

TRACKING - FAMILY MEDICINE OBJECTIVES

Name: _____

Date: _____

In order to pass your family medicine rotation, you are required to complete each of these objectives during your family medicine rotation (1 form for the full 6 weeks). Please have a staff physician or a family medicine resident sign and date each objective when you have completed the objective. **This form must be turned in on the morning of your family medicine examination.**

	Supervisor's/ Resident's Signature	Date
Skills		
<input type="checkbox"/> 1. Administer an im or sc immunization (Obj 3.1)	_____	_____
<input type="checkbox"/> 2. Perform a Pap Smear (Obj 3.5)	_____	_____
<input type="checkbox"/> 3. Demonstrated finding common ground (Obj 4.1)	_____	_____

Patient Clinical Encounters

<input type="checkbox"/> 1. Perform a Diabetic Check-Up (Hx, PE, Mx) (Obj 2.1)	_____	_____
<input type="checkbox"/> 2. Manage a patient with either hypertension or dyslipidemia (discuss medications) (Obj 2.2)	_____	_____
<input type="checkbox"/> 3. Care for an elderly patient (Obj 2.3)	_____	_____
<input type="checkbox"/> 4. Perform a prenatal exam (Obj 2.4)	_____	_____
<input type="checkbox"/> 5. Manage a patient with either asthma or COPD (Hx, PE, Mx) (Obj. 2.5)	_____	_____
<input type="checkbox"/> 6. Conduct a history from an adult patient with depression or anxiety (assess suicidality, discuss medications, contract for safety) (Obj. 2.6)	_____	_____
<input type="checkbox"/> 7. Perform a well-baby exam (Obj 3.2)	_____	_____

8. Perform a periodic health assessment _____
 (on adult male age 50-70, identify appropriate screening for age and sex) (Obj 3.3)

9. Perform a periodic health assessment _____
 (on an adult female age 50-70, identify appropriate screening for age and sex) (Obj. 3.4)

10. Complete a history and physical exam, provide a differential diagnosis and manage the following presenting complaints on an adult or elderly patient: (You must complete 5 of the following 10) (Obj.1.1,1.2, 1.3, 1.4)

	SIGNATURE	DATE
<input type="checkbox"/> New or chronic cough		
<input type="checkbox"/> Fatigue		
<input type="checkbox"/> Low back pain		
<input type="checkbox"/> Fever		
<input type="checkbox"/> Shortness of Breath		
<input type="checkbox"/> Abdominal or Pelvic Pain		
<input type="checkbox"/> Headache		
<input type="checkbox"/> Dizziness		
<input type="checkbox"/> Chest Pain		
<input type="checkbox"/> Lower Leg Swelling		