LIAQUAT INSTITUTE OF MEDICAL AND HEALTH SCIENCES THATTA, SINDH, PAKISTAN

PHYSIOLOGY PRACTICAL LOG BOOK

HISTORY TAKING AND PATIENT`S RECORD NOTE BOOK OF

HISTORY TAKING AND PATIENT`S RECORD NOTE BOOK OF SURGERY and Allied Departments

FOR 3rd YEAR & FINAL YEAR STUDENTS

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES THATTA

BIO DATA

Name: ____

Group ______________________________ **Class Roll No** ______________

Examination Seat No. ____

Institute Enrollment No. ____

Passport Size Picture

CERTIFICATE

This is to certify that Mr.-----------------------------

S/O---------------------------------- has successfully completed history book within the posting period. ---------------------

Professor **Professor**

----------------- -----------------

INSTRUCTIONS

- **You are supposed to take histories and clinical examination of 10 surgical patients admitted in ward of each unit and make presentation with tutor.**
- **Write down these cases with diagnosis and management and get these signed by registrar on duty.**

History

S. No___________, Unit: __________, Date:____________

Biodata

Patient name: Age: Gender:

Address: Marital status:

Religion:

Presenting complaints:

1)
2)
3)

History of present illness:

1) **Elaboration of symptoms**

2) **Systemic inquiry of symptoms**

Past history:

Personal history:

Family history:

Socioeconomic history:

Menstrual history:

Drug history / allergy / immunization / blood transfusions:

General Physical Examination:

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp.**

rate: Dehydration status:

Palor: **Koilonychia:** **Jaundice:** **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal**

edema: Others:

Systemic Examination:

Gatro Intestinal Tract (GIT):

A. Oral cavity:

B. Abdomen:

1) **Inspection**
2) **Palpation**
3) **Percussion**
4) **Auscultation**
5) **Hernia orifices**
6) **DRE**
7) **other**

Respiratory system:

A. Upper Respiratory Tract

Nose:
Pharynx:
Trachea:

B. Chest:

1) Inspection

2) Palpation

3) Percussion

4) Auscultation

5) Others

Cardiovascular system:

A) Precordiu

- m: Inspection

- Palpation

- Auscultation

- Others

B) Arteries

C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

Cranial nerves:
1st:

2nd:

3rd, 4th and 6th:

5th:

7th:

8th:

9th and 10th:

11th:
12th:

Examination of Breast lump:

- **No**
- **Size:**
- **Site:**
- **Mobility**
- **Nipple discharge**
- **Axillary lymph nodes**

Examination of Lumps in Neck:

- **No**
- **Size:**
- **Site:**
- **Mobility**

Examination of Lump in groin & scrotum:

Provisional / differential diagnosis:

Investigations:

Final diagnosis:

Treatment

Summary of patient:

Checked by Name: Designation: Signature

HISTORY TAKING AND PATIENT`S RECORD NOTE BOOK OF

OBSTETRICS & GYNECOLOGY

FOR FINAL YEAR STUDENTS

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES, THATTA

Passport
Size

BIO DATA

Name:____

Group __________________________________ **Class Roll No**________________________________

Examination Seat No.____

Institute Enrollment No.____

CERTIFICATE

This is to certify that Mr-------------------- S/O----------------------

has Successfully completed history

book within the posting period. ---------------------

Coordinator

Professor

Head of department

INSTRUCTIONS

- You are supposed to take histories and clinical examination of 05 obstetric and 5 gynecological patients admitted in ward of each unit and make presentation with tutor.
- Write down these cases with diagnosis and management and get these signed by registrar on duty.

Obstetrics Gynecology Sheet Case

No. 1

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) Inspection

2) Palpation

3) Percussion

4) Auscultation

5) Others

Cardiovascular system:

A) Precordium

 : Inspection

 Palpation

6

 Auscultation

Others

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- **Abdomen:**
  1) Inspection
  2) Palpation
  3) Percussion
  4) Auscultation
  5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 2

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : Inspection

 Palpation

6

 Auscultation

 Others

B) **Arteries**
C) **Veins**

Nervous system:

Higher mental functions

1) **Level of consciousness**

2) **Speech**

3) **Memory**

4) **Cognition**

- **Abdomen:**
  1) **Inspection**

  2) **Palpation**

  3) **Percussion**

  4) **Auscultation**

  5) **Hernia orifices**

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- **sympysio fundal height**
- **lie**
- **presentation**
- **no of fifths palpable above brim**
- **Amount of liquor**
- **Contractions**
- **Estimated fetal weight**
- **Fetal heart rate**

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 3

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : Inspection

 Palpation

6

 Auscultation

Others

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- Abdomen:
  1) Inspection
  2) Palpation
  3) Percussion
  4) Auscultation
  5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 4

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : **Inspection**

 Palpation

6

 Auscultation

Others

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- **Abdomen:**
  1) Inspection
  2) Palpation
  3) Percussion
  4) Auscultation
  5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 5

- ## Biodata:

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : Inspection

 Palpation

6

 Auscultation

Others

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- Abdomen:
  1) Inspection
  2) Palpation
  3) Percussion
  4) Auscultation
  5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 6

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : Inspection

 Palpation

6

 Auscultation

Others

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- Abdomen:
  1) Inspection
  2) Palpation
  3) Percussion
  4) Auscultation
  5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 7

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : **Inspection**

 Palpation

6

 Auscultation

- **Others**

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) **Level of consciousness**

2) **Speech**

3) **Memory**

4) **Cognition**

- **Abdomen:**

  1) **Inspection**

  2) **Palpation**

  3) **Percussion**

  4) **Auscultation**

  5) **Hernia orifices**

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- **sympysio fundal height**
- **lie**
- **presentation**
- **no of fifths palpable above brim**
- **Amount of liquor**
- **Contractions**
- **Estimated fetal weight**
- **Fetal heart rate**

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 8

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : **Inspection**

 Palpation

6

Auscultation

Others

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- **Abdomen:**

1) Inspection

2) Palpation

3) Percussion

4) Auscultation

5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 9

- **Biodata:**

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : Inspection

 Palpation

6

 Auscultation

- **Others**

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- Abdomen:

1) Inspection

2) Palpation

3) Percussion

4) Auscultation

5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Obstetrics Gynecology Sheet Case

No. 10

- ## Biodata:

Bed no: DOA: Registration No:

Name: Age : Address

Gravida: Para: LMP: EDD:

Presenting Complaint:

History of presenting illness:

Obstetric History:

Pregnancy no	Abortion	Gestation weeks	Place of delivery	Duration Of labour	Mode of delivery	sex	outcome	APH/ PPH	Vaccination/ Breast feeding

Menstrual History:

Menstrual Cycle

Mentrual Flow

Dysmenorrhea

Dysparunea

Intermenstrual Bleeding

Post Coital Bleeding H/O

Of Pap Smear Vaginal

Discharge

Past Medical & Surgical History:

Family History:

Personal History

General Physical Examination :

Appearance: **position:**

Pulse: **B.P:** **Temp:** **Resp. rate:**

Dehydration status: **Palor:** **Koilonychia:**

Jaundice: **Bruises:**

Cyanosis: **Lymph nodes:** **Pedal edema:**

Varicose veins

Others:

Systemic Examination:

- **GIT:**
- **Oral cavity:**

Respiratory system:

- **Nose:**
- **Pharynx:**
- **Trachea:**
- **Chest:**

1) **Inspection**

2) **Palpation**

3) **Percussion**

4) **Auscultation**

5) **Others**

Cardiovascular system:

A) **Precordium**

 : **Inspection**

 Palpation

6

 Auscultation

Others

B) Arteries
C) Veins

Nervous system:

Higher mental functions

1) Level of consciousness

2) Speech

3) Memory

4) Cognition

- **Abdomen:**
  1) Inspection

  2) Palpation

  3) Percussion

  4) Auscultation

  5) Hernia orifices

Obstetric Examination:

Findings on inspection: **Findings on palpation:**

- sympysio fundal height
- lie
- presentation
- no of fifths palpable above brim
- Amount of liquor
- Contractions
- Estimated fetal weight
- Fetal heart rate

Gynecologic:

Finding on inspection:

- **Vulva**
- **Vagina**
- **Cervix**
- **Characteristics of discharge if present**
- **Digital vaginal examination**
- **Vulva**
- **Vagina**
- **Tenderness at bartholin area**
- **Cervix**
- **Uterus**
- **Adnexa**
- **Pouch of douglous**

Provisional / differential diagnosis

Investigations

Final diagnosis

Treatment

Summary of patient:

Liaquat Institute of Medical & Health Sciences (LIMHS), Thatta, Sindh,Pakistan

STUDENT LOG BOOK

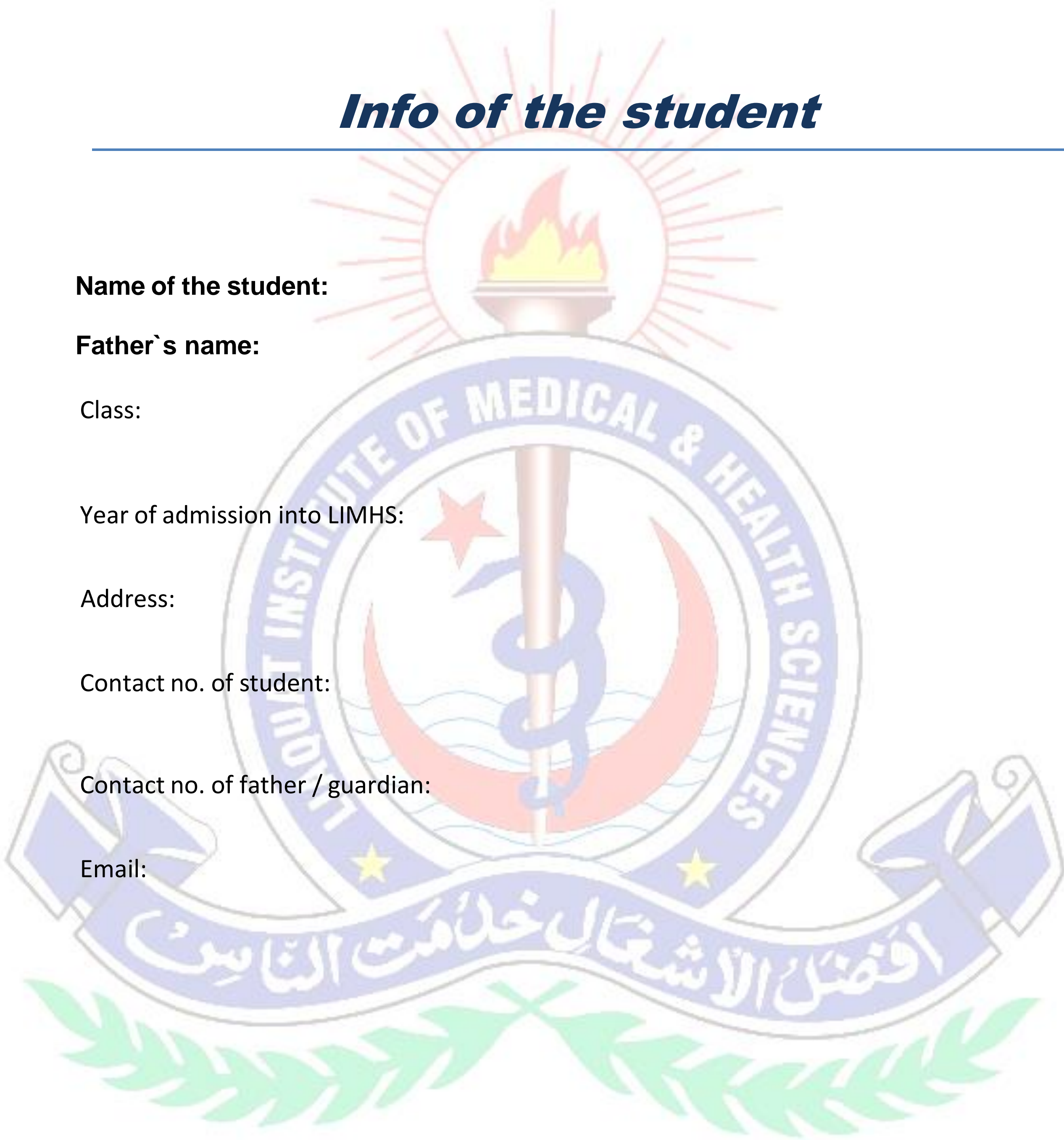
Third, Fourth Final Year

MBBS

Medicine & Allied Subjects

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES

Info of the student



Name of the student:

Father`s name:

Class:

Year of admission into LIMHS:

Address:

Contact no. of student:

Contact no. of father / guardian:

Email:

MESSAGE FROM VICE CHANCELLOR, LUMHS

Liaquat Institute of Medical & Health Sciences, Thatta is a constituent Institute of Liaquat University of Medical and Health Sciences (LUMHS) Jamshoro, Sindh, Pakistan. It has been established with the intention to educate the male candidates to fill the gap of male medical graduate serving the rural areas in Sindh as females are reluctant to serve the rural population despite of their increasing ratio in admission in medical Institutes in Sindh comparing to male candidates.

