一般醫學訓練
臨床診斷學
學習手冊

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臨床診斷學學習手冊

教學門診及病房實習須知

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101/01

1. 醫病關係之建立與訓練

同理心 / 關懷 → 信賴感。

病人的不安與期待 → 病情說明（病人的語言）。

家屬的理解。

2. 病史詢問 / 身體診察(physical examination)

開場白。

把握時間 / 重點。

“你真正擔心的是什麼？”　　”哪裡不舒服嗎？”。

視 / 聽 / 叩/ 觸診。

3. 病歷記載

(1) 應親自詢問病史，身體診察後，書寫病歷。

(2) Assessment 應包含診斷、邏輯分析、檢查/檢驗判讀、精簡的治療經過/病情變化，及計畫。

(3) 簽名及住院醫師核簽

(4) 病名應全名。

4.服裝與儀容

應養成良好衛生習慣及口腔清潔

【男醫師】

(1)不要穿領口、袖子髒的襯衫。

(2)**要結領帶**。

(3)白衣要整潔，鈕釦要扣好。

(4)白衣下露出的褲子與鞋子等也要整齊乾淨。

【女醫師】

(1)上班時間不要配帶大量裝飾品。

(2)頭髮必須是適合醫師的簡潔髮型。

(3)鮮紅的口紅、假睫毛及艷麗的指甲油，都會給人不好的印象。

5. 注意事項

(1)進入醫院院區，切勿穿著短褲、涼鞋。

(2)服裝要整潔。

(3)遵守時間開始診療。

(4)對以前曾經診治過病人的醫師盡量不要批評。

(5)注重與病人家屬的關係。

(6)在病人面前不要與同僚發生言語上的爭論。

(7)在病人面前與同僚談話時，話題也必須注意。

(8)最初的一聲，由醫師方面先說「早安，久等了」。

(9)最後的一言，「要保重」。

如何維持優質的醫病關係

方基存教授

醫師是醫療團隊領導者

現代科學技術越益發達進步，基因科技日新月異，醫學的發展似乎讓照護病人，轉變成更依賴各項科技的檢查與治療，而人與人的溝通也逐漸地疏遠，醫療關係似乎也逐漸遠離人性。在醫療關係中，醫師們越來越著重檢驗單的開立及疾病檢查，並逐漸淡化人與人間彼此人性關懷。過去的醫師常常以權威性命令來給病人診療，亦即是僅以單方向表達或命令來進行溝通，很少有彼此互動。而現代醫療關係是團隊性的，是以一個醫療群來照護病人，這一團隊是由醫師、護理人員、社工人員及相關的醫療人員共同來照顧病患，而醫師是這醫療團隊的領導者，負責整體醫療的運作、決策與醫療的成敗。

醫療團隊需良好溝通及互動

醫病關係的演進由傳統醫師對病人權威式的形態，已經轉變成三個群體之互動。首先，這包括照顧醫師群，如實習醫學生、住院醫師、總醫師及主治醫師等的照顧群體。其間任何一個小地方出了差錯，均會產生醫療上的重大問題，其中實習醫學生亦有其重要角色。例如開刀前實習醫學生須做好無菌工作，否則開再好的刀，傷口受到感染也是缺憾。因此，千萬別以為實習醫學生不重要。其次護理人員(護理師)在照顧病患的角色上非常重要，與他們的互動一定要很好，才能達到完整照護。其他醫療群之相關人員，如社工師、復健師、營養師、藥師、心理師均包括在這個醫療團隊之內。第二個團體是病患的親人與朋友，各種醫療消費者也是。第三個團體是保險機構及法律人員。三者均應保持良好的互動。護理師及其他相關人員應對病患所提出問題有所了解，並反應給醫師群以便能即時解決問題。照顧醫師應以視病人如親人般照顧。照護病人時相關醫療人員都應出席，一起想辦法為病人提供最好治療模式。

醫病關係是醫療滿意度的指標

醫病關係良好與否，將會影響到病患接受治療的配合度。如果醫病關係良

好，病人會比較相信你，在醫囑的執行上較能貫徹。醫病關係亦是病患對醫療體系滿意度的重要指標之一。若醫病關係不佳時，即使身體醫療成功率高，醫療滿意度仍也會被打折扣，更甚者在醫療疏失時，如果醫病關係良好則訴諸法律途徑則較有彈性，反之則容易走上法律途徑。因此現代優質的醫病關係不只是消極的避免醫療糾紛發生，更要積極地促進醫療照護團隊彼此團結合作關懷病患。因此必須藉由團隊合作與用心關懷，才能達成此一目標。

病人期望與以病人為中心醫療

病人的期望包括:良好醫療、溫馨的醫療環境，彼此能溝通的醫師及醫療團隊，希望了解疾病的治療、併發症及預後，希望醫師記住我、仔細瞭解病人心理，當我的良師益友，希望醫師以病人為中心，做完整全人照顧。過去傳統的以醫師為中心的醫療，乃是醫師以專家的身份從病人的病史、理學檢查及檢驗結果中，以科學理論的分析，告訴病人正確的疾病診斷並給予適當的治療。在這整個醫療過程中，都是以醫師的權威性及自主性去照顧病人。而現今以病人為中心的醫療，醫師則進一步的和病人有更真誠的溝通，考慮到病人的處境、心理及情緒反應，也瞭解到病人的盼望、恐懼、信仰、思考、生活環境等等，再告知予診斷及治療計劃，尊重病人的自主權，並幫助病人做最合理、最有利的選擇。以「病人為中心的醫療照顧」是以「醫師為中心的醫療照顧」的昇華，由醫師發揮人文素養，以愛心站在病人的立場，幫助病人解決心身健康的問題。

好醫師所應具備之特質

以下是在病房以問卷方式，所得到病人對好醫師所應具備特質之概況包括：用專長服務病人、親切關愛病人，每天告知患者病情並仔細為病人治療，事事用心，將心比心，親切、詳細告知病人及家屬，有關病人的病況及其應注意事項；以救人為醫德，醫者父母心親切並有醫術高超；問多了不會不高興，會詳實說明病情，不以專有術語來作解釋；能傾聽家屬及病患的疑問和困難，對家屬的困難必須有愛心和耐心的幫忙解決；醫德醫術兼備，給病人適當的精神鼓勵，有耐心。提供大家參考!

尊重病人及適切的同理心

醫病關係之基本態度，乃是每位醫師皆應有人文關懷，例如執行醫療步驟

時在乎病人疼痛否？並能以真誠、尊重病人及適切的同理心來對待病人，並且不以批判的態度來與病人互動；解釋病情或治療不要一意孤行而不考慮病人感受，要有一致性，對病人疾病要保密性，照顧病人的整體面而非只有治療疾病而已。必須是一個負責的醫療團隊，視病猶親及站在病人立場思考。同理心與溝通是從聽開始(溝通不是一直說，而是要用心聆聽) ，了解與病患對話的層次，尤其應試著了解病人靈性層次方面的困擾，不要陷在身體層面的理性。有了這樣的基本態度，相信你的醫病關係就會很好。

良好的專業儀態與尊重

如何開始建立良好之醫病關係？首先要有良好的專業儀態，一定要有禮貌及尊重患者。當一開始接觸到病患時，一定先自我介紹，將自己身份介紹給病患。不論是實習醫學生，住院醫師，總醫師或主治醫師。皆應先介紹自己的身份，而且要很有禮貌。另外服裝、儀容也很重要，希望醫師服是乾乾淨淨的，醫師袍應經常更換清洗乾淨。在精神層面上，要有自信心、責任心、視病猶親。假如病患有任何不適時，要用關懷口吻詢問病情並給予適當處置。當與病人講話時，你的眼睛要一直看著他。如果旁邊有人發言，你就轉頭去面對那個說話的人。保持眼神接觸不只是展現信心的一種方式，也是表示尊重。檢查有結果的醫囑必需詳細地為病患解釋，即使例行簡單的檢查對病人來說都是重要期盼的資訊與掛念。在照顧病人時，要特別記得我們照顧的是病患整個人，而非只是疾病而已！大家經常犯的錯是用床號來取代患者姓名，例如：8D21 稱呼病人而沒記住病人名字。而是應該用邱大銘先生，他是何種疾病來求診，千萬不要用 8D21A 床的病人來稱呼。因為我們照顧的是病患整體而非只有片面疾病的表現及其治療。

確守生命倫理四大原則

1. 尊重自主原則（The principle of respect for autonomy）：例如：誠實（truthfulness）：不隱瞞病人之病情及診斷，如此他們才能根據被告知的訊息做出決定。守密（confidentiality）：醫療專業人士一般有保護病人的隱私、對病人所告知事項保密的義務。知情同意（informed consent）：應當告知病人足夠的訊息，並獲得病人的同意方可對病人進行醫療處置。
2. 不傷害原則（The principle of nonmaleficence）：維持本身有良好的臨床知識及技術、謹慎地執行以達到「適當的照顧標準（standard of due care）」，

並避免讓病人承擔任何不當的、受傷害的風險，即是在履行不傷害原則。人格有問題、能力不足或有詐騙不法行為，便是違反不傷害的義務。

3.行善原則（The principle of beneficence）：在不傷害他人之外，行善原則要求我們要進一步關心並致力提升他人的福祉。行善原則是醫療專業人士須遵從的基本的義務。

4.正義原則（The principle of justice）：公平地分配醫療資源（分配性之正義），尊重人的權利（權利正義）,尊重道德允許的法律（法律正義）

病人為中心與培養自我學習能力

如何兼顧良好照顧病人與學習呢？應以病人為中心、問題導向的照顧與學習及系統分析與照護、培養自我學習分析討論能力。在照顧病人上應以病人為中心，把病人當做是你的朋友，當做是你的老師，病人各種症候表現就是你的教科書，病人的一切一切問題都是在教導訓練你們。把病人當做是你的朋友、老師及教科書，這樣你才能從中學到很多經驗，並與教科書相印證，如此的與病人學習成長才能變成你永遠行醫的珍貴的寶貝與經驗。

審慎用藥及合理安排檢查

行醫中要非常謹慎小心地使用藥物，反覆思考即將要開立的醫囑是否有其適應症？是不是針對診斷來下藥？另外了解藥物帶來的好處是否比害處多？副作用如何？要留心其用藥劑量，從自己手上出去的藥囑一定記得一看再看；一想再想。用了之後要追蹤其成效？任何與用藥有相關問題出現時，一定先停藥或更換其他藥物。千萬不要憑想像而無根據地用藥；一定要有 indication 並追蹤效果及 side effects。其次是合理地安排檢查，勿存有 flight of idea，一定有合理、系統的 thinking process，站在病人的立場安排合理檢查。第三是你要充分了解健保的準則，跟病患解釋健保準則也是我們在照顧病人上非常重要之一點。

病患的照顧原則

病人的照顧原則依我經驗有三點：一是早期診斷早期治療，一定要鉅細靡遺的由病史(history taking)及詳細的身體診察(physical examination)來做診斷。例如休克病人如能早期發現，儘早處理，則其預後會很好。二是可治療的疾病一定要積極治療，即使是末期的病人，也要給良好的 supportive care 以減少

病人之痛苦。第三是避免醫源上的傷害(iatrogenic injury)，任何用藥及醫囑一定再三思考，對治療的 side effects 不只要充分了解，也要時刻注意其發展。病人只要能做到這三點，相信大部份的病人會在你的治療下逐漸康復進步。

有責任感並妥善運用時間來照顧病人

我們在繁忙的醫療環境情況下，要如何妥善運用有限的時間來照顧好病人又能兼顧學習，首先提出的是有責任感，這一點常常是年輕醫師比較缺乏的素養。例如 arterial blood gas 抽了以後一定要馬上追 data 結果及馬上 interpretation (判讀)，如果抽了之後 2、3 天才讀 data，那就不對了！這就是欠缺責任感。如果是病人數很多的情況下，方法就益顯重要。照顧病人時，要依病情之嚴重度來排列先後處理次序，不要呆板地由第一床看到最後一床！應該將病人分為 critical、診斷未明、中等程度穩定及輕度穩定等四群病人。對於 critical 病患一定先看，且一天之中多看幾回穩沒錯的。不要等護士小姐通知病人狀況才去看，一大早來就先主動去看這類病人，有問題就立刻先處理。對診斷未明的病人，病況也是容易快速變化，所以也列入優先診視及多看幾次的病人群，並應針對各種狀況詳細解釋病情。對中等穩定的病人群，一天也至少要看個兩次。輕度穩定者每天可看一次並詳細解釋病情。下班前應習慣地診視探望病人，回想病人的各種問題，是否一一解決了沒有？並預期是否會不會出什麼狀況並交班給值班醫師，以達到持續的治療與觀察。因此，病人病情之交班非常重要！有任何 data 未出來的，一併交班給值班醫師，如此對病人的照護便有整體性及持續一致性了，亦是醫師責任感具體的表現。

解釋病情是醫病關係的基礎

醫病關係要怎樣維持呢？解釋病情是維持醫病關係極重要的因素之一。解釋病情也須經訓練的，應以不同的語言形式因應各種不同背景及家屬來源，並作病情上的解釋。同時要了解到接受解釋的這位家屬在家中的角色是怎樣？並請他擔任分擔傳遞訊息任務。疾病治療過程逐一作解釋，並應前後相一致性。關於醫療處置上的解釋，當病情上需要侵襲性醫療，而有助於診斷或治療時，必須事先向家屬解釋檢查之必要性、時間及可能之危險性、併發症與疼痛不適。在病房中有各種格式同意書，必需將侵襲性檢查的步驟及併發症詳細地告知其家屬。只要是侵襲性檢查當中有任何危險性之可能，就必須做詳實解釋，這點非常要緊。再者是病人家屬對醫療過程如有所不滿的話，

必須用同理心、關懷心來做適當地傳達予家屬及患者。時時為病人及家屬設身處地著想，絕對不能製造糾紛。

愉快地經營自己的事業

醫療工作是團隊性的，從當醫師第一天起就要尊重護理人員，並真誠的相互溝通，與其他相關的醫事人員也應該是一樣的相處方式。在團隊工作中應是相互分擔工作及角色互補、相互尊重、共同成長，如此緊密結合與永遠不斷進步的醫療團隊，病人及家屬才能得到充分照顧。另外要跟大家勉勵的是，各位選擇長庚為訓練地方，一旦踏入這大家庭，一定要認同她，愉快地經營自己的事業。千萬不能狹隘的認定這病人是主治醫師的想法，要以認真與愛心來照顧病人，從照護過程中去學習及成長。

最後以 Hippocrates 誓詞與大家勉勵，希望能將此誓詞無時無刻存在心中並時時省思。

醫師誓詞

准許我進入醫業時：我鄭重地保證自己要奉獻一切為人類服務。

我將要給我的師長應有崇敬及感戴；我將要憑我的良心和尊嚴從事醫業；病人的健康應為我輩首要的顧念；我將要尊重所託予我的祕密，即使在病人死後；我將要盡我的力量維護醫業的榮譽和高尚的傳統；

我的同業應視為我的同胞；我將不容許有任何宗教、國籍、種族、政見或地位的考慮介乎我的職責和病人之間；我將要最高地維護人的生命，自從受胎時起；即使在威脅之下，我將不運用我的醫業知識去違反人道。

我鄭重地、自主地並且以我的人格宣誓以上的約言。

大專校院辦理新制醫學系醫學生臨床實習實施原則

一、教育部（以下簡稱本部）為督導大學校院（以下簡稱大學）醫學系健全新制醫學系臨床實習制度，提供良好臨床學習環境、提升醫學臨床實習之課程品質、維護醫學生學習品質及身心安全等權益，使醫學生能結合學術理論與實務，培養對工作場域與專業倫理之正確認知及保障病人健康與被照護之安全性，特訂定本實施原則。

二、本實施原則，用詞定義如下：

(一) 新制醫學系醫學生：指自一百零二學年度起入學之大學醫學系及一百零四學年度起入學之學士後醫學系之醫學生。

(二) 臨床實習：指大學安排醫學系五年級、六年級及學士後醫學系三年級、四年級醫學生於教學醫院進行實習之課程。

(三) 實習機構：指經衛生福利部評鑑通過之教學醫院，並與設有醫學院、系之大學簽約，提供醫學生進行臨床實作訓練之醫療機構。

(四) 實習指導教師：指設有醫學院、系之大學教師受聘指導實習學生者。

(五) 臨床指導老師：指實習機構之主治醫師及住院醫師，於臨床實習時實際指導實習學生者。

三、醫學生臨床實習屬大學課程之一部分，其目的在於透過臨床醫學實作及訓練，培養成為醫師應具備之臨床知識、技能、態度及行為。大學應在確保醫學臨床教育品質及保障醫學生及病人身心安全之前提下，與實習機構共同規劃推動醫學生臨床實習課程，並提供醫學生臨床實習之指導、資源及行政支持。

四、各設有醫學院、系之大學為規劃推動醫學生臨床實習，並確保醫學生權益，應設立臨床實習委員會，由醫學院院長擔任主任委員，成員應包括醫學院、系相關系所主管、教師、臨床教師代表、實習機代表及醫學生代表等，必要時邀集校外相關專家學者參與，並得視實際需要調整之；其任務如下：

(一) 臨床實習課程及計畫訂定。

(二) 督導醫學系辦理習機構之選定、合作計畫及書面契約內容之訂定。

(三) 學校及實習機構之實習指導機制及人力配置。

(四) 醫學生臨床實習權利義務之訂定。

(五) 醫學生臨床實習期滿前終止實習後之轉介。

(六) 臨床實習成效之評估及檢討。

(七) 實習機構查核及輔導。

(八) 醫學生申訴之處理及其他醫學生權益保障相關事宜。

前項臨床實習委員會之成員產生方式、任期及成員比例等，由各大學定之。其中醫學生代表應有一定比率，並由醫學生團體推派之。

各大學得設申訴小組辦理第一項第八款之醫學生申訴事宜，並應有一定比率之醫學生團體推派之醫學生代表參與。

五、學校應依臨床實習委員會規劃臨床實習課程及計劃，進行實習機構之篩選及評估，並與實習機構簽訂實習計畫合約後，應於校內公告周知，始得辦理。實習機構為學校之附設醫院時，得由學校訂定對附屬機構之實習規範替代實習計畫合約。

六、前點實習計畫合約，應載明實習機構之訓練內涵、實習時數、項目、考核、膳宿、保險、輔導、醫學生安全措施規劃、實習機構與醫學生發生爭議時協商處理方式、醫學生實習期滿前終止實習之條件及程序、與實習機構終止合約之要件及其他相關實習權利義務事項。

七、各校對於醫學生之臨床實習課程，應在臨床指導老師之指導及監督下為之，並依下列原則規劃安排：

(一) 臨床實習以訓練醫學生在照護病人中學習為主，醫學生非屬實習機構之工作人力。

(二) 臨床實習於醫學系五年級及學士後醫學系三年級以三十六週為原則、醫學系六年級及學士後醫學系四年級以四十八週為原則；惟各校醫學系五年級、六年級及學士後醫學系三年級、四年級臨床實習之週數可視各校課程規劃之需要而調整之。

(三) 依醫師法第二條及醫師法施行細則第一條之二規定，學校規劃臨床實習科別，應明確訂定輪流實習之各科別實習週數。

(四) 各校應明確訂定每週之適當實習時數及夜間實習次數；夜間實習每週以不超過一次為原則。過夜實習，宜於過夜實習之隔日視學生之體力及精神狀態減少實習內容，必要時應安排其離院休息至中午

（AM-Off）或午後離院休息（PM-Off）。

(五) 臨床實習應以學習為目的，加入醫療團隊照顧病人，並依學生能力安排適量病人數，且採循序漸進之原則安排（醫學系五年級及學士後醫學系三年級，應由照顧一床住院病人開始）。

(六) 前五款臨床實習課程規劃，應經校內臨床實習委員會通過並公告周知。

八、學校開設臨床實習課程前，應就實習機構選定及名額分配等事宜，與醫學生充分溝通及宣道，並強化醫學生修習實習課程之認知，以確保實習過程之安全、學習及未來職場適應。

九、學校於醫學生臨床實習過程中，應指派實習指導教師定期赴實習機構輔導學生，實習指導教師應確實掌握醫學生臨床實習課程訓練內涵及範疇，指導醫學生、參與實習相關之協調、報告及檢討座談等，以解決醫學生實習所遭遇困難。

