

Behavior	Not Done	Done Incorrectly	Done
<b>Opening</b>			
1. Initial Greeting: verbal intro., uses preferred title of patient			
2. Addresses any obvious source of patient discomfort			
3. States students' role and purpose of interview			
<b>Gathering Information</b>			
1. Uses open to closed questioning			
2. Elicits patient's active concerns			
3. Negotiates priorities for discussion			
4. Elicits chronological account of patient's concerns			
5. Utilizes segment summaries and clarification			
6. Transitions appropriately between interview sections			
7. History elements (see back)			
<b>Closing</b>			
1. Encourages patient questions/comments			
2. Key points summarized			
3. Specifies next step in encounter			
<b>Facilitation Skills</b>			
1. Eye Contact			
2. Open posture			
3. Uses silences when appropriate			
<b>Relationship Skills</b>			
1. Reflection/legitimization			
<b>OVERALL INTERVIEW ASSESSMENT</b> (circle only one)	Not Done	Done incorrectly	Done

Not Done: Unprepared for interview or demonstrates unprofessional behavior or leaves out multiple major sections of the history or is inappropriate. MUST describe in comments section.

Done Incorrectly: MUST describe in comments section.

Done: 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, empathetic, respectful manner.

**PLEASE COMMENT:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

EVALUATOR(s) \_\_\_\_\_ DATE \_\_\_\_\_

**HISTORY 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?
  - 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
 

(Patient's understanding, concerns and impact of the disease on the patient's life/work/relationships. Patient's expectations of the visit.)

**C. Medical History**

1.  Adult Illnesses/Hospitalizations
2.  Health Screening (pap test, colonoscopy, lung cancer screening.)
3.  Immunizations
4.  Obstetric/Gynecological History as applicable
5.  Psychiatric Illness or Psychiatric Hospitalizations
6.  Significant Childhood Illnesses
7.  Injuries/Accidents

**D. Surgical History**

1.  Operations and Indications
2.  Surgical Procedures

**E. Therapies**

1.  Medications and Dosages
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/Personal safety @ home
3.  Employment history/Job satisfaction/Military service
4.  Sexual history/Function/Gender Identity
5.  Significant life events and stressors: deaths, divorce, finances
6.  Sources of Support/Spiritual History
7.  Diet, Sleep, Exercise
8.  Tobacco, Alcohol, Drugs

**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);
- Eyes;
- Ears/Nose/Mouth/Throat;
- Breasts;
- Respiratory;
- Cardiovascular;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Neurologic;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic