Introduction to Clinical Medicine II

HISTORY TAKING AND PHYSICAL EXAM CHECKLIST

STUDENT NAME _____

STANDARDIZED PATIENT / OBSERVERS NAME_____

INDIANA UNIVERSITY
SCHOOL OF MEDICINE

Clinical Skills Training and Assessment Program
Office of Medical Education
Indiana University School of Medicine
2011-2012

Objective Structure Teaching Examination Checklist
2011-12

Item	Asked	Did *Not* Ask
1. SETTING THE STAGE FOR THE INTERVIEW		
a. Introduced him/herself by name.		
b. Identified his/her role.		
c. Asked for the patient's full name.		
d. Stated the patient's full name.		
e. Used patients preferred name/mode of address.		
f. Asked patient's age.		
g. Ensured patient readiness, comfort, and privacy (removed any barriers to communication.		
h. Ensured patient comfort and put the patient at ease.		
i. Elicited or commented on some personal quality or observation about the patient to elicit rapport.		
2. OBTAINING THE AGENDA AND CHIEF CONCERN		
a. Indicated the time available.		
b. Indicated her/his own needs for the visit.		
c. Elicited full list of patient concerns starting with presenting concern.		
d. Summarized and finalized the agenda (negotiated specifics if too many items on the agenda.)		
3. INFORMATION GATHERING PROCESS		
a. Used concise, easily understood questions and comments (avoided medical jargon; avoided inappropriate vernacular.)		
b. Used open-ended and closed questions appropriately, moving from open to closed.		
c. Avoided use of leading questions. (e.g., "you don't have chest pain, do you?")		
d. Approached the patient in an organized way.		
e. Asked the patient if he/she has any thoughts about what might be causing the chief concern.		
f. Used transition statements to explain when moving to different type of question/section of the interview.		
g. Summarized and verified the patient's responses		
h. Asked for and incorporated corrective feedback.		
i. Elicited information from patient and responded to it with follow-up questions in a non-invasive, non-judgmental manner.		
4. HISTORY OF THE PRESENT ILLNESS (HPI)		
a. Characteristics (both quality and severity)		
b. Location and/or radiation		
c. Onset and/or duration		
d. Symptoms associated with the concern		
e. Exacerbating factors		
f. Relieving factors		

Item	Asked	Did *Not* Ask
5. PAST MEDICAL HISTORY		
a. Allergies and/or drug reactions		
b. Medications		
i. Current/recent prescription medications		
ii. Current/recent over the counter medications		
iii. Current/recent herbal/alternative medications		
c. Medical history		
i. Major diseases		
ii. Major treatments		
iii. Toxins and/or industrial exposures		
iv. Doctor visits in the last year		
d. Surgical history		
i. Surgical procedures inpatient and date		
ii. Surgical procedures outpatient and date		
e. Hospitalizations and date		
f. Gynecologic/Obstetric (female)		
i. Menstrual history (onset of menses, cycle length, and/or # pads daily)		
ii. Pregnancy/Childbearing		
iii. Complications of pregnancy		
iv. Menopause (onset)		
v. Contraception (birth control pills and/ or other means)		
vi. History of sexually transmitted diseases		
vii. Mammogram		
viii. Last Pap smear		
g. Immunizations (tetanus-diphtheria in all patients)		
h. Diet (e.g. What did the patient eat the day before including meals and snacks? Salt intake? Fiber intake? Caffeine intake? Sugar intake in patients who have diabetes?)		
i. Trauma history (prior history of injury and how injury was treated)		
j. Growth and development and childhood diseases		

