3RD YEAR MANNUAL FOR WARD TEACHING FOR MBBS

DEPARTMENT OF MEDICINE
LUMHS
JAMSHORO

MANNAUAL FOR 3RD YEAR MBBS TEACHING

DEPARTMENT OF MEDICINE

BY

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ESSENTIAL INSTRUCTIONS FOR STUDENTS

Dear students

You have now reached your clinical years and will be awarded degree of MBBS in 03 years' time. Our dream is to produce doctors with sound professional knowledge, who can practice ethically, have appropriate leadership and

administrative qualities and can serve the community with respect and honor. You need clear learning objectives to achieve these goals, so department f medicine have decided to give you a list of topics and skills you require to learn for passing the exams so that you can organize your time and studies accordingly.

Ward Postings:-

1. All shall wear apron in the ward.
2. Bring you stethoscope, torch, hammer & B.P apparatus to ward every day.
3. Respect you seniors, be courteous with all staff and keep kind & empathetic attitude towards patients.
4. Every student bounds to attend hospital posting with his / her respective group.
5. 75% attendance is compulsory for ward test, so be regular & punctual. If attendance is short due to a genuine reason then student will have to attend with next group to complete 75% attendance for appearing in test.
6. Ward test will be on the last date of posting.

During Ward Postings:

1. Keep a copy / time table of your ward posting.
2. You will most probably have the topics & teaching schedule on first day.
3. Actively participate in case presentations, examination & research projects.
4. All ward tests will be on assessment method of 30% theory 70% clinical.
5. Make sure your objectives are achieved during posting:-
    - History/ Examination
    - Approach to different signs and interpretation

Assignment:

Writing histories

Maintain check lists pf different examinations

EXAM KIT INCLUDES:

- MASKS

GLOVES AND SENITISERS

- Stethoscope
- Inch tape
- Hammer
- Fundoscope

- Monofilament
- Tuning Fork
- Blunt key
- Pin
- Ishihara chart for colour vision
- B.P Apparatus
- Torch
- Gloves
- Mydriatical eye drops (for dilatation of pupil)

LESSONS FOR 3rd YEAR MBBS

- Total duration of posting 1 month.
- 5 days a week
- 2 hours a day.
- For 4 weeks/ 40 hrs. 20 days

Each ward: The group will deal 4 systems along with history and general physical examination.

Breakup of Total time (1-month).

History taking	2 days
General Physical Examination	3 days
Chest	3 days
Abdomen	3 days

CNS	5 days
CVS	3 days
Ward test	1 day

Ward test

Theory	30%
Clinical Examination	75%

Each lesson will have the **objective** and the **learning outcomes** with assessment tools.

10 hours for supervised/ unsupervised assessment of the skills.

3 hours for rehearsal of all components before ward test.

3 hours for ward test.

Day-01 Lesson: 01

Topic: Components of the History

Objective: Student should able to organize the components of History according to the International Standards.

Learning Outcome: At the end of the day each student will be able to write in systemic way.

Assessment tool:
Ask the student to take history from his colleague.

- Biodata of the patient
- Chief complaints
- History of Chief complaints
- Past history
- Family history
- Socio economical history
- Personal History
- Treatment history
- Systemic review

Topic: Main Symptoms

Objective: Student should able to take the comprehensive history regarding the major symptoms.

Learning Outcome: At the end of the day each student should able to ask the proper questions regarding the symptoms of the patient.

Assessment tool:
Give different symptoms to the different students for history taking.

