothers health, illnesses and medication during pregnancy including use of recreational drugs, tobacco, alcohol
  - mentioned duration of labor, type of delivery postnatal period including any complications and hospitalizations
  - mentioned detailed prenatal and postnatal history

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**5. GROWTH AND DEVELOPMENT**

- A Write-up of a Level 4 or above includes all the following
- mentioned growth and development in general
  - emphasized ages at which milestones achieved
  - comment on preschool or school achievement depending upon the age of the patient
  - discusses developmental trajectory, any delays or abnormal motor skill assessments including emotional development

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**6. HEALTH MAINTENANCE**

- A Write-up of a Level 4 or above includes all the following
- covered majority of areas: age appropriate safety, diet exercise, sleep, immunizations, HIV risk and periodicity of health checks
  - covered patient's/parents attitude toward health maintenance: accident prevention, child proofing of the house, alcohol and other substance use/abuse and smoking
  - uses HEADS mnemonic for adolescent patients

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7. SOCIAL HISTORY	<p>A Write-up of a Level 4 or above includes all the following</p> <ul style="list-style-type: none"> <li>- imparted sense of the patient as a person, including education, hobbies, relationships</li> <li>- covered impact on schooling and family function</li> <li>- incorporated social support, family support available for patient and parents</li> <li>- includes domestic violence screening</li> <li>- impact on finances including insurance, employment and additional unmet expenses</li> </ul>
8. FAMILY HISTORY	<p>A Write-up of a Level 4 or above includes all the following</p> <ul style="list-style-type: none"> <li>- includes complete history in terms of screen for heritable diseases</li> <li>- elaborates on relevant family history</li> <li>- includes a pedigree</li> </ul>
9. REVIEW OF SYSTEMS	<p>A Write-up of a Level 4 or above includes all the following</p> <ul style="list-style-type: none"> <li>- covered majority of systems in age appropriate manner</li> <li>- emphasized symptoms rather than diagnoses</li> <li>- positives described in more detail than negatives</li> </ul>
10. PHYSICAL EXAMINATION	<p>A Write-up of a Level 4 or above includes all the following</p> <ul style="list-style-type: none"> <li>- includes age appropriate vital signs,</li> <li>- measures and plots growth charts with percentiles</li> <li>- give general description of the physical, developmental and mental status of the Patient</li> <li>- calculate BMI for age 2 and above with percentile</li> <li>- emphasized systems most pertinent to the patient's problems</li> </ul>
11. PROBLEM IDENTIFICATION, ASSESSMENT DIFFERENTIAL DIAGNOSIS, DIAGNOSTIC REASONING	<p>A Write-up of a Level 4 or above includes all the following</p> <ul style="list-style-type: none"> <li>- prioritized problem list</li> <li>- discussed the most probable cause of each problem, and important alternative possibilities</li> <li>- explained possible interactions among the most likely diagnoses</li> </ul>
12. PLANS	<p>A Write-up of a Level 4 or above includes all the following</p> <ul style="list-style-type: none"> <li>- described appropriate additional diagnostic measures to be taken to clarify unresolved issues</li> <li>- presented appropriate initial treatment plan, including: activity, diet, medications, therapy and IV orders</li> <li>- considered the benefits and risks of procedures and treatments</li> <li>- identify what patient education or motivation is required to carry out the initial treatment plan</li> <li>- identify barriers to treatment of care plan</li> <li>- discuss the utilization of family and community resources in the patient's ongoing care</li> <li>- address all potential problems identified in the history and physical examination</li> </ul>
<p>Please comment on the student's overall strengths and limitations:</p>	