6.	**FAMILY MEDICAL HISTORY**		
a.	Summary of ages of immediate family members (including whether parents and siblings are alive and causes of death.)		
b.	Summary of and states of physical and mental health of immediate family members (including depression or substance abuse)		
c.	Family members with similar symptoms and signs		
d.	Presence of chronic and/or infectious diseases in family members		
e.	Family relationships (note family interaction patterns- e.g., happy, successful, competitive, distant, dysfunctional, love, anger,)		
7.	**PERSONAL/SOCIAL HISTORY**		
a.	Marriage/other relationships and outcome (e.g. spouse, partner, children)		
b.	Household composition/living situation (e.g. alone or with others, relationships; care giving)		
c.	Ethnicity		
d.	Sources of social support (e.g., friends, community, organizations, pets, spiritual beliefs or community)		
e.	Personal background (any three of education, occupation, military, travel, religion, dwelling, financial, stress)		
f.	Directives for care (e.g. living will, health care Power of attorney, transfusions, known health risks)		
8.	**PREVENTIVE/RISK FACTORS**		
a.	Preventative (any three of recreation, exercise, firearms, seat belts, smoke detectors, current stressors, periodic health examinations)		
b.	Tobacco current use		
c.	Tobacco past use		
d.	Alcohol current use		
e.	Alcohol past use		
f.	Recreational drugs current use		
g.	Recreational drugs past use		
h.	Sexual history		
i.	Sexually active		
i.	Partners (must ask male/female/both)		
ii.	Practice safe sex		
iii.	Male: History of sexually transmitted disease (female ask in past medical history)		
j.	Occupational hazard/environmental exposures		
k.	Violence risk: (e.g., Do you feel safe? Are you afraid of anyone? Has anyone hurt you?)		
9.	**REVIEW OF SYSTEMS** *(Within the last year have you experienced….)*		
a.	**General**		
i.	change in weight?		
ii.	change in appetite?		
iii.	overall weakness?		
iv.	lack of energy? (fatigue)		
v.	fever, chills, or sweats?		
vi.	lack of enjoyment in life? (anhedonia)		
b.	**Skin**		
i.	sores?		
ii.	itching or rashes?		
iii.	color or texture changes?		

iv. hair or nail changes?		
v. changes in mole(s)?		
c. Endocrine		
i. the thyroid gland (the area around your Adams Apple) in your neck getting bigger? (thyroid enlargement)		
ii. feeling unusually hot or cold? (heat/cold intolerance)		
iii. loss of sexual drive? (libido)		
iv. salt cravings?		
v. excessive thirst?		
vi. hat or glove size getting bigger? (enlarging glove or hat size)		
d. Hematopoietic		
i. swelling, lumps or bumps anywhere? (lymphadenopathy, enlarging glands)		
ii. bleeding or bruising tendencies?		
iii. frequent or unusual infections?		
e. Musculoskeletal		
i. frequent fractures?		
ii. trouble with your joints such as pain, stiffness or swelling?		
iii. muscle pain or weakness?		
iv. low back pain?		
v. difficulty moving or walking?		
vi. aching or cramping pain in calves with walking? (claudication)		
f. Head and Neck		
i. headaches?		
ii. head injury? (trauma)		
iii. neck stiffness?		
g. Eyes		
i. bright flashes of light?		
ii. changes in vision?		
iii. blind spot bordered by shimmering light? (scintillating scotomata)		
iv. spots in visual field (floaters)?		
v. double vision? (diplopia)		
vi. pain?		
h. Ears, Nose, Sinuses, Mouth and Throat		
i. sore throat?		
ii. painful tooth?		
iii. decreased or a change in your sense of taste?		
iv. difficult speech?		
v. hoarseness?		
vi. nasal drainage or nosebleeds? (epistaxis)		
vii. change or loss of hearing?		
viii. ringing in the ears? (tinnitus)		
i. Breasts		
i. pain?		
ii. masses?		
iii. discharge?		
j. Respiratory		
i. cough?		
ii. shortness of breath? (dyspnea)		
iii. wheezing or tightness in your chest?		

