PEDIATRIC WRITTEN HISTORY AND PHYSICAL EXAM EVALUATION (P-HAPEE) TOOL

Author Name:

A medical student is expected to perform at a score of 3 or better by the end of his/her third year.

HISTORY

1. Patient Introduction: begins with the chief complaint (usually in patient's/caregiver's words), patient identifier, presence/absence of conditions directly relevant to the assessment, and reason for presentation

1	2	3	4	5
Inaccurate , incomplete, and/or includes excessive irrelevant data		Accurate with most of the pertinent information included and most of the irrelevant data omitted		Concise and comprehensive
Notes:				

2. History of Present Illness: begins with the first change in health status related to the chief complaint and concludes at the time writer assumed patient care including reason for admission; identifies history source

1	2	3	4	5
Inaccurate , incomplete, and/or includes excessive irrelevant data		Accurate, mostly organized sequence of relevant events with well-characterized symptoms (quality, severity, etc.) and most of the irrelevant data omitted		Hypothesis (assessment) driven, concise, comprehensive, organized. Includes PMH, FH, SH elements directly relevant to the differential and collateral history if indicated.
Notes:				

3. Additional History: Past Medical History, Family History, Social History, Review of Systems

1	2	3	4	5
Inaccurate, incomplete, and/or poorly described		Accurate, complete, age-appropriate PMH, FH, SH, and ROS		Patient specific. Eg: developmental/nutritional screening; HEADSS for adolescents; seasonal influenza vaccine; close contact Tdap for infants, etc.
Notes:				

PHYSICAL EXAM AND DIAGNOSTIC STUDIES

4. Vital Signs and Growth Parameters

1	2	3	4	5
Inaccurate and/or incomplete		Accurate with complete vital signs and some age-appropriate growth parameters/percentiles (minimum wt and percentile)		All age-appropriate growth parameters/percentiles. Patient specific. Eg: preemie/syndrome specific growth chart; wt for length %; prior growth pattern; orthostatics; pain scale, etc. when appropriate
Notes:				

5. Physical Exam

1	2	3	4	5
Inaccurate and/or incomplete		Accurate, complete, age-appropriate physical exam with some expanded focus based on presenting symptoms.		Hypothesis (assessment) driven. When appropriate, includes subtle positive and negative findings, comparison with past exams, and/or additional maneuvers that distinguish among diagnoses under consideration. Eg: dentition with suspected bulimia; acanthosis nigricans; comparison with prior liver size; psoas sign, etc.
Notes:				

6. Diagnostic Studies

☐ No diagnostic studies (current, past, or pending) relevant to presentation. Proceed to question 7.

1	2	3	4	5
Inaccurate, incomplete, and/or transcribed without appropriate attribution		Accurately reports pertinent positive and negative studies while omitting most of the irrelevant data		Accurately interprets pertinent positive and negative studies. When appropriate, includes review of prior studies, age/gender norms, calculations, and/or own review of diagnostic imaging. Eg: maternal labs; prior HbA1C; prior ejection fraction; Hb mean for age/gender; anion gap; Na correction for glu, etc.
Notes:				

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INFORMATION SYNTHESIS AND CLINICAL REASONING

7. Problem Identification: enumerated separately OR included within the assessment. Problems linked appropriately at highest diagnostic level based on available information (Eg. problems of fever, tachypnea, leukocytosis, RLL crackles and RLL CXR infiltrate linked under problem of RLL pneumonia)

1	2	3	4	5
Absent, inaccurate, splits/joins problems inappropriately, and/or confuses systems and problems		Accurately identifies primary hospital problem/s at highest diagnostic level based on available information		Accurately prioritizes all active problems identified through history, physical exam, and diagnostic studies including secondary problems that should be addressed during hospitalization. Eg: second hand smoke exposure; underimmunized status; developmental delay; obesity; anemia, etc.
Notes:				

8. Assessment: "big picture" synthesis of collected information leading to the formulation of a prioritized differential and identification of the most likely diagnosis. Author (1) **Identifies** critical defining history AND physical exam/diagnostic study findings. (2) **Synthesizes** findings into medical terms and concepts ("started today"→acute; RR 60, retractions, pH 7.2→respiratory distress). (3) **Characterizes** findings using semantic qualifiers (no relevant PMH/PHM significant for; acute/chronic; mild/severe; acidotic/alkalotic).

1	2	3	4	5
Absent, unsupported, misses many critical findings, includes excessive irrelevant data, fails to include physical exam/diagnostic study findings, and/or restates findings without synthesis		Identifies some defining history AND physical exam/diagnostic study findings while omitting most of the irrelevant data. Uses some medical terms and semantic qualifiers to synthesize an assessment.		Selects critical defining history AND physical exam/diagnostic study findings. Uses appropriate medical terms and semantic qualifiers to synthesize an accurate and concise summary statement.
Notes:				

9. Differential Diagnosis

□ No differential diagnosis relevant to presentation. This should be a rare event (Eg. pt presenting for scheduled chemotherapy). Proceed to question 9.

1	2	3	4	5
Absent, unsupported, and/or poorly described		Includes a prioritized differential while committing to a working diagnosis. Supports clinical reasoning with relevant history, physical exam, and diagnostic study elements.		Presents an accurate and concise differential by comparing/contrasting discriminating features of diagnoses under consideration. Includes a differential for secondary problem/s and/or refers to literature when appropriate.
Notes:				

10. Plan: diagnostic, therapeutic, patient/caregiver education, discharge, and follow-up

1	2	3	4	5
Poorly described, unsupported, and/or does not match the problem list or assessment		Addresses most aspects of the identified problems while describing decision making rationale. Includes patient/caregiver education and discharge/follow-up plans when appropriate.		Accurately, concisely, and thoroughly addresses all identified problems. Considers patient/caregiver preferences, literature/practice guidelines, cost effectiveness, and/or contingency plans when appropriate.
Notes:				

Two things the author did well:

1.

2.

Two things the author should continue to work on:

1.

2.

"Stretch" goal:

1.

Overall H&P quality:

□ Below expectations □ Meets expectations □ Exceeds expectations

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