Symptoms:

- **GIT**
  - **A.** Nausea
  - **B.** Vomiting
  - **C.** Diarrhea
  - **D.** Constipation
  - **E.** Abdominal pain
  - **F.** Upper and lower GIT bleeding
  - **G.** Dyspepsia

- **CHEST**
  - **A.** Cough
  - **B.** Blood in sputum

- **CVS**
  - **A.** Chest pain
  - **B.** Swelling of legs
  - **C.** Shortness of breath
  - **D.** Palpitations

- **CNS**
  - **A.** Headache
  - **B.** Fits
  - **C.** Weakness of any area of the body
  - **D.** Vertigo
  - **E.** Loss of consciousness
  - **F.** Decreased vision

- **Miscellaneous**
  - **A.** Weight loss
  - **B.** Generalized wasting
  - **C.** Bleeding from Gum, Nose

D. Petechial spots over the body
E. Fever

Day-02 Lesson: 02

Topic: Writing and obtaining the history from patient

Objective: Student should able to take the proper history regarding the patient's symptoms in a comprehensive manner.

Learning Outcome: At the end of the day each student should able to obtain the history properly and write over the paper in a systemic way.

Assessment tool:
Allot a patient to the student under supervision of a faculty member.

Day-03 Lesson: 03

Topic: General Physical examination

Objective: Student should able to elicit the physical signs.

Learning Outcome: At the end of the day each student should able to observe the physical signs properly.

Assessment tool:
Allot a patient to the group of students under supervision of a faculty member.

- **Vitals**

A. Blood pressure
B. Pulse
C. Respiratory rate
D. Temperature

- **Sub vitals**

A. Face
B. Anemia
C. cyanosis
D. Jaundice
E. Typical appearance
F. Alopecia
G. Parotid enlargement

Day-04 Lesson: 04

Topic: General Physical examination

Objective: Student should able to elicit the physical signs.

Learning Outcome: At the end of the day each student should able to observe the physical signs properly.

Assessment tool:
Allot a patient to the group of students under supervision of a faculty member.

- Hands

A. Clubbing
B. Koilonychia
C. Palmar erythema
D. Leuconychia
E. Muscle wasting
F. Neck
    a. JVP
    b. Carotid pulsation

Feet

A. Edema
    Sacral edema
B. Dehydration

Day-05 Lesson: 05

Topic: General Physical examination

Objective: Student should able to observe the physical signs.

Learning Outcome: At the end of the day each student should able to observe the physical signs properly.

Assessment tool:
Allot a patient to the group of students under supervision of a faculty member.

- **Recording the signs on a paper in a systemic way verified by the Teacher on a printed proforma.**

Day-6 Lesson: 06

Topic: Inspection of chest

Objective: Student should able to inspect the chest properly.

Learning Outcome: At the end of the day each student should able to inspect the chest according the demonstrations.

Assessment tool:
Inspect the patient's chest in ward under supervision of a faculty member.

- **Inspection**
  - **A.** Introduction and consent
  - **B.** Proper exposure
  - **C.** Shape of chest
  - **D.** Respiratory rate
  - **E.** Symmetry of chest
  - **F.** Movements of chest
  - **G.** Abnormal findings
    a. Scar
    b. Pigmentation
    c. Veins
    d. Deformities

Day-07 Lesson: 07
Topic: Palpation of the chest

Objective: Student should able to palpate the chest properly.

Learning Outcome: At the end of the day each student should able to palpate the chest according the Instructions.

Assessment tool:
Palpate the patient's chest in ward under supervision of a faculty member.

- **Palpation**
  - **A.** Ask about tenderness
  - **B.** Trachea
  - **C.** Expansion of the chest
  - **D.** Vocal fremitus
  - **E.** Apex beat

Day-08Lesson: 08

Topic: Percussion of the chest

Objective: Student should able to percuss the chest properly.

Learning Outcome: At the end of the day each student should able to percuss the chest according the Instructions.

Assessment tool:
Percuss the patient's chest in ward under supervision of a faculty member.

- **Percussion**
  - **A.** Anterior
  - **B.** Lateral
  - **C.** Posterior

Topic: Auscultation of the chest

Objective: Student should able to auscultate the chest properly.

Learning Outcome: At the end of the day each student should able to auscultate the chest according the Instructions.

Assessment tool:
Auscultate the patient's chest in ward under supervision of a faculty member.

- **Auscultation**
  - **A.** Breath sounds
  - **B.** Ronchi
  - **C.** Crepitation
  - **D.** Plural rub

Topic: Surprise test for chest examination.