十、實習機構提供醫學生實習，應設專責單位，依與學校所訂之實習計畫合約，推動下列事項：

(一) 推動規劃醫學生之臨床實習課程、教學活動及病人照護之學習內涵。

(二) 安排專責之臨床指導老師，負責監督及協助醫學生於臨床實習照護病人之過程，專責指導醫學生實習，瞭解訓練及學習狀況，與學校指派之實習指導教師共同輔導醫學生。

(三) 負責醫學生臨床實習前之安全講習、實習場所安全防護設備之配置及相關安全措施規劃。

(四) 為醫學生投保相關保險，除學生團體平安保險外，應包括新臺幣一百萬元以上之意外傷害險及醫學生因實習而致死亡、殘廢、傷害或疾病等之保障。

(五) 建立醫學生申訴事件之協商處理機制。

十一、 實習醫學生於實習機構實習，負有病人照護及臨床技能學習之使命，應以保障病人安全及隱私權為優先考量；並配合臨床課程與教學活動，於合格醫事人員監督陪同下，參與病人臨床照護，學校應與實習機構共同訂定醫學生實習應遵循之相關規範，督導學生據以遵循。

十二、 為保障醫學生實習權益並建立申訴溝通管道，學校及實習機構應訂定

醫學生臨床實習權益保障、申訴管道及處理程序，爭議處理之審議，並應有醫學生代表參與；其申訴處理程序如下：

(一) 醫學生經向實習指導教師反映未獲改善，得逕向實習機構專責單位、學校臨床實習委員會或申訴小組申訴。

(二) 學校臨床實習委員會或其所設之申訴小組受理申訴案件後，應即召開臨床實習委員會議或申訴小組會議，於十四個工作天內處理完畢，必要時得以延長至多十四個工作天，並將處理結果通知醫學生；申訴小組受理審議之案件，應另提於臨床實習委員會報告。

(三) 醫學生不服處理結果，應於接到通知書後七個工作天內，檢具理由及相關資料逕向原處理單位提出異議。對異議處理結果不服，得循行政程序提校內學生申訴機制辦理。

十三、 學校及實習機構依本實施原則推動醫學生臨床實習之實施成果及學生申訴之處理情形，納入衛生福利部之教學醫院評鑑考核、本部之醫學校院評鑑考核及本部對學校之獎勵補助及系、所招生名額核定之參考。

教學門診規範

一、目的

教學門診（Teaching Clinics）就是能夠提供教學功能的門診。醫學生在教學門診就是學習如何照護門診病人。學生在教學門診與一般門診的學習差別是，在一般門診學生一般只是在旁跟診，並無法親自參與診療病人。而在教學門診，學生需要親自對於病人做病史詢問與身體檢查，並試著擬出臨床臆斷與後續計畫，整個過程有教師在旁觀察、監測及指導，並於診察病人結束後提供回饋，能提供學生更完整的學習過程與確保學習品質。

二、目標

(一)認知方面

1.能對於門診醫療有基本的概念。

2.能瞭解門診病人類型、需求與處理之原則。

(二)技能方面

1.能正確並熟練對於門診病人之病史詢問與身體檢查。

2.能展現分析門診病人病情之能力與提出適當之醫療計畫。

(三)情意方面

1.能了解門診醫療之重要性。

2.能藉由教學門診的訓練培養對於照護病患之責任感。

三、訓練

教學門診的流程，有以下建議步驟：

(一)事前準備：教學門診病人之表現，是影響教學門診成效之重要因素。教師宜事先約診適合參與教學門診的病人，首要條件是病人同意，接著希望是容易溝通，沒有口說或聽力問題者，同時最好能有耐心讓學生問診，若是已建立穩定醫病關係的長期照顧之病人則更為適合。病人最好有明確的主述與就醫動機，如果只是定期回診追蹤的穩定病人，可能無法呈現讓學生進行病史詢問或身體檢查的切入點，學生的學習成效會打折扣。在病人進入診間之前，教師應先向學生告知看診基本流程，例如先確認病人身分病自我介紹後，再進行問診。是否需

要身體檢查？是否需要向病人說出診斷與治療衛教計畫？都需在看診前先釐清。接著建議先簡介該病人，模擬看診場景讓學生先有一個問診的方向，也可建議學生問診的架構，例如用 LQQOPERA 的概念[附件一]，問到任何主述之後，深入去問該主述症狀的位置（Location）、質與量（Quality & Quantity）、發生時間（Onset）、前驅加重緩解因子（Precipitating, Exaggerating, Relieving factors），最後問到伴隨症狀（Accompanying symptoms/signs），亦介紹“VINDICATE SLEEP”記憶法[附件二]於鑑別診斷之應用。這樣可以大大減少學生的緊張避免想不出問題，也可以避免冗長而不著邊際的問診。

(二) 學生進行問診：教師應仔細觀察學生問診過程的儀態、口條、思路、內容、溝通能力、身體檢查技巧、鑑別診斷能力、決定後續計畫能力等，以便結束後回饋給學生。同時，教師也需根據學生的詢問與身體檢查，決定病人的醫療計畫，以便在學生問診完畢後，迅速完成病人的處置解決病患的醫療問題，避免讓病人久候。

四、評量

評量學生問診過程，必需使用 Mini-CEX 表單或院內自行研擬統一的評量表單。教學門診除了考驗學生收集資訊的能力之外，也希望學生能夠展現分析與決策能力，同時也可以一併考驗及教導學生病歷寫作與病例報告能力。使用設計之教學門診病歷表單，學生以 SOAP 的格式寫一份病歷，指導醫師應依病歷內容逐一檢討學員對每位病患的診療情形，包括病患的鑑別診斷、病歷書寫、理學檢查、診斷、檢查及用藥等內容，同時亦應注意學員之溝通技巧與醫病關係之建立。在最後請學生以幾分鐘的時間總結一下今天看的病人，向教師做一口頭病例報告(使用口頭病例報告評量表)。教師再根據學生病歷寫作與報告的內容給予回饋。最後請學生回饋此次參加教學門診的收穫與心得，以及對於教學門診的建議，以供往後教學改善之參考。

五、核心能力

教學門診可訓練學生的六大核心能力

(一)醫療專業知識（Medical knowledge）：透過教學門診，學生能學習門診病人常見疾病之相關醫學知識、臨床問題分析、鑑別診斷能力、執行治療的能力，以及提供衛教的能力。

(二) 照顧病患及臨床技能（Patient care & clinical skills）：透過教學門診，學生能學習照護門診病人之能力與臨床技能，使之能展現愛心、關懷與同理心，有適切有效處理門診病人常見症狀及緊急醫療狀況的能力。

(三) 人際間的溝通技巧（Interpersonal and communication skills）：透過教學門診，學生能學習如何與門診病人及其家屬溝通，使學員能練習人際溝通能力。

(四) 專業素養（Professionalism）：透過教學門診，學生能學習如何展現專業素養、表現專業責任及堅守醫學倫理原則。具體內容包括：行為舉止符合專業精神、表現出對病人的尊重與愛心、遵守醫學倫理原則、包容跨文化間差異、對病人年齡、性別、種族、宗教差異具一定的了解與敏感度，以及維護醫師團體的社會形象。

(五) 以體系為考量的臨床照護（Systems-based practice）：透過教學門診，學生能學習如何有效運用系統資源以照顧病人、能夠提供高品質的醫療照護、著重病患安全並避免系統性錯誤、檢討各項醫療決策及操作內容及減少系統性錯誤。

(六) 以臨床工作為導向進行學習與改善（Practice-based learning and improvement）：透過教學門診，學生能學習以臨床工作為導向進行學習與改善，使學員能夠具備評估現行醫療照護內容，經過自我學習消化吸收科學實證，從而改善病患照護之能力。

病史探問法

吳德朗教授

這就是有本院寶典之稱的「吳語錄」，內科人不可不讀，見習和實習醫師必備的武林秘笈。大綱如下：

基本資料

主訴

目前病況

既往病史

器官系統評估

社會關係史

家族史

基本資料：

病患之姓名、筆名、字號、過去用過的名字。病患之性別、住址、電話、年齡、出生年月日、出生地點、種族國籍、婚姻狀態、目前與過去的職業。病史原則上由病患本人探取，若因病人年齡太小、病情過重、意識不清或語言不同而無法取得時，則需註明提供病史者與病患之關係，並評估病史之可靠性。

主訴：

先生，你好！為什麼到醫院來？什麼地方不舒服？多久了？

目前病況：

可以說「現在請你詳細的把生病的經過，包括你看過的醫師、吃過的藥、做過的檢查或者住過院等？按照發生的次序告訴我。」

既往病史：

1. 過去的健康情況如何？體重最重的時候幾公斤？最輕呢？有沒有當過兵？過去有沒有做過健康檢查？
2. 過去有沒有得過下列傳染病：麻疹、德國麻疹、腮腺炎、百日咳、水痘、天花、白喉、傷寒、瘧疾、肝炎、猩紅熱、風濕熱、肺炎、肋膜炎、腦炎、肺結核、淋病、梅毒等。如果有的話，有沒有用過抗生素治療？治療多久？對抗生素有沒有不良反應？

3. 過去有沒有動過手術或受過傷？
4. 過去住過幾次醫院？那家醫院？什麼原因住院？是不是可以拿到出院摘要？
5. 過去有沒有對食物或藥物過敏？

器官系統評估：

1. 近來皮膚顏色有沒有變化？皮膚的溫度有沒有改變？汗會不會很多？皮膚會不會變乾燥？會不會發癢？脫皮？發疹？瘀青或出血？
2. 毛髮包括頭髮、腋毛、陰毛及體毛之色澤、柔軟度、分佈情形，有沒有異常或變化？
3. 指甲的色澤、硬度有沒有變化？指甲有沒有下陷彎曲變黑出血的現象？
4. 有沒有淋巴腺腫大的現象？換句話說在頸部、腋窩、腿部、股溝的地方有沒有長瘤？有的話會不會痛？有沒有化膿？
5. 過去有沒有骨折、脫臼、肌肉扭傷、肌肉發炎、肌肉萎縮、關節酸痛、關節炎、關節變形、關節機能喪失或抽筋等現象？
6. 過去有沒有貧血、淋巴腺腫大或容易出血的現象？
7. 你的身高、體重是多少？身體各部份是不是對稱？有沒有畸形發展？手、腳、頭有沒有異常？體毛分佈、皮膚色素有沒有異常？會不會感覺虛弱？甲狀腺有沒有肥大？眼球有沒有凸出？皮膚毛髮會不會乾燥？會不會怕熱易出汗？會不會怕冷？手會不會抖動？有沒有口渴喜喝水？頻尿或飯量增加的現象？你的性發育過程有沒有問題？性生活有沒有問題？
8. 過去有沒有皮膚過敏、皮膚炎、蕁麻疹、濕疹、過敏性鼻炎、氣喘？有的話是不是容易發生在那一個季節？對於花粉、食物、藥物會不會過敏？有沒有打過預防針？
9. 有沒有頭痛、偏頭痛、暈眩、天旋地轉、昏倒、暈厥、抽搐、痙攣、癲癇等現象？
10. 有沒有視力減退、視力喪失、色盲等毛病？會不會把一件東西看成兩個影像（複視）或一隻眼睛半邊看不見（半盲）的現象？過去眼睛有沒有受過傷？有沒有得過眼睛的毛病？帶不帶眼鏡？
11. 你的聽力如何？有沒有耳鳴？會不會有天旋地轉暈眩的現象？耳朵會不會痛？耳道有沒有分泌物？過去有沒有動過手術？耳部的頭骨會不

會痛？

12. 有沒有過敏性鼻炎、慢性鼻炎？鼻竇炎？鼻子會不會流膿？會不會經常流鼻血？
13. 嘴巴、舌頭會不會痛？牙齒、牙周有沒有毛病？會不會容易出血？
14. 喉嚨會不會痛？近來聲音有沒有改變或沙啞？扁桃腺有沒有發炎？
15. 脖子有沒有腫脹？會不會痛？有沒有化膿？有沒有淋巴腺腫？甲狀腺有沒有腫大？脖子會不會僵硬？轉動有沒有問題？
16. 妳乳房發育過程中有沒有問題？有沒有生過小孩餵過奶？乳房會不會痛？有沒有腫塊？乳頭有沒有分泌物？乳頭及它的周圍有沒有變化？
17. 你的乳部沒有問題吧！有沒有像女人那樣子變大的現象？有的話多久了？有沒有分泌物流出來？
18. 胸部會不會痛？呼吸有沒有困難？會不會氣喘？氣喘時有沒有聲音？晚上入睡後會不會因為氣喘而醒來？睡覺時用幾個枕頭？氣喘時坐著舒服呢？還是躺著舒服？會不會咳嗽？咳嗽時有沒有痰？痰中有沒有帶血？會不會咳血？會不會盜汗？
19. 過去有沒有得過肺炎、肺結核、氣喘或其它慢性肺疾病？
20. 心跳怎麼樣？會不會有突發性的跳動過快或亂跳的現象？會不會有心跳過慢或跳動停止的現象？有沒有因心跳問題而發生暈倒過？
21. 運動時，例如爬樓梯、跑步或提重的東西，胸部會不會有壓迫感或收縮性的悶痛？運動時會不會喘不過氣來？夜晚用幾個枕頭？半夜會不會氣喘咳嗽？
22. 你的指甲有沒有發黑彎曲的現象？腿部有沒有水腫？腹部會不會脹痛或腫大？走路或跑步時雙腿會不會發痛？
23. 你的手腳會不會冰冷？腿部有沒有靜脈曲張的現象？過去或現在有沒有腿部腫痛的現象？
24. 過去有沒有高血壓、風濕熱或梅毒？有沒有使用毛地黃、利尿劑、舌下含片或其它心臟藥物？
25. 近來胃口如何？體重有沒有改變？吞東西有沒有困難？會不會喘氣、反胃、氣脹或常常放屁？肚子會不會痛或絞痛？有沒有嘔吐或吐血？有沒有黃膽或眼睛變黃？小便的顏色怎麼樣？大便如何？顏色怎麼樣？有沒有帶血？一天幾次？量多不多？近來大便習慣有沒有改變？
26. 小便有沒有問題？顏色怎麼樣？次數多不多？量會不會很少？夜晚小

便幾次？小便有沒有困難？有沒有失禁的現象？有沒有血尿？有沒有尿道排膿的現象？睪丸會不會痛？有沒有硬塊或長瘤？過去有沒有腎臟或尿道結石的毛病？有沒有得過梅毒、淋病、或其它性病？有的話做過甚麼治療？

27. 妳的月經幾歲來？週期如何？準不準？每次持續幾天？月經的量如何？來經時有沒有不適症狀？有沒有血帶？最後一次來經日期是甚麼時候？甚麼時後停經？停經後有沒有出血？有沒有不適症狀？
28. 妳總共懷孕幾次？有沒有自然流產或人工流產？生產過幾次？有沒有死產？生產過程中有沒有併發症？
29. 嗅覺有沒有問題？眼睛看東西有沒有問題？轉動有沒有問題？眼睛張開或閉上時有沒有困難？嘴巴旁邊有沒有麻麻的奇怪感覺？吃東西、咬東西、咀嚼有沒有困難？臉部肌肉活動有沒有問題？舌頭嚐東西有沒有問題？聽力有沒有問題？走路站立時有沒有不穩的現象？說話、吞東西有沒有困難？脖子轉動有沒有困難？
30. 四肢有沒有麻痺癱瘓？肌肉有沒有萎縮？有沒有無意識無法控制的不自主動作？有沒有過痙攣抽搐？走路步態如何？穩不穩？四肢手腳各部位的協調如何？
31. 有沒有那個地方會痛？這種痛的性質怎麼樣？是不是像電擊那樣有灼熱的感覺？痛的分佈是不是成一束的線狀分佈或帶狀分佈？有沒有感覺錯亂、感覺過敏或感覺麻痺的現象？
32. 大小便有沒有失禁的情況？流汗有沒有異常？對於冷熱的反應有沒有皮膚發紅變紫或蒼白的現象？
33. 情緒如何？會不會經常鬱鬱寡歡？有沒有幻覺？有沒有不尋常的念頭或經驗？有沒有失眠的現象？過去有沒有心理或精神方面的問題？你與你的雙親、太太、小孩、朋友或同事的關係如何？

社會關係史：

1. 你結婚了嗎？太太幾歲？有沒有小孩？只結過一次婚吧！目前靠甚麼過活？收入怎麼樣？過去作過甚麼事情？你受過甚麼教育？
2. 你有沒有使用特殊藥物？抽不抽煙？一天抽多少？抽了幾年？你喝不喝酒？是不是天天喝？喝甚麼酒？多少？多久？有沒有

嚼食檳榔？一天幾顆？

3. 最近有否去哪裡旅遊？

家族史：

1. 令堂令尊還健在嗎？他們的健康狀況如何？如果他們已經仙逝，幾歲時過世？死於甚麼病？
2. 你有幾個兄弟姐妹？他們年紀多大？健康情況如何？如果過世的話，幾歲過世？原因是甚麼？
3. 在你的家族中有沒有肺結核、慢性肝炎、梅毒、癩病、高血壓、糖尿病、心臟病、氣喘、過敏體質、貧血、血流不止、甲狀腺或其它內分泌疾病、癌症、神經肌肉疾病、癲癇或精神病？
4. 家族史應包括至少 3 代之病史

【附件一】問診 LQQOPERA 概念之實際應用

病史詢問 --老阿嬤唱歌仔戲 LQQ OPERA

	發燒	**腳水腫**
Location	從哪裡量?	Unilateral or bilateral?
Quality 質	斷斷續續燒?持續燒?	Pitting or non-pitting?
Quantity 量	最高燒到幾度?	Grading? severity?
Onset	何時開始燒?	When? progressing speed ?
Precipitation factors 前驅	發燒前有無畏寒?	High salt diet?
Exaggerating factors 加重	何種狀況燒得更厲害?洗腎後?輸血後?	Water intake ? Long term standing ?
Relieving factors 緩解	睡冰枕會退燒?	Supine ? Sitting ?
Accompanying symptoms/signs	**全身性症狀**：畏寒、皮疹 **局部性症狀**：從頭想到腳—頭痛、意識變化、五官症狀徵象、呼吸道感染症狀徵象、心血管症狀徵象、消化道症狀徵象、泌尿道症狀徵象、骨骼肌肉神經症狀徵象等 **潛在疾病**：原本就有感染症?腫瘤?	**Kidney disease**—uremic symptoms: poor appetite? nausea? general malaise? short of breath? foamy urine? hematuria? skin itching? generalized bone pain? high BP? pale? nocturia? **Heart disease**—orthopnea, chest tightness, exertional dyspnea? JVE? **Liver disease**—jaundice? ascites? RUQ abdominal symptoms? **Others?**

【附件二】VINDICATE SLEEP 於鑑別診斷之應用

V	Vascular
I	Infection
N	Nutritional/Neoplastic
D	Drugs/Toxins
I	Inflammatory/Idiopathic
C	Congenital
A	Autoimmune
T	Trauma
E	Endocrine
S	Social/spiritual
L	Legal
E	Environmental
E	Economic
P	Psychological

理學檢查 Physical Examination

1. General Appearance, Vital Signs, HEENT & Neck Exam
2. Chest and Thorax Exam
3. Cardiac and Peripheral Vascular Exam
4. Abdominal Exam
5. Screening Neurologic Exam

EQUIPMENT

Stethoscope, blood pressure cuff (sphygmomanometer), oto-ophthalmoscope, tongue depressor, penlight, 512 tuning fork, nonsterile examination gloves, nonsterile small gauze square, pen and paper.

GENERAL APPEARANCE

Simply carefully observing your patient and recording their appearance is the critical first part of your examination. **Your goal** is to be able to create in the mind of your reader a picture of the patient to go with the subsequent information you will provide. **Careful observation** will also detect important findings that enable you to better understand your patient and to arrive at diagnoses.

Checklist

Apparent "physiologic" age	Young, younger middle-aged, middle aged, older middle, aged, elderly
Sex	Man or woman
Body habitus	Cachectic, thin, well nourished, overweight, morbidly obese, approximate BMI
Signs of distress	pain, dyspnea or vomiting
Mood/Affect	anxiety, sadness, tearfulness, and anger
Dress and personal hygiene	(Avoiding insulting description)
skin discoloration, gross body deformities	Pallor or plethora, obvious lesions of hands or face
Ambulation , walking ability, gait, physical function	in a wheelchair, or using a cane, or walks with a limp, ADL/IADL (in)dependent.
Record this part of exam	

Check off each objective upon completion/With the help of your physical examination partner

Examples:

1. Chronically ill, undernourished, older middle-aged, man with flat affect, wearing soiled clothing.
2. Obese, plethoric, middle-aged man in mild respiratory distress with purse-lipped breathing.
3. Smiling overweight elderly woman sitting in wheelchair and conversing with her daughter.