iv.	coughing up a substance such as sputum/phlegm or blood (hemoptysis)?		
v.	chest pain with coughing or breathing? (pleurisy)		
k.	**Cardiovascular**		
i.	chest pain?		
ii.	shortness of breath when lying down or need to sit up to breathe? (orthopnea)		
iii.	waking up at night with shortness of breath? (paroxysmal nocturnal dyspnea)		
iv.	swelling? (edema)		
v.	irregular heartbeats or sensation that your heart is racing or skipping beats? (palpitations)		
l.	**Gastrointestinal**		
i.	difficulty swallowing? (dysphagia)		
ii.	heartburn? (reflux)		
iii.	feeling like you are going to throw up (nausea)?		
iv.	throwing up (vomiting)?		
v.	throwing up blood? (hematemesis)		
vi.	excessive belching/burping? (eructation)		
vii.	excessive gas? (flatulence)		
viii.	difficult or infrequent bowel movements (constipation)?		
ix.	loose or frequent bowel movements (diarrhea)?		
x.	bloody or black tarry stools? (melena)		
xi.	belly pain? (abdominal pain)		
xii.	yellowish discoloration of the skin/whites of the eyes with dark urine that is the color of tea? (jaundice)		
xiii.	rectal pain (proctalgia), rectal discharge or rectal itching (pruritis ani)?		
m.	**Urinary**		
i.	urinating often? (frequency)		
ii.	need to urinate suddenly? (urgency)		
iii.	burning when you urinate? (dysuria)		
iv.	urinating blood? (hematuria)		
v.	getting up more than once a night to urinate? (nocturia)		
vi.	loss of control of urinating? (urinary incontinence)		
vii.	pebbles or gravel in your urine? (renal stones)		
viii.	slow to start urinating? (hesitancy)		
n.	**Female Reproductive**		
i.	vaginal pain?		
ii.	vaginal discharge?		
iii.	sores or lesions on your vagina?		
iv.	heavy periods? (menometorrhagia)		
v.	irregular periods?		
vi.	lack of periods? (amenorrhea)		
vii.	hot flashes?		
o.	**Male Reproductive**		
i.	lump or swelling of your scrotum? (scrotal swelling or mass/ hernia)		
ii.	scrotal pain?		
iii.	discharge from your penis? (urethral discharge)		
iv.	sores on your penis?		

v.	changes in ejaculation? (bloody, retrograde, premature)		
vi.	difficulty getting an erection? (impotence or erectile dysfunction)		
p.	**Neurologic**		
i.	fainting or passing out? (syncope)		
ii.	seizures?		
iii.	weakness on one side of your body? (paralysis)		
iv.	shaking that you can't stop? (tremors)		
v.	loss of feeling (anesthesia) or numbness (parasthesia) in part of your body?		
vi.	dizziness?		
vii.	loss of balance or lack of coordination? (incoordination)		
viii.	alterations in consciousness?		
ix.	sleep disorder?		
x.	memory disorder?		
xi.	migraine headaches?		
q.	**Psychiatric**		
i.	nervousness? (anxiety)		
ii.	being sad or blue? (depression)		
iii.	having a really up mood? (mania)		
iv.	unwelcome thoughts you can't get out of your head (intrusive thoughts)		
v.	loss of good judgment and/or insight?		
vi.	seeing or hearing things that don't exist? (hallucinations)		

PHYSICAL EXAMINATION:

Please assess the student examiner according to the scales below for each of the following physical examination items.

Clinical Courtesy **Comments**

		Performed	Did ***Not*** Perform	
1. The student washed his/her hands in view of the patient.	1.			
2. TOOK NOTES (if done) in a manner that does not interfere with dialogue or rapport. Leave blank if no notes were taken.	2.			
3. The student appropriately draped the patient throughout the physical examination.	3.			
4. The student verbally demonstrated an awareness and respect for patient's comfort level throughout the physical examination.	4.			
5. The student described what they were doing while examining the patient.	5.			
6. The student summarized the findings and plan.	6.			

