**Student Protocol - Acute Visit**

*General Guideline:* This kind of visit focuses on an acute problem for which the patient seeks attention. Other concerns (more complex) may surface, such as need for immunizations, reassessment of unrelated chronic problem. List these concerns in the assessment portion of your write-up and outline your plans for future evaluation under Plan.

**S** = **Complaint**
- history of present illness
- location, characteristics, evolution over time (onset and duration), precipitating and alleviating factors, history of similar problems, pertinent positive and negative association symptoms for ear symptom or problem
- current medications
- allergies
- pertinent family medical history/social history

**O** = **Physical Examination** *(vital signs and relevant sections of examination)*
Physical exams need to be pertinent to the problem areas suggested by history, but remember that it is better to examine more than needed rather than to skip crucial portions of the exam.

**A** = **Diagnosis or Differential Diagnosis**

**P** = **Statement of Plan**
- treatment advised
- symptomatic relief advised
- medications prescribed
- diagnostic tests ordered/completed
- date of return or referral
- follow-up plans
- description of any diagnostic/therapeutic procedure performed in clinic
- instructions to patient, parent, spouse, family

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**Student Protocol - Behavioral Visit**

*General Guidelines:* This type of visit focuses on a psychosocial or behavioral problem that is either directly presented to the physician or is determined to be significant upon meeting with the patient. Typically, the S/O portion may be combined with this type of visit.

**S** = **Subjective Complaint** - Begin with the patient's presenting complaint and his/her chief psychological complaint or problem. Discuss the history of the present complaint (e.g., signs/symptoms, duration, previous treatments, etc). Also include significant family history, living situation, current stressors, employment, schooling, substance use, and so forth.

**O** = **Objective** - In addition to the above, provide any pertinent information obtained from the physical examination and any relevant laboratory data. Also, any psychological or screening questionnaire (e.g., Beck Depression Inventory) results should be provided in this section.

**A** = **Assessment** - List and discuss the patient's problems (both psychological and medical) including all pertinent diagnoses. If you believe the patient has a mental disorder, provide a DSM-IV diagnosis.

**P** = **Plan** - Discuss how you plan to manage or treat the patient. Include both pharmacologic and psychologic management approaches. Include how you would educate the patient and/or
Health promotion is a very important concept in ambulatory medicine and is a priority in the provision of health services to children and adults. The screening processes that are the cornerstone of preventive medicine begin during pregnancy. A goal of prenatal visits is to ensure the optimum health and well-being of mother, child, and family.

**Student Protocol**  
**Well Visit - Prenatal**

S = **Patient Inquiry** about general and particular concerns

- any particular concerns?
- nutrition (maternal, planned for child)
- elimination
- sleep
- psychosocial (parent role, family, financial, housing, work/school, child care)
- activities (general, sports, work)
- safety issues
- social history
- childbirth education (expectations, hospital, classes)
- identify risk status (teen, older, parity, income, transportation problems, isolated [no or little support], lifestyle, nutritional status
- substance abuse/smoking

O = **Physical Examination**

- vital signs
- fetal growth assessment

A = **Diagnosis** - EDC, EGA, pregnancy status

P = **Plan**

- anticipatory guidance
  - areas of parental concern
  - nutrition
  - psychosocial issues (husband/partner support, sibling(s), family)
- danger signs
- prenatal visit schedule
- screening procedures
- immunizations
- medications if prescribed
- symptomatic relief advised
- return and referral
Health promotion is a very important concept in ambulatory medicine and is a priority in the provision of health services to children. The screening processes that are the cornerstone of preventive medicine should begin during pregnancy and continue through infancy and childhood, as well as adulthood. Another goal for each child visit is "anticipatory guidance," that is providing the information that the parent will need between now and the next visit.

