

CLINICAL SKILLS EVALUATION**PATIENT NOTE**

HISTORY: Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives) relevant to this patient's problem(s).

PHYSICAL EXAMINATION: Describe any positive and negative findings relevant to this patient's problem(s). Be careful to include *only* those parts of examination you performed in *this* encounter.

DATA INTERPRETATION: *Based on what you have learned from the history and physical examination*, list up to 3 diagnoses that might explain this patient's complaint(s). List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive or negative findings from the history and the physical examination (if present) that support each diagnosis. Lastly, list initial *diagnostic* studies (if any) you would order for each listed diagnosis (e.g. restricted physical exam maneuvers, laboratory tests, imaging, ECG, etc.).

DIAGNOSIS #1:

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)

(+) Click to add row(s)

DIAGNOSIS #2:

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)

(+) Click to add row(s)

DIAGNOSIS #3:

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)

(+) Click to add row(s)

DIAGNOSTIC STUDIES

(+) Click to add row(s)