VITAL SIGNS

The vital signs are vital. You must be able to ascertain them yourself without the assistance of a nurse. If you are writing a progress note, it is important **NOT** just to write the vital signs from a single time, but to **report the range** (highest and lowest) vital signs for the past 24 hours or since you last saw the patient. You do not want to assume everything is fine when the patient had an episode of fever or tachycardia in the night that you do not know about because you did not review <u>all</u> of the patient's vital signs.

Checklist

Locate the radial and brachial pulse	assessing for synchrony
Determine the pulse rate and rhythm	any extra or dropped beats
Technique to measure respiratory rate	(demonstration and practice)
Placement and sizing of the blood pressure cuff / correct positioning of the patient's (partner's) arm	(demonstration and practice)
Obtaining systolic blood pressure by palpation before obtaining both systolic and diastolic pressures by auscultation.	Use this method every time to avoid missing an auscultatory gap and to minimize the discomfort to your patient. Demonstrate appropriate placement of the stethoscope for auscultation of the Korotkoff sounds.
Obtain a blood pressure reading at the ankle or thigh.	Understand when assessment of a lower extremity blood pressure is useful.
Record the vital signs	

Check off each objective upon completion/With the help of your physical

examination partner

HEENT AND NECK EXAMINATION

The head, eye, ear, nose, throat (HEENT) and neck examination combines several body systems including the endocrine (thyroid), lymphatics and the cranial nerves. Although more detailed examination of the cranial nerves is indicated in some patients, the screening head and neck examination should include a screening cranial nerve examination.

To always have a "ruler" available for measuring length, measure your fingers and find some standards. For example, my middle finger is 10 cm long, 5 cm from tip to MCP joint, and my 5th fingernail is 1 cm across. By knowing this I always have my ruler available.

Checklist

Examine the head	Noting hair texture, density and distribution, skull deformities, and any scalp tenderness or lesions. Any facial abnormalities including skin color (e.g. pallor, plethora or cyanosis) and lesions (e.g. periorbital edema, facial asymmetry, xanthomata, and actinic lesions such as skin cancers).
Examine the eyelids and lacrimal apparatus	Noting the texture of the tear glands, the patency of the tear ducts and any lesions such as eyelid xanthomata.
Examine the eyes	Pupillary symmetry, reactivity to light, scleral icterus, and bulbar and palpebral conjunctivae.
Evaluate visual acuity	Using hand held Rosenbaum eye chart or other appropriate device
Evaluate extraocular muscle movement	EOM in all 6 cardinal positions.
Using the ophthalmoscope	how to hold the ophthalmoscope, approach the patient and visualize the fundus.
Examine the ears	pinnae and external auditory canals
Using the otoscope	Identify the normal landmarks including The short process of the malleus, the handle of the malleus, pars flaccida, and the umbo. Note the appearance of the tympanums including any

	scars or perforations. Using the "finger rub" to grossly evaluate hearing.
Weber and Rinne test	for preliminary assessment of hearing loss
Examine the external nose	Noting any deformities or cutaneous lesions.
Examine the nasal antrum, septum and turbinates	Noting any septal deviation, ulcers or perforation. The size and color of the turbinates. The presence and nature of any secretions, mucosal edema, polyps,etc.
Examine the sinuses	Palpation and percussion of the sinuses for tenderness. Techniques for transillumination of the frontal and maxillary sinuses.
Examine the oral cavity and pharynx	Noting the dentition, gingival mucosa,oral mucosa, mobility and appearance of the papillae of the presence or absence, and size of the tonsils, and the appearance of the pharyngeal mucosa. Techniques to palpate the tongue and oral mucosa. Technique to use the tongue depressor to stimulate the gag reflex and assess cranial nerves IX and X.
Examine cranial nerves	Ask about sense of smell and taste food to assess cranial nerve I. Palpate the temporalis and masseter muscles and check sensation to light touch to assess cranial nerve V. Have the patient raise eyebrows and grimace to assess cranial nerve VII. Check neck rotation and shoulder shrugging strength bilaterally to assess cranial nerve XI, and have patient stick tongue straight out to assess cranial nerve XII.
Examine the neck	
Review the anatomic landmarks	Locations of the hyoid bone, thyroid cartilage, cricoid cartilage, and trachea as well as anterior and posterior "triangles".
Inspect the neck	Noting symmetry, and any masses or scars
Palpate all accessible	Five critical characteristics: size, consistency,

lymph nodes	mobility, tenderness and location
Examine the thyroid gland	Techniques for inspection and palpation of the thyroid gland. Describe the estimated size of each lobe and the consistency and nodularity of the gland.
Record the results of this part of the exam	

Check off each objective upon completion/ With the help of your physical examination partner:

Examples

1. **HEENT (Head Ear Eyes Nose Throat)**: Hair normal. Head atraumatic. External ears without evidence of inflammation or lesions. TMs (Tympanums) intact with good light reflex, ossicles well seen. Bulbar conjunctiva injected, anicteric. PERRLA (Pupils Equal Round Reactive to Light and Accomodation). Nares patent, septum midline, moderate clear discharge. Pharyngeal erythema and bilateral white tonsillar exudate.

   Neck: Five 1x1 cm rubbery, mobile, nontender lymph nodes along left posterior cervical chain. Trachea midline, no thyromegaly.

   Cranial Nerves: (Note that, while the screening cranial nerve examination is performed at the same time as the head and neck examination, it is reported in the Neurologic portion of the Physical Examination report.) CN (Cranial Nerves) grossly intact.

2. **HEENT**: Head atraumatic. Hair coarse and dry with patchy alopecia. **PERRLA**. Periorbital edema with bilateral lid lag. TM visualized on right with good light reflex. Cerumen impaction on left, diminished right hearing by finger rub. Oral cavity normal without erythema or exudate. Nares patent without discharge.

   Neck: No cervical, occipital, submandibular or supraclavicular lymphadenopathy noted Thyroid gland easily palpable, diffusely enlarged with a 2 cm, soft, mobile, non-tender nodule in upper left pole of the thyroid.

   CN: grossly intact (reported with Neurologic examination section)

3. **HEENT**: Well healed right temporal craniotomy scar. Anisocoria: left pupil 5

mm, right pupil 3 mm - both RRL (Round Reactive to Light). TMs intact bilaterally with good light reflex. Nares show no discharge, small fleshy polyp obstructing the right passage. Oral cavity clear without erythema or exudate. Tongue is midline without deviation.

Neck: Well healed tracheotomy scar. No lymphadenopathy or thyromegaly

CN: grossly intact except protruded tongue deviates slightly to right

1. General Appearance, Vital Signs, HEENT & Neck Exam
2. Chest and Thorax Exam
3. Cardiac and Peripheral Vascular Exam
4. Abdominal Exam
5. Screening Neurologic Exam

In examining the chest and thorax, a systematic approach should be adopted in order to prevent missing important diagnostic information. One such approach is to perform **inspection**, followed by **palpation**, and then **percussion** and **auscultation**.

Checklist

Review appropriate draping techniques	
Locate the major landmarks of the thorax	midsternal line; right and left midclavicular lines; anterior, mid, and posterior axillary lines; midscapular lines; manubriosternal junction (angle of Louis) 7th cervical vertebra.
Identify each rib and intercostal space	noting the manubriosternal junction and 2nd anterior rib
Inspect the thoracic spinal column and the configuration of the chest wall	Noting Anterior-Posterior diameter as well as evidence of congenital abnormalities such as pectus carinatum and excavatum
Perform percussion of the thoracic spine	Noting any tenderness
Identify any abnormalities or asymmetry in respiratory muscle mass	Noting use of accessory muscles of respiration.
Observe the pattern of the respiratory	Rate, rhythm, and depth and the inspiratory

cycle	-expiratory ratio
Determine whether chest expansion is symmetric	Inspection with palpation Evaluate tactile fremitus
Percussion of the chest	Locating the right hemi-diaphragm and determining this movement in inspiration.
Auscultation of the lungs	Auscultation of posterior, lateral, and anterior lung fields
Identify the following sounds by auscultation	Pitch and intensity of breath sounds; symmetry of breath sounds; type of breath sounds.
Note the presence of adventitous sounds	Rales, rhonchi, and friction rubs
Assessing presence of bronchophony, whispered pectoriloquy, and egophony	
Inspection, palpation, and percussion of the anterior chest	
Record the results of the physical exam	

Check off each objective upon completion/ with the help of your physical examination partner

Examples of the Written Physical Exam

1. Chest: Apparently increased A-P (Anterior-Posterior) diameter, I:E (Inspiratory to Exhalatory) ratio 1:5. Resonant to percussion. Diffuse exhalatory wheezes without crackles.
2. Chest: Long, thin thorax with mild pectus excavatum. Resonant to percussion and normal tactile fremitus. Bi-basilar fine end-inspiratory crackles.
3. Chest: Normal with normal breathing. Clear to percussion and auscultation.
4. Chest: Mildly tachypneic. Left base dull to percussion with course inhalatory crackles, increased tactile fremitus, bronchophony, and egophony.

THE AXILLAE

This portion of the exam may be combined with the breast examination or the chest exam. It is an important part of the exam for both male and female patients. The exam may be conducted **either in the upright or supine position**. The **most common error** made is not probing deeply and firmly enough into the apex of the

axilla, or not examining all four (4) surfaces of the axilla.

Checklist

Review draping for this part of the exam	
Note various positions for examining the axilla.	Upright or supine position
Examine the axilla for lymph nodes	Examine all four areas where lymph nodes can be found, and know when to use two hands for palpation
If you identify a lymph node, describe its	**5 key characteristics**: location, size, consistency, mobility and tenderness.

Check off each objective upon completion/ With the help of your physical examination partner

Examples of the Written Physical Exam

1. Axilla: No axillary adenopathy or tenderness.
2. Axilla: Node along left axillary artery, 2x2 cm, soft, mobile, moderately tender.

THE BREASTS

Breast examination should be performed on all female patients and on selected male patients. As in other portions of the exam, the only way to become comfortable with what is normal versus pathologic is with practice. Adequate inspection requires exposure of the entire chest. Palpation, however, can occur with a single breast exposed while the other breast is covered.

Checklist

Review appropriate draping	
Inspection of the breasts	noting color and consistency of the skin on the chest, size and symmetry of the breasts, contour of breasts, presence of any nipple discharge
Review patient positioning	"Cahan" position
Palpation of the breasts	
If a nodule is found, describe its	size, shape, location, consistency, relationship to surrounding tissues, mobility, and presence of tenderness

Check off each objective upon completion

Examples of the Written Physical Exam

1. Breasts symmetric without masses.

2. Breast symmetric. No discharge. Moderate fibrocystic tissue apparent in lower breast margins. Prominent 2x3 cm nodule at one O'clock in left breast 5 cm from nipple, firm, mobile, slightly tender, distinct from surrounding tissue.

1. General Appearance, Vital Signs, HEENT & Neck Exam
2. Chest and Thorax Exam
3. Cardiac and Peripheral Vascular Exam
4. Abdominal Exam
5. Screening Neurologic Exam

CARDIOVASCULAR EXAM

EQUIPMENT

Hand cleanser, sphygmomanometer, stethoscope, penlight

Checklist

Appropriate draping.	
Assess rate of capillary refill in the fingernails	Report in terms of seconds
Locate the pulses (radial, brachial, femoral, popliteal, posterior tibial, and dorsalis pedis pulses.)	Noting the rate and rhythm (regular, regular with pauses or extra beats, or irregular) of the pulse, and the strength and symmetry of the individual pulses comparing left and right sides.
Examine the legs	Noting the skin temperature of the feet, relative to that of the abdomen, and one foot compared to the other. Noting the skin appendages (hair, pores), callousing, any lesions and any edema. Measure and record magnitude of pitting edema in terms of millimeters at mid-shin or some other specific location.
Measure blood pressure	a. Always use palpation first to grossly measure systolic pressure. b. Appropriate cuff location, assessment of

	adequacy of cuff size, cuff placement and limb position to obtain measures at the level of the heart. c. Measure blood pressure supine, seated and standing. d. Measure blood pressure in legs
Auscultation for carotid bruits	Bilateral
Palpate the carotid pulses	Character of the upstroke, pulse contour, and any palpable vibration (thrill)
Inspection of the jugular pulse.	Appropriate positioning Noting the wave form and measure the greatest height in centimeters above the sternal angle (JVD) Test for abdomino-jugular reflux
Identify landmarks on the anterior chest	Noting the expected locations of the heart chambers, valves, and great vessels, any deformities, scars or lesions
Inspect the chest for visible impulses	Describing their location in terms of intercostal space and distance from the mid-sternal line.
Palpate the chest to locate	
the apical impulse	Describing its size (centimeters in diameter) and location (intercostal space and distance from mid-sternal line in centimeters). Noting any double beat, or sustained pulse (heave)
any other impulses	Investigating the suprasternal notch, left sternal border, right and left second intercostal spaces and epigastrium
Auscultation of the heart	from the apex, across to the left sternal border, up to the left second interspace, across to the right second interspace, and in the left axilla , using both bell and diaphragm
Listen to the first heart sound	in all auscultatory areas for splitting, variation with respiration, and intensity compared to S2
Listen to the second heart sound	in all auscultatory areas for splitting, respiratory variation, and for the relative intensity of the aortic and pulmonic components

Listen for gallops (S3, S4)	including with the patient rolled into the left lateral decubitus position. Noting the relative intensity with bell and diaphragm
Listen for other sounds	clicks, snaps, rubs
Listen for murmurs, and characterize them by the 7 critical criteria	loudness, timing in the cardiac cycle, variation in loudness, whether heard better with bell or the diaphragm, location on chest where heard best, radiation to neck or left axilla, and respiratory variation.
Use of the valsalva, sitting-squatting, and fist clenching maneuvers to augment cardiac sounds	
Record your findings of the exam	

Check off each objective upon completion./ With the help of your physical examination partner or a volunteer patient

Examples of a written Cardiovascular Examination Report

1. CV: Capillary refill less than 1 second. Peripheral pulses normal and symmetric. Carotid pulses brisk and symmetric. JVD (Jugular Vein Distention) 7 cm above sternal angle. (Capillary refill and peripheral pulses are often described in the Extremities portion of the report. Carotid and jugular pulses are often described in the Neck portion of the report.)
   Heart: Apex hyperdynamic, 3 cm across, 14 cm from MSL (Mid-Sternal Line) in left 6th ICS (Intercostal Space). RR (Regular Rhythm) 84/min. Loud S2 without split. S3 at apex. No murmurs.

2. CV: CR (Capillary Refill) less than 2 second. Peripheral pulses normal and symmetric. Carotids brisk with a 1/2 left lower bruit. JVD 3 cm above sternal angle.
   Heart: Apex 2 cm across, 10 cm from MSL left 5th ICS. Rhythm: irregularly irregular. Rate: 112/min. S1 and S2 faint, no split. No gallops or murmurs.

3. CV: CR less than 1 second. Carotids brisk, without bruits. JVD not well seen.
   Heart: Apex 2.5 cm, 10 cm from MSL left 5th ICS. RR 72/min. Loud S1.

No gallop. II/VI systolic, crescendo-decrescendo murmur with diaphragm at apex without radiation or respiratory variation. No diastolic murmur with patient leaning forward.

1.	General Appearance, Vital Signs, HEENT & Neck Exam
2.	Chest and Thorax Exam
3.	Cardiac and Peripheral Vascular Exam
4.	Abdominal Exam
5.	Screening Neurologic Exam

ABDOMINAL EXAMINATION

EQUIPMENT : **Stethoscope**

To hear undisturbed bowel sounds, auscultate the abdomen before percussing and palpating.

Checklist

Inspect the abdomen	noting the usual locations of the following organs right upper quadrant: liver, gall bladder, duodenum, pancreas, right kidney left upper quadrant: stomach, spleen, left kidney, pancreas, splenic flexure right lower quadrant: cecum / appendix, right tube/ovary left lower quadrant: sigmoid colon, left tube/ ovary midline: bladder, uterus
Examine the skin	Evidence of scars, striae, prominent veins and other lesions
Observe the abdominal contour	Looking for evidence of distention, abdominal hernias, asymmetry, masses, pulsations, increased abdominal girth, prominence of the umbilicus, or a scaphoid appearance.

Note hair distribution.	
Auscultation of the abdomen	Listening for bowel sounds, and Bruits (epigastric, periumbilical, inguinal at costovertebral (CV) angles.)
Percussion of the abdomen	a. gastric bubble and spleen b. upper and lower margins of the liver in the mid-clavicular line to measure the span in centimeters c. shifting dullness to assess for ascites d. CV angle tenderness. A gentle tap is usually plenty to elicit an inflamed kidney. The CV angle is usually examined at the same time as the chest, with the patient is seated.
Palpation of the abdomen	a. superficial masses b. the bladder c. the spleen, including with the patient in a right lateral decubitus position d. the liver margins, texture and consistency and tenderness e. the kidneys f. the aorta g. a fluid wave of ascites h. rebound tenderness i. an obturator sign j. Rovsing's sign k. Murphy's sign l. inguinal adenopathy
Techniques for the male genital and rectal examinations	
Record the results of your examination	

Check off each objective upon completion/ With the help of your physical examination partner or a volunteer patient

Examples of Written Report

1. Abd: Scaphoid, old healed midline vertical scar. Active BS (bowel sound). Nontender. No spleen tip. Liver 14 cm to percuss, 5 cm below ribs

in MCL (midclavicular line). No bruits.

2. Abd: Rigid with marked guarding and tenderness to percussion and palpation, esp. (especially) RLQ (right lower quadrant). BS absent. ++ right obturator sign. No gross mass.
3. Abd: Scaphoid. Soft, nontender. Well-healed lower horizontal surg. scar. Nl (normal) BS. Bilat. periumbilical 1/2 (quiet) bruits. Stool in descending colon LLQ (left lower quadrant). Liver in MCL 9 cm to percuss, firm edge without nodules, 2 cm below ribs. No spleen tip to lateral exam. Few firm mobile nontender, less than 1 cm inguinal nodes bilat.
4. Abd: Soft, non-tender, active bowel sounds. Liver 9 cm. No splenomegaly or mass. Aorta about 3 cm. No bruits.
5. Abd: Soft, but tender in RUQ with Murphy's sign. Active BS, no apparent hepatosplenomegaly. No masses or distension. No bruits.

1. General Appearance, Vital Signs, HEENT & Neck Exam
2. Chest and Thorax Exam
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5. Screening Neurologic Exam

NEUROLOGIC EXAMINATION

A thorough understanding of basic neuroanatomy is pivotal to the diagnosis of neurologic illness. In addition, attention to detail is required, because early manifestations of neurologic illness are often subtle. While a thorough neurologic examination to investigate abnormal findings may take an hour, careful consideration of the history should enable you to tailor the neurologic examination to the patient and the situation.

EQUIPMENT

Hand cleanser, hand-held Rosenbaum Pocket Eye Chart card, ophthalmoscope, tongue depressor, penlight, 512 tuning fork, 128 tuning fork, ball cotton, cotton swab, toothpick, pen and paper, reflex hammer.