LIMHS aims to provide quality education as per the guidelines of Pakistan Medical Commission (PM&DC) formerly called as Pakistan Medical and Dental Council (PM&DC) and Higher Education Commission (HEC) Pakistan under the umbrella of LIMHS. LIMHS followed the updated curriculum of LIMHS being a constituent institute of LIMHS but intends to bring innovation in its implementation regarding teaching/learning and assessment methods. Furthermore, it implements &started integrated modular hybrid curriculum from third batch.

The updated integrated modular hybrid curriculum covers the credit hours filling of log books prescribed by the PM&DC and HEC.

I believe the graduate of LIMHS will be competent to cater the healthcare needs of community.

Professor Dr. Ikram din Ujjan

Vice Chancellor, LUMHS

Contents

Info of the student	
Table of content	
Message from Vice Chancellor (VC) LUMHS	
Message from Pro VC LUMHS & Administrative and Academic head of LIMHS	
Purpose of Log Book	
Clinical Exposure	
How to use this Log book	
Method of writing Reflection in logbook	
Contents of clinical rotations	
Teaching / Learning Third Year MBBS	
Teaching / Learning Fourth Year MBBS	
Teaching / Learning Final Year MBBS	
Skill Lab	
Details of other activities	
Comments about professionalism and behaviors of students	
Other academic and co-curricular activities	
List of certificates of participation in other academic and co-curricular activities	
Evaluation / Assessment Chart	
For student affairs / examination section	

Message from Administrative andAcademic head of LIMHS

The observation and assessment of performance of medical students is an integral part of curriculum. It can be accomplished by different modalities of assessments. Similarly, exposing the students to different clinical activities during the undergraduate medical training is essential. Supervising these activities is mandatory. For that purpose, keeping record of theseevents is important for student's evaluation and inclusion of these activities in grading student`s performance. Logbooks system is in use for many decades in the field of medicine throughout the world, and has some weaknesses like falsification of data, but still it isconsidered to be a useful checklist in assessing the performance of students and record keeping of different activities.

For this purpose, the Liaquat Institute of Medical & Health Sciences, Thatta is introducing the LOG BOOK for students of 4th year and beyond to help the students as well as the faculty in streamlining the teaching, assessment and certification of student`s performance. This activity will ensure structuring and recording student`s activities during their clinical rotations based on the learning objectivesassigned, and will help the faculty in assessing student`s performance. The logbook system willbe converted to a portfolio system in future.

Liaquat Institute of Medical & Health Sciences, Thatta
Administrative and Academic Head LIMHS

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an objective evidence of assessment of student and evaluation of the overall performance of students. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection has been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Principal

Liaquat Institute of Medical & Health Sciences, Thatta

Clinical Exposure

Clinical exposure is one of the integral parts of undergraduate medical education that usually start at 3rd year. However, in contemporary programs, rotations in clinical activities starts right at the start of training called as an early clinical exposure as part of integration attempt.This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into clinical environment. This exposure should be preceded by skill laboratory training, and should be gradual. It has to be according to the learning objectives defined in the curriculum.

The objectives of these rotations include:

1) Application of concepts in real life situations which is being presented in lectures, books and other reading materials
2) Acquisition of clinical skills relevant to the level and understanding of students
3) Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4) Developing communication skills, counseling skills, patient management skills, team work, timemanagement skills, critical thinking skills, decision making skills and interdepartmental collaboration at workplace
5) Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above- mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

Director Medical Education

Liaquat Institute of Medical & Health Sciences, Thatta

How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted duringrotation, record of history taking, field visits, assessment marks and student`s reflection. The3rd part includes attributes of communication skills and professionalism. All students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, record of research publications, co- curricular activities and many others. At the end, there is recordof student's attendance, and end of module assessment score that should be completed bythe student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to makea copy of all these activities so that it can be retrieved in times of loss of log book at the endof the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer status

Level B: Assistant status

Level C: Performed part of the procedure under supervision Level

D: Performed whole procedure under supervision LevelLevel E:

Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient's safety is not endangered. Students of 4th and 5th year are required to achievelevel C and D and in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in the

Logbook

Reflective thinking and writing demands that student recognizes that every student brings valuable knowledge to every experience. It helps students therefore to recognize and clarify the important connections between what student already knows and what student islearning. It is a way of helping student to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includesthe description about the following points:

1) Description of an event (one paragraph)
2) Thinking and feeling of student (one paragraph)
3) Good and bad about the experience (one paragraph)
4) How to avoid bad experiences and pursue good experiences in future (a few words to a paragraph).

The whole reflection document should be about between 200-300 words

Contents of clinical rotations

In 3rd year, the MBBS students are rotated in following departments in groups of about ……………. students:

1) Medicine and Allied Departments
2) Surgery and Allied Departments
3) Skills laboratory

In 4th year, the MBBS students are rotated in following departments in groups of about …………….. students:

1) Medicine and Allied Departments
2) Surgery and Allied Departments
3) Obstetrics & Gynecology
4) Pediatrics
5) Skills laboratory

In Final year, the MBBS students are rotated in following departments in groups of about ……………. students:

1) Medicine and Allied Departments
2) Surgery and Allied Departments
3) Obstetrics & Gynecology
4) Pediatrics
5) Skills laboratory

THIRD YEAR M.B.B.S

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES, THATTA

Daily lessons for teachers & students for ward teaching in Medicine

Each group of students shall be posted in two medical units & each unit will teach

historytaking, GPE & four systems examination.

3RD YEAR WARD TEACHING: MEDICINE

- TOTAL DURATION OF POSTING = 4 months (84 days), 42 days for each ward (vacation included)
- 5 DAYS A WEEK
- 2 HOURS A DAY
- WORKING DAYS = 82
- TOTAL WORKING HOURS = 168

Each ward will deal with four systems along with history taking and general physical examination.BREAK UP OF TOTAL TIME (42 DAYS/84 HOURS)

Components	Allotted Time
History Taking	12 hours/06 days
GPE	10 Hours/05 days
CHEST	10 Hours/05 days
ABDOMEN	10 Hours/05 days
CVS	10 Hours/05 days
CNS	10 Hours/05 days
Assessment	06 Hours/03 days
Supervised Test	06 Hours/03 days
Final Preparation	08 Hours/04 days
Final Test	Last day
Total	84 hours/42 days

3 days History taking & 3 days Symptomatology

DAY-01: LESSON 01

TOPIC: COMPONENTS OF HISTORY

Objectives: Students should be able to organize the components of history according to international standards.Learning outcomes: at the end of the day each student will be able to write history in systemic way Assessment tool: ASK the students to take history from their colleague.

Components of history

- Biodata
- Presenting complaints (P/C)
- HOPC
- Past History
- Family History
- Personal/Social History
- Treatment History
- Menstrual / Obstetric History
- Systemic Review

DAY-02: LESSON 02

TOPIC: MAIN SYMPTOMS

Objective: students should be able to take history according to the symptoms & he should be able to askimportant questions regarding main symptoms.

Learning outcomes: at the end of the day each student will be able to ask proper questions regarding thesymptoms of patient.

Assessment tool: Give different symptoms to small groups of students for history taking

A) **GENERAL**
   - FEVER
   - APPETITE
   - WEIGHT LOSS
   - FATIGUE
   - SLEEP DISTURBANCE

B) **G.I.T.**
   - NAUSEA/VOMITING
   - ABDOMINAL PAIN
   - DYSPEPSIA
   - DIARRHEA
   - CONSTIPATION
   - DISTENSION
   - JAUNDICE
   - UPPER/LOWER G.I. BLEEDING

C) **GENITOURINARY**

- BURNING MICTURATION
- DYSURIA/NOCTURIA
- HEMETURIA
- POLYURIA
- FLANK PAIN
- EDEMA

DAY-03: LESSON 03

TOPIC: MAIN SYMPTOMS

Objective: students should be able to take history according to the symptoms & he should be able to askimportant questions regarding main symptoms.

Learning Outcomes: at the end of the day each student should be able to ask proper questions regarding thesymptoms of patient.

Assessment Tool: give different symptoms to small groups of the students for history taking.

D) CVS
- SOB
- ORTHOPNEA/PND
- CHEST PAIN
- EXERCISE TOLERANCE
- LEG EDEMA
- PALPITATION

E) CNS
- HEADACHE
- FITS
- ALTERED LEVEL OF CONSCIOUSNESS
- DIFFICULTY IN SPEECH
- WEAKNESS/PARALYSIS
- VERTIGO/GIDDINESS
- NUMBNESS/PARASTHESIA
- INVOLUNTARY MOVEMENTS
- ATAXIA

F) ENDOCRINE
- HEAT/COLD INTOLERANCE
- WEIGHT LOSS/WEIGHT GAIN

DAY 04: LESSON 04

TOPIC: MAIN SYMPTOMS

Objective: students should be able to take history according to the symptoms & he should be able to askimportant questions regarding main symptoms.

Learning Outcomes: at the end of the day each student should be able to ask proper questions regarding thesymptoms of patient.

Assessment Tool: give different symptoms to small groups of the students for history taking.

G) MSK
- JOINT PAIN
- STIFFNESS
- JOINT SWELLING
- BACKACHE

H) RESPIRATION
- COUGH/SPUTUM
- HEMOPTYSIS
- CHEST PAIN
- WHEEZE
- SOB

I) BLOOD/SKIN
- BLEEDING
- RASH
- LYMPH NODES
- ITCHING

DAY-05 LESSON: 05

TOPIC: **WRITING AND OBTAINING HISTORY FROM THE PATIENT.**

Objective: students should be able to take history from patient according to the symptoms in comprehensivemanner.

Learning Outcomes: at the end of the day each student should be able to ask proper history & to write it on apaper in systemic way.

Assessment Tool: allot a patient to each student for history taking under supervision.

Day-06 Lesson: 06

Presentation of the history to the teacher.

DAY-07 LESSON: 07

TOPIC: GPE

Objective: students should be able to elicit physical signs.

Learning Outcomes: at the end of the day each student should be able to observe & elicit the physical sign.

Assessment Tool: allot a patient to a group of students to elicit physical sign under supervision.

- VITALS:
  - ✓ PULSE
  - ✓ B.P.
  - ✓ TEMPERATURE
  - ✓ R/R

DAY-08 LESSON: 08

TOPIC: GPE

Objective: students should be able to elicit physical signs.

Learning Outcomes: at the end of the day each student should be able to observe & elicit the physical sign.

Assessment Tool: allot a patient to a group of students to elicit physical sign under supervision.

- SUB VITALS:
  - ✓ FACEIS
  - ✓ PHYSIQUE/POSTURE
  - ✓ ANEMIA
  - ✓ JAUNDICE
  - ✓ CYANOSIS
  - ✓ DEHYDRATION
  - ✓ CLUBBING
  - ✓ KOILONYCHIA
  - ✓ LEUKONYCHIA
  - ✓ EDEMA
  - ✓ LYMPH NODES
  - ✓ THYROID

DAY-09 LESSON: 09

TOPIC: GPE

Objective: students should be able to elicit physical signs.

Learning Outcomes: at the end of the day each student should be able to observe & elicit the physical sign.

Assessment Tool: allot a patient to a group of students to elicit physical sign under supervision.

- PAROTIDS
- OSLER'S NODES

- SPLINTER HEMMORRHAGES

- SPIDER NEVEI
- DEFORMITIES OF RA
- ALOPECIA
- MUSCLE WASTING
- PALMER ERYTHEMA
- JVP
- CAROTIDS
- GYNECOMASTIA
- SACRAL EDEMA

DAY-10 LESSON: 10

TOPIC: ELICITING/DETECT PHYSICAL SIGNS

Objective: students should be able to elicit physical signs.