Objective: Student should able to examine the chest properly.

Learning Outcome: At the end of the test each student should able to do the clinical examination by their own in a systemic way.

Recording the signs on a proforma in a systemic way.

Assessment tool:
Surprised test will conduct by faculty member on patients .

Day-9 Lesson: 9

Topic: Inspection of abdomen

Objective: Student should able to inspect properly.

Learning Outcome: At the end of the day each student should able to inspect the abdomen according the Instructions.

Assessment tool:
Inspection of the abdomen in ward under supervision of a faculty member.

- **Inspection**
    - **A.** Introduction and Consent
    - **B.** Exposure
    - **C.** Shape of abdomen
    - **D.** Movements
    - **E.** Position of umbilicus
    - **F.** Abnormal findings
        a. Scar
        b. Pigmentation
        c. Bulging: Diffuse or localized
        d. Veins
        e. Hernial orifices

Day-10 Lesson: 10

Topic: Palpation of abdomen

Objective: Student should able to palpate the abdomen properly.

Learning Outcome: At the end of the day each student should able to palpate the abdomen according the Instructions.

Assessment tool:
Palpation of the abdomen in ward under supervision of a faculty member.

- **Superficial Palpation**
- **Deep palpation**
- **Visceral palpation**
  a. **Liver** (Size, contour, consistency, upper and lower border surface, edge)
  b. **Spleen**
  c. **Kidneys**
  d. **Para aortic lymph nodes**

Day-11 Lesson: 11

Topic: Percussion of abdomen

Objective: Student should able to percuss the abdomen properly.

Learning Outcome: At the end of the day each student should able to percuss the abdomen according the Instructions.

Assessment tool:
Percussion of the abdomen in ward under supervision of a faculty member.

- **Shifting dullness**
- **Fluid thrill**

Topic: Auscultation of abdomen

Objective: Student should able to Auscultate the abdomen properly.

Learning Outcome: At the end of the day each student should able to Auscultate the abdomen according the Instructions.

Assessment tool:
Auscultation of the abdomen in ward under supervision of a faculty member.

- **Bowel sounds**
- **Bruit (Hepatic, renal)**

Topic: Surprise test for abdominal examination.

Objective: Student should able to examine the abdomen properly.

Learning Outcome: At the end of the day each student should able to do the clinical examination by their own.
Recording of the signs on a paper in a systemic way.

Assessment tool:
Surprised test will be conducted by faculty member on patients.

Day-12 Lesson: 12

Topic: Inspect the precordium

Objective: Student should able to inspect the precordium properly.

Learning Outcome: At the end of the day each student should able to inspect the precordium according the Instructions.

Assessment tool:
Inspect the precordium of the patient in ward under supervision of a faculty member.

- **Inspection**
    - **A.** Introduction and Consent
    - **B.** Exposure
    - **C.** Apex impulse
    - **D.** Pericardial pulsation
    - **E.** Abnormal findings
        a. Scar
        b. Bulging or retraction

Day-13 Lesson: 13 DAY

Topic: Palpate the precordium

Objective: Student should able to palpate the precordium properly.

Learning Outcome: At the end of the day each student should able to palpate the precordium according the Instructions.

Assessment tool:
Palpate the precordium of the patient in ward under supervision of a faculty member.

- **Palpation**

    A. Apical impulse.
    B. Para- sternal heave
    C. Thrill
    D. Isolated areas

Day-14 Lesson: 14

Topic: Auscultation of precordium

Objective: Student should able to Auscultate properly.

Learning Outcome: At the end of the day each student should able to Auscultate according the Instructions.

Assessment tool:
Auscultation of the precordium in ward under supervision of a faculty member.

- **Auscultation**
    - **A.** S1, S2 (Position, intensity, gap)
    - **B.** S3, S4
    - **C.** Murmurs (Timing, phase, intensity, relation to respiration, dynamic maneuvers)
    - **D.** Pericardial rub

Topic: Surprise test for CVS examination.