Vital Signs

Procedure **Comments**

		Performed	Did ***Not*** Perform	
1. BP: Ex should slightly flex patients arm, and support arm (table, hold arm, etc).	1.			
2. BP: Ex should check size of cuff, locate brachial artery by palpation, and place cuff snugly about upper arm, centering the bladder over the brachial artery – arm should be free of clothing.	2.			
3. BP: Ex should place stethoscope (bell preferred, diaphragm acceptable) over brachial artery, and pump up cuff 20 to 30 mm Hg above palpable systolic pressure, and then release cuff slowly, at rate of 2 – 3 mm Hg per second, listening for Korotkoff sounds. Ex should record blood pressure.	3.			
4. PULSE: Ex should palpate the radial artery for at least 15 seconds.	4.			
5. RESPIRATION: Ex should stand in front or behind you and observe your breathing at rest for at least 30 seconds (normal rate is 10-16 breaths per minute). ASK Ex what your respiratory rate was during the feedback session.	5.			

Head, Neck & Eyes

Procedure		**Performed**	**Did *Not* Perform**	**Comments**
1-9. LYMPH NODES: The ex should palpate the following lymph nodes. 1. *preauricular* – in front of ears 2. *postauricular* – behind the ears 3. *occipital* – base of the back of the neck 4. *posterior cervical* – back of the sternomastoid muscle 5. *cervical/tonsillar* – angle of jaw 6. *submandibular* – halfway between angle of jaw and chin 7. *submental* – center of body under chin 8. *cervical chain* – along sternomastoid muscle 9. *supraclavicular* – in angle formed by collarbone and sternomastoid muscle.	1. 2. 3. 4. 5. 6. 7. 8. 9.			
10. TRACHEA: Ex should place his/her thumb along each side of the trachea in the lower portion of the neck. Pt should be asked to extend neck while Ex places index finger and thumb of one or both hands on each side of the trachea below the thyroid isthmus.	10.			
11. THYROID: Ex should stand behind Pt while seated. Ex should ask Pt to bend head to neutral position or slightly forward. Two fingers of each hand should be placed on either side of the trachea. Ex should then ask Pt to swallow (or to take a sip of water) while he/she feels the isthmus. The Ex should then displace trachea to the left and ask Pt to swallow while palpating trachea. Repeat on the left side.	11.			
12. EYE INSPECTION: Ex should ask you to look upward as Ex gently moves the LOWER LIDS of each eye downward. In the same way, you should look downward as Ex gently moves the UPPER LIDS upward. Cranial Nerve II (visual acuity) is examined in special circumstances.	12.			
13. PUPIL RESPONSE: With lights OFF, Ex should shine a penlight or the light of the ophthalmoscope on each pupil. Ex should avoid shining the light into both pupils simultaneously and should not allow you to focus on the light.	13.			
14. OPHTHALMOSCOPY: With lights OFF, Ex should instruct you to look at a distant point directly in front, and focus on that point. Ex should place his/her hand on your head to orient himself/herself. Ex should hold ophthalmoscope in right hand to view your right eye and left hand to view your left eye. Ex should begin from 10" – 15" laterally and move in slowly, changing lens strength if necessary in the process, and move to 1" – 3" away from the eye until foreheads almost touch. Ex should ask you to briefly look directly into the light at some point during the exam.	14.			
15. EXTRAOCULAR MOVEMENT: Ex should be positioned in front of you and request that without moving your head, your eyes follow Ex's finger or a pencil in four directions ("H" or "+" pattern). Ex should also ask you to look at the tip of your nose. *CNIII, IV, VI*	15.			