Learning Outcomes: at the end of the day each student should be able to observe & elicit the physical sign.

Assessment Tool: allot a patient to a group of students to elicit physical sign under supervision.

A check list of physical signs will be provided to each student who will get sign by teacher afterobserving/eliciting physical signs.

Day -11. Assessment

Assessment of GPE of all students.

DAY-12 LESSON: 12

TOPIC: INSPECTION OF CHEST

Objective: students should be able to inspect the chest properly.

Learning Outcomes: at the end of the day each student should be able to inspect the chest properly.

Assessment Tool: student will inspect the chest of a patient under supervision.

- HAND SHAKE
- INTRODUCTION/CONSENT
- POSITION/EXPOSURE
- GENERAL OBSERVATIONS
- SHAPE/ SYMMETRY
- TYPE/RATE OF RESPIRATION

- MOVEMENTS
- TRACHEA
- APEX BEAT
- PROMINENT VEINS / PULSATION
- SCAR/ PIGMENTATION

DAY-13 LESSON: 13

TOPIC: PALPATION OF CHEST

Objective: students should be able to Palpate the chest properly.

Learning Outcomes: at the end of the day each student should be able to palpate the chest properly.

Assessment Tool: student will palpate the chest of a patient under supervision.

- ASK TENDERNESS
- TRACHEA
- MOVEMENTS
- EXPANSION
- VOCAL FERMITUS
- APEX BEAT

DAY-14 LESSON: 14

TOPIC: AUSCULTATION OF CHEST

Objective: students should be able to percuss the chest properly.

Learning Outcomes: at the end of the day each student should be able to percuss the chest properly.

Assessment Tool: student will percuss the chest of a patient under supervision.

- ANTERIOR CHEST
- LATERAL CHEST
- POSTERIOR CHEST

DAY-15 LESSON: 15

TOPIC: AUSCULTATION OF CHEST

Objective: students should be able to auscultate the chest properly.

Learning Outcomes: at the end of the day each student should be able to auscultate the chest properly.

Assessment Tool: student will auscultate the chest of a patient under supervision

- BREATH SOUNDS (INTESITY/ CHARACTER)
- ADDED SOUNDS (RHONCHI/CREPITATION)
- VOCAL RESONANCE
- PLEURAL RUB

DAY-16 LESSON: 16

TOPIC: STUDENT PRACTICE CHEST EXAMINATION

Objective: Student should be able to examine the chest properly.

Learning Outcome: At the end of day, each student should be able to examine the chestproperly.

Assessment Tool: Student will examine chest of a patient in small groups under supervision

DAY-17 LESSON: 17

TOPIC: SURPRISE TEST OF CHEST EXAMINATION

At the completion of one system examination, student will undertake a surprise test conductedby a faculty.

DAY-18 LESSON: 18

TOPIC: INSPECTION OF ABDOMEN

Objective: Student should be able to inspect the abdomen properly.

Learning Outcome: At the end of day, each student should be able to inspect the abdomenproperly.

Assessment Tool: Student will inspect abdomen of a patient under supervision.

- HAND SHAKE
- INTRODUCTION/CONSENT
- POSITION/EXPOSURE
- GENERAL OBSERVATIONS
- SHAPE/SYMMETRY

- UMBLICUS

- MOVEMENTS
- EPIGASTRIC PULSATIONS
- PROMINENT VEINS
- STRIAE/SCARS
- PIGMENTATION
- HERNIAI. ORIFICES

DAY-19 LESSON: 19

TOPIC: PALPATION OF ABDOMEN

Objective: Student should be able to palpate the abdomen properly.

Learning Outcome: At the end of day, each student should be able to palpate the abdomenproperly.

Assessment Tool: Student will palpate abdomen of a patient under supervision.

- SUPERFICIAL TENDERNESS
- DEEP TENDERNESS
- LIVER
- SPLEEN
- KIDNEYS
- AORTA
- PARA AORTIC NODES

DAY-20 LESSON: 20

TOPIC: PERCUSSION OF ABDOMEN

Objective: Student should be able to percuss the abdomen properly.

Learning Outcome: At the end of day, each student should be able to percuss the abdomenproperly.

Assessment Tool: Student will percuss abdomen of a patient under supervision.

- SHIFTING DULLNESS
- FLUID THRILL
- PERCUSSION OF VISCERAS

DAY-21 LESSON: 21

TOPIC: AUSCULTATION 0F ABDOMEN

Objective: Student should be able auscultate the abdomen properly.

Learning Outcome: At the end of day, each student should be able to auscultate the abdomenproperly.

Assessment Tool: Student will auscultate the abdomen of a patient under supervision.

- BOWEL SOUNDS
- RENAL BRUIT
- LIVER BRUIT

DAY-22 LESSON: 22

TOPIC: STUDENT PRACTICE ABDOMEN EXAMINATION

Objective: Student should be able examine the abdomen properly.

Learning Outcome: At the end of day, each student should be able to examine the abdomenproperly.

Assessment Tool: Student will examine the abdomen of a patient in small groups undersupervision.

Day 23 LESSON 23

TOPIC: HIGHER MENTAL FUNCTIONS (HMF)

Objective: Students should be able asses HMF properly .

Learning outcomes: at the end of day each student will be able to record the HMF properly.

Assessment Tool: student will Examine HMF of a patient under supervision

- GLASGOW COMA SCALE GCS
- SPEECH (FLUENCY, COMPREHENSION, REPITITION, CALCULATION, READING, WRITING)
- ORIENTATION (PLACE, PERSON, TIME)
- MEMORY (IMMEDIATE, RECENT, REMOTE)
- HALLUCINATIONS/DELLUSIONS/ILLUSIONS
- M.M.E.

DAY-24 LESSON: 24
TOPIC: CRANIAL NERVES

Objective: Student should be able to examine the cranial nerves properly.

Learning Outcome: At the end of day, each student should be able to examine the cranial nervesproperly.

Assessment Tool: Student will examine cranial nerves of a patient under supervision.

CRAN IAL NERVES:

- I, II, III, IV, V, VI.

DAY-25 LESSON 25
TOPIC: CRANIAL NERVES

Objective: Student should be able to examine the cranial nerves properly.

Learning Outcome: At the end of day, each student should be able to examine the cranial nervesproperly.

Assessment Tool: Student will examine cranial nerves of a patient under

supervision.Cranial nerves:

- VII, VIII, IX, X , XI, XII

DAY-26 LESSON: 26

TOPIC: MOTOR SYSTEM (UPPER LiMB/LOWER- LIMB)

Objective: Student should be able to examine the motor system properly.

Learning Outcome: At the end of day, each student should be able to examine the motor systemproperly.

Assessment Tool: Student will examine motor system of a patient under supervision.

- INSPECTION (BULK, FASCICULATIONS, ABNORMAL MOVEMENTS)
- PALPATION (TENDERNESS, FASCICULATIONS)
- TONE
- POWER
- REFLEXES
- CLONUS
- PLANTERS
- ABDOMINAL REFLEX
- GAIT

DAY-27 LESSON: 27

TOPIC: CEREBELLUM

Objective: Student should be able to examine the cerebellum properly.

learning Outcome: At the end of day, each student should be able to examine the cerebellumproperly.

Assessment Tool: Student will examine cerebellum of a patient under supervision.

- NYSTAGMUS
- SCANNING SPEECH
- FINGER-NOSE TEST
- DYSDIODOKINESIA
- TONE
- PAST POINTING
- INTENTIONALTREMORS
- PENDULAR KNEEJERKS
- HEEL SHIN TEST
- ATAXIC GAIT
- TENDEM WALK
- ROMBERG'S TEST

DAY—28 LESSON: 28

TOPIC: SENSORY SYSTEM (U.L & L.L)

Objective: Student should be able to examine the sensory system properly.

Learning Outcome: At the end of day, each student should be able to examine

the sensorysystem properly.

Assessment Tool: Student will examine sensory system of a patient under supervision.

- LIGHT TOUCH
- PAIN
- TEMPERATURE
- CRUDE TOUCH
- JPS
- VIBRATION
- 2-POINT DISCRIMINATION
- STEREGNOSIS

DAY—29 LESSON: 29

TOPIC: SIGNS OF MENINGEAL IRRITATION

Objective: Student should be able to elicit signs of meningeal irritation properly.

Learning Outcome: At the end of day, each student should be able to elicit signs of meningealirritation properly.

Assessment Tool: Student will elicit signs of meningeal irritation in a patient under supervision.

- NECK RIGIDITY
- KERNING'S SIGN
- BRUDINZKI'S SIGN
- S.L.R.

DAY-30 LESSON: 30

TOPIC: PRACTICE OF CNS EXAMINATION BEFORE FINAL TEST

Objective: Student should be able to examine CNS properly.

Learning Outcome: At the end of day, each student should be able to examine the CNS properly.

Assessment Tool: Student will examine CNS of a patient under supervision.

DAY 31: LESSON 31

TOPIC: REHEARSAL OF ALL COMPONENTS TAUGHTCNS EXAM

DAY 31 & 33

Examination of the motor system of Upper Limb

DAY-34/35/36 LESSON: 34/ 35/36

DAY-37 LESSON: 37

TOPIC: INSPECTION OF PRECORDIUM

- HAND SHAKE
- INTRODUCTION/CONSENT
- POSITION/EXPOSURE
- APEX BEAT
- PRECORDIAL PULSATIONS
- CHEST DEFORMITY
- PROMINENT VEINS
- STERNOTOMY SCAR
- EPIGASTRIC PULSATION

DAY-38 LESSON: 38

Objective: Students should be able to palpate the pericardium properly .

Learning outcomes: at the end of day each student will be able to palpate the precordium properly.

Assessment Tool: student will palpate precordium of a patient under supervision

- APEX BEAT
- LPH
- THRILL

DAY-39 LESSON: 39

TOPIC: AUSCULTATION OF PRECORDIUM

Objective: Students should be able to auscultate the pericardium properly .

Learning outcomes: at the end of day each student will be able to auscultate the precordium properly.

Assessment Tool: student will auscultate precordium of a patient under supervision

- S1 & S2 (INTENSITY, SPLITTING)
- S3 & S4
- MURMUR (SITE, TIMING, INTENSITY, RADIATION, EFFECT OF RESPIRATION)
- PERICARDIAL RUB

DAY-40 LESSON: 40

TOPIC: STUDENT PRACTICE WHOLE CVS EXAMINATION

Objective: Students should be able to Examine the pericardium properly.

Learning outcomes: at the end of day each student will be able to Examine the precordium properly.

Assessment Tool: student will Examine precordium of a patient under supervision

DAY-41&42

GRAND TEST & VIVA2

DAYS

General Physical Examination (GPE)

CHECK LIST OF PHYSICAL SIGNS FOR 3RD YEAR MBBS

Medical unit:________________________________**Ward**___________________________

Student's Name:_____________________________**Roll No**___________**Group**_________

S.No	Signs	CAN DETECT/ APPRECIATE/ ELICIT				Initials
		Good	Satisfactory	Average	Poor	
Pulse:						
1.	**a)** Rate					
	b) Rhythm					
	c) Volume					
	d) Paradox					
	e) Collapsing					
	f) R-R delay					
	g) R-F delay					
	h) Vessel Wall					
2	Tempreture					
3	B.P					
4	Respiration					
5	Clubbing					
6	Cyanosis					
7	Anemia					
8	Jaundice					
9	Koilonychia					
10	Leukonychia					
11	Dehydration					

12	Edema					
13	Palmer Erythema					
Lyphnodes:						
14	a) Cervical					
	b) Axillary					
	c) Inguinal					
15	Ptosis					
16	Corneal arcus					
17	Xanthelesma					
18	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	Osler’s Nodes					
28	Malar Flush					
29	Xanthomas					
30	Dupuytrene’s Contracture					
31	Flapping Tremors					
32	Angular stomatitis					

33	Aphthous ulcers					
34	Nicotine Marks					
35	Smooth Tongue					
36	Goiter					
37	Carotids					
38	Brachials					
39	Dorsalispedis					
40	Popliteals					
41	Posterior Tibial					
42	JVP					
43	Insulin Injection Marks					
44	Acanthosis Nigricans					

Teacher Name:________________________________Signature__________________

Co-Teacher Name:_____________________________Signature_________________

Medical unit____LIMHS, Thatta

Gastrointestinal Tract (G.I.T) EXAMINATION

CHECK LIST OF PHYSICAL SIGNS FOR 3RD YEAR MBBS

Medical unit:______________________________Ward_________________________

Student's Name:___________________________Roll No__________Group_________

S.No	Signs	CAN DETECT/ APPRECIATE/ ELICIT				Initials
		Good	Satisfactory	Average	Poor	
1	Cushingoid face					
2	Ecchymosis					
3	Tattoos					
4	Purpura/Petechiae					
5	E. Nodosum					
6	P. Gangrenosum					
7	Pigmentation					
8	Acanthosis Nigricans					
9	Bronze Skin					
10	Uremic Complexion					
11	Hepatic fetor					
12	Uremic fetor					
13	Uremic frost					
14	Hyperventilation					
15	Scleroderma facies					
16	Anemia					
17	Jaundice					
18	Clubbing					
19	Palmer Erythema					
20	Leukonychia					
21	Koilonychia					
22	*½ & ½ nails*					

23	Dupuytrene's Contracture					
24	Flapping Tremors					
25	Joint deformities					
26	Scratch Marks					
27	A-V Fistula					
28	Insulin Marks					
29	Epitrochlear Nodes					
30	B.P.					
31	Parotids					
32	Spider angiomas					
33	K-F ring					
34	Butterfly rash					
35	Circumoral Pigmentation					
36	Angular Stomatitis					
37	Cheilosis					
38	Telengiectasia					
39	Aphthous ulcers					
40	Gum Hypertrophy					
41	Dehydration					
42	Oral thrush					
43	Gynecomastia					
44	Axillary hair					
45	L. Nodes					
46	Bone Tenderness					
47	Umblicus					
48	Epigastric Pulsations					
49	Striae					

50	E. Ab igne					
51	Caput medusae:					
52	Superficia l Tenderness					
53	Deep Tenderness					
54	Liver					
55	Spleen					
56	Kidneys					
57	Murphy's Sign					
58	Urinary bladder					
59	Aorta					
60	Para aortic nodes					
61	Inguinal nodes					
62	Hernial orifices					
63	Genita lia					
64	Shifting dullness					
65	Fluid Thrill					
66	Bowel sounds					
67	Renal bruit					
68	Murphy's Punch					
69	Spine Tenderness					

Teacher Name:_______________________________________Signature______________________

Co-Teacher Name:____________________________________Signature______________________

Medical unit____LIMHS, Thatta

Respiratory Tract EXAMINATION

Examination of Chest

CHECK LIST OF PHYSICAL SIGNS FOR 3RD YEAR MBBS

Medical unit:______________________________Ward_________________________

Student's Name:___________________________Roll No__________Group________

S.No	Signs	CAN DETECT/ APPRECIATE/ ELICIT				Initials
		Good	Satisfactory	Average	Poor	
1	Posture /Physique					
2	Cyanosis					
3	Dyspnea					
4	Purse lips					
5	Nicotine marks					
6	Clubbing/HPOA					
7	Wheeze/hoarseness					
8	Flapping Tremors					
9	Wasting of small muscles					
10	Pallor/plethora					
11	Parotids					
12	Rash					
13	Homer's					
14	Sputum Mug					
15	02 cylinder					
16	Nebulizer/inhaler					
Radials:						
17	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	lndrawing of l/C spaces					
24	Chest Tenderness					
25	Trachea					
26	Apex beat					
27	Epigastric					
28	Crico Sternal 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:____LIMHS, Thatta

ASSESSMENT FORM FOR 3RD YEAR PROMOTIONAT THE END OF WARD POSTING

Student's Name:___________________________Roll No__________Group_________

Medical unit:______________________________Ward__________________________

Date of Assessment:________________Teacher______________Co-Teacher_________

GRADES ACHIEVED IN LAST WARD

Abdomen	Performance/ grade	Suggestion for improvement	Date of next assessment	Cross examined by	Remarks after 2"d test
General Observation					
Inspection • Shape & Symmetry Movements • Umblicus • Prominent Veins • Pulsations • Scars/Striae					
Palpation: • Tenderness • Liver Spleen • Kidneys • Fluid Thrill • Aorta • Para aortic nodes • Inguinal nodes • Hernial Orifices					
Percussion: • Shifting Dullness • Percussion for visceras					
Auscultation: • Bowel Sounds • Renal Bruit • Hepatic Bruit					

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= Reposting for 2 weeks,2 = Reposting for few days for particular mistakes, 3 = Singleday 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

ASSESSMENT FORM FOR 3RD YEAR PROMOTIONAT THE

END OF WARD POSTING

Student's Name:___________________________Roll No_________Group________

Medical unit:______________________________Ward_________________________

Date of Assessment:_______________Teacher_____________Co-Teacher________

GRADES ACHIEVED IN LAST WARD

Abdomen	Performance/ grade	Suggestion for improvement	Date of next assessment	Cross examined by	Remarks after 2"d test
General Observation					
General Observation Inspection: • Shape,Symmetry • Movements • Prominent Veins/pulsation • Rate/Type of Resp • Trachea • Apex beat					
Palpation: • Tenderness • S/C Emphysema • Trachea • Apex Beat • Movements • V. Fermitus • Expansion					
Percussion:					

• Lungs • Upper liver border Auscultation: • Breath Sounds • Added Sounds • V. Resonance • Pleural Rub					

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= Reposting for 2 weeks,2 = Reposting for few days for particular mistakes, 3 = Singleday posting for rehearsal of all systems, 4 = Satisfactory.

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

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

NEUROLOGICAL EXAMINATION

CHECK LIST OF PHYSICAL SIGNS FOR 3RD YEAR MBBS

Medical unit:______________________________**Ward**__________________________

Student's Name:____________________________**Roll No**__________**Group**_________

S.No	Signs	CAN DETECT/ APPRECIATE/ ELICIT				Initials
		Good	Satisfactory	Average	Poor	
1	Characteristic Facies					
2	Ptosis					
3	Proptosis					
4	Facial Tics					
5	Involuntary Movements					
Orientation:						
6	a) Time					
	b) Place					
	c) Person					
7	Hallucinations					
8	Delusions					
9	Illusions					
10	GCS					
Memory:						
11	a) Recent					
	b) Remote					
12	Intelligence					
13	Grasp reflex					
14	Sucking reflex					
15	Snout reflex					

16	Palmomental reflex					
17	Glabellar reflex					
18	Apraxia					
Aphasia:						
19	a) Motor					
	b) Sensory					
20	c) Conduction					
	d) Nominal					
	e) Acalculi					
	f) Dyslexia					
21	Dysarthria					
22	Olfactory Nerve					
Optic:						
23	a) Visual acuity					
	b) Color vision					

23	c) Field of vision.					
	d) Fundoscopy					
Ill/IV/VI Nerves:						
24	a) Movements					
	b) Nystagmus					
	c) Diplopia					
	d) Squint					
	e) Light reflex					
	f) Accommodation Reflex					

Trigeminal:						
25	a) Corneal reflex					
	b) Sensory part					
	c) Motor part					
	d)Jaw Jerk					
Facial Nerve:						
26	a) Inspection					
	b) Motor function					
	c) Taste sensation					
Vestibulocochlear:						
27	a) Rinnie's Test					
	b) Weber Test					
	c) Doll's Eye					
	d) Positional Vertigo					
IX/X Nerves:						
	a) Gag reflex					
	b) Aah Test					
Accessory:						
28	a) Trapezius					
	b) Sternomastoid					
29	Hypoglossal					
30	Fasciculations in muscles					
31	Measure Bulk					
32	Tone					
Power:						
33	a) Upper limb					
	b) Lower limb					

34	Knee jerk					
35	Ankle Jerk					
36	Planter reflex					
37	Triceps jerk					
38	Biceps jerk					
39	Supinator jerk					
40	Finger reflex					
41	Abdominal reflex					
42	Ankle clonus					
43	Patellar clonus					
44	Finger-Nose test					
45	Dysdiodokines ia					
46	Heel-shin test					
47	Gait					
48	Tandem walk					
49	Romberg's test					
50	Pain sensation					
51	Touch sensation					
52	Temperature					
53	JPS					
54	Vibration					
55	2 Point discrimination					
Cortical Functions:						
56	a) Localization					
	b) 2 point discrimination					
	c) Stereognosis					
	d) Graphasthesia					

	e) Sensory inattention					
57	Neck rigidity					
58	Kerning's sign					
59	Brudzinski's sign					
60	S.L.R.					

Teacher Name:___________________________________Signature____________________

Co-Teacher Name:_________________________________Signature____________________

Medical unit____LIMHS, Thatta

CARDIOVASCULAR EXAMINATION

CHECK LIST OF PHYSICAL SIGNS FOR 3RD YEAR MBBS

Medical unit:________________________________**Ward**___________________________

Student's Name:_____________________________**Roll No**__________**Group**________

S.No	Signs	CAN DETECT/ APPRECIATE/ ELICIT				Initials
		Good	Satisfactory	Average	Poor	
1	Posture					
2	Cyanosis					
3	Malar Flush					
4	Chorea					
5	Nicotine marks					
6	Clubbing					
7	Splinter hemorrhages					
8	Osier's Nodes					
9	Janeway lesion					
10	Xanthomas					
11	Quinkie's sign					
Radials:						
12	e) Rate					
	f) Rhythm					
	g) Volume					
	h) Collapsing					
	i) Paradox					
	j) PulsusAlternans					
	k) R-R delay					
	I) R-F delay					
13	Brachials					
14	B.P.					
15	Carotids					

16	J.V.P.					
17	Corneal arcus					
18	Muller's sign					
19	Sternotomy scar					
20	Prominent veins {SVC Obs.)					
21	Pulsations of Coarctation Aort a					
22	Epigastric pulsations					
23	Apex beat					
24	Left Parasternal heave					
25	Thrill					
26	Sl & S2					
27	S3 & S4					
28	Murmur					
29	Opening snap					
30	Pericardial rub					
31	Sacral edema					
32	Auscultation of lung bases					
33	Femorals					
34	Durozier murmur					
35	Popliteals					
36	Dorsalispedis					
37	Pedal edema					
38	Fundoscopy					

Teacher Name:_____________________________________Signature_____________________

Co-Teacher Name:__________________________________Signature____________________

Medical unit____LIMHS, Thatta

ASSESSMENT FORM FOR 3RD YEAR PROMOTIONAT THE
END OF WARD POSTING

Student's Name:__________________________Roll No__________Group________

Medical unit:_____________________________Ward___________________________

Date of Assessment:_______________Teacher______________Co-Teacher________

GRADES ACHIEVED IN LAST WARD

Abdomen	Performance/ grade	Suggestion for improvement	Date of next assessment	Cross examined by	Remarks after 2"d test
General Observation					
Higher Mental Functions: • **Appearance/Behavior** • **GCS** • **Orientation** • **Memory**					
Speech • Dysphasia • Dvsarthria					
Cranial Nerves: • I • II • III/IV/VI • V • VII • VIII • IX/X • XI • XII					
Motor System: • Bulk/Tenderness • Involuntary Movements • Fasciculations • Tone • Power • Reflexes • Co ordination • Back • Gait					
Sensory system: • Touch					

• Pain • Temperature • JPS • Vibration					
Signs of Meningeal Irritation: • Neck rigidity • Kerning's sign • Brudzinski's sign • S.L.R.					

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= Reposting for 2 weeks,2 = Reposting for few days for particular mistakes, 3 = Singleday 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

ASSESSMENT FORM FOR 3RD YEAR PROMOTIONAT THE END OF WARD POSTING

Student's Name:__________________________Roll No__________Group________

Medical unit:_____________________________Ward__________________________

Date of Assessment:_______________Teacher______________Co-Teacher_________

GRADES ACHIEVED IN LAST WARD

CVS	Performance/ grade	Suggestion for improvement	Date of next assessment	Cross examined by	Remarks after 2"d test
General Observation					
Inspection: • Patient's • Position • Symmetry of chest • J.V.P. • Prominent Vein/pulsation • Apex beat Palpation: • Apex Beat					
Palpation: • Pulse • Apex Beat • Thrill • LPH					
Precussion: • Heart					
Auscultation: • Sl & S2 • S3 & S4 • Murmurs • Pericardial rub					

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= Reposting for 2 weeks,2 = Reposting for few days for particular mistakes, 3 = Singleday 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

Details of other activities in Medicine & Allied Subjects

<table>
<tr><th>Competencies</th><th>Details</th><th>Supervisor`s comments / signature</th></tr>
<tr><td>Introduction to Common symptoms and diseases in ENT</td><td>Presented by:</td><td></td></tr>
<tr><td>Details of history and examination
* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol</td><td>*Mention 3 symptoms and system involved
1)
2)
3)</td><td></td></tr>
<tr><td>Case Based Discussion (CBD)</td><td></td><td></td></tr>
<tr><td>End of the ward assessment</td><td>Marks:__________out of ______________</td><td></td></tr>
<tr><td colspan="2">Any other event that you want to record during your stay in the unit (provide details)</td><td></td></tr>
<tr><td colspan="2">Reflection by student</td><td></td></tr>
</table>

Comments about professionalism and behaviors of students in Medicine & Allied Subjects

(To be filled by the supervisor)

S. No	Statement	Supervisor comments			
		Yes	No	Any other point	
1	Was polite with patients, nurses, paramedical staff, seniors and colleagues				
2	Was ready to take responsibility				
3	Kept calm in difficult situations				
4	Maintained an appropriate appearance / dress				
5	Avoided derogatory remarks in the unit				
6	Presentation skills were up to the mark				
7	Total attendance		Out of=		
7	Overall assessment of professional conduct	A: High		B: Moderate	C: Low

<table>
<tr><th rowspan="2">S. No</th><th rowspan="2">Date</th><th rowspan="2">Competencies</th><th colspan="5">Level
A: Observer status
B: Assistant status
C: Performed part of the procedure under supervision
D: Performed whole procedure under supervision
E: Independent performance</th><th rowspan="2">Supervisor`s comments / signature</th></tr>
<tr><th>A</th><th>B</th><th>C</th><th>D</th><th>E</th></tr>
<tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Details of other activities in Medicine & Allied Subjects

Competencies	**Details**	**Supervisor`s comments / signature**
Introduction to skill lab.	Presented by:	
	Conducted by:	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students in Medicine & Allied Subjects

(To be filled by the supervisor)

<table>
<tr><th rowspan="2">S. No</th><th rowspan="2">Statement</th><th colspan="4">Supervisor comments</th></tr>
<tr><th>Yes</th><th>No</th><th colspan="2">Any other point</th></tr>
<tr><td>1</td><td>Was polite with staff, seniors and colleagues</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>2</td><td>Was ready to take responsibility</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>3</td><td>Kept calm in difficult situations</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>4</td><td>Maintained an appropriate appearance / dress</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>5</td><td>Avoided derogatory remarks in the unit</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>6</td><td>Presentation skills were up to the mark</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>7</td><td>Total attendance</td><td></td><td>Out of=</td><td colspan="2"></td></tr>
<tr><td rowspan="2">7</td><td rowspan="2">Overall assessment of professional conduct</td><td colspan="2">A:
High</td><td>B:
Moderate</td><td>C:
Low</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
</table>

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

***The student can paste photocopies of certificates of presentations on this page**

List of certificates of participation in other academic and co-curricular activities*

Medicine & Allied Subjects

S. No	Name of activity / society / other	Position	From --- to (date)	Signature of organizer / in-charge

***Student can paste the proof / certificate / office order of the activities / events**

Evaluation / Assessment Chart in Medicine & Allied Subjects

S. #	Date	Duration	Activity	Performance	Assessed By	Student Sign	Teachers Sign

For student affairs / examination section

Details of marks of internal assessments in Medicine & Allied Subjects

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book				**Out of: 50**			
	%age							

Deputy / Controller of examination **Director Medical Education**

Sign____________________________ **Sign**_______________________

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES (LIMHS), THATTA, SINDH, PAKISTAN

STUDENT LOG BOOK

THIRD PROFESSIONAL

(Fourth Year) MBBS

Ear Nose & Throat (ENT)

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

Info of the student

Name of the student:

Father`s name:

Class:

Year of admission into LIMHS:

Address:

Contact no. of student:

Contact no. of father / guardian:

Email:

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

Contents

Info of the student	3
Table of content	5
Message from Vice Chancellor (VC) LUMHS	7
Message from Pro VC LUMHS & Administrative and Academic head of LIMHS	8
Purpose of Log Book	9
Clinical Exposure	10
How to use this Log book	11
Method of writing Reflection in logbook	12
Contents of clinical rotations	13
Ways of teaching and learning in ENT Location of learning 14 Introduction to ENT `4 OPD Cases Worked up during posting 15 Operative procedures observed during posting 16 ENT examination performed during posting 17 ENT instruments seen and discussed during posting 18 Presentation attended during posting 19	14-19
Skill Lab in ENT	20
Details of other activities in ENT	21
Comments about professionalism and behaviors of students in ENT	22
Other academic and co-curricular activities in Ophthalmology	23
List of certificates of participation in other academic and co-curricular activities in ENT	24
Evaluation / Assessment Chart ENT	25
For student affairs / examination section ENT	26

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
اَفضَلُ الاَشغَالِ خدُمَتُ النّاسِ

Message from Administrative and Academic head

of LIMHS

The observation and assessment of performance of medical students is an integral part of curriculum. It can be accomplished by different modalities of assessments. Similarly, exposing the students to different clinical activities during the undergraduate medical training is essential. Supervising these activities is mandatory. For that purpose, keeping record of these events is important for student's evaluation and inclusion of these activities in grading student`s performance. Logbooks system is in use for many decades in the field of medicine throughout the world, and has some weaknesses like falsification of data, but still it is considered to be a useful checklist in assessing the performance of students and record keeping of different activities.

For this purpose, the Liaquat institute of Medical & Health Sciences, Thatta is introducing the LOG BOOK for students of 4th year and beyond to help the students as well as the faculty in streamlining the teaching, assessment and certification of student`s performance. This activity will ensure structuring and recording student`s activities during their clinical rotations based on the learning objectives assigned, and will help the faculty in assessing student`s performance. The logbook system will be converted to a portfolio system in future.

Liaquat institute of Medical & Health Sciences, Thatta
Administrative and Academic Head LIMHS

Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an objective evidence of assessment of student and evaluation of the overall performance of students. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection has been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Principal

Liaquat institute of Medical & Health Sciences, Thatta

Clinical Exposure

Clinical exposure is one of the integral parts of undergraduate medical education that usually start at 3rd year. However, in contemporary programs, rotations in clinical activities starts right at the start of training called as an early clinical exposure as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into clinical environment. This exposure should be preceded by skill laboratory training, and should be gradual. It has to be according to the learning objectives defined in the curriculum.

The objectives of these rotations include:

1) Application of concepts in real life situations which is being presented in lectures, books and other reading materials
2) Acquisition of clinical skills relevant to the level and understanding of students
3) Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4) Developing communication skills, counseling skills, patient management skills, team work, timemanagement skills, critical thinking skills, decision making skills and interdepartmental collaboration at workplace
5) Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above-mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

Director Medical Education

Liaquat institute of Medical &

Health Sciences, Thatta

How to use this Log book

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted during rotation, record of history taking, field visits, assessment marks and student`s reflection. The 3rd part includes attributes of communication skills and professionalism. All students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, record of research publications, co- curricular activities and many others. At the end, there is record of student's attendance, and end of module assessment score that should be completed by the student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrieved in times of loss of log book at the end of the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer status

Level B: Assistant status

Level C: Performed part of the procedure under

supervision Level D: Performed whole procedure under

supervision Level Level E: Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient's safety is not endangered. Students of 4th and 5th year are required to achieve level C and D and in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in the Logbook

Reflective thinking and writing demands that student recognizes that every student brings valuable knowledge to every experience. It helps students therefore to recognize and clarify the important connections between what student already knows and what student is learning. It is a way of helping student to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includes the description about the following points:

1) Description of an event (one paragraph)
2) Thinking and feeling of student (one paragraph)
3) Good and bad about the experience (one paragraph)
4) How to avoid bad experiences and pursue good experiences in future (a few words to a paragraph).

The whole reflection document should be about between 200-300 words

Contents of clinical rotations

In 4th year, the MBBS students are rotated in following departments in groups of about

…...........students:

1) Ophthalmology
2) ENT
3) Gynecology & Obstetrics
4) Pediatrics
5) Medicine and Allied Departments
6) Surgery and Allied Departments
7) Skills laboratory

In the next sections, a list of competencies, level of achievement, professionalism attributes and supervisor`s observations / approval with dates are mentioned.

WAYS OF TEACHING AND LEARNING IN Ophthalmology

Locations For Learning

- Lecture hall
- OPD clinics
- Ward
- Operation theatre

Introduction to ENT

Category	Date	Name of the teacher
Introduction to ENT		
History Taking		
Examination of Ear		
Examination of Nose		
Examination of Throat		

1. OPD cases worked up during ENT posting

S. No.	Date	Name of Patient	Age / Sex	Diagnosis

2. Operative procedures observed during ENT posting

S. No.	Date	Operative Procedure	Sign of surgeon

3. Number of ENT examinations performed during ENT posting

Name of Examination	Total numbers performed
Anterior Rhinoscopy	
Posterior Rhinoscopy	
Oral Examination	
Otological Examination	
Indirect Laryngoscopy	
Neck Examination	

4. ENT Instruments seen and discussed during posting

S. No.	Instruments	Uses

5. Presentations attended during ENT posting

S. No.	Presenter	Topic	Date

Skills laboratory learning in ENT

S. No	Date	Competencies	Level					Supervisor's comments	Signature
			A	**B**	**C**	**D**	**E**		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

A: Observer status

B. Assistant Status

C. Performed part of the procedure under supervision
D, Performed whole procedure under supervision

E. Independent Performance

Details of other activities in ENT

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in Ophthalmology	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)		
End of the ward assessment	Marks:__________out of ______________	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students in ENT

(To be filled by the supervisor)

<table>
<tr><th rowspan="2">S. No</th><th rowspan="2">Statement</th><th colspan="4">Supervisor comments</th></tr>
<tr><th>Yes</th><th>No</th><th colspan="2">Any other point</th></tr>
<tr><td>1</td><td>Was polite with patients, nurses, paramedical staff, seniors and colleagues</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>2</td><td>Was ready to take responsibility</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>3</td><td>Kept calm in difficult situations</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>4</td><td>Maintained an appropriate appearance / dress</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>5</td><td>Avoided derogatory remarks in the unit</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>6</td><td>Presentation skills were up to the mark</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>7</td><td>Total attendance</td><td></td><td>Out of=</td><td colspan="2"></td></tr>
<tr><td rowspan="2">7</td><td rowspan="2">Overall assessment of professional conduct</td><td colspan="2">A:
High</td><td>B:
Moderate</td><td>C:
Low</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
</table>

Other academic and co-curricular activities in ENT

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

***The student can paste photocopies of certificates of presentations on this**

List of certificates of participation in other academic and co-curricular activities* in ENT

S. No	Name of activity / society / other	Position	From --- to (date)	Signature of organizer / in-charge

***Student can paste the proof / certificate / office order of the activities / events**

Evaluation / Assessment Chart in ENT

S. #	Date	Duration	Activity	Performance	Assessed By	Student Sign	Teachers Sign

For student affairs / examination section

Details of marks of internal assessments in ENT

<table>
<tr><th>S. No</th><th>Assessment module</th><th>Marks obtained</th><th>Total mark s</th><th>MCQ</th><th>SAQ</th><th>OSCE / viva / practical</th><th>%age</th><th>Pass / Fail</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Total marks of all modules</td><td colspan="7"></td></tr>
<tr><td></td><td>Total marks of log book</td><td colspan="4"></td><td colspan="3">Out of: 50</td></tr>
<tr><td></td><td>%age</td><td colspan="7"></td></tr>
</table>

Deputy / Controller of examination

Sign______________________

Director Medical Education

Sign

Liaquat Institute of Medical & Health Sciences, (LIMHS), Thatta, Sindh, Pakistan

STUDENT LOG BOOK

THIRD PROFESSIONAL

(Fourth Year) MBBS

Ear Nose & Throat (ENT)

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

Info of the student

Name of the student:

Father`s name:

Class:

Year of admission into LIMHS:

Address:

Contact no. of student:

Contact no. of father / guardian:

Email:

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

Contents

Info of the student	3
Table of content	5
Message from Vice Chancellor (VC) LUMHS	7
Message from Pro VC LIMHS & Administrative and Academic head of LIMHS	8
Purpose of Log Book	9
Clinical Exposure	10
How to use this Log book	11
Method of writing Reflection in logbook	12
Contents of clinical rotations	13
Ways of teaching and learning in ENT Location of learning 14 Introduction to ENT `4 OPD Cases Worked up during posting 15 Operative procedures observed during posting 16 ENT examination performed during posting 17 ENT instruments seen and discussed during posting 18 Presentation attended during posting 19	14-19
Skill Lab in ENT	20
Details of other activities in ENT	21
Comments about professionalism and behaviors of students in ENT	22
Other academic and co-curricular activities in Ophthalmology	23
List of certificates of participation in other academic and co-curricular activities in ENT	24
Evaluation / Assessment Chart ENT	25
For student affairs / examination section ENT	26

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

MESSAGE FROM VICE CHANCELLOR, LUMHS

Liaquat Institute of Medical & Health Sciences, Thatta is a constituent Institute of Liaquat University of Medical and Health Sciences (LUMHS) Jamshoro, Sindh, Pakistan. It has been established with the intention to educate the male candidates to fill the gap of male medical graduate serving the rural areas in Sindh as females are reluctant to serve the rural population despite of their increasing ratio in admission in medical Institutes in Sindh comparing to male candidates.