Objective: Student should able to examine the CVS properly.

Learning Outcome: At the end of the day each student should able to do the clinical examination by their own.

Recording of the signs on a paper in a systemic way.

Assessment tool:

Surprised test will be conducted by faculty member on patients

Day-15 Lesson: 15

Topic: Higher mental functions

Objective: Student should able to do Glasgow coma scale properly.

Learning Outcome: At the end of the day each student should able to do Glasgow coma scale according the Instructions.

Assessment tool:
Perform the Glasgow coma scale in ward over the patient under supervision of a faculty member.

- **Glasgow coma scale**

Topic: Higher mental functions; language functions (speech, calculation ,reading, & writing)and memory

Objective: Student should able to do scalespeech, calculation ,reading & writing properly.

Learning Outcome: At the end of the day each student should able to do speech, calculation ,reading & writing according to Instructions.

Assessment tool:
Perform the types of speech, calculation ,reading , writing and memory in ward over the patient under supervision of a faculty member.

- Speech (fluency ,comprehension &repetition)
- Calculation

Reading
Memory; immediate, recent and remote.

Day-16 Lesson: 16 **Cranial nerves.**

Topic: cranial nerves.

Objective: Student should able to do cranial nerve examination properly.

Learning Outcome: At the end of the day each student should able to do cranial nerve examination according to Instructions.

Assessment tool:

Perform the cranial nerves over the colleague under supervision of a faculty member.

(1, 2,3,4,5,6,7,9,10,11 & 12)

Day-17 Lesson: 17 **motor system (upper limb).**

Topic: motor system.

Objective: Student should able to do motor system(upper limb**)**examination properly.

Learning Outcome: At the end of the day each student should able to do motor system of upper limb according to Instructions.

Assessment tool:
Perform the motor system of upper limb over the colleague under supervision of a faculty member.

Inspection (bulk, Abnormal involuntary movements)
Tone
Power

Reflexes.

motor system (lower limb).

Topic: motor system 2

Objective: Student should able to domotor system(lower limb**)**examination properly.

Learning Outcome: At the end of the day each student should able to do motor system of lower limb according to Instructions.

Assessment tool:
Perform themotor system of lower limb over the colleague under supervision of a faculty member.

a) Bulk & inspection
b) Tone
c) Reflexes
d) Power
e) Plantar reflex
f) Abdominal reflex
g) Gait

Day-18 Lesson: 18 **Cerebellar system**

Topic: Cerebellar system

Objective: Student should able to do Cerebellar system examination properly.

Learning Outcome: At the end of the day each student should able to do Cerebellar system according to Instructions.

Assessment tool:
Perform the Cerebellar system over the colleague under supervision of a faculty member.

a) Nystagmus
b) Speech (scanning)
c) Tone
d) Pendullar knee jerk
e) Past pointing
f) Heel shin test
g) Gait

Day-19 Lesson: 19 **Sensory System .**

Topic: sensory system

Objective: Student should able to dosensory system examination properly.

Learning Outcome: At the end of the day each student should able to do sensory system according to Instructions.

Assessment tool:
Perform the sensory system over the colleague under supervision of a faculty member.

a) Joint position
b) vibration
c) light touch
d) crude touch
e) Thermal sensation
f) Pain

Pulse	Rate	
	Rhythm	
	Volume	
	Character	
	Comparision with other pulses	
	Condition of vessel wall	
Blood pressure		
Neck veins		
Precordial examination		
inspection	Chest deformity	
	Bulging of precordium	
	Visible scar marks	
	Visible veins	
	Visible pulsations	Apex beat site and character
		Abnormal pulsations
Palpation	Apex beat site and character	
	Palpable heart sounds	
	thrill	
	Left parasternal heave	
	Pericardial friction rub	
percussion		
auscultation	Heart sounds including intensity and splitting	S1
		S2
		S3