Ears, Nose and Throat

Procedure				**Comments**
		Performed	**Did *Not* Perform**	
1. OTOSCOPY: Ex should gently pull the auricle up and back. While holding the otoscope the Ex should slowly insert the speculum with a downward and forward movement into the ear canal. Repeat with opposite ear.	1.			
2. HEARING ACUITY: Ex should ask Pt to block one ear with finger while Ex checks the auditory acuity in the opposite ear. Ex will then rub fingers together 3 ft. from the unobstructed ear and then move fingers in until Pt can hear the rubbing. AND / OR The Ex should whisper a word or number while standing approximately 3 feet from Pt's side and ask him/her to repeat word.	2.			
3. SPECULUM: Ex should be positioned in front of Pt while gently inserting the short wide-tipped speculum into Pt's nostril. Ex should examine the lower portions of the nose and then ask Pt to tilt head slightly backwards.	3.			
4-6. INSPECTION: 4. Ex should use a light to inspect the buccal mucosa and the BACK of the mouth and throat. Using a tongue depressor Ex should depress more than halfway back on the tongue. Ex may have Pt phonate while inspecting the throat.	4.			
5. Ex should ask Pt to bite down. Ex will probably inspect the TEETH and GUMS at the same time.	5.			
6. Ex should ask Pt to extend TONGUE and move it from side to side. Ex should inspect the floor of mouth.	6.			

Upper Extremity

Procedure		Performed	Did *Not* Perform	Comments
1. WRIST and HAND Inspection: Assess symmetry, deformity and discoloration. Assess thenar and hypothenar eminence. (Ex should state what they are inspecting for)	1.			
2. WRIST and HAND Palpation: Examiner palpates wrist, CMC, MCP and PIP joints.	2.			
3. WRIST and HAND Range of motion: Pt flexes and extends wrist. Pt moves hand to ulnar and radial sides. Patient flexes and extends fingers at MCP joint with fingers straight, and makes fist.	3.			
4. WRIST and HAND Strength: Examiner resists patient while patient flexes and extends wrist, assesses grip strength, resists finger abduction, and resists opposition of thumb and small finger.	4.			

Lower Extremity

Procedure		Performed	Did *Not* Perform	Comments
1. KNEE Inspect: Ex inspects knee with patient supine for swelling and discoloration	1.			
2. KNEE Palpate: Ex should palpate popliteal space, tibiofemoral joint space laterally and medially, and patella.	2.			
3. KNEE Range of motion: Ex asks patient to flex and extend knee.	3.			
4. KNEE Strength: Ex should resist patient while patient flexes and extends knee.	4.			

Chest and Lung

Procedure **Comments**

		Performed	Did *Not* Perform	
1. INSPECTION OF CHEST: Ex should visually inspect Pt's chest while sitting for shape and symmetry, symmetry of respiratory excursion, pulsations, heaving and respiratory effort. (Ex should state what they are inspecting for)	1.			
2. THORACIC EXPANSION: While standing behind Pt, Ex should place thumbs parallel and several inches lateral to his/her mid to lower spine. Pt should then be asked to inhale deeply while Ex feels the range and symmetry of Pt's respirations.	2.			
3. TACTILE FREMITUS: While standing behind Pt, Ex should place his/her palmar or ulnar surface of both hands on Pt's upper, middle, and lower back. Ex should ask Pt to recite a few words or numbers (ex. "99") while he/she palpates with a firm, light touch both sides simultaneously.	3.			
4. PERCUSSION: Ex percusses over posterior and anterior chest. Ex should move from one side across to the other and down PERCUSSION TECHNIQUE: Ex places middle finger, which is hyperextended, against your skin, lifting the rest of the stationary hand up. Using the middle finger of the dominant hand, Ex should bounce it off the stationary one.	4.			
5. POSTERIOR BREATH SOUNDS: Ex should ask Pt to breathe deeply through mouth while Ex listens to AT LEAST ONE FULL BREATH AT EACH POSITION on the back. Ex should move from one side of the back across to the other and down.	6.			
6. ANTERIOR BREATH SOUNDS: Ex should use stethoscope to listen to both sides of the front of Pt's chest. Ex should progress from side to side moving downward using the same sequence while listening to one full respiration on each location.	7.			
7. AUSCULTATION TECHNIQUE: Ex should listen to the Pt's chest using the diaphragm of the stethoscope, which should be pressed firmly onto chest.	8.			
8. VOCAL RESONANCE: While auscultating with the stethoscope over the back, the examiner asks the patient to say "eee" The examiner should move the stethoscope from one side to the other, moving downward, while listening to patient say "eee" at each location.	9.			