Checklist

Assess level of alertness-arousal and Glasgow	Qualitatively describe the status of consciousness, i.e., comatose, obtunded, stuporous, somnolent,

coma scale.	alert; Semi-quantitative description: E4V5M6.
Assess orientation to date, place and person.	Orientation to person or name is rarely abnormal. In recording findings specify in what ways the patient is oriented. Avoid “Oriented x 3.”
Assess sense of smell	Asking your patient about smell and taste of food. If appropriate and feasible, use a sample odor. Make sure to block one side of the nose so as to test only one olfactory nerve at a time.
Evaluate peripheral vision by "confrontation".	This may include assessing the size of the "blind spot" with a small brightly colored object.
Test central visual acuity.	Using a hand-held Rosenbaum Pocket Eye Chart card.
Test pupillary contour and reactivity, EOM, nystagmus, pupillary accommodation.	Perform the "swinging flashlight test" to check for afferent pupillary defects.
Use of the ophthalmoscope to identify the red reflex and optic disc.	Holding the ophthalmoscope, and approach the patient with either hand.
Assess mass and contraction of the masseter and temporalis muscles.	Palpate the consistency and muscle bulk, and observe contour (atrophy) and fasciculation, of the masseter and temporalis muscles.
Test light touch and pinprick (pain) sensations of the face.	In all three divisions of the trigeminal nerve.
Test the “corneal reflex.”	Corneal sensation to light touch by cotton tip
Test facial muscle strength.	Show teeth, smile, whistle, look up to wrinkle forehead and close eyes
Describe how to assess taste	Tested by salt and glucose water
Test hearing	Using the finger rub. Be sure to occlude the opposite ear by gently pressing the tragus, so as to assess hearing in each ear separately.
Assess hearing loss	Weber and Rinne tests by 512 tuning fork
Assess the movement of the soft palate and pharynx	Say “Ah” to look for asymmetrical movement of the uvula
Assess the patient’s voice for	Touch the tonsil or the back of the pharynx on

hoarseness and test the gag reflex	each side with a cotton swab
Test the strength of the sternocleidomastoid and trapezius muscles.	Shrug bilateral shoulders and push up hard; turn the head against the examiner’s hand on each side
Examine the patient's tongue	Observe atrophy, fasciculations while opening , and symmetry of movement
Assess peripheral muscle strength	Grading muscle strength on the zero to 5 point MRC scale. (Test shoulder abductors, elbow flexors, elbow extensors, wrist extensors and flexors, intrinsic hand muscles, hip flexors, extensors, abductors, and knee flexors, knee extensors, ankle dorsiflexors, evertors, invertors, and plantar flexors.
Test sensation to pain, light touch, temperature, and proprioception of the body and extremities.	To test pain (pin prick by toothpick or disposable pin), light touch by cotton, temperature by test tubes filled with hot (40-45 degrees) and cold (5-10 degrees) water, and proprioception (position sense and vibration by 128 tuning fork).
Elicit deep tendon reflexes. Use of reinforcement to enhance deep tendon reflexes.	The hammer strike the tendons at the biceps, triceps, brachioradialis, patella and Achilles tendons. If the reflex is absent, asking the patient to interlock the fingers and then pull apart hard at the moment before hammer strike the tendon (Jendrassik’s maneuver).
Elicit the plantar reflex (Babinski sign).	Use a blunt object (such as a key) to stroke up the lateral aspect of the sole, and curve inwards before it reaches the toes, moving towards the middle metatarsophalangeal joint.
Assess cerebellar function.	Use standard testing techniques including finger-nose-finger, heel-to-shin, and rapid alternating movements (dysdiadochokinesis).
Evaluate gait.	Walk normally for a few meters and then turn around quickly and walk back. Walk heel-to-toe

	(Tandem), walk on toes, and walk on heels.
Perform the Romberg test and simultaneously test for pronator drift.	Stand erect with the feet together then close the eyes (Romberg test). With the patient's upper extremities outstretched to the front, palms up with the eyes closed, observe the position of each extremity for at least 20 to 30 seconds (pronator drift).
Record your findings	

Check off each objective upon completion/ With the help of your physical examination partner or a volunteer patient.

Examples of a written report

1. Neuro: Alert, appropriate. CN II – XII grossly intact. Strength 5/5, symmetric. Sense intact to light touch, pain and vibration in hands and feet. Normal cerebellar function, by finger-nose, heel-shin, and rapid alternating movements. Normal gate, tandem and heel walk. DTRs (Deep Tendon Reflexes) 2/5 biceps, patella and Achilles. Babinski downgoing (Plantar reflex flexor).
2. Neuro: Alert. Oriented to day, date, NCKU hospital and situation. CN grossly intact. Strength 5/5 symmetric. Diminished sense to pin prick in hands, feet and lower legs. Markedly diminished sense to vibration up to knees. Unable to elicit DTR patellae and Achilles with reinforcement. Biceps DTR present with reinforcement. Finger-nose, heel-shin and gait grossly normal.
3. Neuro: A & O to day, date, ED. Left facial droop. Left side weak 2-3/5 in arm and leg. Sense intact to light touch and pain in hands and feet. DTR 2/2 on right, but 3/2 brisk without clonus at left biceps, brachioradialis, patella and Achilles. Left great toe upgoing (Babinski present).

PUTTING THE EXAM TOGETHER
THE REGIONAL APPROACH

Goals: To observe and practice performing the examination regionally in an efficient sequence that minimizes patient and physician movement.

Objectives:

1. Observe your faculty tutor demonstrate an entire "screening" exam, with reference to the "checklist".
2. Practice putting the exam together, in a regional manner, on your examination partner, minimizing the number of times you ask your partner to change positions.

Summary of Checklists

General appearance

Apparent "physiologic" age	
Sex	
Body habitus	
Signs of distress	
Mood/Affect	
Dress and personal hygiene	
skin discoloration, gross body deformities	
Ambulation , walking ability, gait	
Record this part of exam	

Vital signs

Locate the radial and brachial pulse	
Determine the pulse rate and rhythm	
Technique to measure respiratory rate	
Placement and sizing of the blood pressure cuff / correct positioning of the patient's (partner's) arm	
Obtaining systolic blood pressure by palpation before obtaining both systolic and diastolic pressures by auscultation.	
Obtain a blood pressure reading at the ankle or thigh.	
Record the vital signs	

HEENT and Neck

Examine the head	
Examine the eyelids and lacrimal apparatus	

Examine the eyes	
Evaluate visual acuity	
Evaluate extraocular muscle movement	
Using the ophthalmoscope	
Examine the ears	
Using the otoscope	
Weber and Rinne test	
Examine the external nose	
Examine the nasal antrum, septum and turbinates	
Examine the sinuses	
Examine the oral cavity and pharynx	
Examine cranial nerves	
Examine the neck	
Review the anatomic landmarks	
Inspect the neck	
Palpate all accessible lymph nodes	
Examine the thyroid gland	
Record the results of this part of the exam	

Axillary lymph node examination

Review draping for this part of the exam	
Note various positions for examining the axilla.	
Examine the axilla for lymph nodes	
If you identify a lymph node, describe its characteristics	

Breast examination

Review appropriate draping	
Inspection of the breasts	
Review patient positioning	
Palpation of the breasts	
If a nodule is found, describe its characteristics	

Cardiovascular examination

Appropriate draping.	
Assess rate of capillary refill in the fingernails	
Locate the pulses (radial, brachial, femoral, popliteal, posterior tibial, and dorsalis pedis pulses.)	
Examine the legs	
Measure blood pressure	

Auscultation for carotid bruits	
Palpate the carotid pulses	
Inspection of the jugular pulse.	
Identify landmarks on the anterior chest	
Inspect the chest for visible impulses	
Palpate the chest	
the apical impulse	
any other impulses	
Auscultation of the heart	
Listen to the first heart sound	
Listen to the second heart sound	
Listen for gallops (S3, S4)	
Listen for other sounds	
Listen for murmurs and describe its characteristics	
Use of the valsalva, sitting-squatting, and fist clenching maneuvers to augment cardiac sounds	
Record your findings of the exam	

Abdominal examination

Inspect the abdomen	
Examine the skin	
Observe the abdominal contour	
Note hair distribution.	
Auscultation of the abdomen	
Percussion of the abdomen	
Palpation of the abdomen	
Techniques for the male genital and rectal examinations	
Record the results of your examination	

Screening neurological examination

Assess level of alertness-arousal, Glasgow coma scale	
Assess orientation to date, place and person.	
Assess sense of smell	
Evaluate peripheral vision by "confrontation"	
Test central visual acuity	
Test pupillary contour and reactivity, EOM, nystagmus, pupillary accommodation	
Use of the ophthalmoscope to identify the red reflex and optic disc	

Assess mass and contraction of masseter and temporalis m.	
Test light touch and pinprick (pain) sensations of the face	
Test the “corneal reflex.”	
Test facial muscle strength.	
Describe how to assess taste	
Test hearing	
Assess hearing loss	
Assess the movement of the soft palate and pharynx	
Assess the patient’s voice for hoarseness and test the gag reflex	
Test the strength of the sternocleidomastoid and trapezius m.	
Examine the patient's tongue	
Assess peripheral muscle strength	
Test sensation of the body and extremities	
Elicit deep tendon reflexes. Use of reinforcement to enhance deep tendon reflexes	
Elicit the plantar reflex	
Assess cerebellar function	
Evaluate gait	
Perform the Romberg test and simultaneously test for pronator drift	
Record your findings	

REFERNCE

1. Bates’ Guide to Physical Examination and history taking, 10th edition, 2009
2. Physical examination tutorial manual by Professor Harrison G. Weed
3. Mark H. Swartz, MD Textbook of Physical Diagnosis, 6th edition,2009

婦產科臨床診斷學學習手冊

婦產科教學門診及病房實習須知

一、婦產科病史詢問：

婦產科病史的詢問，應該要包括病人的月經史及生產史，月經史必須包含最後一次及最近幾次的月經時間、初經時間、月經週期、月經持續時間、經血量、是否有經痛或併發其他不舒服、或者是否停經，有任何懷疑時皆應安排尿液妊娠試驗以確定有無懷孕，生產史則包括懷孕次數、生產次數、人工或流產次數等，詢問生產方式或手術史等有時可以提供一些有用的資訊。而詢問性生活史時語氣最好儘量委婉，可以先詢問婚姻狀態，最後一次或最近幾次的性行為時間及狀況也十分重要，有時急性腹痛常發生在性行為之後，必要時應該詢問性伴侶人數、是否有固定性伴侶(有時詢問職業可以幫助了解)，目前的避孕方式也必須考慮到，另外是否曾接受子宮頸抹片篩檢或曾經做過的婦科檢查，例如像婦科超音波、子宮鏡等，有時都能提供重要的線索。

二、婦產科骨盆腔身體診察：

婦產科的理學檢查，應該要有骨盆腔理學檢查(內診檢查)，內診檢查是直接使用理學檢查方式檢查外陰部、陰道、子宮頸，及骨盆腔內包含子宮與卵巢等可能的問題與疾病，如果是男醫師，應該要有女護士陪在旁邊，醫師的態度應表現出專業與莊重、不可輕浮。執行內診前一定先要再三確認病人是否有過性行為，如果病人從未有過性行為，而醫師又認為有骨盆腔理學檢查的必要時，可以考慮使用肛診來執行骨盆腔理學檢查，但需要事先充分溝通告知。婦產科的骨盆腔理學檢查應包括窺陰器(鴨嘴)檢查及雙手檢查: 先窺視外陰部有無異常，然後置放適當鴨嘴以檢視陰道及子宮頸外觀，移除鴨嘴後再用雙手合併內診觸壓，以檢視子宮大小及兩側附屬器等。

內診檢查步驟順序依次為：

1. 請女性護理人員引導病人謹慎躺在內診診療台上，擺好正確姿勢及適當的遮蔽。
2. 向病人充分告知及安撫後，先窺視檢查外陰部的外觀，包括大陰唇、小陰唇、會陰體、肛門口等。
3. 再將小陰唇輕輕撥開，這時候檢查陰蒂、尿道口、處女膜遺跡等。
4. 選擇大小適當的鴨嘴，注意鴨嘴的溫度及確定鴨嘴的上下葉完全閉合，鴨嘴前端應沾溫水或潤滑劑潤滑，以戴手套之手協助撥開陰唇，鴨嘴以平行或稍微斜角輕柔的滑入陰道，再轉成垂直撐開鴨嘴，調整角度以便子宮頸完全進入視野內。
5. 在足夠的燈光下，觀察子宮頸、陰道壁，以及分泌物的狀況，必要時可以使用抹片刷或抹片棒直接採取子宮頸的細胞做化驗。
6. 必要時也可以使用陰道鏡，加上醋酸染色或是切片檢查，結束後鬆開鴨嘴轉成平行再緩緩取出鴨嘴，但注意勿完全閉合以免夾住陰道壁造成疼痛，並觀察陰道壁。
7. 再次向病人告知準備執行雙手內診來檢查骨盆腔內的問題。
8. 將食指及中指手套潤滑，撥開陰唇並使之放入陰道，手指頭放在後穹窿處將子宮頸往上抬，另一隻手放在腹部感覺子宮大小、是否有長腫瘤或疼痛發炎等，然後檢查左右兩側附屬器感覺卵巢大小、是否有長腫瘤或疼痛發炎等，如果懷疑有子宮內膜異位症，在骨盆腔底有時可以用手感覺到有結節組織。
9. 檢查結束後請女性護理人員協助引導病人小心離開內診診療台。

產科的理學檢查應包含 Leopold 氏手法以檢查胎兒位置，量子宮底至恥骨聯合之距離（FSD）以評估胎兒大小，以及內診檢查可以用來評估產婦產程的進展。產科內診檢查前一定要先確認病人沒有前置胎盤的情形，如有任何疑慮應先安排超音波檢查或是改用鴨嘴窺視，確認後將戴手套之手撥開陰唇並放入陰道中，手指頭要觸摸檢查子宮頸口，包含評估子宮頸變薄程度、子宮頸擴開程度，及胎頭下降程度等以評估產程的進展。

產科 PV：（切記：內診時間不宜過長，且不宜在產婦面前討論，並需注意無菌觀念）

⇩ 先用潤滑或消炎藥膏抹在一手之食指及中指

⇩ 用拇指及第四指將 labia majora 及 minora 撐開

⇩ 再將食指及中指伸入 vagina 內，用兩隻指頭感覺子宮頸之下列各項：

- **Os dilatation**：Close, FT (finger tip), 1 ~ 9 cm, NF (near full), Full。
  （以食指及中指撐開子宮頸之寬度或子宮頸兩邊剩下之寬度判斷之，全開為 10 公分）
- **Effacement**：Poor（似鼻尖硬度），Moderate（似耳垂厚度及硬度），Good（軟而薄）。
- **Station**：floating, Dipping, engaged (+/- 0), +1 ~ +3 (以 ischia spine 以下 1 ~ 3 公分為準)。（變通方法：若食指及中指伸入陰道頂到胎頭，尚能露出一指節為+1，兩指節為+2，三指節為+3）
- **Fetal presentation**：Vertex or breech, ant/post fontanel, ROA/LOA, ROP/LOP。

Bishop score：用以評估子宮頸之狀況，分數愈高愈易引產。

	0	1	2	3
Dilatation (cm)	0	1 ~ 2	3 ~ 4	5 ~ 6
Effacement	0 ~ 30%	40 ~ 50%	60 ~ 70%	80%
Station	-3	-2	-1 ~ 0	+1 ~ +2
Consistency	Firm	Medium	Soft	—
Position	Posterior	Mid	Anterior	—

Leopold 氏手法：

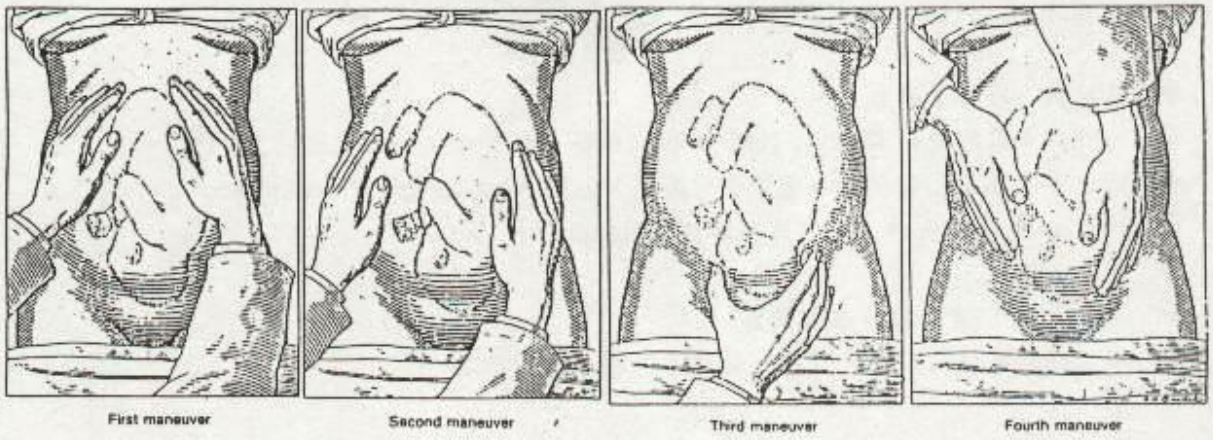


Fig. 10–10. Longitudinal lie. Palpation in left occiput anterior position (LOP) (maneuvers of Leopold). See also Figure 11–5A.

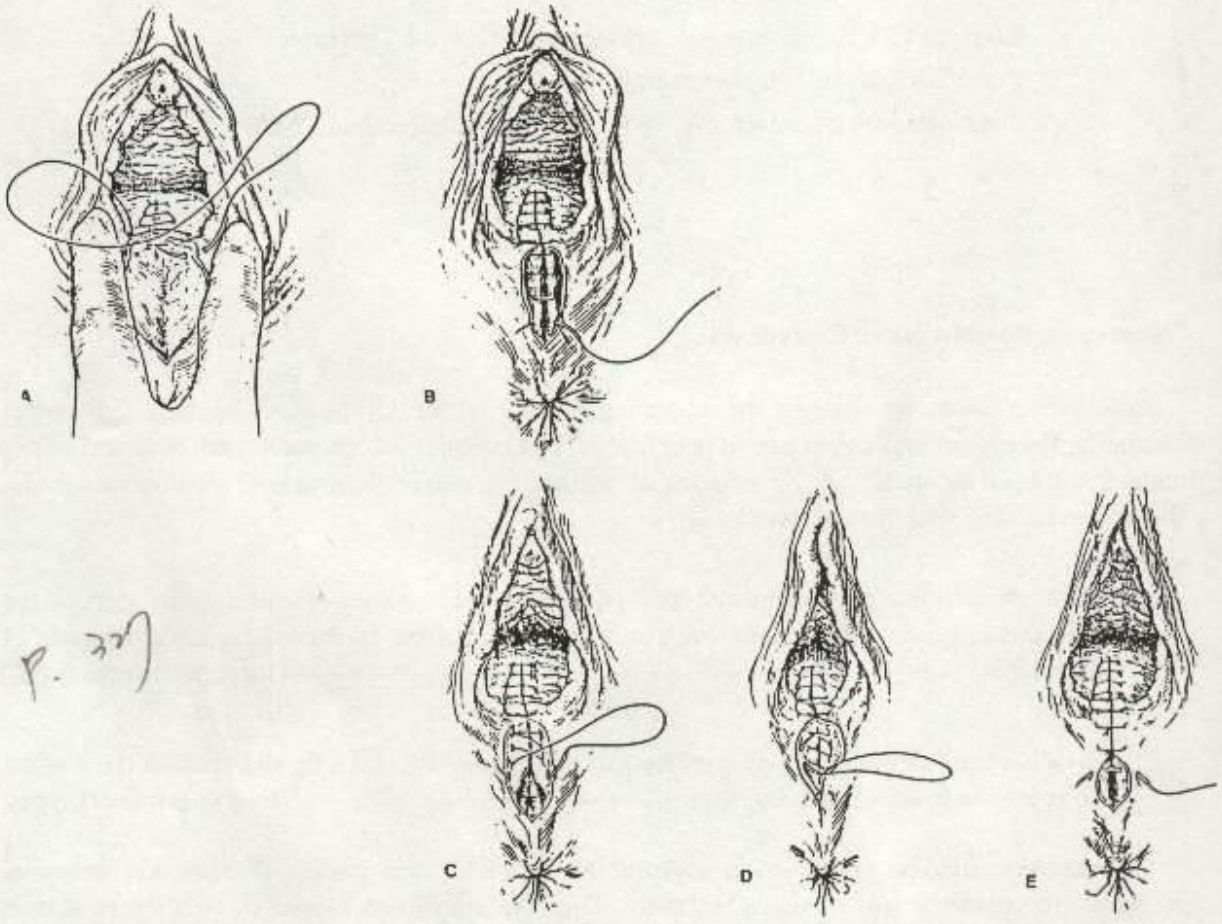
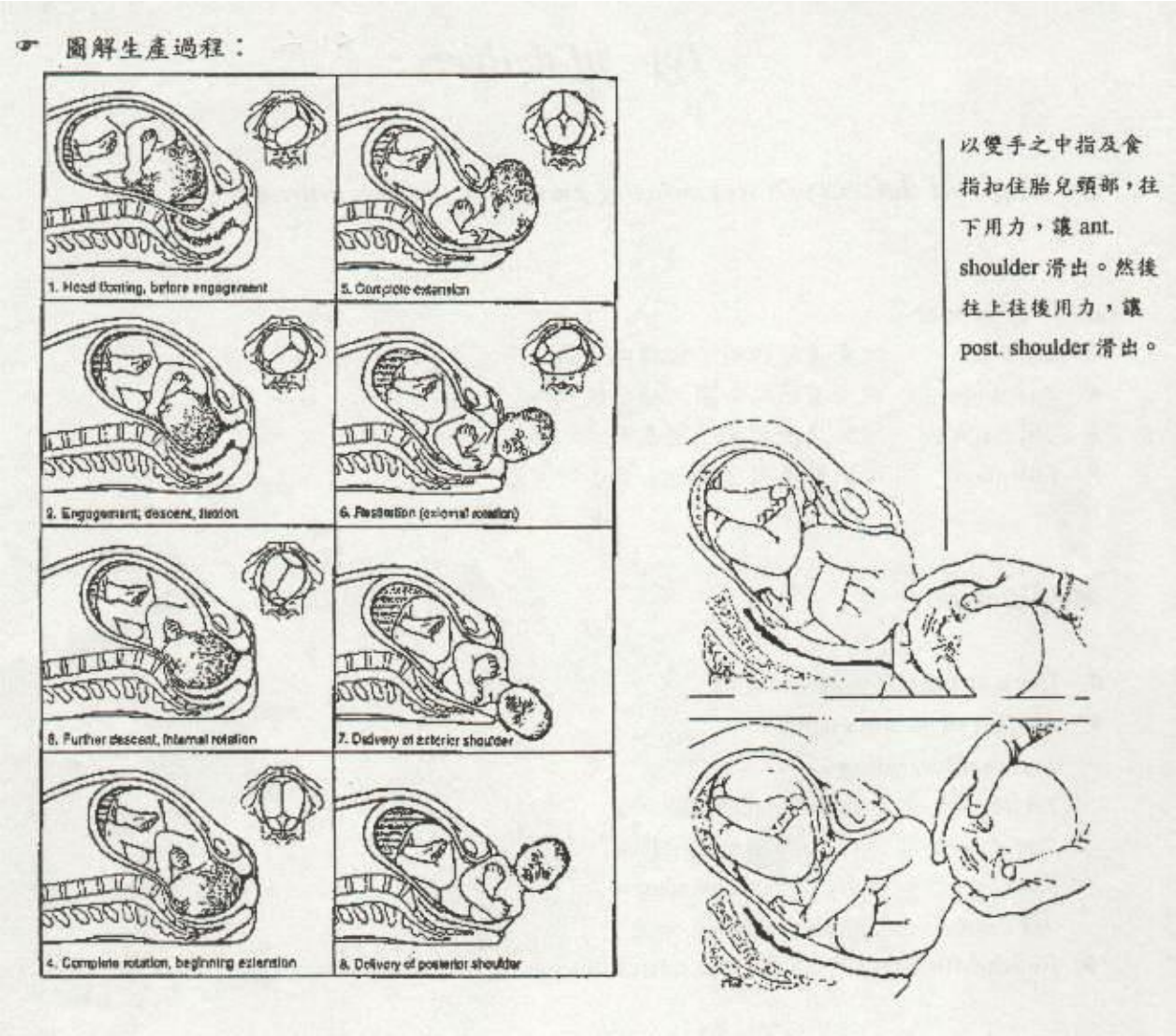


Fig. 14–18. Repair of median episiotomy. A. Chromic catgut 00, or preferably 000, is used as a continuous suture to close the vaginal mucosa and submucosa. B. After closing the vaginal incision and reapproximating the cut margins of the hymenal ring, the suture is tied and cut. Next, 3 or 4 interrupted sutures of 00 or 000 catgut are placed in the fascia and muscle of the incised perineum. C. A continuous suture is carried downward to unite the superficial fascia. D. Completion of repair. The continuous suture is carried upward as

自然生產過程：



三、婦產科骨盆腔身體診察自我檢測要點：

Checklist

1. Inspect the vulva and perineum:
   Labia majora, Labia minora, Perineum, Anus
2. Vagianl speculum examination:
   Cervix, Vagina
3. Bimanual examination:
   Uterus, Bilateral adnexa

耳鼻喉科身體診察

POSITIONING FOR EXAMINATION

A. Examination of the head and neck is usually performed with the patient sitting in front of the doctor, with the doctor either standing or sitting depending on the facilities available.

B. The patient should sit upright and should not slouch in the chair. Constant repositioning of the head is necessary to obtain adequate visualization of the various areas.

ILLUMINATION

A. Good illumination is essential for adequate examination.

B. Familiarity with all instruments is ideal because different clinical situations may necessitate different light sources

EXAMINATION OF THE NECK

A. A thorough knowledge of the anatomy of the neck is essential for adequate examination.

B. A systematic approach is necessary in order to avoid missing any pathologic findings.

C. One should avoid concentrating on the obvious mass and neglecting the rest of the neck examination.

1. Inspection

a. Always inspect the neck before palpation. This may provide vital information. Note any scars or asymmetry, as well as whether there is any limitation of movement.

b. Look for any abnormal masses that may be better seen than palpated, for example, a thyroid mass or a soft cystic mass. A laryngocele may only be seen on Valsalva maneuver and may not be palpable.

2. Palpation

a. Two approaches to palpation of the neck

1. Standing behind the patient.
    a. Less awkward.
    b. Enables the examiner to palpate both sides simultaneously, allowing comparison.
    c. Patient’s neck should be slightly flexed to relax the musculature and make palpation easier.
2. Standing or sitting in front of the patient.
    a. Logistics of room setting may dictate this approach.

3. Auscultation

a. Auscultation of the neck should be performed routinely in order to detect audible bruits in carotid stenosis or vascular tumors.

The Cervical Lymphatics

Memorial Sloan-Kettering Cancer Center developed the lymph node regional definitions most widely used today. To describe the lymph nodes of the neck for neck dissection, the neck is divided into 6 areas called Levels. The levels are identified by Roman numeral, increasing towards the chest. A further Level VII to denote lymph node groups in the superior mediastinum is no longer used. Instead, lymph nodes in other non-neck regions are referred to by the name of their specific nodal groups.

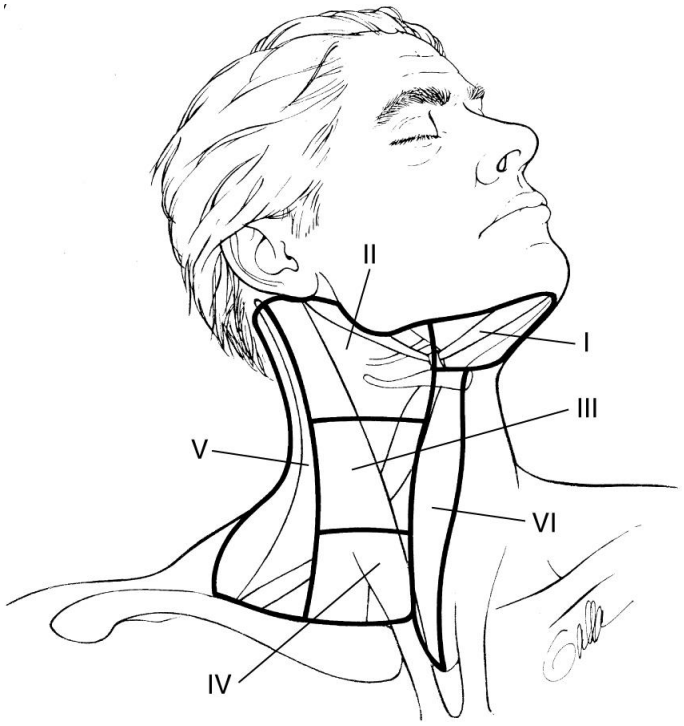
- Region I: Submental and submandibular triangles. Ia is the submental triangle bound by the anterior bellies of the digastric and the mylohyoid. Ib is the triangle formed by the anterior and posterior bellies of the digastric and body of mandible.

  Region II, III, IV: nodes associated with the IJV; fibroadipose tissue located medial to the posterior border of SCM and lateral to the border of the sternohyoid.
- Region II: upper third including the upper jugular and jugulodigastric nodes and the upper posterior cervical nodes. Region bound by the digastric muscle superiorly and the hyoid bone (clinical landmark), or the carotid bifurcation (surgical landmark) inferiorly. IIa contains nodes in the region anterior to the spinal accessory nerve and IIb posterior to the nerve.
- Region III: middle third jugular nodes extending from the carotid bifurcation superiorly to the cricothyroid notch (clinical landmark), or inferior edge of cricoid cartilage (radiological landmark), or omohyoid muscle (surgical landmark).
- Region IV: lower jugular nodes extending from the omohyoid muscle superiorly to the clavicle inferiorly.
- Region V: posterior triangle group of lymph nodes located along the lower half of the spinal accessory nerve and the transverse cervical artery. The supraclavicular nodes are also included in this group. The posterior boundary is the anterior border of the trapezius muscle, the anterior boundary is the posterior border of the sternocleidomastoid muscle, and the inferior boundary is the clavicle.
- Region VI: anterior compartment group comprises lymph nodes surrounding the midline visceral structures of the neck extending from the level of the hyoid bone superiorly to the suprasternal notch inferiorly. On each side, the

lateral boundary is the medial border of the carotid sheath. Located within this compartment are the perithyroidal lymph nodes, paratracheal lymph nodes, lymph nodes along the recurrent laryngeal nerves, and precricoid lymph nodes.

These chains of nodes are connected by a vertical chain of lymph nodes running along the length of the internal jugular vein. These are divided into upper, middle, and lower groups.

- Palpate first the upper and then the lower horizontal chains anteriorly to posteriorly, followed by the vertical chain.
- The relationship of the sternocleidomastoid muscle to the vertical groups of nodes should be noted. This muscle will need to be displaced anteriorly or posteriorly to adequately palpate the nodes.
- Using the above approach, all palpable node groups will be felt except for the Delphian nodes, which are located over the cricothyroid membrane and require a special effort to palpate them.
- The site, size, number, and consistency of the nodes should be noted and recorded. Much can be determined from the **consistency of the nodes**, e.g.:
  Metastatic Cancer: Hard
  Lymphoma: Firm and rubbery
  Hyperplastic Nodes: Softer
  Metastatic Malignant Melanoma: Maybe very soft



The Thyroid Gland

1. Can frequently be better seen than palpated and therefore, a moment should be taken to look at the neck in profile.
2. In most individuals, the normal gland is barely palpable, but if it is enlarged one should note if it is smooth, diffuse, or nodular swelling.
3. If nodular, it should be determined whether it is a single nodule or multinodular. If a single nodule is palpated and the rest of the gland is enlarged, this probably represents a dominant nodule in a multinodular goiter.
4. If doubt exists as to whether the palpable mass is truly thyroid in origin, the patient should be asked to swallow and if it moves, it is likely thyroid. Signs of compression of surrounding structures may be obvious, for example, displacement of the trachea, carotid arteries, or jugular veins.
5. If the lower aspect of the gland cannot be palpated above the suprasternal notch, retrosternal extension should be suspected, particularly if there are signs of superior mediastinal syndrome, for example, cervical venous engorgement and facial edema.

The Major Salivary Glands

a. Submandibular Glands:
   1. Easily palpable in the submandibular area of the neck.
   2. In older patients, they tend to sag lower and be more prominent in the neck and therefore, may be mistaken for a tumor.
   3. The best method of assessment is by bimanual palpation, with one finger in the floor of the mouth and the other in the neck. Intraoral inspection and palpation of the submandibular duct is necessary to evaluate saliva flow and consistency and to palpate for a calculus.

b. Parotid Glands:
   1. Easily palpated in the periauricular area, but the deep lobe lies in the parapharyngeal area and tumor may grow undetected until it has achieved an advanced stage.
   2. The oropharynx should be inspected for any distortion of the lateral wall if a deep lobe tumor is suspected.
   3. One should not forget to examine the parotid duct opening onto the buccal mucosa opposite the second upper molar tooth.

The Larynx and Trachea

Palpation of the external laryngeal skeleton is easily performed.

1. Feel for the trachea in the suprasternal notch and then follow it up to the more prominent cricoid cartilage.
2. The cricothyroid membrane above this becomes obvious. This is an

important landmark, as it is the site through which an emergency cricothyrotomy is performed.

3. The thyroid cartilage is palpated, with the prominent thyroid notch being obvious.
4. The hyoid bone is easily palpable just superior to the thyroid notch.

Other Structures

Once these major structures have been evaluated, the rest of the neck needs to be assessed in an orderly manner. Knowledge of the anatomy of the skin and subcutaneous tissue and the position of the underlying muscles, nerves, and blood vessels is essential. In addition, one must never forget to evaluate the cervical spine by palpation to determine whether there is a full range of movement without any discomfort of limitation.

ASSESSMENT OF A NECK MASS

As one examines a mass in the neck, the following questions should be asked:

A. What structure is it arising from?
B. Is it a lymph node?
C. If not, is the mass arising from a normally occurring anatomic structure in the area, for example, nerve, blood vessel, muscle?
D. Could it be arising from an abnormally occurring anatomic structure, for example, a laryngocele, pharyngocele, branchial, cleft cyst, or cystic hygroma?

Once the anatomic site of origin has been established, the pathologic diagnosis should be considered, i.e. is it congenital, inflammatory, traumatic, neoplastic, degenerative, or idiopathic? Using this approach, very few masses will elude diagnosis.

EXAMINATION OF THE ORAL CAVITY AND OROPHARYNX

General Principles

1. Often inadequately examined, with most clinicians being taught to insert a tongue depressor blindly into the patient's mouth and ask the patient to say "ah," which results in a glimpse of the oropharynx.
2. Patient is asked to remove all dentures, whether partial or complete. There should be no exceptions to this rule in spite of the amazing reluctance of many patients to comply with this request.
3. Have a systematic approach to the examination.

A. <u>Lips</u>

1. Regarded as part of the oral cavity.
2. Should first be inspected for any lesion, distortion or asymmetry of movement.

3. Should be palpated between thumb and forefinger in order to detect any submucosal masses that may not be visible.

B. Buccal Mucosa

1. Using two tongue blades, or one tongue blade and a gloved finger, the buccal mucosa is examined first on one side, then the other.
2. The parotid duct openings are identified and saliva flow is determined by massaging the parotid gland while observing the duct.

C. Teeth and Gingiva

1. The teeth and gingival should be inspected for any obvious abnormality.
2. If the gingival bleeds easily on palpation, the possibility of chronic infection should be suspected.
3. The teeth should be tapped gently in order to determine whether this maneuver elicits any pain indicative of underlying infection.
4. Perform a systematic examination of the dentition and supporting structures.

D. Floor of the Mouth

1. Ask the patient to elevate the tongue; the entire U-shaped area on the floor of the mouth can be examined. Inspection reveals the frenulum in the midline, with the openings of the submandibular ducts on either side. Pressure on the submandibular glands will provoke a visible flow from these ducts.
2. The sublingual glands are visible beneath the mucosa. On the ventral surface of the tongue submucosal varicosities are often found. A bony protuberance (torus mandibularis) arising from the inner table of the mandible can achieve variable size and is a common normal finding.
3. Bimanual palpation of the floor of the mouth will allow the submandibular glands to be felt in their entirety.

E. Tongue

1. Consists of the base (posterior one-third) and the mobile portion (anterior two-thirds).
2. Even with full protrusion, only the anterior two-thirds is clearly visible.
3. The tongue should be assessed both in its natural position in the mouth and during protrusion.
4. One must not forget to inspect the ventral surface of the tongue.
5. Lesions of the base of the tongue may be suspected if the patient complains of dysarthria or an inability to protrude the tongue fully.
6. The base of the tongue is best visualized using a mirror, but it can be palpated in most individuals.
7. The circumvallate papillae between the base and anterior two-thirds of the

tongue are often misinterpreted by both patients and physicians as representing pathologic lesions.

8. Lingual tonsils may vary in size and may mimic malignancy.

F. Hard and Soft Palate

1. To examine the hard palate, the patient is asked to tilt the head backward.
2. A midline, bony exostosis (torus palatinus) is a frequent finding and may be misdiagnosed as a tumor.
3. Soft palate can be inspected after depressing the tongue with a tongue blade. The mobility of the palate can be assessed by getting the patient to say "ah." Asymmetry in movement should be looked for.
4. Junction of the hard and soft palates should be inspected and palpated, looking for evidence of a submucous cleft. In this condition, the mucosa may look normal, but a notch rather than the spine will be palpated along the posterior aspect of the hard palate in the mid-line.

G. Oropharynx

1. The whole oropharynx, with the exception of the base of the tongue, can usually be adequately visualized if the tongue is depressed. In performing this maneuver, one must avoid placing the tongue blade too far posteriorly, as this will result in gagging.
2. The area should be evaluated as a whole, looking for any obvious asymmetry that may be due to a pathologic condition in the oropharynx proper or parapharyngeal space, which will distort the oropharynx.
3. Tonsils should be assessed. They may vary considerably in size, particularly in children, but are usually equal and symmetric.
4. If tonsils are asymmetrically enlarged, malignancy, particularly lymphoma, needs to be excluded.
5. The tonsils may be hyperplastic and fill the oropharynx in young patients, but tend to atrophy as the patient gets older.
6. Crypts in the tonsils are occasionally filled with debris, which may be misinterpreted as an infectious membrane. This debris may, however, cause a persistent sore throat or result in halitosis. Following tonsillectomy, there may be significant distortion of the oropharynx with loss of the anterior and posterior pillars and varying degrees of scarring.
7. Residual tonsillar tissue, following inadequate tonsillectomy, may be present and can cause significant symptoms.
8. The posterior pharyngeal wall should be evaluated. Although overt postnasal drip may be seen, more commonly lymphoid hyperplasia due to the drip may manifest just in the posterior tonsil pillars (lateral pharyngeal bands). A granular

pharyngitis across the posterior wall may be present and this is usually indicative of mouth breathing or irritation, for example, from cigarette smoking.

9. The base of the tongue is best evaluated with a laryngeal mirror or palpation.

EVALUATION OF THE PARANASAL SINUSES

A. Although the paranasal sinuses are best evaluated radiographically, clinical evaluation can give valuable information in determining the presence and type of sinus disease.

B. Probably the best indicator of sinus disease is the status of the nasal mucosa, which is obviously in continuity with the sinus mucosa and, therefore, will reflect any disease process involving the sinus, for example, infection or allergy. Examination of the middle meatus may reveal exudates discharging from the sinus ostia, thereby suggesting the type of secretion in the sinus. Palpation of the sinuses, particularly the frontal and maxillary ones, can be useful, with severe tenderness being suggestive of an empyema of the sinus.

EXAMINATION OF THE EAR

Pinna:

- Always inspect the pinna and surrounding structures before looking in the external ear with an otoscope.
- Low-slung ears, abnormal shaped pinna may indicate a congenital syndrome.
- Post-auricular swelling may indicate regional lymphadenitis or mastoiditis.

External Canal:

- There is never a need to insert the otoscope speculum deep into the canal. By gently retracting the pinna posterosuperiorly, and adequate view of the ear canal and tympanic membrane can be obtained with the tip of the speculum at the external meatus.
- A tender canal to palpation or traction on the pinna is indicative of diffuse otitis externa or a furuncle.
- Small exostoses are a common finding in the external canal and may obscure the view of the tympanic membrane.

Middle Ear:

- The tympanic membrane is usually semi-transparent.
- Look for the cone-like light reflex from the tip of the malleus to the periphery.
- A retracted tympanic membrane or fluid filled middle ear is usually easily apparent.
- If perforation is seen, one should note if it is a central or peripheral.
- If there is discharge emitting through the perforation, its consistency and color should be noted.

眼科身體診察

一、眼科初診單

包括 chief complaint / present illness /past history /vital signs/ body weight

1. External eye examination 外眼部檢查

→ 觀察眼皮是否

(i)正常 (ii)ptosis 下垂 (iii)lagophthalmos 閉合不完 (iv)retraction 退縮

可利用角膜中心光反射及眼皮之邊緣之距離測量眼皮下垂或退縮之程度

→ 眼球是否凹陷或凸出

→ 觸摸眼窩骨骼是否完整

2. visual acuity 視力檢查

→ distance visual acuity (遠距離視力)：在六公尺處以 Landol+C 視力表箱檢查，先檢查裸力，視力減退者再作矯正視力

(1) 先檢查右眼，把左眼遮住

(2) 視力低於 0.1 時，請受測者走近視力表

(3) 視力低於 0.02 時，數檢查者手指

(4) 如果在 5cm 處，仍不能數手指，辨認有無手動

(5) 在 5cm 處不見手動，測是否有光覺

→ near visual acuity (近距離視力)：用近距離視力表以 30cm 之距離處紀錄受測者能看清楚最小一行字

3. Intraocular pressure 眼壓

→ Non-contact Air-puff tonometry 非接觸性氣壓式眼壓計：

受測者把下巴、額頭固定在機台上，利用一般噴出的空氣來壓平角膜中心，同時儀器本身也發出一束光線，由接收器接收中心角膜反射回來的光線，轉換成壓力值

→ 接觸式眼壓計，需先點眼麻醉劑藥水再測量

(1) Goldman 眼壓計需用螢光染劑，測量眼角膜中心壓平所需之壓力，即兩個半弧型連接在一起時的壓力

(2) Tonopen (Electric Identification Tonometry)

使用筆型的眼壓觸碰角膜中心，測量角膜被壓平所需的壓力，使用前需更換眼壓計前端之無菌套子

4. Eye position & ocular motily 眼位及眼球運動

→ 紀錄眼位：ortho (正位)、Esotropia (ET、內科)、Exotropia、XT、外斜眼球運動：adduction(內轉)、abduction(外轉)、Elevation(向上)、depression(向下)是否有侷限

5. pupil function 瞳孔反應

→ 在暗室使用光照射一眼觀察瞳孔是否有收縮 (direct reaction) 同時觀察另一眼瞳孔反應 consensual reaction，利用 swinging test 反覆來回照射瞳孔，測量是否有 afferent papillary defect (Marcus Gunn pupil)

6. Visual field 視野檢查

→ 以 confrontation test 測量視野，先測一眼，遮住另一眼，受測者與檢查者對坐約一臂之距離，受測者固定注視前方如測試者之臉，測試者伸手搖動手指從各不同方向測試，看受試者能否察覺哪邊手指在動

7. Ophthalmoscopy 眼底鏡檢查

→ 使用直接眼底鏡檢查眼底(direct ophthalmoscope)，檢查者先調整直接眼底鏡上的度數到夠清楚物體，再以右眼檢查受試者右眼，左眼檢查受試者左眼，要觀察①視神經是否有水腫、視神經盤大小 ②黃斑部反射是否有水腫、出血 ③視網膜血管有無扭曲、出血

8. Slit lamp Examination 細隙燈檢查

→ 用細隙燈上不同寬度的光線及放大倍率觀察角膜病變，眼睛前方深淺及水晶體是否混濁(白內障)

參考資料：Eye examination wikipedia
Clinical procedures in primary eye care-second edition (2003) David B Elliot Butterworth Heinemann

身體診察自我檢測要點 Physical Examination checklist

Cardiovascular Examination

Appropriate draping.	
Assess rate of capillary refill in the fingernails	■ Report in terms of seconds
Auscultation for carotid bruits	■ Bilateral
Palpate the carotid pulses	■ Character of the upstroke, pulse contour, and any palpable vibration (thrill)
Inspection of the jugular pulse.	■ Appropriate positioning Noting the wave form and measure the greatest height in centimeters above thesternal angle (JVD) Test for abdominojugular reflux
Identify landmarks on the anterior Chest	■ Noting the expected locations of the heart chambers, valves, and great vessels, any deformities, scars or lesions
Inspect the chest for visible impulses	■ Describing their location in terms of intercostal space and distance from the mid-sternal line.
Palpate the chest to locate	
the apical impulse	■ Describing its size (centimeters in diameter) and location (intercostal space and distance from mid-sternal line in centimeters). Noting any double beat, or sustained pulse (heave)
any other impulses	■ Investigating the suprasternal notch, left sternal border, right and left second intercostal spaces and epigastrium
Auscultation of the heart	■ from the apex, across to the left sternal border, up to the left second interspace, across to the right second interspace, and in the left axilla , using both bell and diaphragm
Listen to the first heart sound	■ in all auscultatory areas for splitting, variation with respiration, and intensity compared to S2
Listen to the second heart sound	■ in all auscultatory areas for splitting, respiratory variation, and for the relative intensity of the aortic and pulmonic components

Listen for gallops (S3, S4)	■ including with the patient rolled into the left lateral decubitus position. Noting the relative intensity with bell and diaphragm
Listen for other sounds	■ clicks, snaps, rubs
Listen for murmurs, and characterize them by the 7 critical criteria	■ loudness, timing in the cardiac cycle, variation in loudness, whether heard better with bell or the diaphragm, location on chest where heard best, radiation to neck or left axilla, and respiratory variation

Chest examinations

Inspection General appearance / HEENT / Neck/ Extremities	■ Normal speech: no disrupted speech ■ Normal Breathing movement: no thoraco-abdominal dissociation; Symmetric expansion ■ Normal Breathing pattern : No tachypnea, no bradypnea, no hypopnea, no hyperpnea, no Cheyne-Stokes breathing, no ataxic breathing, no orthopnea, no pursed lip breathing ■ Lip: no central cyanosis ■ Nose: no nasal flaring ■ No accessory muscle recruitment (neck : sternocleidomastoid and scalene muscle; abdomen : abdominal oblique muscle) ■ Tracheal position: No deviation (lateral shift) ■ Extremities: No clubbing fingers, No palm erythema, no edema, no cyanosis
Inspection Chest/Thorax / Breast	■ Chest wall : No deformities (Barrel chest , Funnel chest, Pigeon chest, scoliosis, kyphosis); No local tenderness; No subcutaneous emphysema; No local bulge of chest wall ■ Breast : Symmetry, no edema, no skin retraction, no nipple retraction, no mass, no tenderness
Auscultation of the Chest	■ Breathing sound: all clear (tracheal sound, bronchial sound, bronchovesicular sound, vesicular sound) , no stridor, no crackles (coarse or fine, diffuse or localized, all respiratory phase or expiratory only), no wheezes

	■ Tactile fremitus (no egophony; E turn into A) ■ No pleural rub
Percussion of the Chest	■ Normal resonance (no hyperresonance, no tympany, no dullness, no flatness)
Palpation of the Chest	■ Detecting masses/lymphadenopathy ■ Muscular resistance and areas of tenderness

Gastroenterological examinations

Inspection	■ Scleral icterus ■ Conjunctiva color ■ Spider angioma ■ Palmar erythema ■ Gynectomastia ■ Surface characteristics (abdomen) Color, venous return, nodules/lesions, scars ■ Contour (abdomen) ■ Abdominal movement
Auscultation of the abdomen	■ Bowel sounds: use diaphragm of a warm stethoscope ■ Vascular sounds: use bell of the stethoscope
Percussion of the abdomen	■ Liver span ■ Spleen span ■ Shifting dullness (ascites)
Palpation of the abdomen	■ Assessing liver and spleen ■ Detecting masses/lymphadenopathy ■ Muscular resistance and areas of tenderness
Hepatic encephalopathy	■ Conscious disturbance ■ Flapping tremor (asterixis) ■ Constructional apraxia ■ Writing difficulty ■ Serial seven subtraction test ■ Reitan number connection test
Abdominal sign	■ Blumberg ■ Cullen ■ Grey Turner ■ McBurney ■ Murphy ■ Obturator

	■ Psoas ■ Rovsing
Digital examination	

Nephrology examination

HEENT	■ Eye: look for pale conjunctiva ■ Neck: observe for jugular vein engorgement
Chest	■ Observe for breathing pattern ■ Auscultation for abnormal breathing sound (crackles, wheeze)
Heart	■ Palpation for heave ■ Percussion for cardiomegaly ■ Listen for S1,S2 and gallops (S3, S4)
Inspect the abdomen	■ note the usual locations of the following organs ■ <u>right upper quadrant</u> right kidney ■ <u>left upper quadrant</u> left kidney ■ <u>midline</u> bladder
Examine the skin	■ Evidence of scars, skin turgor and skin lesions (herpes zoster)
Observe the abdominal contour	■ Looking for evidence of distention, asymmetry, masses
Auscultation of the abdomen	■ Listen for bowel sounds, and ■ Bruits (epigastric, costovertebral (CV) angles, periumbilical and inguinal)
Percussion of the abdomen/back	■ CV angle tenderness. ■ A gentle tap is usually plenty to elicit an inflamed kidney. The CV angle is usually examined at the same time as the chest, with the patient is seated.
Palpation of the abdomen	■ superficial masses ■ the bladder ■ the right/left kidneys
Assessing for lower leg pitting edema	■ Grade 1-4 (2mm-8mm)
Record the results of your examination	

Hema-oncology examination

■ HEENT	■ Eye: Pale conjunctiva ■ Icteric sclera ■ Oral cavity: Glossitis ● Candidiasis ● Gum hypertrophy
■ Chest	■ Sternal tenderness
■ Lymph node ■ Palpation of peripheral lymphadenopathy	■ Location: ■ Neck, infra-clavicular, axillary, pre-trochlear, inguinal, femoral and popliteal area ■ Describe the location, size, number, consistency, movability and tender of the palpable lymph nodes
■ Abdomen	■ Liver: Hepatomegaly ■ Spleen: splenomegaly
■ Examine the skin	■ **Bleeding signs** ■ Petechiae ■ Ecchymosis ■ Purpura ■ Hematoma ■ **Nutrition deficiency anemia** ■ Nail: irregularity of nail border (fragile) Concave of nail bed (Spoon nail) ■ Hair color (nature color discoloration)
■ Abnormal visible tumor	■ Describe the location, size, consistency, movability, tender and appearance (ex. necrosis, touching bleeding, discharge …et al.)
■ Record the results of your examination	

Rheumatology examinations

General Inspection	■ Identification of arthritis and distinction of tendinitis/fasciitis ■ Rheumatoid nodule ■ Assessment of joint range of motion and muscle power ■ Assessment for tender and swollen joint counts for rheumatoid arthritis (DAS28)
Hand	■ Allen’s Test ■ Vascular sounds: use bell of the stethoscope ■ Finkelstein’s test

	■ Carpal lift sign ■ Herberdan's and Bouchard's nodes ■ Hand squeeze test
Shoulder	■ Impingement sign ■ Mazion's maneuver ■ Dugas' test
Elbow	■ Olecrenon bursitis
Knee	■ Varus and valgus tests ■ Anterior and posterior drawer sign
Back	■ Schober's test ■ Spine lordosis assessment
Foot	■ Tophus deposition ■ Sausage toe/finger
Skin	■ Malar rash ■ Discoid rash ■ Heliotrope sign ■ Gottron sign ■ Skin vaculitis ■ Psoriasis ■ Keratoderma blenorrhagica ■ Scleroderma

Metabolism/Endocrinology examination

DM foot examination

Sensory peripheral neurophaty 周邊感覺神經系統評估	■ Vibration abnormality ■ Monofilament test abnormality
Motor peripheral neuropathy/ structural abnormalities 運動神經病變/結構異常	■ Hammer toes ■ Claw toes/Prominent metatarsal heads ■ Hallux valgus ■ Charcot foot
Autonomic neuropathy 自主神經病變	■ Skin dry/scaly/stiff/fissures ■ Onychomycosis
Peripheral Arterial Ischemia/ Circulation Assessment 周邊動脈組織缺血/血管評估	■ Lower extremity pulsation evaluation: dorsalis pedis/ medial malleus/ posterior tibialis /femoral ■ Cyanotic change ■ Gangrene (dry/wet)

Infection assessment 感染評估	■ Erythematous change ■ Local heat ■ Local swelling ■ Tenderness ■ Pus/abscess formation ■ Cripitus ■ Bullae/Bilster formation

Diabetic Foot Classification (**Wagner system)**	
Grade	特　徵
0	屬於高危險足部（有結構異常或蜂窩性組織炎），無潰瘍
1	表淺的潰瘍，涵蓋了部分或整層皮膚
2	潰瘍侵犯到韌帶、肌腱、關節腔或深部筋膜，但沒有膿瘍或骨髓炎的發生
3	深層的潰瘍，合併膿瘍、骨髓炎或關節敗血症（joint sepsis）
4	局部的壞疽，包含了部分的腳尖或腳跟
5	延深的壞疽，包含了整個腳

Cushing's syndrome/ Cushing's disease

Cushing appearance	■ Loss of scalp hair ■ Moon face ■ Plethoric face ■ Facial hirsutism/pigmentation/acne ■ Buffalo hump ■ Central obesity, thinning of limbs ■ Abdominal/thigh purple striae ■ paper-thin skin ■ Proximal muscle wasting and weakness ■ skin ecchymosis or ulceration ■ Edema ■ Hypertension ■ Evidence of (rheumatoid) arthritis treated with steroids ■ Personality change (Depression or psychosis) ■ Polyuria, polydipsia Other informations from History: ■ Amenorrhea ■ Medication (include herb/電台藥) usage ■ Increased body weight

Thyroid Physical examination

Inspection	■ Always offer the patient a glass of water. You should inspect while the patient is at rest as well as when they take a drink of water. The thyroid gland should move with swallowing. ■ You should first make out the classic landmarks: thyroid cartilage, cricoid ring and the two heads of the sternocleidomastoid. ■ The thyroid isthmus should lie right on top of the cricoid ring or just beneath it. When you inspect, you are observing the overall size of the thyroid and whether there is any asymmetry or masses.
Palpation	■ You should palpate each lobe at rest as well as when the patient swallows. You are palpating for the overall **size** of the thyroid, the **texture**, **tenderness,** for **nodularity** and nodular size.
Chart Record checklist about thyroid and neck	■ Goiter size ■ Goiter texture: elastic/soft/firm/stony hard ■ Nodule: Y/N Number: multiple or n (➔make a sketch) Consistency: elastic/soft/firm/stony hard ■ Tenderness: Y/N ■ Above cover skin: normal/erythematous/petechia/ ecchymosis/wound ■ Neck Lymphadenopathy: N/Y➔number, level, fixed/movable, size, tenderness
Thyroid disease associated other physical examination	■ Vital sign check pulse (tachycardia? Sweating?) ■ Body Height ■ Body Weight ■ General appearance: anxious/slow response ■ Eye: Stare: Y/N ■ Lid Lag: Y/N ■ Exophthalmos(proptosis): Y/N ■ Extremity: Hand fine tremor: Y/N ■ Onycholysis: Y/N ■ Clubbing finger: Y/N ■ Pretibial Myxedema: Y/N ■ Generalized Skin: moist/hot/cold

Acromegaly examination

Local tumor effects	■ Visual-field defects ■ Cranial-nerve palsy, ocular palsy ■ Headache
Somatic systems	■ Acral enlargement : such as Large nose, large tongue, large(broad) hands, large(broad) feet ■ Prominent supraorbital ridges, thick skin ■ Gigantism ■ Prominent supraorbital ridges ■ Jaw prognathism or jaw malocclusion/separation of teeth ■ Arthralgias and arthritis ■ Carpal tunnel syndrome ■ Acroparesthesia ■ Proximal myopathy ■ Hypertrophy of frontal bones
Skin and gastrointestinal system	■ Hyperhidrosis ■ Oily texture ■ Skin tags ■ Colon polyps
Cardiovascular system	■ Hypertension ■ Congestive heart failure ■ Valvular heart disease ■ Arrhythmia
Visceromegaly	■ Tongue ■ Thyroid gland ■ Liver ■ Spleen ■ Kidney ■ Prostate
Endocrine and metabolic systems	■ Menstrual abnormalities ■ Galactorrhea ■ Decreased libido or impotence ■ Impaired glucose tolerance/ Hyperinsulinemia/ Diabetes mellitus

Checklist of Neurologic examination

Maneuver	**What is tested**	**Record of performance**
Visual acuity: Snellen eye chart,	CN II	■ Right ■ Left

Counting fingers, Hand movement, Finger movement, Light sense		
Fundus	CN II	■ Right ■ Left
Visual field by confrontation	CN II	■ Right ■ Left
Light reflex	CNs II & III	■ Right ■ Left
Eye of movement & convergence	CNs III, IV & VI	■ Both eyes ■6 directions
Corneal reflex	CNs V & VII	■ Right ■ Left
Close eyes	CN VII	■ Yes
Show teeth, smile & whistle	CN VII	■ Yes
Weber, Rinne, rubbing finger, whisper, watch	CN VIII	■ Right ■ Left
Nystamus	CN VIII	■ 5 directions
Open mouth, say “ah”, watch palate	CNs IX & X	■ Yes
Gag reflex	CNs IX & X	■ Right ■ Left
Shrug shoulders, turn head	CN XI	■ Right ■ Left
Stick out tongue	CN XII	■ Yes
Arms out with eyes closed (drift)	Corticospinal tracts	■ Yes
Finger-nose-finger, eyes closed	Cerebellum, proprioception	■ Right ■ Left
Finger-nose-finger, eyes open	Cerebellum	■ Right ■ Left
Spread fingers against resistance	Corticospinal tracts	■ Right ■ Left
Snap fingers, rapid tapping movements	Corticospinal tracts	■ Right ■ Left
Deep tendon reflexes, 4 limbs, jaw jerk	Corticospinal tracts	■ Right ■ Left ■ Jaw ■ Biceps ■ Brachioradialis ■ Triceps ■ Knee ■ Ankle
Hoffman reflex	Corticospinal tracts	■ Right ■ Left
Babinski‘s sign	Corticospinal tracts	■ Right ■ Left
Heel-knee-shin	Cerebellar system	■ Right ■ Left
Cotton touch: face, hands, feet	Spinothalamic tracts	■ Right ■ Left
Pinprick sensation: face, hands,	Spinothalamic	■ Right ■ Left

feet	tracts	
Vibration sense, 128 Hz tuning fork: face, hands, feet	Posterior columns	■ Right ■ Left
Joint position, hands and feet	Posterior columns	■ Right ■ Left
Station and posture	Multiple systems	■ Yes
Walk, turn, armswing	Multiple systems	■ Yes
Tandem gait (heel-to-toe)	Cerebellar system	■ Yes
Deep knee bend (Squatting)	Proximal motor strength	■ Yes
Walk on heels	Distal motor strength	■ Yes
Walk on toes	Distal motor strength	■ Yes
Hop on each foot	Corticospinal tracts	■ Yes
Balance on each foot	Multiple systems	■ Right ■ Left
Tap toes with heel fixed on floor	Corticospinal tracts	■ Right ■ Left
Tap heels with ankles dorsiflexed	Cerebellar system	■ Right ■ Left
Romberg maneuver	Posterior columns	■ Yes
Check muscle tone, hands and feet	Motor system	■ Right ■ Left
Patient protection while patient away from the chair or bed	Preventing falling down, quality	■ Yes
Record of neurological findings	Written training of record	■ Complete

CN = Cranial nerve.

Dermatology examinations

Skin Inspection	■ Color ■ Erythema, purpura, pigmentation, depigmentation, jaundice, carotenemia ■ Moisture ■ Dryness, sweating, oiliness ■ Texture ■ Roughness, smoothness ■ Lesion ■ Type ● Primary lesions ✓ Macule, patch, papule, nodule, cyst, plaque,

	wheal, blister (vesicle, bulla), pustule, purpura (petechia, ecchymosis), telangiectasia ● Secondary lesion ✓ Erosion, ulcer, excoriation, scar, desquamation/ scaling, fissure, curst, lichenification ● Special lesion ✓ Comedo, milium, burrow ■ Shape/Arrangement of lesions ● Annular, arcuate, circinate, confluent, discoid, grouped, linear, reticulated, serpiginous, zosteriform ■ Distribution over the body ● Extent ✓ Localized, generalized, universal, disseminated, dermatomal, sun-exposed, sun-protected ● Location ■ Size
Skin Palpitation	■ Consistency ■ Soft, elastic, hard, firm, infiltrated, mobile, tender ■ Temperature ■ Warm, cold
Hair	■ Quantity ■ Alopecia ● Localized, diffuse ● Scarring, non-scarring ■ Hirsutism ■ Distribution ■ Localized, diffuse, patchy, universal ■ Texture ■ Coarse, fine
Nail	■ Paronychia, clubbing, onycholysis, leukonychia, pitting, oily spot, splinter hemorrhage, subungual hyperkeratosis ■ Transverse white band (Mee's line) ■ Transverse linear depression (Beau's line)

Eye Examination

Vision	■ Distance visual acuity(Landolt C Chart) ■ Near visual acuity (Rosenbaum pocket vision screener) ■ Color vision
Intraocular pressure	■ Air puft Tonometer

	■ Tonopen
Eye position and ocular motility	■ Light reflex to check Esotropia, Exotropia ■ Elevation, depression, abduction/ adduction
External eye	■ Look for ptosis, lagophthalmos retraction of eyelids ■ Palpation for eyelid mass ■ Enophthalmos or Exophthalmos
Pupil function	■ Direct light reflex ■ Indirect light reflex ■ Pupil size (mm) ■ Shape of pupil round, irregular, posterior synechiae
Slit lamp	■ Cornea- epithelial defect/foreign body/scar ■ Anterior chamber- Depth/hyphema/hypopyon
Direct Fundoscopy	■ Optic disc- cupping, margin ■ Macula-normal hemorrhages, exudates ■ Retinal vessels ■ caliber ■ occlusions
Visual field	■ Confrontation test

Urological Examination

Inspection General appearance /HEENT	■ Signs of distress ■ Mood
Examination of the abdomen Kidney Bladder Groin	■ Scars/ Hernia / Mass? ■ Bimanual palpation/ abdominal pain/ tender flanks ? ■ Distended urinary bladder ? ■ Inguinal lymphadenopathy?
Examination of the penis Prepuce Glans Penile shaft	■ Retraction of the prepuce? phimosis/ paraphimosis? ■ Frenulum breve? ■ Hypospadia? ■ Genital ulcers? hygiene? tumor? ■ Induration or angulation of the penile shaft ?
Examination of the testes and scrotum Testes Inguinal canal Spermatic cord Scrotal skin	■ Testicular size/ position? Palpable mass or enlargement? ■ Palpable vas deferens? ■ Varicocele in supine or upright position? ■ Edema/ redness /wound/ necrosis?