**S = Patient Inquiry regarding general or particular concerns**
- any particular concern?
- nutrition
- elimination
- sleep
- psychosocial (maternal-child interaction, temperament)
- development (gross motor, fine motor, language and speech, social)
- behavior
- immunization-side effects
- safety issues
- social history-family stresses (i.e., single mother, finances)

**O = Physical Examination** (includes red light reflex, strabismus check, Hirschberg's and Bruckner's test, vision and hearing, cardiac exam, hip clicks, & neurologic exam)
- growth parameters (height, weight, head circumference, with percentiles)
- vital signs

**A = Diagnosis and Differential Diagnosis** - If all is well, "well month-old infant with normal growth and development," pertinent finding in history may be mentioned, to be followed closely, such as "nutrition-mother pressured to introduce solids early" or "difficult financial situation, poor family support, needs referral to social services."

**P = Plan**
- anticipatory guidance
  - areas of parental concerns
  - nutrition
  - sleep
  - psychosocial issues: discipline, temperament
  - encouraging development: expected milestones
  - behavioral: separation, temper tantrums
  - accident prevention
- screening procedures: Hct, UA, lead screen (if at risk), TB Tine at 9-12 months
- immunization
- medications if prescribed
- return and referral
**Student Protocol**

**Well Visit - Preschooler (1-5 years)**

**S =** Patient Inquiry about general or specific concerns

- any particular concerns?
- nutrition
- elimination
- sleep
- psychosocial (parent/child interaction, autonomy, temperament, socialization, discipline)
- development (gross motor, fine motor, language and speech, social)
- behavior
- immunizations-side effects
- safety issues
- social history-family stresses

**O =** Physical Examination (includes strabismus check, visual acuity, hearing, speech)

**A =** Diagnosis and Differential Diagnosis - If all is well, "four year-old child with normal growth and development." If significant findings are found in history, they can be remarked here (Family history shows increased cardiovascular risk; cholesterol screen needed at four years).

**P =** Plan

- anticipatory guidance
  - areas of parental concerns
  - nutrition
  - sleep
  - psychosocial issues: discipline, temperament
  - encouraging development: expected milestones
  - behavioral: separation, temper tantrums
  - accident prevention
- screening procedures: Hct, UA, and TB Time once during period
- immunizations
- medications if prescribed
- return and referral

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**Additional Protocol**

**Well Visit - School Age (5-12 years)**

**S =** Patient Inquire about general or specific concerns

- any particular concerns?
- nutrition
- elimination (enuresis?, encopresis?)
- sleep
- psychosocial (parent-child interaction, independence, temperament, peer relations, discipline)
• development (school adjustment and progress, extracurricular activities)
• behavior
• safety issues
• social history-family stresses

O = Physical examinations (includes strabismus check, gait, visual acuity, scoliosis, hearing, speech, and check school readiness for kindergarten
  • growth parameters (height, weight, weight for stature)
  • vital signs (include BP)

A = Diagnosis and Differential Diagnosis - If all is well, "Six year-old child with normal growth and development." Pertinent findings in the history may be mentioned, such as, "nutrition problem of excessive sodium intake; need dietary counseling."

P = Plan
  • anticipatory guidance
    o areas of parental concerns
    o nutrition
    o elimination - enuresis, encopresis
    o physical activity
    o sleep
    o psychosocial - peer relations, independence, responsibilities
    o TV viewing and video games
    o continued need for adult supervision
    o accident prevention
    o prepare ten year-old females for menarche/puberty
  • screening procedures - Hct, UA, and TB Tine once during period
  • medications if prescribed
  • return and referral
Student Protocol
Well Visit-Adolescent

S = Patient Inquiry about general or specific concerns

- any particular concerns?
- nutrition
- sleep
- psychosocial (parent-adolescent interaction, independence, emancipation, peer relations including sexuality, personality, self-image, depression)
- development (school performance, extracurricular activities)
- substance abuse
- safety issues
- social history-personal and family stresses

O = Physical examination (includes Tanner staging, scoliosis check, gait, acne, tibial tubercle, sports fitness, gynecomastia in males). If sexually active and has discharge or problem, or "YD exposure" then VDRL, GC, Chlamydia, pap smear in females.

A = Diagnosis and Differential Diagnosis - If all is well, "Sixteen year-old with normal growth and development" or "with mild acne vulgaris." Pertinent findings in the history may be included such as "Teen concerned with history of alcohol abuse in the family, presently is an abstainer."