Heart & Blood Vessels

Procedure **Comments**

		Performed	Did *Not* Perform	
1. JUGULAR VENOUS PULSE INSPECTION: Pt should recline to 30 to 45 degrees from horizontal while Ex shines his/her pen light over right side of the Pt's neck. (Will only be assessed if exam table inclines)	1.			
2. PRECORDIAL INSPECTION: Ex inspects precordium (looks at area and states: "I am checking the precordium for visible pulsations" or similar statement).	2.			
3. PRECORDIAL PALPATION: Ex should use the palmar surface of his/her fingers to gently palpate the left sternal border and the base while lying.	3.			
4. APICAL IMPULSE PALPATION: Ex should ask Pt to "exhale and hold it" while, Ex locates the pulse. Ex may need to roll pt midway to the left while lying.	4.			
5-8. HEART: Ex should listen to the heart in each of the following FOUR AREAS while Pt is lying down: 5. Aortic area 6. pulmonic area 7. tricuspid area 8. mitral area In select situations, it may be best to listen to the patient sitting upright and in a left lateral decubitous postion. This is a special maneuver and is not required.	5. 6. 7. 8.			
9. AUSCULTATION TECHNIQUE: Ex should listen to Pt's heart using the diaphragm AND bell of the stethoscope. When using the diaphragm, it should be pressed firmly onto chest. When using the bell, it should be applied lightly to produce an air seal with its rim against chest.	9.			
10 – 14. PULSES: Ex should locate and palpate the following pulses bilaterally: 10. brachial 11. radial 12. popliteal 13. dorsalis pedis 14. posterior tibial	10. 11. 12. 13. 14.			
15. CAROTID PULSE: Ex should exert gentle pressure with the pads of fingers on pt's carotid artery just below the corner of the jaw. This procedure should be repeated on the opposite side and should <u>not</u> be done simultaneously. Ex should use stethoscope to listen to the carotid artery. Pt should be asked to hold breath while Ex listens.	15.			

Abdominal

Procedure **Comments**

		Performed	Did *Not* Perform	
1. INSPECTION: Ex should inspect abdomen for color, contour, symmetry, movement, scars.(Ex should state what they are inspecting for.)	1.			
2. AUSCULTATION: Ex should listen to ALL FOUR QUADRANTS of the abdomen: right upper, left upper, right lower, and left lower. The ex MUST auscultate before palpating or percussing. Ex should listen to the AORTIC artery (located in the middle of the abdomen above the umbilicus), the RENAL arteries (located above the umbilicus), the ILIAC arteries (located below the umbilicus, bilaterally)	2.			
3. LIVER PERCUSSION: Ex should begin percussing the liver in the right midclavicular line at the level between the lower right chest and the umbilicus and proceed superiorly. Then, Ex should begin in the right midclavicular line over the lung and proceed inferiorly.	3.			
4. LIGHT PALPATION TECHNIQUE: Ex should first palpate all four quadrants and the epigastrium LIGHTLY while using the palmar surface of the fingers to identify any masses or areas of tenderness.	4.			
5. DEEP PALPATION TECHNIQUE: Ex should palpate all four quadrants and the epigastrium more DEEPLY while using the palmar surface of the fingers.	5.			
6. LIVER - RIGHT COSTAL MARGIN: Ex should place his/her right hand on the right upper quadrant of the patient's abdomen and gently press in and upward. Ex should ask Pt to take a deep breath and then exhale while Ex moves his/her hand upward toward the right.	6.			
7. SPLEEN - LEFT COSTAL MARGIN: Ex should place his/her left hand around Pt's left lower rib cage and gently press upwards against back. Ex's right hand is placed below the left costal margin and pressed inward toward the spleen. Ex should start in the lower left quadrant and work up towards the upper left quadrant.	7.			
8. AORTIC PULSE: Ex should use opposing thumb and finger or palmar surface of fingers and palpate the aortic pulsation located in the upper abdomen slightly to the left of midline.	8.			