CVS check list

	S4
murmurs	Site
	timing
	character
	site of maximum intensity
	Grade
	Radiation
	Effect of respiration
	Effect of posture
Other sounds	Opening snaps
	Ejection clicks
	Mid systolic click
	Pericardial rub

Motor system examination

BULK	**TONE**	**REFLEXES**	**POWER**	**COORDIATION**	**ABD REFLEX**
INSPECTION	HYPER	GRADING	GROUP	HEEL SHIN	POSITIVE
HYPERTROPHIC	HYPO	REINFORCEMENT	GRADING	NOSE FINGER	NEGATIVE
ATROPHIC	RIGIDITY				
HAIR	SPASTICITY				
LESION	GANGEHELTON				

:

Abdominal examination check list

Task	Essential	Additional
Place		*
exposure permission	*	
Greetings	*	
Explanation		*
	*	
Shape	*	
Movements	*	
Position and shape of umbilicus	*	
Skin color		*
Pigmentation	*	
Hernial orifices	*	
Straie	*	
Superficial palpation	*	
Deep palpation	*	
Liver	*	

Spleen	*	
Lt kidney	*	
Rt kidney	*	
Bladder		*
Hernail orifices	*	
Paraortic lymph nodes	*	
Shifting dullness	*	
Fluid thrill	*	
Percussion over all abdomen		*
Auscultation	*	
Bruit	*	
Hump		*
Bowel sounds	*	

CHEST EXAMINATION

INSPECTION	**PLPATION**	**PERCUSSION**	**AUSCULTATION**	**ADD GPE SIGN**
R/R	TENDERNESS	RESONANT	TYPE OF BREATH SOUNDS	CYANOSIS
SHAPE	TRACHEA	HYPERREONANT	RHONCHI	PLETHORA
SYMMETERY	EXPANSION	IMPAIRED	CREPITATIONS	LYMPH NODES
MO VEMENT	VOCAL FERMITUS	DULL	RUB	EDEMA
	APEX BEAT			

Presenting Complain and HOPC:

I. Pain

Onset_____.
Site_____.
Character_____.
Duration_____.
Radiation_____.
Aggravating factor_____.
Relieving factor _____.
Canadian Cardiovascular class_____.
Associated symptoms_____.

II. SOB (Dyspnoea)

Onset_____.
Duration_____.
Progressive or non progressive.
How much exertion precipitates.
H/O Orthopnea_____.
PND_____.
Associated symptoms_____.
NYHA class_____.

iii. **Palpitation:**

Onset_____.
Duration_____.
At rest or exertion_____.
Regular or Irregular_____.
Episodic Yes No.
Associated Symptoms.

Iv Syncope.

Premonitory Symptoms_____.
History of Prolong standing and heavy meals_____.
Recovery time_____.
Neurological Deficit_____.

. 5 **HEMOPTYSIS :**

Onset_____.
Duration_____.
COLOR_____.
AMOUNT_____.
WITH CHEST PAIN OR WITHOUT CHEST PAIN
FREQUENT OR INFREQUNET

. 6 **EDEMA:**

Onset_____.
Duration_____.
ASCENDING OR DESCENDING_____.
PAIN FULL OR PAINLESS_____.
MORNING OR LATE EVENING ___.
Associated Symptoms.

7 FIT

Onset_____.
Duration_____.
LOCALOR GENERAL_____.

WITH OR EITHOUT CONCSCIOUS NESS _____.
RECURRENT OR SINGLE .
Associated Symptom
PRE MONITORY SYMPTOMS
POST FIT SUMPTOMS
SLEEP INDUCED OR NOT
AGGRAVATING FACTORS

8 HEADACHE

Onset_____.
Site_____.
Character_____.
Duration_____.
Radiation_____.
Aggravating factor_____.
Relieving factor _____.
SEVERITY _____.
Associated symptoms_____.

9 WEAKNESS OF LIMB

Onset_____.
AREA_____.
Duration_____.
PROGRESSION _____.
ASCENDING OR DECSENDING
Aggravating factor_____.
Relieving factor _____.
Associated symptoms_____.

