

	am Checklist #1 neral, Vital Signs, Skin, Hair, and Nails	Performed satisfactorily (1 point)	Performed less than satisfactorily (0.5 point)	Did not perform (0 point)
GF	NERAL			
1.	Introduces self to patient including full name and status (2 nd year osteopathic medical student).			
2.	Demonstrates respect in addressing patient.			
3.	Washes hands before shaking hands.			
4.	Washes hands before beginning physical exam.			
VI	TAL SIGNS			
5.	Takes radial pulse rate.			
6.	Palpates radial pulse bilaterally.			
7.	Takes respiratory rate.			
8.	Takes BP, patient seated comfortably, feet on floor, cuff at heart level and arm supported.			
9.	Explains vital sign results to patient.			
SK	IN			
10	 Inspects entire skin surface, explaining reason for inspection to patient 			
11	 Demonstrates proper draping to preserve patient modesty. 			
12	 Palpates skin for turgor, texture, and capillary refill. 			
HA	IR			
13	 Notes observed hair distribution on scalp and body. When possible and appropriate, includes pelvic hair distribution. 			
14	 Describes scalp hair color, distribution and character (thick, thin, straight, curly). 			
NA	NILS			
15	 Describes nail abnormalities- color, shape, texture, thickness (lines, brittleness, thickening, discoloration, pitting, ridges, spooning) 			

Score/15	Student Name:	
Student Name:	Community Campus:	
Signature of Preceptor:	Name of Preceptor:	
Date of Completion:		

Physical Exam Checklist #2:		Performed	Performed less	Did not perform
		satisfactorily (1 point)	than satisfactorily	(0 point)
		(i point)	(0.5 point)	
EYI	ES			
1.	Visual Acuity (CN II.)			
2.	Visual Fields to confrontation			
3.	Extraocular Movements: (CNs - III, IV, VI.)			
4.	Eye Inspection (Brows, lids, lashes, lacrimal			
	apparatus, cornea, sclera, conjunctiva)			
5.	Pupillary Response to light and accommodation.			
	(CN II, III)			
6.	Fundoscopic Exam: Red reflex, disc, retina			
HE	AD			
7.	Scalp: Inspect and palpate scalp.			
8.	Facial Symmetry: Patient smiles, raises			
	eyebrows, closes eyes and resists opening, puffs			
	cheeks (CN VII.)			
9.	Jaws: Patient clenches jaws (CN V)			
10.	Light touch forehead, maxilla, mandible (CN V,			
	three branches.)			
EA	RS			
11.	Hearing: Rub fingers near ear, or conduct a			
	whisper test (CN VIII.)			
	DUTH			
12.	Patient to say "AH." Palate elevates			
	symmetrically: (CN X.)			
13.	Gag Reflex: Test gag reflex (CN X,IX)			
14.	Tongue: Patient to protrude tongue, move from			
	side to side, say "lah lah lah" (CN XII.)			
NE				
15.	Neck: Patient turns head against resistance.			
1	Patient shrugs shoulders against resistance (CN			
1	XI.)			

Score/15	
Student Name:	Community Campus:
Signature of Preceptor:	Name of Preceptor:

Date of Completion: _____



Physical Exam Checklist #3:		Performed satisfactorily	Performed less than	Did not perform (0 point)
Ear,	Nose and Throat	(1 point)	satisfactorily	
			(0.5 point)	
	-			
EAR				
1.	Inspect auricle and surrounding tissue.			
2.	Palpate mastoid and perform tug test.			
3.	Otoscope exam: inspect ear canal, TM, cone of light			
4.	Test hearing by rubbing fingers near ear or whisper test.			
5.	Perform Weber testing.			
6.	Perform Rinne testing.			
NOS	E			
7.	Use otoscope to inspect septum, turbinates,			
	mucosa.			
8.	Palpate maxillary and frontal sinuses for			
	tenderness.			
THR	OAT			
9.	Using tongue depressor and penlight, inspect			
	lips, tongue, uvula (midline), hard palate,			
	soft palate, mucosa, post pharynx and			
	tonsils.			
	Inspect dentition and gums.			
11.	Palpate TMJ just anterior to tragus, have			
	patient open and close jaw palpating for			
	crepitance.			
NEC				
	Inspect for masses, asymmetry.			
13.	Palpate for lymphadenopathy: anterior,			
	posterior cervical chains, supraclavicular,			
	pre- and post- auricular.			
	Examine trachea for position.			
15.	Palpate thyroid for enlargement, nodules,			
	and asymmetry.			
Sco	re /15 Student N	ame:		

