

Assessment Inventory

Please assess your experience level in HISTORY taking:

Category	No Experience	Some Experience	Much Experience
HPI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PMH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ROS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health Maintenance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please assess your experience level in performing a PHYSICAL EXAMINATION:

Category	No Experience	Some Experience	Much Experience
Vital Signs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEENT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulmonary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdomen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GU	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Musculoskeletal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vascular	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rectal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sports Physical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infant/Pediatric Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adult Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnant Patient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Geriatric Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please assess your experience level in performing the following PROCEDURES:

Category	No Experience	Some Experience	Much Experience
EKG's	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joint Aspiration/Injection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GYN Speculum Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PAP Smear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GYN Bimanual Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

GYN KOH/Wet Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GYN Cultures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Heart Tones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Cath (female)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Cath (male)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin KOH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suturing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing Stool for Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis (Dip)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis (Micro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat Culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerumen Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluorescein Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Place PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read PPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peak Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tympanometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse Ox.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please assess your experience level interpreting the following TESTS:

Category	No Experience	Some Experience	Much Experience
EKG Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tympanometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis (Dip)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis (Micro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CBC's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BMP's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LFT's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Panels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABG's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FLP's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Blood Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Radiographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Radiographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please assess your experience level in evaluating the following PATIENTS:

Category	No Experience	Some Experience	Much Experience
Newborn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pediatric	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Young Adult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Geriatric	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnant Patient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please assess your experience level in evaluating patients with the following:

Category	No Experience	Some Experience	Much Experience
Weight Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hyperlipidemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHF	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arrhythmias	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Edema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COPD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinusitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergic Rhinitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conjunctivitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Otitis Media	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea/Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GERD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PUD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
UTI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hematuria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STD's	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menopause	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menstrual Irregularities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BPH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list FOUR topics you would like to address during this rotation:

Topic #1 _____

Topic #2 _____

Topic #3 _____

Topic #4 _____