COURSE OVERVIEW

The course provides students with an organized, sequential approach to the history and physical examination. Students will become competent in establishing relationships with patients through a variety of techniques and learning modalities, and will learn to appreciate the impact of culture on health beliefs and practices. Students will be able to perform both complete and directed histories and physical examinations and accurately document their findings.

CREDIT

Five credits

SESSIONS

The course consists of approximately 85 hours of instruction that incorporates both lecture (62.5 hours) and practicum time (22 hours) spanning modules I and II.

TEACHING STRATEGY

Includes lectures, small group presentations, labs and videos.

EVALUATION

The students will be evaluated by four (4) equally weighted examinations related to lecture and laboratory content. Each examination must be passed with a minimum grade of 77%. The minimum passing grade for this course is a C+.

If a student fails to achieve a grade of 77% on any of the examinations, s/he must take a remake and achieve a 77%. The maximum grade that will be recorded for the remake of the exam is 77%. In the event that a student does not pass a remake examination with a 77%, an average of the two grades will be used to calculate the final grade.
RATIONALE

The purpose of this course is to develop skills in obtaining a medical history and performing a physical examination and to begin to apply clinical reasoning to understand and assess patient problems. The students will learn the importance of cultural sensitivity as it relates to patient care. Students will learn appropriate documentation methods for both the directed and complete history and physical examination.

LEARNING GOALS

Upon completion of this course students should be able to:

1. Utilize appropriate clinical, descriptive and morphologic terminology when communicating with patients, their families and other health care providers.
2. Build a rapport with the patient while performing the history and physical examination.
3. Educate and counsel patients regarding illness and risks for illness.
4. Perform and record a complete medical history and physical examination.
5. Formulate problem lists, differential diagnoses, and assessment and plans for patients.
6. Perform an oral presentation that includes pertinent medical history and physical examination.

TOPIC OUTLINE

1. Introduction to the Medical Record and Complete Medical History
2. Setting the Stage/Interviewing Techniques
3. Interviewing Selected Populations
4. Optimizing the Interview
5. Patient History and Cross Cultural Communication
6. Chief Complaint and History of Present Illness
7. Past Medical History
8. Psychosocial History
9. Family History
10. Review of Systems
11. Case Presentations
12. Documentation and Risk Management
13. Problem Lists
14. Assessment and Plan, Progress Notes and Critical Thinking
15. General Approach to the Physical Examination
16. General Survey and Vital Signs
17. Head, Eye, Ear, Nose and Throat (HEENT) and Neck
18. Funduscoppy
19. Thorax and Lungs
20. Cardiovascular System
21. Peripheral Vascular System
22. Breasts
23. Lymphatic System
24. Abdomen
25. Musculoskeletal System
26. Motor Strength and Deep Tendon Reflexes
27. Cranial Nerves
28. Sensory System

**COURSE OBJECTIVES**

**Introduction to the Medical Record and Complete Medical History**

1. Diagram the components of the problem oriented medical record (POMR) and explain their use in patient care.
2. Outline the components of the patient data base.
3. Discuss the functions of the medical interview.
4. Differentiate the 4 different types of listening skills and give an example of each type.
5. Outline the components of the complete medical history.

**Setting the Stage/Interviewing Techniques**

1. Identify the different components of basic communication skills.
2. Describe the three interviewing stages.
3. Distinguish the different types of verbal and nonverbal interviewing techniques.

**Interviewing Selected Populations and Optimizing the Interview**

1. Modify techniques to address the special concerns related to interviewing pediatric, adolescent and geriatric patients.
2. Integrate specific communication techniques to enhance the interview.
3. Identify the common interviewing pitfalls that can create discomfort and inhibit patient response.
4. Describe how personal biases can impact the ability to perform a successful interview.
5. Weigh how your concerns as a student may impact on the interview and know how you can address them.

**Patient History and Cross Cultural Communication**

1. Describe the LEARN (listen, explain, acknowledge, recommend, negotiate) model for improving cross cultural communication.
2. Identify the existence of patient diversity and demonstrate respect for people as unique individuals.
3. Describe the impact that patient diversity can have on medical history taking, health beliefs and practices and patient care.
4. Discuss interviewing techniques useful in approaching patients of diverse backgrounds.