10 VERTIGO

Onset_____..
SUBJECTIVE OR OBJECTIVE _____.
Duration_____.
GAIT _____.
Aggravating factor_____.
Relieving factor _____.

Associated symptoms_____.

SEVEIRITY

11 UNCONSCUIOSNESS

Onset_____
TIME _____.
Duration_____.
TRUAM OR INTOXICATION _____.
1ST OR RECURRENT _____.
FIT OR NON FIT _____
Associated symptoms_____

12 JOIN PAIN

Onset_____
SUBJECTIVE OR OBJECTIVE _____.
Duration_____.
AREA _____.
Aggravating factor_____.
Relieving factor _____.

Associated symptoms_____.

SEVEIRITY

BACKACHE

13 BLEEDING

Onset_____.
Duration_____.
COLOR_____.
AMOUNT_____.
FREQUENT OR INFREQUNET
FEVER, FATIGUE, PAIN, WEIGHT LOSS
SKIN LESIONS

VOMITING

DIRRHEA

JAUNDICE

HEMITURIA

POLYURIA

DYSURIA

COLD OR HEAT INTOLEARNCE
IMPOTNCE
MENSTRUAL PROBLEMS
WEIGHT CHANGES
HYPER/ HYPO PIGMENTATION

G.P.E

CHECKLIST OF PHYSICAL SIGNS

Medical Unit: _____ Ward: _____
Student's Name: _____ Roll No. _____ Group: _____

Sr. No.	Sign	Can detect / appreciate / elicit				Initials
		Good	Satisfactory	Average	Poor	
01	Pulse:					
	a. Rate					
	b. Rhythm					
	c. Volume					
	d. Paradox					
	e. Collapsing					
	f. R.R delay					
	g. R-F delay					
	h. Vessel Wall (Condition)					
02	Temperature					
03	B.P					
04	Respiration					
05	Clubbing					

06	Cyanosis					
07	Anemia					
08	Jaundice					
09	Koilonychia					
10	Leukonychia					
11	Dehydration					
12	Edema					
13	Palmer Erythema					
14	Lymph Nodes:					
	a. Cervical					
	b. Axillary					
	c. Inguinal					
15	Ptosis					
16	Proptosis					
17	Corneal arcus					
18	Xanthelesma					
19	Wasting of small muscles					
20	Parotid gland					
21	Deformities of RA					

22	Spider Nevei					
23	Striae					
24	Gynecomastia					
25	Purpura / Petechiae					
26	Splinter Hemorrhages					
27	Malar Flush					
28	Flapping Tremors					
29	Angular Stomatitis					
30	Aphthous Ulcers					
31	Nicotine Marks					
32	Smooth Tongue					
33	Goiter					
34	Carotids					

Teacher Name: _____ Signature: _____

Co-Teacher Name: _____ Signature: _____

Medical Unit: I / II / III / IV
Liaquat University of Medical &
Health Sciences, Jamshoro

G.I.T

CHECKLIST OF CLINICAL SIGNS

Medical Unit: _____ Ward: _____

Student's Name: _____ Roll No. _____ Group: _____

Sr. No.	Sign	Can detect / appreciate / elicit				Initials
		Good	Satisfactory	Average	Poor	
01	Cushingoid face					
02	Ecchymosis					
03	Tattoos					
04	Purpura / Petechiae					
05	Pigmentation					
06	Uremic Complexion					
07	Hepatic Fetor					
08	Hyperventilation					
09	Scleroderma Facies					
10	Anemia					
11	Jaundice					
12	Clubbing					
13	Palmer Erythema					
14	Leukonychia					
15	Koilonychia					
16	Flapping Tremors					
17	Join Deformities					
18	Scratch Marks					
19	Insulin Marks					
20	B.P					
21	Parotids					
22	Spider Angiomas					
23	Butterfly rash					
24	Circumoral Pigmentation					
25	Angular Stomatitis					
26	Cheilosis					
27	Telengiectasia					
28	Aphthous Ulcers					
29	Gum Hypertrophy					
30	Dehydration					
31	Oral Thrush					
32	Gynecomastia					