Score ____/15

Student Name: ______ Community Campus: ______

Signature of Preceptor: ______ Name of Preceptor:______

Date of Completion: _____

Ĺ	SOMA OMS II Media	cal Skills	Compe	tencies
Fx:	am Checklist #4:	Performed	Performed	Did not perform
	rdiovascular/Pulmonary	satisfactorily (1 point)	less than satisfactorily (0.5 points)	(0 points)
CA			(0.0 poinco)	
-	RDIOVASCULAR			
1.	Examine patient from right side and demonstrate			
	proper draping technique to preserve patient			
2	modesty throughout examination.			
2.	Measure JVP. Evaluate carotid pulses bilaterally and			
3.	assess for carotid bruits bilaterally. Inspect precordium. Note barrel chest, pectus			
5.	excavatum/carniatum, breathing pattern and use of			
	accessory muscles.			
4.	Palpate pulmonic and aortic valve areas. Palpate			
4.	PMI.			
5.	Auscultate at aortic, pulmonic, tricuspid and mitral			
5.	valve posts while patient supine. Auscultate at PMI			
	with patient on left side.			
6.	Auscultate for aortic, renal, femoral bruits. Palpate			
	abdominal aorta using the two-handed technique.			
7.	Auscultate at aortic, pulmonic, tricuspid and mitral			
	valve posts while patient seated.			
8.	Auscultate at left lower sternal border and apex while			
	patient sitting up and leaning forward.			
9.	Measure blood pressure in right arm while patient			
	seated. Check capillary refill.			
10.	Evaluate and grade bilateral brachial, radial, femoral,			
	popliteal, posterior tibial, and dorsalis pedis pulses.			
11.	Inspect bilateral upper and lower extremities for			
	edema and varicosities.			
PUI	MONARY			
12.	Note respiratory rate, oxygen saturation, work of			
	breathing, retractions. Inspect anterior and posterior			
	chest wall for symmetry, range of motion, rib cage			
	movement and chest wall deformities. Observe for			
	clubbing, cyanosis.			
13.	Palpate anterior and posterior chest wall for tissue			
	texture changes, tenderness, somatic dysfunction,			
	skin abnormalities, tactile fremitus, and chest			
	expansion.			
14.	Percuss anterior and posterior chest wall: 8 anterior and 8 posterior stations in "ladder" formation.			
15.	Auscultate anterior and posterior chest wall, asking		1	
	patient to breathe through an open mouth: 8 anterior			
	and 8 posterior stations in "ladder formation".			
	Perform egophony, bronchophony, and whispered			
L	pectoriloquy.			
Sco	·	e:		
Stuc	lent Name: Community	Campus:		
-	ature of Preceptor:	Name of Precep	otor:	
Date of Completion: Form Updated 7/10/15				

Physical Exam Checklist #5: Abdomen		Performed satisfactorily (1 point)	Performed less than satisfactorily (0.5 points)	Did not perform (0 points)
	DOMEN			
1.	Examine patient from right side and demonstrate			
	proper draping technique to preserve patient			
2	modesty throughout examination.			
2.	Inspect: skin, contour, symmetry, pulsations,			
3.	masses. Auscultate for bowel sounds in 4 quadrants.			
4.	Auscultate for aortic bruit.			
5.	Auscultate for renal, iliac and femoral bruits.			
6.	Percuss 4 quadrants- noting any areas of dullness			
_	or tympany.			
7.	Perform light palpation of 4 quadrants- note tissue			
	texture changes, somatic dysfunction, tenderness,			
•	rigidity, masses.			
8.	Perform deep palpation of 4 quadrants- note tenderness, rigidity, abdominal wall defects,			
	masses- noting size, location, texture.			
9.	Percuss and palpate for liver size.			
_	Percuss and palpate for spleen size.			
-	Palpate kidneys and assess for CVA tenderness.			
12.	Perform fluid wave test and check for shifting			
42	dullness.			
	Evaluate for Murphy's sign.			
14.	Evaluate for rebound tenderness at McBurney's			
45	point and evaluate for psoas sign.			
15.	Palpate suprapubic area for bladder distention.			
Sco	re/15 Student Na	ame:		

Student Name: Community Campus:

Signature of Preceptor: ______ Name of Preceptor:______

Date of Completion: _____



Exa	m Checklist #6: Upper Extremities	Performed satisfactorily (1 point)	Performed less than satisfactorily (0.5 points)	Did not perform (0 points)
GE	NERAL			
1.	Inspect for asymmetry, muscle atrophy, skin changes, masses, nodules.			
2.	Assess bilateral upper extremity strength: deltoids, biceps, triceps, wrist flexion and extension, intrinsic hand muscles.			
3.	Assess sensation bilaterally of C5-T2. Assess radial pulses bilaterally.			
4.	Evaluate bilateral upper extremity reflexes: triceps, biceps, brachioradialis.			
SH	OULDER			
5.	Starting at sternal notch, palpate bilaterally: clavicles, AC joint, acromion, medial border of scapula, SC joint, coracoid process, biceps tendon, and scapular spine.			
6.	Assess bilateral shoulder active ROM in all planes and then passive ROM: flexion, extension, abduction, adduction, internal rotation, external rotation.			
7.	Demonstrate the crossover test and Apley scratch test.			
8.	Demonstrate Neer's impingement sign and Hawkin's impingement sign.			
9.	Demonstrate rotator cuff muscle strength testing including performing empty can test and drop-arm sign.			
ELE	BOW			
10.	Assess bilateral elbow active and passive ROM: extension and flexion, supination and pronation.			
	Palpate olecranon notch, including subolecranon bursa. Palpate radial head while supinating/pronating forearm. Evaluate for lateral tendonitis (wrist extension			
12.	with forearm pronated, 'turn knob' against resistance.) Evaluate for medial tendonitis (wrist flexion with forearm supinated.)			

WRIST		
13. Assess bilateral wrist active and passive ROM: extension, flexion, radial and ulnar deviation.		
14. Evaluate for De Quervain's tenosynovitis (ulnar deviation of wrist while hand in fist position.) (Finklestein.)		
15. Demonstrate testing for Phalen's and Tinel's signs.)		

Score/15	Student Name:	-
Student Name:	Community Campus:	
Signature of Preceptor:	Name of Preceptor:	
Date of Completion:		



	om Checklist #7: Back and Lower remities	Performed satisfactorily (1 point)	Performed less than satisfactorily (0.5 points)	Did not perform (0 points)
GF	NERAL			
1.	Inspect for asymmetry, landmarks of			
	unlevelness, muscle atrophy, skin changes, gait			
	abnormalities. Measure leg length.			
2.	Palpate spine. Evaluate for somatic dysfunction,			
	curvatures, and pain. Evaluate para-spinal			
	muscles and note TART changes.			
3.	Assess lumbar-thoracic ROM: forward flexion,			
	extension, rotation, side-bending. Perform			
	standing and seated flexion testing.			
4.	Assess strength of bilateral Iliopsoas, quads,			
	hamstrings, plantar flexion/dorsiflexion.			
5.	Assess sensation bilaterally, L1 - S1.			
6.	Evaluate reflexes bilateral (patellar and Achilles).			
HIF	Р/ВАСК			
7.	Assess active ROM and then passive ROM in all			
	planes of bilateral hips: flexion, extension,			
	internal rotation, external rotation, abduction,			
	adduction.			
8.	Palpate trochanteric head of femur and sciatic			
	notch.			
9.	Perform the straight leg-raising test and the			
	crossed straight leg-raising test.			
KN	EE			
10.	Palpate suprapatellar tendon, patella,			
	infrapatellar tendon, tibial tuberosity, bilateral			
	joint lines, posterior knee.			
11.	Assess active and passive ROM of bilateral			
	knees. Balot knee for effusion. Perform			
	Patellofemoral grinding test.			
12.	Assess ligament and menisci stability of the knee			
	with patient supine: McMurray test,			
	valgus/varus stress tests, anterior drawer sign,			
	Lachman test, posterior drawer sign.			
AN	KLE/FOOT			

 13. Observe for ankle valgus/varus deformity. Assess bilateral active and passive ROM at ankle: dorsiflexion/plantar flexion, supination and pronation. 			
14. Palpate anterior talofibular ligament and deltoid			
ligament. Perform Talar tilt test to assess			
integrity of deltoid and calcaneofibular			
ligaments.			
15. Evaluate for plantar fasciitis (palpate calcaneal			
bone on medial sole of foot and evaluate plantar			
fascia/fat pad).			
Score/15 Student Name	e:		
Student Name: Community	Campus:		
Signature of Preceptor:	Name of Precept	or:	
Date of Completion:			



Exam Checklist #8:	Performed	Performed	Did not
Genitourinary, Female; Breast, Female	satisfactorily (1 point)	less than satisfactorily	perform (0 point)
		(0.5 point)	(0 point)
BREAST			
1. Have appropriate chaperone present. Explain			
examination to the patient prior to and throughout			
examination.			
2. Attention given to patient comfort. Demonstrate			
proper draping technique to preserve patient			
modesty throughout examination.			
3 . Patient seated: Observe breasts for symmetry, skin changes, dimpling with patient hands at sides,			
overhead, on hips, leaning forward.			
4. Patient supine: Palpate bilateral breasts and axillae.			
Note any nodes, nipple discharge, edema, erythema			
or lesions.			
GU FEMALE			
5. Ask patient history questions to assess anatomy			
(hysterectomy, menopause).			
6. Explain examination to the patient prior to and			
throughout examination.			
7. Assist patient with positioning and feet placement			
in foot rests.			
8. Observe perineum and note hair distribution, skin			
lesions, external anatomy.			
9. Palpate Skene's and Bartholin's glands.			
10. Insert speculum into vagina using pressure			
downward to avoid pressure on urethra and			
clitoris.			
11. Locate cervix.			
12. Collect cultures for wet mount, GC/CT.			
13. Perform pap smear and preserve sample			
appropriately.			
14. Inspect vaginal walls as remove speculum.			
15. Evaluate for cystocele and rectocele using			
speculum or two finger approach.			
Score/15 Student Name:			
Student Name: Community	Campus:		

Signature of Preceptor: ______ Name of Preceptor:______

Date of Completion: _____



	m Checklist #9: nito-Urinary, Male	Performed satisfactorily (1 point)	Performed less than satisfactorily (0.5 points)	Did not per- form (0 points)
GU	MALE			
1.	Have appropriate chaperone present. Explain examination to patient prior to and throughout examination.			
	Attention given to patient comfort. Demonstrate proper draping technique to preserve patient modesty throughout examination.			
3.	Inspect penis – noting foreskin/circumcision, lesions or urethral discharge.			
4.	Observe pubic hair for hair distribution, nits, lice.			
5.	Observe location of urethral meatus. Compress glands gently between index finger and thumb to inspect for discharge.			
6.	Palpate for plaques or induration.			
7.	Palpate testes for masses, size and symmetry.			
8.	Palpate epididymis. Note consistency.			
9.	Palpate spermatic cord. Note nodules or swelling.			
10.	Perform digital exam for assessment of inguinal canal hernia, asking patient to cough or perform valsalva.			
DIG	ITAL RECTAL EXAM			
11.	Ask patient to bear down as if straining at stool while lying on his left or right side.			
12.	Gently insert index finger after sphincter relaxes.			
	Perform a 360 ° sweep of rectum including anal sphincter tone, tenderness, nodularity, or masses.			
	Examine prostate surface for nodularity, texture - evaluate lateral lobes, median sulcus.			
15.	Upon completion of examination - observe for grossly bloody stool and test for stool occult blood.			

Score/15	Student Name:	
Student Name:	Community Campus:	
Signature of Preceptor:	Name of Preceptor:	
Date of Completion:		

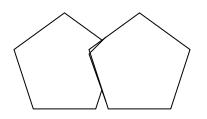


Exa	ım Checklist #10:	Performed satisfactorily	Performed less than	Did not perform (0 points)
Mi	ni Mental Exam and Scoring	(each worth 1.25 points for a	satisfactorily (each worth	(o points)
Stud	lent may use MMSE form as guide during examination.	total of 15)	0.63 points)	
	IENTATION (10 points)			
1.	Ask the patient to name the date, day, month, year			
	and season (Score 1 point for each correct answer).			
2.	Ask the patient to name the place where exam is			
	happening; place, floor or address, city, county,			
	state (Score 1 point for each correct answer).			
W	DRKING MEMORY – REGISTRATION (3 points)			
3.	Examiner names 3 unrelated objects and asks			
	patient to repeat them (up to 6 trials). (Score 1			
	point for each object remembered).			
AT	TENTION AND CALCULATION (5 points)			
4.	Ask the patient to begin with 100 and count			
	backwards by sevens. Stop after five subtractions			
	(93, 86, 79, 72, 65) - (Score 1 point for each correct			
	subtraction). <i>If the patient cannot or will not</i>			
	perform the subtraction task go to #2 below.			
5.	Ask the patient to spell the word "world"			
	backwards. (Score 1 point for each correct letter).			
RE	CALL (3 points)			
6.	Ask the patient if he or she can recall the three			
	words previously asked of him or her to remember.			
	(Score 1 point for each correct word).			
LA	NGUAGE AND PRAXIS (9 points)			
7.	Naming: Show the patient a wrist watch and ask			
	the patient what it is. Repeat with either pen or			
L	pencil. (Score 1 point for each item- up to 2 points).			
8.	Repetition: Ask the patient to repeat the sentence			
	after you ("No ifs, ands, or buts."). (Score 1 point if			
_	repeated exactly).			
9.	3-Stage command: Give patient a piece of blank			
1	paper and say, "take this paper in your right hand,			
	fold it in half, and put it on the floor." (Score 1			
40	point for each correct execution – up to 3 points).			
10.	Reading: On a blank piece of paper print the			
	sentence "close your eyes" in letters large enough			
	for the patient to see. Ask the patient to read the			
	sentence and do what it says. (Score 1 point for			
	following written command correctly).			

11. Writing: Give the patient a blank piece of paper	
and ask him or her to write a sentence for you. Do	
not dictate the sentence; it should be written	
spontaneously. The sentence must contain a	
subject, a verb and make sense. Correct grammar	
and punctuation are not necessary. (Score 1 point	
for correct sentence).	
12. Copying: Show the patient the picture of two	
intersecting pentagons and ask the patient to copy	
the figure exactly as it is. All ten angles must be	
present and two must intersect. Ignore tremor and	
rotation. (Score 1 point for correct copy design).	
Score/15 Student Name	e:
Student Name: Community	Campus:
Signature of Preceptor:	Name of Preceptor:
Date of Completion:	

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Form Updated 7/10/15



Interpretation of the MMSE Scores:

e impairment
ve impairment
itive impairment

Sources: Tombaugh, TN, McIntyre NJ. The mini-mental state examination: a comprehensive review. Journal American Geriatric Society, 1992; 40(9): 922-935



	vsical Exam Checklist #11: urology Exam	Performed satisfactorily (1 point)	Performed less than satisfactorily (0.5 point)	Did not perform (0 point)
ME	INTAL STATUS			
1.	Assess orientation to person, place, and time. Assess attention with serial 7's and spell "world" backwards.			
2.	Assess new learning ability by asking to remember 3 words and ask patient to repeat the words in 3 minutes. Assess higher cognitive function by asking patient to name last 4 presidents and interpret a proverb.			
SPI	EECH			
3.	Observe speech for quantity, rate, volume, articulation, fluency. Test for aphasia by assessing word comprehension and word repetition.			
CR	ANIAL NERVES			
4.	Test CN II: visual acuity, visual fields, fundoscopic exam. Test CN II, III: pupillary reactions. Test CN III, IV, VI: extraocular movements.			
5.	Test CN V: facial sensation, jaw movements. Test CN VII: facial movements.			
6.	Test CN VIII: hearing. Test CN IX, X: rising palate, gag reflex. Test CN V, VII, IX, X, XII: voice & speech.			
7.	Test CN XI: shoulder & neck movements. Test CN XII: tongue symmetry & position.			
M	DTOR			
8.	Observe body position. Inspect muscle bulk and tone.			
9.	Test and grade muscle strength bilateral upper and lower extremities.			

SENSORY			
10. Test pain and light touch in 4 dermatomes bilat.			
Perform monofilament exam on feet.			
11. Test vibratory sensation on distal bilateral upper			
and lower extremity bony prominences. Test			
proprioception of lower extremities.			
GAIT/CEREBELLAR			
12. Test rapid alternating movement and point-to-			
point movement.			
13. Observe natural gait, tandem walk. Perform			
Romberg test.			
REFLEXES			
14. Test bilateral biceps, brachioradialis, patellar,			
Achilles reflexes. Check plantar response.			
CEREBROVASCULAR			
15. Auscultate for carotid bruits bilaterally.			
Score/15 Student Name	:		
Student Name: Community C	Campus:		
Signature of Preceptor:	Name of Preceptor	:	
Date of Completion:			