Digital Rectal Examination (DRE) Anus Rectum Prostate	■ Hemorrhoids? Scaring? Anal fissure? Sphincter tone? ■ Rectal tumor? Blood on the glove? ■ Prostate size? Consistency? Indurated nodules? Tenderness? Fluctuations?
Pelvic Examination Urethra Vulva Vagina	■ Position of the meatus ■ Indurations? Tumor? ■ Cystocele or rectocele ? ■ Urine leak under Valsalva? ■ Pattern of body hair?
Examination of Extremities	■ Skin turgor /lower leg pitting edema? bilateral or unilateral?

Gynecology Examination

Inspect the vulva and perineum	■ Looking for evidence of lesions ■ Vulva: Condyloma, Bartholin's cyst,… ■ Urethra orifice: Caruncle, Urethral prolapse,… ■ Perineum ■ Anus: Hemorrhoid,…
Examine the external genitalia (Vagianl speculum examination)	■ Looking for evidence of lesions ■ Vagina: Condyloma, Cystocele, Rectocele, Leukorrhea,… ■ Cervix: Polyps, Nabothin cyst, Erosion, Uterine prolapse,…
Examine the internal genitalia (Bimanual examination)	■ Palpation for evidence of lesions ■ Uterus: myomas or masses,… ■ Bilateral adnexa: ovarian tumor,… ■ Cul-de sac: nodularity,... ■ Lifting the cervix for evidence of pelvic inflammatory disease

Otolaryngology-Head and Neck Examination

Examination of the ear	■ Check the gross appearance of the auricle and surrounding soft tissue ■ The use of otoscopy, describe the external auditory canal condition, the appearance of tympanic membrane ■ Look for the cone-like light reflex from the tip of the malleus to the periphery

	■ Note if there is a central or peripheral perforation
Examination of the nose	■ Check the gross appearance of the nose ■ use anterior rhinoscopy, describe the appearance of nasal septum, inferior turbinates ■ use the mirror to check the nasopharynx
Examination of the paranasal sinuses	■ Do local treatment for mucosal shrinkage ■ Examination of the middle meatus ■ Palpation of the sinuses
Examination of the oropharynx and oral cavity	Lips ■ inspected for any lesion, distortion or asymmetry of movement. ■ palpation between thumb and forefinger in order to detect any submucosal masses Buccal mucosa ■ examined first on one side, then the other ■ retromolar and buccogingival region should be included Teeth and gingiva ■ inspection and palpation. Perform a systematic examination of the dentition and supporting structures. Floor of the mouth ■ elevate the tongue then inspection ■ Bimanual palpation of the floor of the mouth will allow the submandibular glands to be felt in their entirety. Tongue ■ The tongue should be assessed both in its natural position in the mouth and during protrusion ■ inspect and palpate the ventral surface and base of the tongu Hard and Soft Palate ■ Soft palate can be inspected after depressing the tongue with a tongue blade Oropharynx ■ The whole oropharynx can usually be adequately

	visualized if the tongue is depressed ■ assess bilateral tonsils ■ evaluate the posterior pharyngeal wall
Examination of the larynx	■ after traction the patient's tongue, use mirror the observe the hypopharynx and larynx ■ Note the movement of bilateral vocal cords ■ Observation if there is nodule, polyp, or cyst over vocal cord.
Examination of the neck	■ Inspection ■ Palpation: A systematic approach is necessary in order to avoid missing any pathologic findings (from level I to level VI) ■ The site, size, number, and consistency of the neck mass should be noted and recorded.
Examination of the major salivary glands	■ bimanual palpation ■ Intraoral inspection and palpation

住院病歷書寫參考範本

長庚醫院林口總院 Dr.李明勳/Dr.方基存

日期:　年　月　日

一般資料:(General Data)

姓名:　　年齡:　　性別:

職業:

婚姻: Married or single or divorced

籍貫:

職業病史:

資料來源: According to patient himself or family (who?)

CHIEF COMPLAINT:

- 主訴應儘量使用症狀與時間；不要用日期（date）
- 症狀儘量不超過兩個

例: RUQ pain and fever for 3 days

Chest tightness and palpitation since 6/10, 730pm (Bad example)

→ **Chest tightness and palpitation for 1 hour**

PRESENT ILLNESS:

內容須包含

1. 與此次住院有關的 past illnesses & previous hospitalizations 需予載入第一段且以 chief complaint 為中心，有系統的將各項問題、相關症狀及病程演變依時序完整記錄。應含有無造成症狀改善或惡化之因素。

   症候可以 LQQOPERA 描述

   (1) 位置 (Location)： 局部性 (localized)、瀰漫性 (diffuse) 、移位性 (migratory) 、放射性 (radiation)等等

   (2) 形態 (Quality)： 刺痛 (needling)、銳利 (sharp pain)、頓痛 (dull ache) 、壓迫性 (oppressive)、難忍的 (excruciating) 等等

   (3) 歷時/時相 (Quantity)： 持續性 (persistent) 、間歇性 (intermittent): 其頻率、單次持續時間及發作間隔

   (4) 起病狀態 (Onset mode)： 超急性 (abrupt)、突然 (sudden) 、 緩慢性 (insidious)

(5) 情境、誘發因素 (Precipitating factors)

(6) 加重因素 (Exaggerating factors)

(7) 緩解因素 (Relieving factors)

(8) 伴隨因素 (Accompanying symptoms)

2. 第二段則著重於你的鑑別診斷 (Your differential diagnosis)，有那些反證 (negative findings) 和本院急診與院外已知的檢查結果及治療反應，能夠排除鑑別診斷中的其他疾病。同時強調為什麼讓病人入院? 例如: 嚴重的社區型肺炎，UGI bleeding with postural dizziness or fainting etc.,

3. 最後一段則描述同時發生的毛病 (Concurrent diseases)，和主訴所推論得到的診斷無關，卻一併出現的問題 (Co-morbidity)。

例:

This 46-year-old woman has a history of diabetes mellitus and stroke with left-sided weakness, and has been taking medication for 10 years as doctor's prescription. She has suffered from flatulence and epigastric distress sometimes accompanied by mild fever since January 23, 2007. Her distress was often precipitated by fatty foods or eggs with accompanying right upper quadrant pain lasting several minutes sometimes. The distress or pain could refer to the homolateral infraclavicular region accompanied by vomiting and prostration. Three days before entry to our ER, a sharp, knife-like pain burst abruptly in the right upper quadrant region about one hour after taking fried rough food. The colic lasted about 20 minutes and vanished spontaneously then relapsed twice with spiking fever, chills and radiation to the infrascapular area upward.

She was admitted to a local hospital and received some blood tests and radiological examination. With the impression of acute cholecystitis, she received IV fluid supplement and pain control, but her symptoms were not relieved. She was then transferred to our ER as family requested. In our ER, physical examinations revealed RUQ tenderness with positive Murphy's sign. Laboratory findings revealed leuokocytosis and slightly elevated liver enzymes (AST ?? U/L AlK-P ?? U/L). Total bilirubin was within normal limit. Sonography disclosed multiple gallstones, distended gallbladder and wall thickening. The common bile duct and intrahepatic duct were not dilated. Under the impression of gallstones with acute cholecystitis, she was admitted to GI ward for continuing the antibiotic treatment and observe if the progression will need surgical intervention.

Throughout the whole course of present illness, there were fever, nausea, vomiting and abdominal fullness, but no tea-colored urine.

PAST HISTORY:

1. DM [用藥、追蹤院所、固定不固定、平日血糖控制於多少]
2. Hypertension [用藥、追蹤院所、固定不固定、平日血壓控制於多少] or other cardiovascular disorders[用藥、追蹤院所、固定不固定]
3. Denied history of pulmonary TB, COPD or other pulmonary diseases
4. Denied history of liver diseases.
5. Denied history of surgery
6. Previous operations: [診斷、手術名稱及手術日期、院所]

過去史逐項列出，包括 active 和 inactive problems。如果與現在病史有關之過去史均應列入現在病史中敘述。

PERSONAL HISTORY:

1. Denied history of smoking :
2. Denied history of alcohol drinking
3. Denied history of allergy to food or drugs
4. 旅遊史: (是否至疫區?)
5. 動物接觸史:

FAMILY HISTORY :

DO NOT USE “Non-contributory”, “Nil” or “Nothing particular”

家族史應儘量列出三代的 pedigree tree，不要只寫 non-contributory，並圈出與病人同住的家人，以及住所的環境。

REVIEW OF SYSTEM:

系統整理是一個系統器官的總覽，可做為全身各系統器官的症狀的總評估。病人求診時雖不會遺漏和主訴相關的症狀，但對於其他系統器官的症狀或變化卻未必會主動告知醫生，因此只有經由 Review of Systems (ROS)才會一一將病患正在進行或已靜止的問題完全顯現出來，也藉此才能讓我們醫師的處置更完整。系統整理亦可載入評估病人住院時之身心、營養、身體機能及需要照護程度狀況等。

系統整理主旨在彌補因為醫師問診技巧不足、病人的教育水準參差不齊、或

是病人記憶有失，所造成現症史的缺失，能夠在這方面給大家一個重新的評估。若問到 positive findings 必須追問其症狀出現的部位、時間、性質及強度……等。

例如

General

Consciousness (Drowsy) E2V2M4 → 寫出 Drowsy 此 positive finding 可追加描述其 Coma scale; 切記不可單以 Consciousness (+) or (-) 表示有無!!

Dehydration (Yes) Dry tongue and poor skin turgor 描述發現其 Dehydration 的根據

<review of system> 範例:

1. General：
   weakness:(no), fatigue:(no), anorexia:(no), fever:(no), insomnia:(no)
2. Integument (skin, hair and nails)：
   changes in color:(no), pruritus:(no), rash:(no), hair loss:(no)
3. HEENT：
   a. Head - headache:(no), dizziness:(no), vertigo:(no)
   b. Eyes - visual acuity:(normal), color vision:(normal), corrective lenses: (yes), photophobia:(no), diplopia:(no), pain:(no)
   c. Ears - pain:(no), discharge:(no), hearing loss:(no), tinnitus:(no)
   d. Nose - epistaxis:(no), discharge:(no), stuffiness:(no), sense of smell: (normal)
   e. Throat - status of teeth:(normal), gums:(normal), dentures:(no), taste: (normal), soreness:(no), hoarseness:(no), lump:(no)
4. Respiratory：cough:(no), sputum:(no), hemoptysis:(no), wheezing:(no), dyspnea:(no)
5. CV：edema:(no), chest distress:(no), chest pain:(no), palpitation:(no) intermittent claudication:(no), cold limbs:(no), cyanosis:(no)
6. GI：dysphagia:(no), nausea:(no), vomiting:(no), abdominal distress/pain: (no), change in bowel habit:(no), hematemesis:(no), melena:(no), bloody stool:(no)
7. GU：urinary frequency:(no), hesitancy:(no), urgency:(no), dribbling:(no), incontinence:(no), dysuria:(no), hematuria:(no), nocturia:(no), polyuria:(no), impotence:(no);
8. Metabolic and endocrine：growth:(fair), development:(normal), weight change:(no), heat/cold intolerance:(no), nervousness:(no), sweating:(no), polydipsia:(no)

9. Hematotologic: anemia:(no), easy brusity or bleeding:(no), lymphadenopathy: (no), transfusions:(no)
10. Neuropsychiatry：dizziness:(no), syncope:(no), seizure:(no), speech disturbance:(no), loss of sensation:(no), paresthesia:(no), ataxia:(no), weakness or paralysis: (no), tremor:(no), anxiety:(no), depression:(no), irritablility:(no)
11. Musculoskeletal：joint pain:(no), stiffness:(no), limitation of motion: (no), muscular weakenss:(no), muscle wasting:(no)

PHYSICAL EXAMINATIONS:

1. 避免主訴、入院診斷與理學檢查不符
2. 決定內容要寫哪些東西以後，要盡量把觀察到的問題"定量化", Ex., Pitting edema **(+)** or (++), **Gr. II/VI** Pansystolic murmur over left lower sternal border with radiating to left axilla

<PE> 範例:

GENERAL APPEARANCE:

Fair looking

CONSCIOUSNESS:

Clear, E 4 V 5 M 6

HEENT:

Sclerae: NOT icteric

Conjunctivae: NOT pale

Oral cavity : Intact oral mucosa

NORMAL tongue appearance

Throat NOT injected

NECK:

Supple

No jugular vein engorgement

Trachea NOT deviated

No lymphadenopathy

Carotid Pulse:

Amplitude: NORMAL

Rhythm: regular

Rate: equal TO heart rate

Bruits: no

CHEST:

Breath pattern: smooth, Bilateral symmetric expansion

No USE OF accessory muscles

Breathing sound:bilateral clear AND symmetric breathing sound

Wheezing: No wheezing

Crackles: No basal crackles

Palpation:NORMAL

Percussion:bilateral symmetric normonoresonance

No sternal tenderness

Lung-Liver border: Anteriorly over ___ intercostal SPACE, Posteriorly over ___ intercostal SPACE

HEART:

Regular heart beat without audible murmur

S1,S2 normal; No audible S3; No audible S4

Palpable PMI __cm over __th intercostal SPACE OF left-mid-clavicular line

Heave: no

ABDOMEN:

Soft AND flat, No superficial vein engorgement

No umbilicus herniation

Liver AND spleen NOT palpable

No shifting dullness

No tenderness; No rebounding pain

No muscle guarding

No Murphy`s SIGN

Bowel sound: normoactive

No visible spider angioma

BACK:

No knocking pain over bilateral flank area

EXTREMITIES:

No joint deformity

Freely movable

No pitting edema

Peripheral pulse: symmetric

SKIN:

No petechiae OR ecchymosis

No abnormal skin rash

Laboratory Findings: (檢驗值單位要寫)
已做之有關檢查檢驗及其他必要資料(包括, Cultures, 各種影像學檢查, 例如 KUB, Sonography of abdomen, abdominal CT scan) & 外院相關資料

IMPRESSION:(臆斷)
將所有異常發現之可能診斷依重要性詳細列出，並且包括過去重要或相關的疾病，目前正在active 的疾病或問題排序在前，非主要或inactive的 problems 排列其後。
診斷以能有 etiological diagnosis 最佳,其次是 anatomical diagnosis, symptomatic diagnosis 應儘量避免。例如：

- Duodenal ulcer→anatomical diagnosis
- NSAID induced ulcer→etiological diagnosis
- Abdominal pain, caused to be determined→symptomatic diagnosis

PLANS
內容應包括各種診斷及處置計劃，每一個診斷對照一個診斷及處置計劃，切記一個診斷及處置計劃後面均必須描述為什麼要安排這些檢驗或檢查(意即適應症)。加入對病患的衛教或建議。

【Admission Note】書寫範本

姓名:　　學號:　　系別:

【Admission Note】

姓名		病歷號碼		床號		性別		出生日期	

<u>入院日期</u>：

<u>一般資料：(General Data)</u>

職業：

婚姻：

教育：

宗教：

種族：

精神心理：

社會經濟：

旅遊史：

接觸史：

群聚：

職業病史：

主要照顧者：

資料來源：

<u>主訴：(Chief Complaint)</u>

<u>現在病症：(Present Illness)</u>

<u>過去病史：(Past History)</u>

<u>個人病史：(Personal History)</u>

Allergy：

Smoking：

Alcohol：

Betalnut：

**本院現狀用藥：

**非本院用藥：

家族史：(Family History)

系統整理：(Review of System)

1. General：

weakness: , fatigue: , anorexia: , fever: , insomnia:

2. Integument (skin, hair and nails)：

changes in color: , pruritus: , rash: , hair loss:

3. HEENT：

a. Head - headache: , dizziness: , vertigo:

b. Eyes - visual acuity: , color vision: , corrective lenses: ,photophobia: , diplopia: , pain:

c. Ears - pain: , discharge: , hearing loss: , tinnitus:

d. Nose - epistaxis: , discharge: , stuffiness: , sense of smell:

e. Throat - status of teeth: , gums: , dentures: , taste: ,soreness: , hoarseness: , lump:

4. 【Respiratory System】

cough: , sputum: , hemoptysis: , wheezing: ,dyspnea:

5. 【Cardiovascular System】

edema: , chest distress: , chest pain: , palpitation:

intermittent claudication: , cold limbs: , cyanosis:

6. 【Gastrointestinal System】

dysphagia: , nausea: , vomiting: , abdominal distress/pain:

change in bowel habit: , hematemesis: , melena: , bloody stool:

7. 【Genito-Urinary System】

urinary frequency: , hesitancy: , urgency: , dribbling: ,incontinence:

dysuria: , hematuria: , nocturia: , polyuria: ,impotence:

8.【Metabolic and endocrine】

growth: , development: , weight change: , heat/cold intolerance:

nervousness: ,sweating: ,polydipsia:

9.【Hematotologic】

anemia: , easy brusity or bleeding: ,lymphadenopathy: , transfusions:

10.【Neuropsychiatry】

dizziness: , syncope: , seizure: , speech disturbance: , loss of sensation:

paresthesia: , ataxia: , weakness or paralysis: , tremor: , anxiety:

11.【Musculoskeletal】

joint pain: , stiffness: , limitation of motion: ,muscular weakenss: , muscle wasting:

理學檢查：(Physical Examination)

BP：　　/mmHg　P：　/min　R：　/min　T：　ºC　身高：　　cm　體重：　　kg　BMI：

疼痛評估：

【General Appearance】

【Consciousness】

【HEENT】

【Neck】

【Chest】

【Heart】

【Abdomen】

【Back】

【Extremities】

【Skin】

【Neurologic examination】

實驗室檢查：(Laboratory Findings)

臨床臆斷：(Impression)

處理計畫：(Plan)

Diagnostic：

Therapeutic：

Patient Education：

Measurable goals:

口述病例報告注意事項

1. 口述病例報告(oral case presentation)是內科實習醫學生完訓時應該具備的基本能力，學員應有能力在病史詢問、身體檢查、判讀基本檢驗檢查數據與建立初步臆斷之後，整合相關有用的資訊，以口語方式提出簡潔、明確、有條理的病例說明，用於與醫療團隊溝通與討論。

2. 口述病例報告的基本內容與病歷寫作類似，包括：
   A. 病人基本資料：病人姓名、床位、年齡、性別、婚姻狀態、職業等
   B. 住院主訴與現在病症：何時住院、住院主述原因、主訴的性質（何時開始？陣發性或漸進性？嚴重度？什麼情況下發生？加重/緩解因素？相關症狀？）、現在病況。
   C. 過去病史：以前有否相同情況？若有，曾經做哪些檢查？告知了什麼結果？有哪些治療？預後如何？
   D. 有意義之個人史、家族史、社交史、用藥史、過敏史、旅遊史等
   E. 有意義之身體檢查結果
   F. 有意義之檢驗檢查結果
   G. 臨床臆斷或診斷：說明最有可能的診斷與其他的鑑別診斷，說明思考流程
   H. 後續計畫：說明進一步的檢驗檢查項目、預估病情預後、治療計畫、如何監測治療結果、治療過程與對於治療之反應。
   I. 醫病溝通：病患與家屬的想法、在意點與期待，有無要求何種幫助？

3. 口述病例報告之技巧
   A. 能明確清晰：口述報告應口齒清晰、音調宜有抑揚頓挫、音量應符合場合與聽眾需求。
   B. 能精準控制時間：根據報告場合判斷報告所需時間長短，根據報告所需時間長短精簡或增添報告內容。例如若是晨會一個小時時間預計僅討論一個個案，該個案的報告便須詳細；若是於主治醫師病房迴診時做口述病例報告，則內容便需精簡不宜太冗長。
   C. 能恰當呈現重點：根據治療療程時間點與病情需要，調整報告之重點。若是剛住院之新病人，重點應放於為何住院、現在病史與初步之檢驗檢查報告分析與鑑別診斷，以及初步的處理。若是病房迴診時報告住院多日已與主治醫師共同探視多次的病患，擇重點在於對於治療的反應以及後續治療計畫。

D.能條理分明：口述報告須具邏輯思維並條理分明，可用問題導向的結構陳述病人臨床問題與思考過程，可依時間順序陳述病人病情之變化，用語須明確不宜模擬兩可，並須建構在基本的醫學知識以及正確的臨床資訊之上。

E.能以病人為中心：以完整姓名稱呼病人而非床號，實踐以病人為中心的觀念，治療一個"病人"而非"疾病"，可適時加入敘事醫學的素養，展現對於病人的關懷。

F.能妥善準備：做口述報告時應展現對於報告內容之熟悉，眼神盡量看著聽眾，避免全程盯著病歷或電腦螢幕，應能背誦呈現重要時間點、檢驗數據、檢查結果等重要資訊。

G.能做結論與摘要：若做較長之口述病例報告，最後應有一小段摘要，再次強調重點資訊，依重要程度羅列病人之臨床問題。

H.能檢討改進：口述報告時應能注意聽眾反應，每次報告完畢應能能尋求回饋與檢討改進。

病例報告 Case presentation

New case presentation should include the following

(34 items in less than 5 minutes)
Evidence-based Medicine by Sacket DL, et al p34

1. Surname
2. age
3. gender
4. occupation
5. when admitted
6. The Chief Complaint that led to admission
7. where in the body it's located
8. quality
9. quantity, intensity, and degree of impairment
10. chronology: when it began, constant/episodic, progressive
11. is setting: under what circumstances did it occur
12. any aggravating or alleviating factors
13. any associated symptoms
14. Whether a similar complaint had happened previously, if so:
15. how it was investigated
16. what the patient was told about its cause
17. how the patient has been treated for it.
18. Pertinent past history of other conditions that are either of prognostic significance or would affect the evaluation of treatment of the chief complaints
19. And how those other conditions have been treated.
20. Family history, if pertinent to chief complaint or hospital care.
21. Social history if pertinent to chief complaint or hospital care
22. Their:
    - ideas (what they think is wrong with them)
    - concerns (about their illness, and other issues)
    - expectations (of what's going to happen to and for them)
23. Their condition on admission:
    - Acutely and/or chronically ill
    - severity
    - requesting what sort of help.
24. The pertinent physical findings on admission.
25. The pertinent diagnostic test results.