33	L. Nodes					
34	Bone Tenderness					
35	Umbilicus					
36	Epigastric Pulsations					
37	Striae					
38	Spine Tenderness					

Teacher Name: _____ Signature: _____

Co-Teacher Name: _____ Signature: _____

Medical Unit: I / II / III / IV
Liaquat University of Medical &
Health Sciences, Jamshoro

RESPIRATORY EXAMINATION

CHECKLIST OF CLINICAL SIGNS

Medical Unit: _____ Ward: _____

Student's Name: _____ Roll No. _____ Group: _____

Sr. No.	Sign	Can detect / appreciate / elicit				Initials
		Good	Satisfactory	Average	Poor	
01	Posture					
02	Cyanosis					
03	Dyspnea					
04	Purse Lips					
05	Nicotine Marks					
06	Clubbing / HPOA					
07	Wheeze / Hoarseness					
08	Flapping Tremors					
09	Wasting of small muscles					
10	Pallor / Plethora					
11	Parotids					
12	Rash					
13	Horner's					
14	Sputum Mug					
15	O_2 Cylinder					
16	Nebulizer / Inhaler					
17	Radials:					
	a. Rate					
	b. Rhythm					
	c. Volume					
	d. Paradox					
18	Prominent Veins (SVC Obs)					
19	R/R					
20	Type of Resp.					
21	Shape / Symmetry of Chest					
22	Use of accessory Muscles					
23	Indrawing of I/C Spaces					
24	Chest Tenderness					
25	Trachea					
26	Apex beat					
27	Epigastric pulsations					
28	Crico sterna space					

29	Tracheal Tug					
30	S/C Emphysema					
31	Chest Movements					
32	Expansion					
33	V.F					
34	Percussion					
35	Breath Sounds					
36	Added Sounds					
37	V.R					
38	Pleural rub					

Teacher Name: _____ Signature: _____

Co-Teacher Name: _____ Signature: _____

Medical Unit: I / II / III / IV
Liaquat University of Medical &
Health Sciences, Jamshoro

ABDOMEN	Performance / Grade	Suggestion of improvement	Date of next assessment	Cross examined by	Remarks after 2nd test
General Observation					
Inspection: • Shapes & Symmetry Movements • Umbilicus • Prominent Veins • Pulsations • Scars / Striae					
Palpation: • Tenderness • Liver • Spleen • Kidneys • Fluid Thrill • Aorta • Para aortic node • Inguinal nodes • Hernia orifices					
Percussion: • Shifting • Dullness • Percussion for visceras					

Auscultation: • Bowel Sounds • Renal Bruit • Hepatic Bruit					

Key:

Grades of performance: 1 = Average 2 = Satisfactory 3 = Good

2nd Test = Cross Examined by faculty member from other unit: _____

_____ _____ _____

Signature of 1st Assessor Signature of 2nd Assessor Signature of HOD

RESPIRATION	Performance / Grade	Suggestion of improvement	Date of next assessment	Cross examined by	Remarks after 2nd test
General Observation					
Inspection: • Shapes & Symmetry Movements • Prominent Veins / Pulsations • Rate / Type of Resp. • Trachea • Apex beast					
Palpation: • Tenderness • S/C Emphysema • Trachea • Apex beast • Movements • V. Fermitus • Expansion					
Percussion: • Lungs • Upper liver border					
Auscultation: • Breath Sounds					

• Added Sounds • V. Resonance • Pleural Rub					

Key:

Grades of performance: 1 = Average 2 = Satisfactory 3 = Good

Suggestion for improvement:
1 = Reporting for 02 weeks
2 = Reporting for few days for particular mistakes
3 = Single-day posting for rehearsal of all systems
4 = Satisfactory