**Chief Complaint and History of Present Illness**

1. Describe the importance of introductory demographic information as it relates to the history.
2. Define “chief complaint” and be able to distinguish the actual chief complaint from ostensible chief complaint.
3. Discuss interviewing techniques most useful to elicit the chief complaint and give examples of each technique.
4. Discuss the key points to consider when documenting the patient’s chief complaint.
5. Define history of present illness.
6. Explore the most useful types of interview questions used to elicit an accurate history of present illness.
7. Describe in detail, the “elite eight” symptom characteristics used in formulating the history of present illness.
8. Incorporate other relevant historical information in the history of present illness.
9. Elicit the demographic data, chief complaint and history of present illness from a patient and accurately document that information in the proper format.

**Past Medical History**

1. Review interviewing techniques specific to obtaining the past medical history.
2. Describe each component of the past medical history.
3. Define the term risk factor as it applies to patients and disease.
4. Discuss the use of risk factors in the clinical thinking process.
5. Document the past medical history in the proper format.
**Psychosocial History**

1. Investigate the importance of a psychosocial history.
2. Name the components of a psychosocial history.
3. Investigate a patient’s occupational history and evaluate potential risks for medical illnesses.
4. Identify the major components of the lifestyle section and describe their importance as they relate to the psychosocial history.
5. Identify verbal and nonverbal cues.
6. Explore a patient’s risk for domestic violence by utilizing the SAFE (stress, afraid, friends, emergency) questions.
7. Explore a patient’s risk for alcoholism by utilizing the CAGE (concerned, annoyed, guilty, eye opener) questions.
8. Investigate a patient’s sexual history and evaluate potential risks for sexually transmitted diseases.
9. Document the psychosocial history in the proper format.

**Family History**

1. Explain the importance of the family history in assessing predisposition to disease including identifying Mendelian and complex disease risk factors.
2. Formulate questions that are most useful in obtaining an accurate family history.
3. Describe the interviewing techniques that are most helpful to decrease patient anxiety when discussing a family history.
4. Translate a family history from outline format to pedigree format using appropriate symbols.
5. Elicit a comprehensive family history including a three generation pedigree using standard pedigree symbols.
6. Analyze a pedigree in order to recognize possible modes of inheritance and/or to decide if the family history merits altering the patient’s treatment plan.
7. Identify five “red flags” in the family history that are useful in assessing risk for genetic transmission of diseases.
8. Locate and utilize local and national resources to locate family history tools and genetics professionals for both patients and health care professionals.

**Review of Systems (ROS)**

1. Summarize the goals of the ROS section of the medical history.
2. Demonstrate interviewing techniques used to elicit the ROS.
3. Elicit the review of systems from a patient and accurately document that information in the proper format.
Case Presentations

1. Describe the purposes for orally presenting patient cases.
2. List the various types of case presentations.
3. Differentiate the information typically required in each type of oral patient presentation.
4. Distinguish between pertinent positive and pertinent negative information.
5. Explain the techniques used in preparing for an oral case presentation.
6. Create and present a complete medical history.

Documentation and Risk Management

1. Summarize the goals of risk management in the health care field.
2. Explore the importance of documentation and identify the general guidelines to follow when making an entry into the medical record.
3. Compare and contrast the importance of communication in health care and identify behaviors that contribute to good communication.
4. Explain the process of informed consent.
5. List and document the elements of informed consent.
6. Identify the four basic elements of negligence.

Problem Lists

1. Define patient “problem” and recommend examples of various types of problems.
2. Compose a problem list.
3. Summarize the rules for updating a problem list.

Assessment and Plans, Progress Notes and Critical Thinking

1. Develop clinical thinking skills that lead to the recognition and assessment of patient’s problems.
2. Create a list of information that is commonly included in a patient assessment.
3. Construct 3 types of patient plans and give examples of each.
4. Organize the information included when documenting a patient assessment and plan.
5. Describe the indications for and use of patient progress notes.
6. Formulate S-O-A-P notes and evaluate which type of patient information belongs in each section.
7. Illustrate the association between the problem list and the patient assessment, plans and progress notes.

General Approach to the Physical Examination
1. Incorporate techniques that take into consideration patient concerns, modesty and comfort.
71802448. Design an appropriate environment for the physical examination.
71802449. Differentiate between direct and comprehensive physical examinations.
71802450. Develop a systematic and gentle approach to the physical examination.
71802451. Show the correct use of various types of equipment utilized for physical examination.
71802452. Identify the anatomic landmarks commonly utilized in the physical examination.
71802453. Describe the components of the comprehensive physical examination.

General Survey and Vital Signs

1. Assess the patient’s general appearance.
2. Demonstrate the ability to assess the arterial pulses including rate, rhythm, amplitude and contour.
3. Demonstrate the proper technique of measuring blood pressure.
4. Compare techniques used to assess a patient’s temperature.
5. Demonstrate the proper technique of assessing respirations including rate, rhythm, depth and effort of breathing.
6. Explain the indications for pulse oximetry.

Head, Eyes, Ears, Nose, Throat (HEENT) and Neck

1. Identify anatomic landmarks used in examining the head, eyes, ears, nose, throat (HEENT), and neck.
2. Recognize normal characteristics during inspection and palpation of the hair, scalp, skull, and face.
3. Assess visual acuity, visual fields and extra-ocular movements (EOMs).
4. Describe the normal appearance and common abnormalities of the eyelids, eyelashes, lacrimal ducts, pupils, conjunctiva, and sclerae and demonstrate examination of each.
5. Assess gross pressure of the eyes using direct palpation and ballotment.
6. Identify key anatomic structures of the ear and demonstrate the components of the exam of the external ear, auditory canal, and tympanic membrane.
7. Evaluate hearing including Weber and Rinne tests and interpret findings for sensorineural vs. conduction loss.
8. Describe the normal appearance and common abnormalities of the nose and sinuses and demonstrate examination of each.
9. Identify key anatomic structures of the mouth, pharynx and neck, and demonstrate the components of each.
10. Locate the lymphatic chains in the head and neck and describe characteristics of normal and abnormal nodes.
11. Identify the anatomic landmarks of the thyroid and demonstrate its examination.
12. Record the examination of the HEENT and neck.

Funduscscopy
1. Describe the gross anatomy of the eye and investigate the relationship between anatomy and the funduscopic examination.
2. Demonstrate the correct use of the ophthalmoscope.
3. Systematically describe the critical characteristics of the ocular fundus to include the disc, vessels, general background and retinal integrity, and macula.
4. Illustrate the method for identifying and reporting the location of funduscopic findings.
5. Identify and describe common abnormalities found in the ocular fundus.
6. Compare and contrast normal and abnormal findings of the ocular fundus.
7. Compare systemic diseases based on their abnormal funduscopic findings.
8. Record the examination of the ocular fundus.

Thorax and Lungs
1. Identify anatomic landmarks used in the examining the thorax and lungs.
2. Summarize normal findings of inspection and palpation of the thorax and lungs, including contour, breathing pattern, respiratory expansion and fremitus.
3. Compare the normal and abnormal percussion notes.
4. Demonstrate the proper technique and pattern for percussion of the thorax, including diaphragmatic excursion.
5. Distinguish between the various types of normal and adventitious breath sounds.
6. Explore the significance of bronchophony, egophony, and whispered pectoriloquy and demonstrate the performance of each.
7. Record the exam of the thorax and lungs.

Cardiovascular System
1. Describe the anatomy and physiology as it relates to the cardiovascular system.
2. Diagram the events (systole and diastole) in the cardiac cycle.
3. Contrast the cardiovascular changes that occur in adolescent, adult and geriatric patients.
4. Diagram the surface locations for aortic, pulmonic, tricuspid, and mitral valve sounds.
5. Differentiate the heart sounds of S₁, S₂, S₃ and S₄ and explain their significance in relation to cardiovascular diseases.
6. Distinguish normal heart sounds from heart murmurs.
7. Describe a murmur in terms of its timing, shape, intensity, pitch, quality, location, and radiation.
8. Recite the 6-point grading scale used to define intensity of a murmur.
9. Illustrate the conduction system of the heart and compare its relationship to waveforms on the resting surface EKG.
10. Summarize the mechanism and measurement of jugular venous pressure waves.
11. Demonstrate the cardiovascular exam.
12. Review the indications, techniques, and significance of special maneuvers utilized when examining the cardiovascular system.
13. Record the examination of the cardiovascular system.

**Peripheral Vascular System**

1. Explain the anatomy and physiology of the veins, arteries, and lymphatics of the upper and lower extremities.
2. Compare the changes that can occur in the peripheral vascular system as a person ages.
3. Describe the components of and demonstrate proper technique for evaluating the peripheral vascular system.
4. Draw the 4-point numeric classification utilized when describing pulses and edema.
5. Review the indications, techniques, and significance of the special maneuvers used to evaluate the peripheral vascular system.
6. Summarize the physical exam findings associated with peripheral vascular disease.
7. Record the physical examination of the peripheral vascular system.