Neurological

Procedure **Comments**

		Performed	Did ***Not*** Perform	
1. MENTAL STATUS: The ex should ask Pt questions pertaining to his/her orientation (person, place, time, situation). Ex should ask a minimum of 3 questions.	1.			
(NOTE: EYE/ CNs II, III, IV and VI ARE ASSESSED IN HNE SECTION)				
2– 7. CRANIAL NERVES: 2. ***V – Trigeminal.*** Ex should ask to clench Pt's teeth while he/she palpates the muscles of Pt's jaw. Ex should ask Pt to close his/her eyes and identify bilateral facial touch as soft or sharp. 3. ***VII – Facial.*** The ex should examine Pt's facial muscles while asking him/her to squeeze eyes shut, raise eyebrows, wrinkle forehead, frown, whistle, etc. At least one of the above expressions must be requested. 4. ***VIII – Acoustic***. Ex should ask Pt to tell him/her when Pt begins to hear the ticking of Ex's watch or rubbing of fingers. The Ex will begin with watch or fingers approx 3 feet from the side of Pt's head and will move in closer until identified. Ex may ask Pt to distinguish whisper in each ear. Either technique is fine.	2. 3. 4.			
5. IX and X – Glossopharyngeal. The Ex should press down on or near the posterior wall of the throat with a tongue depressor to elicit the gag reflex. 6. ***XI – Spinal Accessory.*** The Ex should ask Pt to push his/her head against Ex's hand in a side-ways fashion OR ask Pt to shrug shoulders up against Ex's hands. 7. ***XII – Hypoglossal.*** Ex should ask Pt to stick his/her tongue out of the mouth and move it from side to side.	5. 6. 7.			
8 – 9. SENSORY FUNCTIONS: The Ex should test sensory functions by touching Pt bilaterally with alternating soft and sharp OR warm and cold objects. 8. ***Arms/hands*** – forearms and hands 9. ***Legs/feet*** – calves, ankles, feet	8. 9.			
10. POSITION SENSE: The Ex should hold either side or the tip of Pt's finger with his/her two fingers. Ex should then move the finger up or down and ask Pt to say which way it is being moved. REPEAT with the big toe.	10.			
11. VIBRATION SENSE: The Ex should place a vibrating tuning fork against the bony prominence of Pt's WRIST AND ANKLE OR FINGER AND TOE and ask Pt to state when the vibration stops.	11.			
12.REFLEX TECHNIQUE: The movement of the hammer should be a rapid downward snap of the wrist. The hammer should not be held too firmly.	12.			
13 – 18. REFLEXES: Each of the following reflexes should be tested bilaterally: 13. Biceps 14. Triceps 15. Brachioradial 16. Patellar 17. Achilles Tendon 18. Plantar (Babinski)	13. 14. 15. 16. 17. 18.			

Procedure **Comments**

		Performed	Did ***Not*** Perform	
19. MOTOR FUNCTIONS / COORDINATION OF UPPER EXTREMITIES: The Ex should ask Pt to touch Ex's index finger and Pt's nose. The Ex should place his/her index finger 18 inches from Pt while changing the location of his/her finger several times. This procedure should be repeated with the Pt's other hand. AND / OR The Ex should ask Pt to rapidly and repeatedly touch his/her thumb with each finger on the same hand. Repeat with the Pt's other hand.	19.			
20. MOTOR FUNCTIONS / COORDINATION OF LOWER EXTREMITIES: The Ex should ask Pt to run the heel of one foot up and down the shin of the opposite leg. Repeat with opposite leg. AND / OR The Ex should ask Pt to walk a straight line in a heel-to-toe fashion.	20.			
21. ROMBERG SIGN: Ex should observe Pt stand with his/her arms stretched out in front or beside him/her with eyes closed.	21.			
22. GAIT: The Ex should observe Pt walk, turn, and return.	22.			

END TIME:

General Comments from the Preceptors: