

(Please Print)

**Resident:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**University:** \_\_\_\_\_ **Start:** \_\_\_\_\_ **Finish:** \_\_\_\_\_

**Patient Characteristics (Age/Gender):** \_\_\_\_\_

**Patient's Problem(s):** \_\_\_\_\_

**INTERVIEWING**

**YES      BORDERLINE      NO      N/A**

Did the resident:

Introduce him/herself and explain the situation, use patient's name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attempt to establish rapport with parent and child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Direct questions when appropriate to child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use words that are easily understood; avoid medical jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask open-ended questions in history-taking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask specific closed questions when necessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listen attentively to patient/parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Display empathy and sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Display awareness of and respond to family's concerns / agenda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have acceptable non-verbal communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Close the interview appropriately: summary, parents' concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rate this resident's interviewing skills **at the current PGY training level:**    1    2    3    4

- Satisfactory - meets expectations
- Borderline (\* comment required)
- Unacceptable – below expectations (\* comment required)

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HISTORY-TAKING**

	YES	BORDERLINE	NO	N/A
<u>Did the resident obtain a pertinent history including the following:</u>				
<u>Present Illness</u>				
Chief complaint(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Onset of illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thorough description of chief complaint(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms associated with chief complaint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progress through the course of the illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family's management of the illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Define current status of illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with medical personnel: tests, treatment offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For an infectious disease: possible contacts, day care, travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Family History</u>				
Parents' age, consanguinity, health/illness relevant to child's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings: sex, age, health and illness relevant to child's illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other extended family illness as appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Mother's Pregnancy, Birth ,Newborn Period</u>				
Mother's health during pregnancy, illness, drugs, alcohol, cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth weight, gestational age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neonatal problems: jaundice, cyanosis / respiratory problems, seizures, birth anomalies, low Apgar score	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Infancy</u>				
Infant feeding (breast, formula, solids)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems, colic, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Development</u>				
Gross motor skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine motor skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Immunizations</u>				
Routine immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Identification Number: \_\_\_\_\_

<u>Past Illness</u>	<b>YES</b>	<b>BORDERLINE</b>	<b>NO</b>	<b>N/A</b>
Past illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalizations/ operations/injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Functional Inquiry/Review of Systems</u>				
Appropriate and comprehensive review of systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organized review of systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Pyscho-Social</u>				
Parent's occupations, family living situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug or alcohol abuse, smoking in child/family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impact of the illness on the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impact of the illness on the child's activities of daily living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School progress, physical and social activities, interests, peer relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk-taking, sexual behaviors, nutrition and eating habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific concerns of the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Overall History-taking** \* A **No** or **Borderline** rating in any of the following items in this section constitutes borderline/unacceptable, *PLEASE COMMENT BELOW.*

	<b>YES</b>	<b>BORDERLINE</b>	<b>NO</b>
The primary concerns of the patient/family, prioritization of problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An overview of the problem in context to the child and family's life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sufficient information to adequately manage the major problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rate this resident's history-taking **at the current PGY training level:**     1     2     3     4

- Satisfactory – meets expectations
- Borderline (\* comment required)
- Unacceptable – below expectations (\* comment required)

Comments:

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**PHYSICAL EXAMINATION**

	YES	BORDERLINE	NO	N/A
<u>Did the resident perform a physical exam that included:</u>				
<u>General</u>				
Wash hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtain height/length, weight, head circumference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtain vital signs: pulse, respiratory rate, blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pause to observe the whole child: activity, appearance, hydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Head and Neck Exam</u>				
Head size, shape, fontanel, scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye movements, abnormalities, ophthalmoscopic exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears – otoscopic exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth, teeth, palate, pharynx, nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpate neck for cervical lymph nodes, thyroid gland, masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory System</u>				
Observation of chest size, shape, movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auscultation of chest – comparing both sides, front and back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Percussion of chest – diaphragm levels, both sides, front and back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardio-Vascular System</u>				
Peripheral Exam – femoral pulses, clubbing, capillary refill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpate precordium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auscultate four areas of precordium and back when appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Abdominal Exam</u>				
Observe size, distention, shape and look for abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gentle palpation for tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific palpation for liver, spleen, kidneys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific palpation for other masses, ascites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auscultation of abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Percussion of abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observation/examination of external genitalia, for herniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indicate the need for a rectal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Extremities</u>				
Observe for any deformities, obvious joint abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Identification Number: \_\_\_\_\_

	<b>YES</b>	<b>BORDERLINE</b>	<b>NO</b>	<b>N/A</b>
Observe gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examine relevant joints for swelling, tenderness, range of movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Examine hips for congenital dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Test for scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Skin Exam</i></u>				
Observe overall skin for lesions and abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Neurologic Exam</i></u>				
Assess cranial nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess level of consciousness and cognitive ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess appropriate motor power, tone, coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess reflexes/symmetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess vision, hearing, sensation as appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observe balance, stance, gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Development Assessment</i></u>				
Assess developmental and cognitive skills, to corroborate history from parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Overall Physical Examination** \* A **No** or **Borderline** rating in any of the following items in this section constitutes borderline/unacceptable, PLEASE COMMENT BELOW.

	<b>YES</b>	<b>BORDERLINE</b>	<b>NO</b>
A focused, thorough, problem-oriented physical exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opportunistic flexible approach in examining the child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate exam for time, situation and parent/child comfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correct physical examination maneuvers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rate this resident's physical examination skills **at the current PGY training level:**

1     2     3     4

- Satisfactory – meets expectations
- Borderline (\* comment required)
- Unacceptable – below expectations (\* comment required)

Comments:

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Identification Number: \_\_\_\_\_

**PRESENTATION OF CASE SUMMARY AND PROBLEM (10 minutes)**

<u>Did the resident:</u>	<b>YES</b>	<b>BORDERLINE</b>	<b>NO</b>	<b>N/A</b>
Present accurate data from history and physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present succinctly the important positive and negative points	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present a complete problem list	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present a prioritized problem list	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present a good evaluation of the child's problem with a differential diagnosis of the major problem where applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rate this resident's case summary skills **at the current PGY training level:**

1     2     3     4

- Satisfactory – meets expectations
- Borderline (\* comment required)
- Unacceptable – below expectations (\* comment required)

Comments:

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**Overall**

Did the resident demonstrate any errors of omission or commission that would:

- i. endanger the child or put the child at risk (e.g. being physically rough with the child or leave the child unattended)
- ii. compromise the relationship with the child (e.g. being rude or disrespectful, not paying attention to the modesty of the child)
- iii. compromise the relationship with the parent (e.g. being disrespectful of the parent, making inappropriate sexual, racial or judgmental comments)
- iv. lead to an incorrect or inadequate assessment of the child's pediatric problems (e.g. missing a major abnormality on history or physical examination)

**NO**         **YES** (\*Comment required)

Comments: \_\_\_\_\_

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Identification Number: \_\_\_\_\_

### OVERALL EVALUATION

Rate this resident's performance **at the current PGY training level:**  1  2  3  4

Meets expectations

Below expectations

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Weaknesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
**Observer** (Please Print)

\_\_\_\_\_  
(Signature)

**This is to attest that I have read this assessment:**

\_\_\_\_\_  
Resident (Signature) Date

**In order to make the STACER experience better, please give us a feedback on how your STACER went. i.e. scheduling, patient selected, examiner selected**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_