**Breast**

1. Review the anatomy and physiology of the breasts and axillae.
2. Explore the anatomic changes that occur with age.
3. Describe the techniques of the breast examination.
4. Review the special techniques used in the examination of the breast.
5. Instruct a patient in breast self-examination.
6. Record the exam of the breasts and axillae.

**Lymphatic System**

1. Review the anatomy and physiology of the lymphatic system.
2. Identify the groups of palpable lymph nodes.
3. Demonstrate the exam of the lymphatic system.
4. Recognize abnormal lymph node findings.
5. Record the exam of the lymphatic system.

**Abdomen**

1. Review the anatomy of the abdomen.
2. Explain and demonstrate the specific techniques of the abdominal examination.
3. Describe and demonstrate the special tests of the abdomen.
4. Distinguish normal and abnormal exam findings.
5. Record the exam of the abdomen.

**Musculoskeletal System**

1. Describe the functions of the musculoskeletal system.
2. Compare and contrast the different types of joint articulations in the human body and give an example of each type.
3. Describe the bony and soft tissue anatomy of all the major joints of the human body.
4. Summarize anatomic terminology used to describe musculoskeletal physical examination findings.
5. Explore the general approach for the patient with musculoskeletal complaint.
6. Demonstrate the techniques and special tests for examining each of the major joints of the body.
7. Differentiate active from passive range of motion and know the examination techniques for each.
8. Explain the requirement for a concurrent neurovascular examination for patients with musculoskeletal complaints.
9. Investigate exam findings that deviate from expected findings.
10. Record the exam of the musculoskeletal system.

**Motor Strength and Deep Tendon Reflexes**
1. Review the anatomy and physiology of the motor system, reflexes, and coordination.
2. Explain the initial assessment of a patient’s overall general movements and body position.
3. Demonstrate the evaluation of muscle bulk and tone.
4. Perform motor strength testing and categorize the findings using the standard 0-5 scale.
5. Evaluate coordination, including rapid alternating movements, point-to-point, gait and stance testing.
6. Apply proper technique for eliciting and grading of deep tendon and superficial reflexes.
7. Distinguish between normal and abnormal findings on the examination.
8. Record the examination of motor strength and deep tendon reflexes.

**Cranial Nerves**

1. Review the anatomy and physiology of the cranial nerves including their names, origins, types, branches and functions.
2. Demonstrate the examination of the 12 cranial nerves including proper operation of instruments.
3. Recognize exam findings that deviate from expected findings for each of the cranial nerves.
4. Record the results of the cranial nerve exam.

**Sensory System**

1. Review the anatomy of the sensory system.
2. Describe the 5 primary modalities of somatic sensation and diagram their corresponding neurologic pathways.
3. Demonstrate the examination of somatic sensation.
4. Demonstrate the various exam techniques of cortical discrimination.
5. Compare normal and abnormal findings.
6. Record the results of the sensory examination.

**REQUIRED READING:**

*Bates’ Guide to Physical Examination and History Taking, Bickley and Szilagyi, 10th edition, Lippincott William and Wilkins, 2009*

*Lecture handouts and journal articles*

**Americans with Disabilities Act:**

If you have a physical, psychological, medical or learning disability that may impact your course work, please contact Disability Support Services, ECC (Educational Communications Center)

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Building, room 128, (631) 632-6748. They will determine with you what accommodations, if any, are necessary and appropriate. All information and documentation is confidential.

**Academic Integrity:**

Each student must pursue his or her academic goals honestly and be personally accountable for all submitted work. Representing another person's work as your own is always wrong. Faculty are required to report any suspected instances of academic dishonesty to the Academic Judiciary. Faculty in the Health Sciences Center (School of Health Technology & Management, Nursing, Social Welfare, Dental Medicine) and School of Medicine are required to follow their school-specific procedures. For more comprehensive information on academic integrity, including categories of academic dishonesty, please refer to the academic judiciary website at http://www.stonybrook.edu/uaa/academicjudiciary/

**Critical Incident Management:**

Stony Brook University expects students to respect the rights, privileges, and property of other people. Faculty are required to report to the Office of Judicial Affairs any disruptive behavior that interrupts their ability to teach, compromises the safety of the learning environment, or inhibits students' ability to learn. Faculty in the HSC Schools and the School of Medicine are required to follow their school-specific procedures.