LIMHS aims to provide quality education as per the guidelines of Pakistan Medical Commission (PM&DC) formerly called as Pakistan Medical and Dental Council (PM&DC) and Higher Education Commission (HEC) Pakistan under the umbrella of LIMHS. LIMHS followed the updated curriculum of LIMHS being a constituent institute of LIMHS but intends to bring innovation in its implementation regarding teaching/learning and assessment methods. Furthermore, it implements &started integrated modular hybrid curriculum from third batch.

The updated integrated modular hybrid curriculum covers the credit hours filling of log books prescribed by the PM&DC and HEC.

I believe the graduate of LIMHS will be competent to cater the healthcare needs of community.

Professor Dr. Ikram din Ujjan

Vice Chancellor, LUMHS

Message from Administrative and Academic head

of LIMHS

The observation and assessment of performance of medical students is an integral part of curriculum. It can be accomplished by different modalities of assessments. Similarly, exposing the students to different clinical activities during the undergraduate medical training is essential. Supervising these activities is mandatory. For that purpose, keeping record of these events is important for student's evaluation and inclusion of these activities in grading student`s performance. Logbooks system is in use for many decades in the field of medicine throughout the world, and has some weaknesses like falsification of data, but still it is considered to be a useful checklist in assessing the performance of students and record keeping of different activities.

For this purpose, the Liaquat Institute of Medical & Health Sciences, Thatta is introducing the LOG BOOK for students of 4th year and beyond to help the students as well as the faculty in streamlining the teaching, assessment and certification of student`s performance. This activity will ensure structuring and recording student`s activities during their clinical rotations based on the learning objectives assigned, and will help the faculty in assessing student`s performance. The logbook system will be converted to a portfolio system in future.

Liaquat Institute of Medical & Health Sciences, Thatta
Administrative and Academic Head LIMHS

Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an objective evidence of assessment of student and evaluation of the overall performance of students. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection has been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Principal

Liaquat Institute of Medical & Health Sciences, Thatta

Clinical Exposure

Clinical exposure is one of the integral parts of undergraduate medical education that usually start at 3rd year. However, in contemporary programs, rotations in clinical activities starts right at the start of training called as an early clinical exposure as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into clinical environment. This exposure should be preceded by skill laboratory training, and should be gradual. It has to be according to the learning objectives defined in the curriculum.

The objectives of these rotations include:

1) Application of concepts in real life situations which is being presented in lectures, books and other reading materials
2) Acquisition of clinical skills relevant to the level and understanding of students
3) Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4) Developing communication skills, counseling skills, patient management skills, team work, timemanagement skills, critical thinking skills, decision making skills and interdepartmental collaboration at workplace
5) Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above-mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

Director Medical Education

Liaquat Institute of Medical &

Health Sciences, Thatta

How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted during rotation, record of history taking, field visits, assessment marks and student`s reflection. The 3rd part includes attributes of communication skills and professionalism. All students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, record of research publications, co- curricular activities and many others. At the end, there is record of student's attendance, and end of module assessment score that should be completed by the student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrieved in times of loss of log book at the end of the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer status

Level B: Assistant status

Level C: Performed part of the procedure under

supervision Level D: Performed whole procedure under

supervision Level Level E: Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient's safety is not endangered. Students of 4th and 5th year are required to achieve level C and D and in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in the Logbook

Reflective thinking and writing demands that student recognizes that every student brings valuable knowledge to every experience. It helps students therefore to recognize and clarify the important connections between what student already knows and what student is learning. It is a way of helping student to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includes the description about the following points:

1) Description of an event (one paragraph)
2) Thinking and feeling of student (one paragraph)
3) Good and bad about the experience (one paragraph)
4) How to avoid bad experiences and pursue good experiences in future (a few words to a paragraph).

The whole reflection document should be about between 200-300 words

Contents of clinical rotations

In 4th year, the MBBS students are rotated in following departments in groups of about

……………students:

1) Ophthalmology
2) ENT
3) Gynecology & Obstetrics
4) Pediatrics
5) Medicine and Allied Departments
6) Surgery and Allied Departments
7) Skills laboratory

In the next sections, a list of competencies, level of achievement, professionalism attributes and supervisor`s observations / approval with dates are mentioned.

WAYS OF TEACHING AND LEARNING IN Ophthalmology

Locations For Learning

- Lecture hall
- OPD clinics
- Ward
- Operation theatre

Introduction to ENT

Category	Date	Name of the teacher
Introduction to ENT		
History Taking		
Examination of Ear		
Examination of Nose		
Examination of Throat		

1. OPD cases worked up during ENT posting

S. No.	Date	Name of Patient	Age / Sex	Diagnosis

2. Operative procedures observed during ENT posting

S. No.	Date	Operative Procedure	Sign of surgeon

3. Number of ENT examinations performed during ENT posting

Name of Examination	Total numbers performed
Anterior Rhinoscopy	
Posterior Rhinoscopy	
Oral Examination	
Otological Examination	
Indirect Laryngoscopy	
Neck Examination	

4. ENT Instruments seen and discussed during posting

S. No.	Instruments	Uses

5. Presentations attended during ENT posting

S. No.	Presenter	Topic	Date

Skills laboratory learning in ENT

S. No	Date	Competencies	Level					Supervisor's comments	Signature
			A	**B**	**C**	**D**	**E**		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

A: Observer status

B. Assistant Status

C. Performed part of the procedure under supervision
D, Performed whole procedure under supervision

E. Independent Performance

Details of other activities in ENT

Competencies	Details	Supervisor`s comments / signature
Introduction to Common symptoms and diseases in Ophthalmology	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)		
End of the ward assessment	Marks:__________out of ______________	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students in ENT

(To be filled by the supervisor)

<table>
<tr><th rowspan="2">S. No</th><th rowspan="2">Statement</th><th colspan="4">Supervisor comments</th></tr>
<tr><th>Yes</th><th>No</th><th colspan="2">Any other point</th></tr>
<tr><td>1</td><td>Was polite with patients, nurses, paramedical staff, seniors and colleagues</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>2</td><td>Was ready to take responsibility</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>3</td><td>Kept calm in difficult situations</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>4</td><td>Maintained an appropriate appearance / dress</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>5</td><td>Avoided derogatory remarks in the unit</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>6</td><td>Presentation skills were up to the mark</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>7</td><td>Total attendance</td><td></td><td>Out of=</td><td colspan="2"></td></tr>
<tr><td rowspan="2">7</td><td rowspan="2">Overall assessment of professional conduct</td><td colspan="2">A:
High</td><td>B:
Moderate</td><td>C:
Low</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
</table>

Other academic and co-curricular activities in ENT

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

***The student can paste photocopies of certificates of presentations on this**

List of certificates of participation in other academic and co-curricular activities* in ENT

S. No	Name of activity / society / other	Position	From --- to (date)	Signature of organizer / in-charge

***Student can paste the proof / certificate / office order of the activities / events**

Evaluation / Assessment Chart in ENT

S. #	Date	Duration	Activity	Performance	Assessed By	Student Sign	Teachers Sign

For student affairs / examination section

Details of marks of internal assessments in ENT

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book				Out of: 50			
	%age							

Deputy / Controller of examination **Director Medical Education**

Sign______________________ **Sign**

27

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES (LIMHS), Thatta, Sindh, Pakistan

STUDENT LOG BOOK

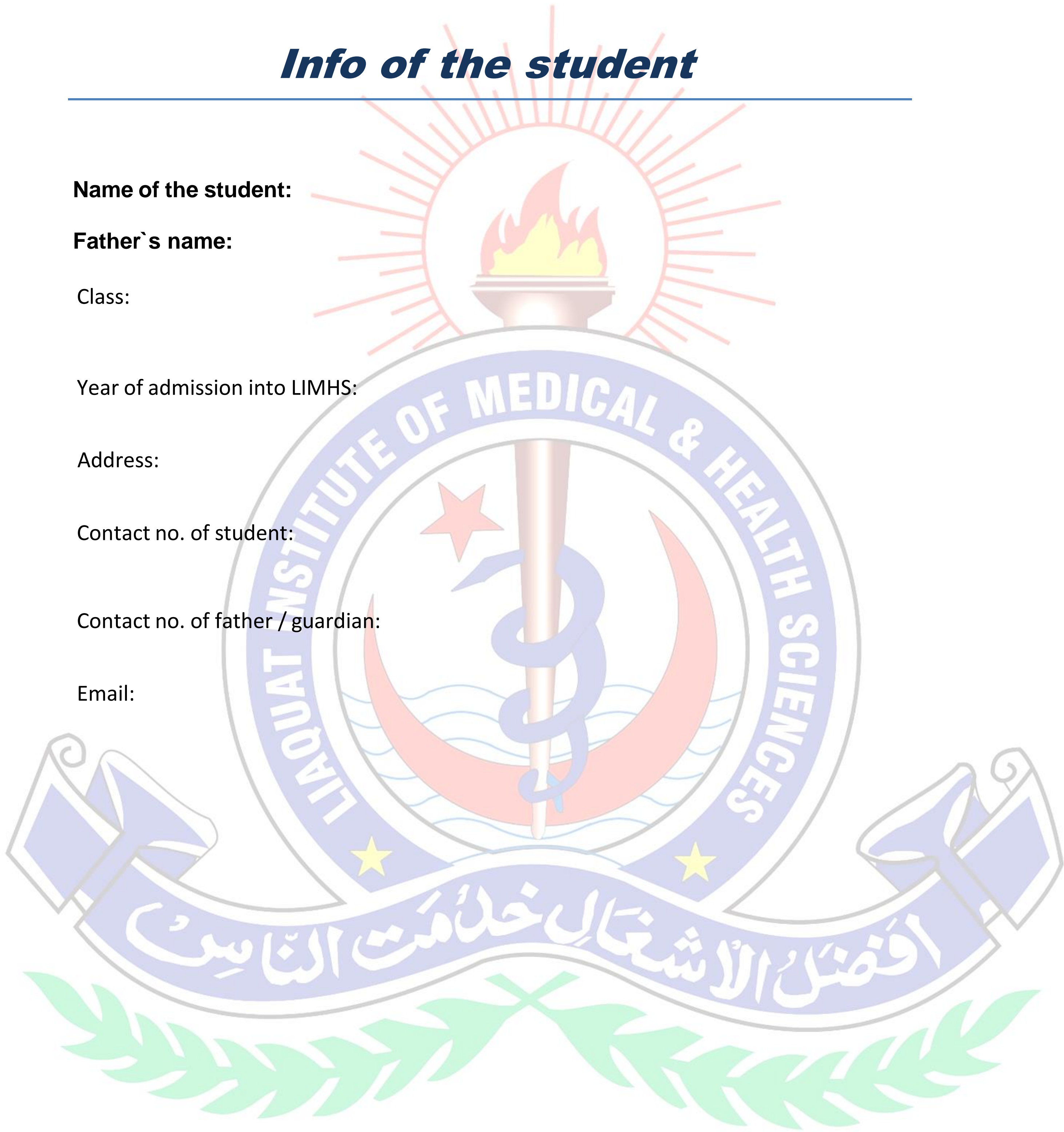
THIRD PROFESSIONAL

(Fourth Year) MBBS

Ophthalmology

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

Info of the student



Name of the student:

Father`s name:

Class:

Year of admission into LIMHS:

Address:

Contact no. of student:

Contact no. of father / guardian:

Email:

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

Contents

Info of the student	3
Table of content	5
Message from Vice Chancellor (VC) LUMHS	7
Message from Pro VC LUMHS & Administrative and Academic head of LIMHS	8
Purpose of Log Book	9
Clinical Exposure	10
How to use this Log book	11
Method of writing Reflection in logbook	12
Contents of clinical rotations	13
Ways of teaching and learning in Ophthalmology	14
Learning objectives for key conditions Ophthalmology	15
Learning objectives in Ophthalmology Clinics	17
Skill Lab in Ophthalmology	18
Details of other activities in Ophthalmology	19
Comments about professionalism and behaviors of students in Ophthalmology	20
Other academic and co-curricular activities in Ophthalmology	21
List of certificates of participation in other academic and co-curricular activities in Ophthalmology	22
Evaluation / Assessment Chart Ophthalmology	23
For student affairs / examination section Ophthalmology	24

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES
افضل الاشغال خدمت الناس

MESSAGE FROM VICE CHANCELLOR, LUMHS

Liaquat Institute of Medical and Health Sciences (LIMHS) is a constituent college of Liaquat Institute of Medical and Health Sciences (LUMHS) Jamshoro, Sindh, Pakistan. It has been established with the intention to educate the male candidates to fill the gap of malemedical graduate serving the rural areas in Sindh as females are reluctant to serve the rural population despite of their increasing ratio in admission in medical collegesin Sindh comparing to male candidates.

LIMHS aims to provide quality education as per the guidelines of Pakistan MedicalCommission (PMC) formerly called as Pakistan Medical and Dental Council (PMDC)and Higher Education Commission (HEC) Pakistan under the umbrella of LUMHS. LIMHS followed the updated curriculum of LUMHS being a constituent institute of LUMHS but intends to bring innovation in its Implementation regardingteaching/learning and assessment methods. Furthermore, it implements &startedintegrated modular hybrid curriculum from third batch.

The updated integrated modular hybrid curriculum covers the credit hours filling of log books prescribed by the PMC and HEC.

I believe the graduate of LIMHS will be competent to cater the healthcare needs of community.

Professor Dr. Ikram din Ujjan

Vice Chancellor, LUMHS

Message from Administrative and Academic head of LIMHS

The observation and assessment of performance of medical students is an integral part of curriculum. It can be accomplished by different modalities of assessments. Similarly, exposing the students to different clinicalactivities during the undergraduate medical training is essential. Supervising these activities is mandatory. For that purpose, keeping record of these events is important for student's evaluation and inclusion of these activities in grading student`s performance. Logbooks system is in use for many decades in the field of medicine throughout the world, and has some weaknesses like falsification of data, but still it is considered to be a useful checklist in assessing the performance of students and record keeping of different activities.

For this purpose, the Liaquat Institute of Medical and Health Sciences is introducing the LOG BOOK for students of 4th year and beyondto help the students as well as the faculty in streamlining the teaching, assessment and certification of student`s performance. This activity will ensure structuring and recording student`s activities during their clinical rotations based on the learning objectives assigned, and will help the faculty in assessing student`s performance. The logbook system will be converted to a portfolio system in future.

Liaquat Institute of Medical and Health Sciences
Administrative and Academic Head LIMHS

Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an objective evidence of assessment of student and evaluation of the overall performance of students. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection has been added to this log book with the intent to convert this document into a reflective portfolio in future. Record of these activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Principal

Liaquat Institute of Medical and Health Sciences

Clinical Exposure

Clinical exposure is one of the integral parts of undergraduate medical education that usually start at 3rd year. However, in contemporary programs, rotations in clinical activities starts right at the start of training called as an early clinical exposure as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into clinical environment. This exposure should be preceded by skill laboratory training, and should be gradual. It has to be according to the learning objectives defined in the curriculum.

The objectives of these rotations include:

1) Application of concepts in real life situations which is being presented in lectures, books and other reading materials
2) Acquisition of clinical skills relevant to the level and understanding of students
3) Understanding the concepts of patient safety, hospital organization and roles of doctors in clinical situations
4) Developing communication skills, counseling skills, patient management skills, team work, time management skills, critical thinking skills, decision making skills and interdepartmental collaboration at workplace
5) Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above-mentioned purposes, but include other activities and accomplishments of students like research, presentations and record of participation in co-curricular activities.

Director Medical Education
Liaquat Institute of Medical
and Health Sciences

How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit. Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of students, 2nd part relates to other activities like knowledge imparted during rotation, record of history taking, field visits, assessment marks and student`s reflection. The 3rd part includes attributes of communication skills and professionalism. All students are required to dully attest each activity in the log book. The log book also includes record of activities not related to clinical rotations. Those activities include, presentation skills, recordof research publications, co- curricular activities and many others. At the end, there is recordof student's attendance, and end of module assessment score that should be completed bythe student affairs / examination section. This log book will have an important weightage infinal assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to makea copy of all these activities so that it can be retrieved in times of loss of log book at the endof the year. It is important to mention that level of competence has been shown in individualrotations as follows:

Level A: Observer

statusLevel B:

Assistant status

Level C: Performed part of the procedure under

supervision Level D: Performed whole procedure under

supervision LevelLevel E: Independent performance

Third year students will achieve only level A and B in most of the situations except a few where patient's safety is not endangered. Students of 4th and 5th year are required to achievelevel C and D and in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in the Logbook

Reflective thinking and writing demands that student recognizes that every student brings valuable knowledge to every experience. It helps students therefore to recognize and clarifythe important connections between what student already knows and what student islearning. It is a way of helping student to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includesthe description about the following points:

1) Description of an event (one paragraph)
2) Thinking and feeling of student (one paragraph)
3) Good and bad about the experience (one paragraph)
4) How to avoid bad experiences and pursue good experiences in future (a few words to a paragraph).

The whole reflection document should be about between 200-300 words

Contents of clinical rotations

In 4th year, the MBBS students are rotated in following departments in groups of about

……………. students:

1) Ophthalmology
2) ENT
3) Gynecology & Obstetrics
4) Pediatrics
5) Medicine and Allied Departments
6) Surgery and Allied Departments
7) Skills laboratory

In the next sections, a list of competencies, level of achievement, professionalismattributes and supervisor`s observations / approval with dates are mentioned.

WAYS OF TEACHING AND LEARNING IN Ophthalmology

Locations For Learning

- Lecture hall
- OPD clinics
- Ward
- Operation theatre

Learning in Operation Theater

Students should learn about:

- Sterilizatio

nObserve the
case of

- Canalization surgery
- Excision of pterygium
- Extra Capsular Cataract Surgery
- Phacoemulsification Surgery
- Dacryocystorhinostomy

LEARNING OBJECTIVES FOR KEY CONDITIONS in Ophthalmology

Abnormalities of lids

- Chalazion
- Stye
- Blepharitis
- Ptosis

Abnormalities of lacrimal system

- Acute Dacryocystitis
- Chronic Dacryocystitis
- Nasolacrimal duct blockage

Conjunctiva

- Conjunctivitis
- Pterygium
- Pingucula
- Conjunctival cyst

Differential diagnosis of Red eyes cornea

- Corneal ulcers
- Keartoconus
- Corneal degenerations

Sclera

- Episcleritis
- Anterior Scleritis
- Posterior scleritis

Pupil

- Pupillary reactions
- Pupillary abnormalities

Glaucoma

- Acute angle closure glaucoma
- Chronic open angle glaucoma

Lens abnormalities

- Congenital cataract
- Senile Cataract
- Secondary cataract
- Ectopia lentis

Endophthalmitis

- Acute endophthalmitis
- Chronic endophthalmitis

Uveitis

- Anterior uveitis
- Posterior uveitis
- Acute and chronic uveitis

Squint

- Esotropia
- Exotropia

Macular diseases

- Age related macular diseases
- Central serious chorioretinopathy

Optic nerve diseases

- Optic neuritis
- Papilloedema

Diabetic retinopathy

Hypertensive

retinopathy

Trauma of eye ball and orbit

Learning objectives in Ophthalmology Clinics

A. **History Taking**

1. Particular of the patients
2. Chief complaints
3. History of present illness
4. Past history
5. Drug History
6. History of allergy
7. Personal history
8. Family history

B. **Examination**

i. visual acuity
ii. color vision
iii. Tests of optic nerve functions
iv. Tests of macular functions
v. Torch examination
vi. Examination of orbit
vii. Examination of lacrimal system
viii. Examination of anterior chamber with torch
ix. Slit lamp examination

C. **Overview of Instruments used in Ophthalmic clinics**

- Direct ophthalmoscope
- Indirect ophthalmoscope
- Slit lamp

D. **Different diagnostic lenses used in ocular examination**

E. **Common medications used during ocular examination**

F. **Provisional Diagnosis/Differential Diagnosis**

G. **Drugs used for common conditions**

H. **When to refer patient to specialist**

Skills laboratory

S. No	Date	Competencies	Level					Supervisor's comments	Signature
			A	**B**	**C**	**D**	**E**		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

A: Observer status

B. Assistant Status

C. Performed part of the procedure under supervision
D, Performed whole procedure under supervision

E. Independent Performance

Details of other activities in Ophthalmology

Competencies	Details	Supervisor` scomments / signature
Introduction to Common symptoms and diseases in Ophthalmology	Presented by:	
Details of history and examination * You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol	*Mention 3 symptoms and system involved 1) 2) 3)	
Case Based Discussion (CBD)		
End of the ward assessment	Marks:__________out of ______________	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students in Ophthalmology

(To be filled by the supervisor)

<table>
<tr><th rowspan="2">S. No</th><th rowspan="2">Statement</th><th colspan="4">Supervisor comments</th></tr>
<tr><th>Yes</th><th>No</th><th colspan="2">Any other point</th></tr>
<tr><td>1</td><td>Was polite with patients, nurses, paramedical staff, seniors and colleagues</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>2</td><td>Was ready to take responsibility</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>3</td><td>Kept calm in difficult situations</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>4</td><td>Maintained an appropriate appearance / dress</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>5</td><td>Avoided derogatory remarks in the unit</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>6</td><td>Presentation skills were up to the mark</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>7</td><td>Total attendance</td><td></td><td>Out of=</td><td colspan="2"></td></tr>
<tr><td rowspan="2">7</td><td rowspan="2">Overall assessment of professional conduct</td><td colspan="2">A:
High</td><td>B:
Moderate</td><td>C:
Low</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
</table>

Other academic and co-curricular activities In Ophthalmology

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

***The student can paste photocopies of certificates of presentations on this**

List of certificates of participation in other academic and co-curricular activities* in Ophthalmology

S. No	Name of activity / society / other	Position	From --- to (date)	Signature of organizer / in-charge

***Student can paste the proof / certificate / office order of the activities / events**

Evaluation / Assessment Chart in Ophthalmology

S. #	Date	Duration	Activity	Performance	Assessed By	Student Sign	Teachers Sign

For student affairs / examination section

Details of marks of internal assessments in Ophthalmology

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marksof all modules							
	Total marks of log book				Out of: 50			
	%age							

Deputy / Controller of examination **Director Medical**
Education

Sign______________________ **Sign**

LOG BOOK

For 3rd --- Final Year MBBS

DEPARTMENT OF SURGERY

LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCES, THATTA

BIO DATA

Name:____

Group______________________**Class Roll No**__________

Examination Seat No.______________________________

Institute Enrollment No.____________________________

Passport Size Picture

Clinical Academic Year & Departments	Internal Evaluation	Attendance	Cumulative Marks	Signature of Teacher
Department of General Surgery				
Department of Orthopedic Surgery				
Department of Plastic Surgery				
Department of Radiology				
Skill Lab				
Third Year				
Final Year				

SIGNATURE OF PRINCIPAL LIAQUAT INSTITUTE OF MEDICAL & HEALTH SCIENCE, THATTA

Contents

	Page#
Purpose of Log Book	01
Objectives of clinical rotations	02
How to use this Log book	03
Method of writing Reflection in logbook	04
Contents of clinical rotations	05
Ways of teaching and learning in surgery	06
Learning objectives for key conditions	07
Department of General Surgery	08
Summarization of history	10
Skill Lab	11
Details of other activities	12
Details of other activities	13
Comments about professionalism and behaviors of students	14
Other academic and co-curricular activities	15
List of certificates of participation in other academic and co-curricular activities	16
Evaluation / Assessment Chart	17
For student affairs / examination section	18

Purpose of Logbook

This Logbook is intended to develop, record, assess and certify student`s activities during clinical and other rotations. These activities are based on the learning objectives defined in the curriculum document. Recording and certification of clinical and educational activities provides an objective evidence during assessment of student and evaluation of the overall performance of institution and curriculum. Adding reflection by students during activity log enhances the academic performance of students. A section of reflection has been added to this log book with the intent to convert this document into a reflective portfolio in future. Record ofthese activities will ultimately improve patient safety, as the students will be aware of their limits, duties and responsibilities.

