## Patient Centered Medicine (PCM)

**Loyola University Chicago Interview Feedback Form (LUCIFF)**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>DEFINITION</th>
<th>ASSESSMENT Comment on Strengths/Recommendations for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initial Greeting:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o verbal introduction</td>
<td>States name and role on team</td>
<td></td>
</tr>
<tr>
<td>o shake hands</td>
<td>Greets warmly</td>
<td></td>
</tr>
<tr>
<td>o address patient as: Mr., Mrs., Ms.</td>
<td>Minimizes distractions  Attends to patient’s comfort and privacy</td>
<td></td>
</tr>
<tr>
<td>• Puts patient at ease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• States purpose of interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information Gathering</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Questioning: Uses open-to-closed cone</td>
<td>Starting with multiple open-ended questions followed by closed-ended</td>
<td></td>
</tr>
<tr>
<td>• Negotiates priorities for problems to be discussed.</td>
<td>questions. Avoids multiple and leading questions  Avoids the use of</td>
<td></td>
</tr>
<tr>
<td>• Establishes a narrative thread</td>
<td>jargon/technical language</td>
<td></td>
</tr>
<tr>
<td>• Re-directs and /or interrupts (if necessary)</td>
<td>Sets agenda and verifies it with patient, if appropriate.</td>
<td></td>
</tr>
<tr>
<td>• Problem Survey</td>
<td>Eliciting a chronological account. Lets patient tell story without</td>
<td></td>
</tr>
<tr>
<td>• Segment Summary/Clarification</td>
<td>unnecessary interruptions and listens carefully.  Follows significant</td>
<td></td>
</tr>
<tr>
<td>• Transitions smoothly between interview sections</td>
<td>leads</td>
<td></td>
</tr>
<tr>
<td>• Recognizes when patient is rambling, circumstantial, tangential,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Asks, “What else?” until all major concerns are expressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Paraphrases patient’s story and clarifies as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Avoids abrupt changes in content areas</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:**
- Faculty
- Peer
- Self

**Mode:**
- Video
- Live

Updated: Aug. 2013

Page 1 of 4
### Closing
- Encourages patient’s questions or invites comments
- States appreciation for patient’s efforts.
- Specifies next step

| Definition | ASSESSMENT
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Answers questions clearly and appropriately</td>
<td>Strengths/Recommendations for Improvement</td>
</tr>
</tbody>
</table>

### Facilitation Skills
- Eye contact
- Open posture
- Reinforces patient’s responses.
- Uses silences when appropriate.

| Definition | ASSESSMENT
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conveys interest and attentiveness.</td>
<td>Positive body language and appropriate blocking</td>
</tr>
</tbody>
</table>

### Relationship Skills
- Reflection/legitimatization
- Respect
- Support/partnership

| Definition | ASSESSMENT
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expresses understandability of patient’s emotions</td>
<td>Being appropriately deferential</td>
</tr>
<tr>
<td></td>
<td>Willingness to be helpful, to work together</td>
</tr>
</tbody>
</table>

### Patient Education
- Delivers diagnostic and instructional statements in simple language
- Verifies that patient understands.
- Involves patient in process

| Definition | ASSESSMENT
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Explains what patient needs to know without using jargon</td>
<td>COMMENTS</td>
</tr>
</tbody>
</table>

### Flow
- Smooth transition from one component to the next, with key points summarized and ending with an appropriate closure.

| Definition | ASSESSMENT
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMMENTS</td>
</tr>
</tbody>
</table>

### History Data Base (Content Area Form, page 4)
- Completed Satisfactory ✓
- 

### Professional Appearance & Conduct
- Satisfactory? ✓
## OVERALL INTERVIEW ASSESSMENT

<table>
<thead>
<tr>
<th>Please Check only ONE Box in this Row</th>
<th>Does Not Meet Expectations *</th>
<th>Meets Expectations, but with Concerns *</th>
<th>Meets Expectations</th>
</tr>
</thead>
</table>

### Does Not Meet Expectations
Unprepared for interview, or demonstrates unprofessional behavior, or leaves out multiple major sections of the history, or is inappropriate. MUST DESCRIBE IN COMMENTS SECTION

### Meets Expectations, but with Concerns
MUST DESCRIBE IN COMMENTS SECTION

### Meets Expectations
Is well prepared for the interview, established rapport, puts the patient at ease, and obtains the important information with logical flow. Approaches the patient in a kind, empathic, respectful manner. DOES NOT REQUIRE COMMENTS

### COMMENTS ( * These areas, if checked, require comments.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Evaluator:  
Date:

Updated: Aug. 2013
Page 3 of 4
HISTORY DATA BASE OUTLINE: Key Content Areas – check if discussed

A. **Chief Complaint** _________________________________________________________

B. **History of the Present Illness**
   1. Characteristics of Symptoms
      a. Location
      b. Radiation
      c. Quality
      d. Severity/Intensity
      e. Timing (onset, duration)
         i. Sudden, gradual
         ii. Acute, chronic
      f. Frequency/Pattern (intermittent, continuous, progressive)
      g. Setting
      h. Aggravating/Exacerbating factors
      i. Alleviating factors
      j. Associated manifestations
   2. Associated active medical, surgical or psychiatric problems which may impact the Chief Complaint
   3. **Past experience** with symptom(s)
      a. Prior Treatment? Response? Data from past charts?
      b. What has patient done about the symptom(s)
   4. Significant positives and negatives
   5. What was the psychosocial context of the onset of the symptoms?
   6. Patient’s Perspective of the Illness
      a. Patient’s understanding of the disease? Especially causes/implications/fears
      b. Impact of the disease and/or its treatment on the patient’s life, work, relationships
      c. Patient expectations
      d. Patient’s reason for visit

C. **Medical History**
   1. Childhood illnesses
   2. Health Screening (prior exams, cholesterol, etc.)
   3. Immunizations
   4. Adult illnesses/hospitalizations (including psychiatric)
   5. Injuries/Accidents
   6. Obstetric/Gynecological History

D. **Surgical History**
   1. Operations
   2. Surgical Procedures

E. **Therapies**
   1. Medications
   2. Complementary/Alternative Medicine

F. **Allergies**
   1. Allergies and Drug Reactions

G. **Psychosocial History**
   1. Marital status and relationship satisfaction
   2. Living arrangements/Family structure
   3. Personal safety at home
   4. Tobacco, Alcohol, Drugs
   5. Support/Secondary Gains
   6. Employment history/job satisfaction/military service
   7. Sexual history/function
   8. Significant life events and stressors: deaths, divorce, finances
   9. Diet, Sleep, Exercise

H. **Family History**
   1. Current health of parents, siblings, children
   2. History of significant illnesses (branching diagram if appropriate)
   3. Deaths: dates and ages at death

I. **Review of Systems**
   - Constitutional: Integumentary (Skin &/or Breasts);
   - Head: Eyes; Ears/Nose/Mouth/Throat; Neck;
   - Respiratory; Cardiovascular;
   - Gastrointestinal; Genitourinary;
   - Musculoskeletal; Neurologic;
   - Psychiatric; Endocrine;
   - Hematologic; Allergy/Immunologic