P = Plan

- anticipatory guidance
- areas of parental or adolescent's concerns
- nutrition
- physical activity
- sleep
- variations in growth and development
- psychosocial issues (peer relations, independence, responsibilities, confidentiality, family communication)
- substance abuse - smoking, drugs
- accident prevention
- adolescent sexuality (abstinence, birth control, pregnancy)
- self-examination; breasts, scrotum
- school/academic performance
- vocational/educational planning
- immunizations: TD every 10 years, Mumps and Rubella if missed before
- screening procedures: Hct, UA, and TB Tine once during period
- medications if prescribed
- return and referral

Student Protocol
Well Visit-Adolescent Safe Times

S = Sexuality
   • Physiology of reproduction
   • Extent of sexual activity, type of relationship, symptoms of
   • Contraceptive

Affect - Symptoms of depression (feeling down or "blue") or hopelessness, "discouraged about the future

A = Abuse - Use of tobacco, alcohol, marijuana, cocaine, other drugs

F = Family
   • Who the patient lives with and if there is any family conflicts or problems
   • Family history-medical, psychiatric

E = Exam
   • Self-breast or self-testicular exam (middle to late adolescence)
   • Explain pelvic exam (if indicated)

T = Timing of Development - For early adolescents - "Is your development going too fast, too slow, or about the right speed?" and "Do you feel too thin, heavy, or about the right weight?"

I = Immunizations
   • Tetanus-diphtheria (TD) needed every 10 years
   • Rubella for females if serology indicates need
   • Measles if no documentation of live vaccine given after 1968
   • PPD yearly for high risk groups
   • Pneumovax, influenza is chronic disease

M = Minerals
   • Iron - by less than 2 servings of meats daily or by low Hct
   • Calcium - required, especially in females, for those who drink less than 2-3 glasses of milk daily (e.g., TUMS 3-4 tablets daily)
   • Cholesterol - intake of fats, lipid levels

E = Education
   • If in school, what grades attained, any problems?
   • Work history and future plans

S = Safety
   • Care safety - use of seat belts, drinking and driving, or accepting rides from drivers using drugs
• Motorcycles, mopeds, all terrain vehicles

Student Protocol
Well Visit - Adult

S = Patient Inquiry about general of specific concerns

• any particular concerns?
• nutrition
• sexuality/marital relations
• psychosocial (work, peer relations, depression, family, parenting)
• substance abuse
• occupational stressor
• pre-retirement planning and retirement
• history - any significant changes/events since last visit

O = Physical Examination (standard abbreviation exam)

• height, weight, BP
• visual acuity
• screening procedures
  o as dictated by age, occupation, family history, or other risk factors

A = Diagnosis and Differential Diagnosis

P = Plan

• anticipatory guidance
• immunizations
• need for subsequent screening and/or laboratory work
• medications if prescribed
• symptomatic relief advised
• instructions to parent, spouse, family
• return and referral

Student Protocol
Well Visit - Geriatric
(65 years and older)

S = Patient Inquiry about general specific concerns

• any particular concerns?
• nutrition/dietary intake
• sexuality/marital relations
• psychosocial (peer relations, depression, family, mental status)
• substance abuse (tobacco, alcohol, drug use)
• physical activity
• stressors
• retirement, financial issues
• history: any significant changes/events since last visit
• functional status at home (able to bathe, dress, clean, cook, etc.)
• remain alert for depressions symptoms, suicide risk factors, bereavement, changes in
cognitive function, signs of physical abuse or neglect, malignant skin lesions, and tooth
decay/poor dentition
• any symptoms of memory loss or TIA

O = Physical Examination (standard abbreviation exam)

• height, weight, BP
• visual acuity
• hearing exam
• screening procedures
  o as dictated by age, occupation, family history, or other risk factors such as skin
  exam and carotid bruits

A = Diagnosis and Differential Diagnosis

P = Plan

• anticipatory guidance (diet and exercise elimination of substance abuse, injury
  prevention, dental health, glaucoma testing, and skin injury protection)
• immunizations
• need for subsequent screening and/or laboratory work (total cholesterol, urinalysis,
mammogram)
• medications if prescribed
• symptomatic relief advised
• instructions to patient, spouse, family
• return and referral