2nd Test = Cross Examined by faculty member from other unit: _____

Signature of 1st Assessor Signature of 2nd Assessor Signature of HOD

NEUROLOGICAL EXAMINATION

CHECKLIST OF CLINICAL SIGNS

Neurology: _____ Ward: _____

Student Name: _____ Roll No: _____

Group: _____

Sr. No.	Sign	Can detect / appreciate / elicit			
		Good	Satisfactory	Average	Poor
01	Characteristic Facies				
02	Ptosis				
03	Proptosis				
04	Facial Asymmetry				
05	Involuntary Movements				
06	Orientation: a. Time b. Place c. Person				
07	Hallucinations				
08	Delusions				
09	Illusions				
10	GCS				
11	Memory: a. Recent b. Remote				
12	Intelligence				
13	Grasp reflex				
14	Sucking reflex				
15	Snout reflex				
16	Palmomental reflex				
17	Glabellar reflex				
18	Apraxia				
19	Aphasia: <u>Dysphasia</u>: a. Motor (Brocas) b. Sensory (Wernickers) <u>Dysarthria</u>: a. Cortical b. Cerebellar c. Bulbar				

	Dysphonia				
20	Olfactory nerve				
21	Optic: a. Visual acuity b. Color vision c. Field of vision d. Funoscopy				
22	III / IV / VI Nerves: a. Movements b. Nystagmus c. Diplopia d. Squint e. Light reflex f. Accommodation reflex				
23	Trigemial: a. Corneal reflex b. Sensory part c. Motor part d. Jaw jerk				
24	Facial Nerve: a. Inspection b. Motor function c. Taste sensation				
25	Vestibulocochlear: a. Rinnie's Test b. Weber Test c. Doll's Eye d. Positional Vertigo				
26	IX / X Nerves: a. Gag reflex b. Aah Test				
27	Accessory: a. Trapezius b. Sternomastoid				
28	Hypoglossal				
29	Fasciculations in muscles				
30	Measure Bulk				
31	Tone				
32	Power: a. Upper limb b. Lower limb				
33	Knee Jerk				

34	Ankle Jerk				
35	Planter reflex				
36	Biceps, Triceps & Supinator jerk				
37	Abdominal reflex				
38	Ankle clonus				
39	Patellar clonus				
40	Finger-Nose test				
41	Dysdiodokinesia				
42	Heel-Shin test				
43	Giat				
44	Tandem walk				
45	Romberg's Test				
46	Pain sensation				
47	Touch sensation				
48	Temperature				
49	Vibration and position sense				
50	2 Point discrimination				
51	Cortical Functions: a. Localization b. 2 Point discrimination c. Stereognosis d. Graphasthesia e. Sensory inattention				
52	Neck rigidity				
53	Kerning's sign				
54	Brudzinski's sign				

Teacher Name: _____ Signature: _____

CNS	Performance / Grade	Suggestion of improvement	Date of next assessment	Cross examined by	Remarks after 2nd test
General Observation					
Higher Mental Function: • Appearance / Behavior • GCS • Orientation • Memory					
Speech: • Dysphasia • Dysarthia					
Cranial Nerves: • I • II • III / IV / V • VI • VII • VIII • IX / X • XI • XII					
Motor System: • Bulk /Tenderness • Involuntary • Movements					

• Fasciculations • Tone • Power • Reflexes • Co-ordination • Back • Giat					
Sensory System: • Touch • Pain • Temperature • JVS • Vibration					
Signs of Meningeal Irritation: • Neck rigidity • Kerning's signs • Brudzinski's sign					

Key:

Grades of performance:
1 = Poor
2 = Average but not promoted
3 = Satisfactory, needs some improvements but promoted
4 = Good, Grade-1 & Grade-2 achievers will have to retake the test

Suggestion for improvement:
1 = Reporting for 02 weeks
2 = Reporting for few days for particular mistakes 3 = Single-day posting for rehearsal of all systems 4 = Satisfactory

2nd Test = Cross Examined by faculty member from other unit:

_____

Signature of 1st Assessor Signature of 2nd Assessor