History and Physical Written Assessment

Student: **Evaluator:** **Date:**

_____ _____ _____

Part I.

Rate the quality of each section of the written note based on the extent to which defined elements are present:
1 = minimal
2 = some to many elements
3 = most or all elements

WRITTEN HISTORY

Detailed history of presenting illness: Defined as include a complete description of the complaint(s) such as location, quality, severity, duration, timing, radiation, favors that aggravate or alleviate symptoms	1	2	3
Descriptive history of presenting illness: Defined by use of semantic and descriptive vocabulary such as acute or chronic, sharp or dull, continuous or intermittent	1	2	3
Chronologic history of presenting illness: Defined as telling a clear story that flows logically	1	2	3
Contextualized history of presenting illness: Defined by identification and inclusion of key findings from past, family and social history, and relevant other symptoms that might otherwise belong in later portions of the comprehensive history	1	2	3
Complete comprehensive history: Defined as complete, past, family, and social histories and complete review of systems	1	2	3

WRITTEN PHYSICAL

Complete physical examination: Defined as documenting a comprehensive examination	1	2	3
Key physical examination findings: Defined as including an exam that highlights the absence and presence of key exam findings, as suggested by the diagnostic possibilities	1	2	3

WRITTEN ASSESSMENT

Interpretive summary: Defined as providing a concise summary statement that uses semantic vocabulary to highlight the most important elements from the history, exam, and testing and to interpret and represent the patient's main problem	1	2	3
Differential diagnosis: Defined as offering more than one relevant diagnostic possibility, committing to what is most likely and considering what is less likely or unlikely yet important to consider	1	2	3
Explained well: Defined as explaining the reasoning behind the lead diagnosis, including the epidemiology and key features and how these compare/contrast with the patient's presentation	1	2	3

Alternatives well considered 1 2 3
Defined as explaining the reasoning behind alternative diagnoses, including the epidemiology and key features and how these compare/contrast with the patient's presentation and the lead diagnosis

WRITTEN PLAN

Well-reasoned plan 1 2 3
Defined as including reasons for diagnostic testing and treatments and summarizing the evidence used to support decisions

Part II.
Please rate the skills this student documented in this patient note:

Reporting skills (based on Written History and Physical Exam Findings)

- ☐ Early: includes *some* important elements of history, exam, and test findings (1 point)
- ☐ Good: includes *many* important elements of history, exam, and test findings (2 points)
- ☐ Excellent: includes *nearly all or all* important elements of history, exam, and test findings (3 points)

Diagnostic reasoning skills (based on Written Assessment)

- ☐ Early: *errors* in diagnostic accuracy OR *limited explanation* of reasoning OR *errors* in reasoning (1 point)
- ☐ Good: *commits* to *at least one* pertinent diagnosis, accurately defines *epidemiology* and *key features* of diagnosis and compares to the patient's history, exam, and test findings (2 points)
- ☐ Excellent: includes *complete, pertinent* different diagnosis, commits to most likely diagnosis, *accurately* defines epidemiology and key features of most likely diagnosis and alternative diagnoses, and compares/contrasts with the patient's history, exam, and test findings (3 points)

Decision making skills (based on Written Plan)

- ☐ Early: *lists* diagnostic testing and treatment plans (1 point)
- ☐ Good: *uses sound reasoning* to support some diagnostic testing and treatment plans (2 points)
- ☐ Excellent: *uses evidence* to support most important diagnostic testing and treatment plans, considers patient preferences (3 points)

Total points = / 9

Comments:

(Adapted from IDEAs Assessment Tool – Dr. Elizabeth Baker, MD, MHPE)

Updated 5/7/21 MRE