Objectives of clinical rotations

Clinical rotation is one of the integral parts of undergraduate medical students that usually start

at 3rd year. However, in contemporary programs, rotations in clinical activities starts right at the start of training as part of integration attempt. This document will be extended in future amongst students of early years. Clinical skills learning requires the exposure of students into

clinical environment. This exposure should be preceded by skill laboratory training, and should

be gradual. It has to be according to the learning objectives defined in the curriculum.

The objectives of these rotations include:

1) Application of concepts in real life situations which is being presented in lectures,books and other reading materials
2) Acquisition of clinical skills relevant to the level and understanding of students
3) Understanding the concepts of patient safety, hospital organization and roles of doctorsin clinical situations
4) Developing communication skills, patient management skills, team work, timemanagement skills, and interdepartmental collaboration at workplace
5) Developing and enhancing professionalism in medical students

It is important to mention that this logbook is not only intended for the above-mentioned purposes,but include other activities and accomplishments of students like research, presentations and recordof participation in co-curricular activities

How to use this Logbook

The log book is divided into sections according to the specialties and units whom the students visit.Rotation in each unit is represented into 3 parts; 1st part represents clinical skills required of

students, 2nd part relates to other activities like knowledge student`s reflection. The 3rd part

includes attributes of communication skills and professionalism. All the students are required to dully attest each activity in the log book. The log book also includes record of activities not relatedto clinical rotations. Those activities include, presentation skills, record of research publications, co- curricular activities and many others. At the end, there is record of student's attendance, and end of module assessment marks that should be completed by the student affairs / examination section. This log book will have an important weightage in final assessments of students and students who fail to present this log book in final assessment will not be considered for promotion to next class. Students are advised to make a copy of all these activities so that it can be retrievedin times of loss of log book at the end of the year. It is important to mention that level of competence has been shown in individual rotations as follows:

Level A: Observer

statusLevel B:

Assistant status

Level C: Performed part of the procedure under

supervisionLevel D: Performed whole procedure

under supervision Level E: Independent

performance

Third year students will achieve only level A and B in most of the situations except a few where

patient safety is not endangered. Students of 4th and 5th year are required to achieve

level C and Dand in some cases level E (where patient safety is not endangered).

Methods of writing Reflection in theLogbook

Reflective thinking and writing demands that you recognize that you bring valuable knowledgeto every experience. It helps you therefore to recognize and clarify the important connections between what you already know and what you are learning. It is a way of helping you to become an active, aware and critical thinker and learner.

It is mandatory for students to write about his / her experience and reflective thinking of clinical rotation in each unit in the space given in logbook. The reflective document includes the description about the following points:

1) Description of an event (one paragraph)
2) Thinking and feeling of student (one paragraph)
3) Good and bad about the experience (one paragraph)
4) How to avoid bad experiences and pursue good experiences in future (a fewwords to a paragraph).

The whole reflection document should be about between 200-300 words

Contents of clinical rotations

In 3rd year, the MBBS students are rotated in following departments in groups of about 10 students:

S. No	Departments
01	Department of General Surgery
02	Department of Orthopedic Surgery
03	Department of Plastic Surgery
04	Department of Radiology
05	Skill Lab

WAYS OF TEACHING AND LEARNING IN SURGERY

Locations For Learning

- Timetable – planned to allow time in the operating theatre, in clinic and on the ward
- Operating theatre
- Day case surgery
- Outpatient clinics (general)
- Outpatient clinics (specialized)
- Other clinics: DVT clinic, breast clinic, pain management, others
- Seeing emergency referrals/attendances (in the emergency unit or surgical assessment unit)
- Preoperative assessment clinic – fitness for surgery
- Surgical wards
- Intensive Care Unit
- Multidisciplinary team (MDT) meetings
- Skill Lab

Useful Ways of Learning

- Planned opportunities to follow patients through the system
- Ward rounds
- Participation in clinics
- Participation in surgery in the operating theatre
- Post-operative ward cover
- Planning of follow-up, interaction with GP and community care
- Planning administration paper work
- Case based discussion
- Discussion of tumour and other guidelines
- Team-based working
- Spending time or teaching session with allied health professionals or surgical carepractitioners
- Tutorials and one-to-one teaching
- Simulation
- Audits

LEARNING OBJECTIVES FOR KEY CONDITIONS

1. Abdominal Pain
2. Abdominal lump
3. Change in the Bowel Habit / rectal bleeding
4. Hematemesis
5. Dysphagia.
6. Jaundice
7. Lump and pain in groin
8. Lumps scrotum / scrotal pain
9. Pain loin
10. Urinary out flow obstruction
11. Hematuria
12. Leg Ulceration
13. Painful Limb
14. Breast Lumps and nipple discharge
15. Lumps in Neck
16. Peripheral nerve injuries / palsies
17. Consent for surgery including mental capacity
18. Caring for the post- operative patients, including nutrition, enhanced recovery and critical illpatient, advise re return to activities.
19. Understanding wound healing
20. Trauma
21. Sepsis and infection
22. Surgical safety
23. Caring for the patient before and after surgery including fitness
    a. Fluid optimization
    b. Nutritional Optimization
    c. Safety issues and booking patients for surgery
    d. Antibiotic / thromboprophylaxis
    e. Pre- operative assessment / investigations

General Surgery

Surgical unit: I / II

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature	
			A	B	C	D	E		
1		**History taking from patient**							
		surgical unit							
2		**General physical examination**							
		❑ Pulse							
		❑ BP							
		❑ Temperature							
		❑ Respiratory rate							
		❑ Anaemia							
		❑ Jaundice							
		❑ Others (specify)							
3		**Systemic examination**							
1		Skin and soft tissue							
2		General scheme of case taking							
3		A few special symptoms and signs							
4		Examination of a lump or a swelling							
5		Examination of Ulcer							
6		Examination of sinus and fistula							
7		Examination of peripheral vascular disease and gangrene							
8		Examination of varicose veins							
9		Examination of lymphatic system							
10		Examination of peripheral nerve lesion							
11		Disease of muscles, tendons and fasciae							
12		Examination of disease of bone							
13		Examination of bone and joint injuries							
14		Examination of injuries about individual joints							
15		Examination of pathological joints							

16			Examination of individual joint pathologies						
17			Examination of head injuries						
18			Investigation of intracranial space – occupying lesions						
19			Examination of spinal injuries						
20			Examination of spinal abnormalities						
21			Examination of the hand						
22			Examination of the foot						
23			Examination of the head and face						
24			Examination of jaws and temporomandibular joint						
25			Examination of the palate, cheek, tongue and floor of the mouth						
26			Examination of salivary glands						
27			Examination of neck						
28			Examination of the thyroid gland						
29			Examination of injuries of chest						
30			Examination of disease of the chest						
31			Examination of breast						
32			Examination of case of dysphagia						
33			Examination of abdominal injuries						
34			Examination of acute abdomen						
35			Examination of chronic abdominal condition						
36			Examination of abdominal lump						
37			Examination of Rectal case						
38			Examination of a urinary case						
39			Examination of a case of hernia						
40			Examination of a swelling in the inguinoscrotal region						
41			Examination of male external genitalia						

SUMMARIZATION OF HISTORY

1. Particular of the patients
2. Chief complaints
3. History of present illness
4. Past history
5. Drug History
6. History of allergy
7. Personal history
8. Family history
9. History of immunization

A. Physical Examination

B. Systemic / Local Examination

C. Provisional Diagnosis

D. Investigations

Skills laboratory

S. No	Date	Competencies	Level A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					Supervisor`s comments / signature
			A	B	C	D	E	
1		IV line insertion						
2		Nasogastric tube insertion						
3		Foley`s catheter insertion						
4		Fluid aspirations						
		❑ Ascitic:						
		❑ Pleural:						
		❑ CSF:						
		❑ Joint fluid:						
		❑ Others (specify)						
5		CPR						
6		Endotracheal intubation						
7		DRE Others						

Details of other activities

<table>
<tr><th>Competencies</th><th>Details</th><th>Supervisor`s comments / signature</th></tr>
<tr><td>Introduction to Common symptoms and diseases in general surgery</td><td>Presented by:</td><td></td></tr>
<tr><td>Details of history and examination
* You have to write 2 histories in each ward along with examination, provisional diagnosis, relevant investigations, results of procedures, final diagnosis, treatment and follow-up protocol</td><td>*Mention 3 symptoms and system involved
1)
2)
3)</td><td></td></tr>
<tr><td>Case Based Discussion (CBD)</td><td></td><td></td></tr>
<tr><td>End of the ward assessment</td><td>Marks:__________out of _____________</td><td></td></tr>
<tr><td colspan="2">Any other event that you want to record during your stay in the unit (provide details)</td><td></td></tr>
<tr><td colspan="2">Reflection by student</td><td></td></tr>
</table>

Details of other activities

Competencies	Details	Supervisor`s comments / signature
Skill lab.	Presented by:	
BLS workshop	Conducted by:	
Other activities	prepare the patient for and know the procedure of doing X-Ray , chest, abdomen, KUB, barium studies, ultrasound, CT scan, MRI and others	
Any other event that you want to record during your stay in the unit (provide details)		
Reflection by student		

Comments about professionalism and behaviors of students
(To be filled by the supervisor)

<table>
<tr><th rowspan="2">S. No</th><th rowspan="2">Statement</th><th colspan="4">Supervisor comments</th></tr>
<tr><th>Yes</th><th>No</th><th colspan="2">Any other point</th></tr>
<tr><td>1</td><td>Was polite with patients, nurses, paramedical staff, seniors and colleagues</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>2</td><td>Was ready to take responsibility</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>3</td><td>Kept calm in difficult situations</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>4</td><td>Maintained an appropriate appearance / dress</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>5</td><td>Avoided derogatory remarks in the unit</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>6</td><td>Presentation skills were up to the mark</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>7</td><td>Total attendance</td><td></td><td>Out of=</td><td colspan="2"></td></tr>
<tr><td rowspan="2">7</td><td rowspan="2">Overall assessment of professional conduct</td><td colspan="2">A:
High</td><td>B:
Moderate</td><td>C:
Low</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
</table>

Other academic and co-curricular activities

List of presentations*

S. No	Title of presentation / lecture	Venue	Date	Signature of supervisor / organizer

*The student can paste photocopies of certificates of presentations on this page

List of certificates of participation in other academic and co-curricular activities*

S. No	Name of activity / society / other	Position	From ---- to (date)	Signature of organizer / incharge

***Student can paste the proof / certificate / office order of the activities / events**

Evaluation / Assessment Chart

S. #	Date	Duration	Activity	Performance	Assessed By	Student Sign	Teachers Sign
			Department of General Surgery				
			Department of Orthopedic Surgery				
			Department of Plastic Surgery				
			Department of Radiology				
			Skill Lab				

For student affairs / examination section

Details of marks of internal assessments

S. No	Assessment module	Marks obtained	Total marks	MCQ	SAQ	OSCE / viva / practical	%age	Pass / Fail
	Total marks of all modules							
	Total marks of log book							
	%age							

Deputy / Controller of examination **Director Medical Education**

Sign____________________
_

Sign____________________
_