26. Your concise, one-sentence problem synthesis.
27. What you think the most likely diagnosis is
28. And the other items in your differential diagnosis
29. Any further diagnostic studies you plan to carry out.
30. Your estimate of the patient's prognosis
31. Your treatment plans
32. How will you monitor the treatment?
33. And what will you do if the patient doesn't respond to treatment?
34. The educational prescription you would like to write for yourself in order to better understand the patient's pathophysiology, clinical findings, differential diagnosis, diagnosis, prognosis, therapy, prevention or other issue in order to become a better clinician

Presentation of an "old" case for "follow-up" rounds

(20 items in 2 minutes)

Evidence-based Medicine by Sackett DL p187

1. The patient's surname
2. The age
3. gender
4. occupation / social role
5. When admitted
6. Chief complaint that led directly to admission
7. The number of **active problems** at the present time. For each **active problem** (which may be a symptom, sign, event, diagnosis, injury, psychological state, or social predicament, etc.)
8. The most important symptom, if any
9. The most important Sign, if any
10. The result of diagnosis or other investigations
11. The explanation for the problem (Diagnosis or state)
12. The treatment plan instituted for the problem
13. The response to the treatment
14. The future plans for managing this problem.
15. Repeat 8 to 14 for each **active problem**
16. Your plans for discharge, post-hospital care and follow-up
17. Whether you've filled the educational prescription that you requested when this patient was admitted (in order to better understand the patient's pathophysiology, clinical findings, diagnosis, prognosis, therapy, prevention of

recurrence, quality of care or other important issue in order to become a better clinician). If so:

18. How you found the relevant evidence
19. What you found. The clinical bottom line derived from that evidence.
20. Your critical appraisal of that evidence for its **validity and applicability**
21. How that critically appraised evidence will alter your care of that (or the next similar) patient. If not, when you are going to fill it?

Example of "follow-up" case presentation

Mr./Mrs./ Dr. 1111, is a 2222 year-old 3333, 4444 who was admitted on 5555 with the chief complaint of 6666.
The patient has 7777 active problems.
The first active problem is ----------. It is characterized by 8888 and 9999 and we performed a --------- which revealed 101010. We decided that the cause for this problem was 11, 11, 11 and we started 12, 12, 12 to which he/she responded with 13,13,13. We plan to 14,14,14,
The second/third/fourth active problem is ----------. (repeat 8-14)
At the time of his/her admission, I didn't understand ----- as well as I'd like to and I requested an education Rx to answer the question: ----------
I found the relevant evidence by 17,17,17, and its clinical bottom line is 18,18,18. I believe that this bottom line is not valid because 19a,19a,19a and believe that it is/is not applicable because 19b,19b,19b. I therefore plan to manage this and future, similar patient by 20,20,20.

內科常見疾病之診斷書寫記錄範本

109/02/20

CV 常見疾病之診斷書寫記錄範本

1. Congestive Heart failure, New York Heart Association Functional Class III, Stage C, due to ischemic heart disease, sinus rhythm without LBBB or RBBB
2. Acute non-ST segment elevation myocardial infarction, Killip III, anterior wall, complicated with pulmonary edema and respiratory failure
3. Atrial fibrillation, paroxysmal, CHA2DS2-VASc score 3, HAS-BLED score 3
4. Pulmonary embolism, bilateral main trunk, probably due to deep vein thrombosis secondary to prolonged immobilization, complicated with pulmonary hypertension and right ventricular systolic dysfunction
5. Severe mitral regurgitation, secondary to annulus dilatation, with impaired left ventricular ejection fraction, pulmonary hypertension, and persistent atrial fibrillation

Chest 常見疾病之診斷書寫記錄範本

1. Chronic obstructive pulmonary disease with acute exacerbation due to secondary infection, complicated with angina
2. Bronchiectasis with secondary infection, presented with hemoptysis, pathogen: Pseudomonas
3. Right lung adenocarcinoma with brain and bone metastasis, T4N3M1b, stage IVB, with initial presentation as hemoptysis, post palliative chemotherapy, disease in progression
4. Pneumonia, RUL, community-acquired pneumonia, Streptococcus sepsis, comorbidity with hypertension
5. Acute mixed type respiratory failure, asthma with acute exacerbation related, post intubation with endotrachea tube and ventilator support

胃腸肝膽科常見疾病之診斷書寫記錄範本

1. Acute on chronic liver failure due to chronic hepatitis B with flare
2. Liver cirrhosis, alcohol related, Child-Pugh class C, complicated with recurrent spontaneous bacterial peritonitis
3. Esophageal variceal bleeding, HCV related cirrhosis, Child-Pugh class B
4. Acute necrotizing pancreatitis, alcohol related, and pseudocyst formation
5. Bacterial cholangitis with sepsis from common bile duct stone and bile duct obstruction, gall bladder stone
6. Chronic hepatitis B with flare due to co-infection of hepatitis delta virus

腎臟科常見疾病之診斷書寫記錄範本

1. End-stage renal disease, due to diabetic nephropathy, under regular hemodialysis via right forearm arteriovenous fisula.
2. Chronic kidney disease, stage V, due to chronic tubulointerstitial nephritis from non-steroid anti-inflammatory drugs, complicated with normocytic anemia. and hypekalemia

3. Acute kidney injury, RIFLE failure stage, due to Uroseptic shock, complicated with oliguria, fluid overloading, and hyperkalemia; under temporary hemodialysis via right femoral double lumen.
4. Acute left pyelonephritis, with Escherichia coli Urosepsis.
5. Peritoneal-dialysis associated peritonitis, caused by Candida tropicalis infection, status post removal of Tenckhoff catheter.
6. End-stage renal disease, due to Lupus nephritis, under continuous ambulatory peritoneal dialysis, complicated with anemia.

Meta 常見疾病之診斷書寫記錄範本

1. Type II diabetes mellitus, poorly controlled, complicated with diabetic retinopathy & nephropathy & neuropathy
2. Diabetic ketoacidosis, due to pneumonia complicated with acute kidney failure and altered mental status
3. Right diabetic foot ulcer, Wagner Grade 5, status post debridement (or above-knee or below-knee amputation)
4. Bilateral peripheral artery occlusive disease status post percutaneous transluminal angioplasty with stenting or bypass grafts
5. **** thyroid cancer, TxNxMx, Stage x, (with xxxxx metastasis)

範例　Paplliary thyroid cancer, T3N1M1, Stage IV, with lung metastasis

6. Hyperosmolar hyperglycemic state complicated with acute kidney injury with altered mental status

Hema 常見疾病之診斷書寫記錄範本-底線的部分是隨個案病情而改變的

1. Non-Hodgkin lymphoma, diffuse large B-cell, Ann-Arbor stage IIIA, International Prognostic Index 2
2. Multiple myeloma, IgG kappa, Durie-Salmon stage IIIA, international staging system III
3. Acute myeloid leukemia, M2 with t(8;21), in complete remission for post-remission chemotherapy
4. Acute lymphoblastic leukemia, with recurrent genetic abnormalities
5. Neutropenic fever suspect sepsis
6. Hypochromic Microcytic Anemia due to Iron deficiency
7. Macrocytic anemia possible due to pernicious anemia (Vit B12 or folic acid deficiency)

腫瘤科常見 5 個 疾病之診斷書寫記錄範本

1. Left breast cancer (invasive ductal carcinoma), T2N1M1, stage IV, with liver and bone metastases on palliative chemotherapy
2. Lung cancer (adenocarcinoma), right lower lung with lung to lung and bone metastases and with mediastinal lymph node involvement , T3N2M1b, stage IV status post palliative chemotherapy

3. Ascending colon cancer(adenocaricinoma) with appendix , peritoneal, liver and lung metastases status post right hemicolectomy and appendectomy, T3N1aM1, stage IV
4. Cancer cachexia with general anasarca
5. Pneumonia, Right upper lobe, Hospital acquired, pseudomonas aeruginosa infection

Rheuma 常見疾病之診斷書寫記錄範本

1. Systemic lupus erythematosus, diagnosed in 2007, with presentation of malar rash, serositis, proteinuria, positive ANA and anti-dsDNA, under prednisolone and hydroxychloroquine treatment, stable disease status.
2. Lupus nephritis, WHO class III, under azathioprine maintenance therapy, in remission status.
3. Rheumatoid arthritis, stage II, under combinational DMARDs and anti-TNF alpha treatment, in low disease activity status.
4. Diffuse cutaneous systemic sclerosis, with pulmonary fibrosis
5. Dermatomyositis, with intertitial lung disease, under prednisolone and cyclophosphamide treatment.

Inf 常見疾病之診斷書寫記錄範本

1. Urinary tract infection, indwelling catheter related, with E. coli bacteremia and sepsis
2. Right/left upper arm cellulitis, predisposing by lymphedema, complicated with Streptococcal bacteremia
3. Liver abscess with Klebsiella pneumoniae bacteremia and sepsis, complicated with endophthalmitis
4. Peripheral arterial occlusive disease with deep soft tissue infection, left low leg
5. Acute pyelonephritis of right kidney, nephrolithiasis related

GM 常見疾病之診斷書寫記錄範本

1. Pneumonia, right lower lobe, community-acquired, comorbidity with old CVA, hypertension, diabetes mellitus and cancer
2. Urinary tract infection with urosepsis, associated with chronic kidney disease stage V, or diabetes mellitus.
3. Pressure ulcer with wound infection, NPUAP sage V, comorbidity with CVA with bed-ridden, status dementia, hypertension, diabetes mellitus and malnutrition.
4. Conscious disturbance , possibly related to infection, CVA, electrolyte imbalance (hyponatremia), metabolic encephalopathy and intracranial brain disease.
5. Dyspnea, Possibly related to chronic obstructive lung disease, or congestive heart failure, or pneumonia, or sepsis, or anemia , or chronic kidney disease , or coronary artery disease or cancer
6. General Edema due to malnutrition with hypoalbuminemia

臨床推理 Clinical Reasoning 簡介

鄭昌錡 醫師

臨床推理被認為是一個認知的過程，與臨床推理相關的研究，包括了認知科學、決策理論，以及電腦科學（尤其是人工智慧)等，它們提供我們洞悉教育與學習臨床診斷及處理原則的重要資訊。臨床推理是醫師的基本能力，要具備這個能力，才能靈活運用診斷敏感度與周詳的思考分析，在檢查與治療之間取得效益與風險之間的平衡，提供適切的病患照顧。

臨床推理目前被區分為兩種模式，包括(1)分析式的(analytical)：屬於速度較慢的假說演繹過程，是審慎與詳盡的推理；與(2)非分析式的(non-analytical)，是直覺的、快速的模式識別。一般認為初學者(Novice)較常用第一種方法推理，而專家(Expert)常用第二種方式。但最近的研究顯示，其實不管是生手或是有經驗的醫師，其推理過程都是兩者並用的。這兩種推理方式，也沒有好壞的分別，都是做臨床決定時會運用到的方法。

臨床推理的過程，簡單來說就是診斷病患與制定病患處置計劃的過程。而臨床診斷的知識與技能:包括病史詢問、理學檢查，病歷報告與寫作，皆是展示學習者臨床推理能力的過程。我們在臨床上聽到病人陳述的主述、觀察到病人的徵象，會先產生診斷假說；接下來會進行假說的精確化，會經由收集相關的資料，來進行假說的演化與列出鑑別診斷；在收集相關資料的過程中，會運用到診斷性測試，在這裡可能會運用到一些統計的概念，像是機率理論、敏感度與特異性的概念、貝氏法則 Bayes' Rule、臨界點(threshold)等概念。當然，並非所有臨床狀況都能用數學與機率的概念就能解答，臨床推理中有一個重要的概念是因果推理，相當多的臨床複雜狀況必須運用因果推理的概念來處理與解釋多重變項之間的關聯性。當上述步驟都逐步完成了，我們會得到一個可行的診斷(working diagnosis)，接下來就是診斷驗證的過程。

得到正確的診斷並不容易，需要符合所謂的效度準則，也要避免被最近的經驗影響與提早定案。除了下診斷需要臨床推理，擬定治療決策也是需要推理，當治療選擇的價值相近時，要有一定的原則在利與弊之間做個權衡。實證醫學的運用也是檢視證據的一個必要方法。如何了解認知過程與避免認知錯誤，也是學習臨床推理過程中必須的步驟。學習臨床推理，除了了解一些基本理論之外，透過臨床實際案例來學習是必經的過程。對初學者來說，我們在學習臨床推理時，盡量不要一次窺見案例的全貌，而是模擬臨床處理病人的場景，循序漸進地獲取一部分一部分的資訊，並且於過程中說出所想(think aloud)，透過同儕討論的方式腦力激盪相互學習，並且由專家前輩適時指導，必能對臨床推理能力之發展有所裨益。

醫學訓練六大核心能力

美國畢業後醫學教育評鑑委員會 (ACGME,Accreditation Council for Graduate Medical Education) 之六大臨床核心能力(Six Competencies)

- 醫學知識(Medical knowledge)
  包括生物、心理、社會、種族、文化等與健康相關知識的理解與應用。臨床問題的研究與分析並懂得運用專業相關的基礎與臨床知識處理病人問題。

- 病人照顧與臨床技能(Patient care and clinical skills)
  展現愛心、關懷與同理心，提供病患適切有效的治療以解決其健康問題。能夠收集必要資訊，綜合研判，提供適當的預防與治療。學習各種治療、預防、健康促進、諮詢、資訊使用等能力。能夠與病患及家屬團隊解決問題。

- 人際與溝通技巧(Interpersonal and communication skills)
  住院醫師必須有足夠人際溝通以便與病患，家屬及專業人員進行資訊交換。有效與病患及家屬溝通、醫療團隊溝通，學習良好的傾聽、表達與同理心。在學術交流上與同儕溝通、建立良好的團隊合作。

- 專業素養(Professionalism)
  對各種病患展現專業素養,表現專業責任,堅守醫學倫理原則。行為舉止符合專業精神，表達尊重、紀律與愛心，維護醫師團體的社會形象。了解病人年齡、性別、種族、宗教差異並包容跨文化間差異。

- 系統為基礎的醫療(Systems-based practice)
  認知並展現足夠能力與責任感，進而有效整合所有資源以提供適切醫療照護。有效運用系統資源，提供高效價比的醫療照護品質。檢討各項醫療決策及操作內容，以根本問題分析法評估系統資源內容著重病患安全並避免系統性錯誤。

- 執業基礎的學習與改進(Practice-based learning and improvement)
  具備能力以評估現行醫療照護內容，追求醫療品質改善，落實終身學習。蒐集分析及應用實證醫學資料，評判資料之可靠性與在病人的適用性，進而改善病患照護。

健康照護矩陣 Healthcare Matrix

健康照護矩陣（ Healthcare Matrix）由 University of Vanderbilt 的 John Bingham, Doris Quinn 等學者在 2004 年研究發展出來的工具。矩陣的橫軸是 IOM (Institute of Medicine)於 2001 年提出之六大醫療品質指標所形成，依序為安全(Safety)、及時(Timely)、有效(Effective)、效率(Efficient)、公平(Equitable)及病人中心(Patient-centered)，而縱軸是 1999 年 ACGME 提出之稱職醫師六大核心能力，分別為病人照護(Patient Care)、知識技能(Medical Knowledge and clinical skills)、人際溝通 (Interpersonal and Communication skills)、專業素養倫理 (Professionalism)、系統為基礎的醫療(System-based practice)、執業為基礎之學習與改進(Practice-based learning and Improvement)。

以健康照護矩陣來進行臨床個案討論，可以讓學習者與醫療團隊瞭解要提供有品質的醫療照護必須運用何種核心能力，去分析無法達到各項品質指標是何種核心能力缺乏，進而指出值得學習改進之處，並擬訂改進之道以落實執業為基礎之學習與改進(Practice-based learning and Improvement)，提昇醫療品質。健康照護矩陣提供了一個學習討論，原因分析之架構，
討論後可以自省：這個病人是否得到我們有能力提供有品質的醫療照護? 若是沒有，是缺乏什麼核心能力，擬訂改善計劃與落實後，同樣臨床狀況的病人照護品質是否可以提升改進。

健康照護矩陣可運用在各級學員自我反省臨床病人照護、個案討論會、跨科團隊討論會、醫護討論會、死亡病例或共病症病例討論 (Mortality &Morbidity Conference)，也適合跨團隊學習以促進團隊合作(Teamwork)以提昇團隊服務品質。健康照護矩陣結合醫學教育與醫療品質，讓醫療團隊在臨床工作中持續進步，也讓醫師學習注重醫療品質的提昇。

Reference:

1. http://www.acgme.org/outcome/implement/rsvp_current55.asp
2. Using a healthcare matrix to assess patient care in terms of aims for improvement and core competencies.
   Bingham JW, Quinn DC, Richardson MG, Miles PV, Gabbe SG.
   Jt Comm J Qual Patient Saf. 2005 Feb;31(2):98-105.

健康照護矩陣 Healthcare Matrix

病例診斷：　　性別：　　年齡：

醫療品質 / 稱職能力	安全的醫療 SAFE	及時的服務 TIMELY	有用的處置 EFFECTIVE	效率的工作 EFFICIENT	平等的就醫 EQUITABLE	病人為中心 PATIENT-CENTERED
病人照護 **(是/否)** PATIENT CARE						
照顧評估						
醫學知識 MEDICAL KNOWLEDGE (應該熟知的)						
人際溝通技巧 INTERPERSONAL and COMMUNICATION SKILLS (應該表達的)						
專業素養倫理 PROFESSIONALISM (應該做為的)						
系統基礎之執業 SYSTEMS-BASED PRACTICE (應該支援的)						
學習改進						
執業基礎之學習改進 PRACTICE-BASED LEARNING and IMPROVEMENT						
科別： 填表人：		健康照護成員： 日期：				

ACGME Six Competencies:

A. Patient Care：具有憐憫同情心，能適當而有效率的診療病痛、預防疾病及增進病人健康。
B. Medical Knowledge：具備已確立及發展中的生物醫學、臨床醫學及社會科學的知識，並能運用至照顧病患上。
C. Interpersonal and Communication Skills：與病患及其家人或其他醫療照護成員建立團隊精神，維持有效的溝通管道。
D. Professionalism：實踐專業責任、堅守倫理原則、尊重多樣性群體差異之行為。
E. Systems-Based Practice：有熱誠理解醫療照護體系之運作，並有能力運用體系資源，提供最適切的醫療照護。
F. Practice-Based Learning and Improvement：自我評估醫療行為，運用科學證據，提昇醫療照護品質。

IOM Six Aims for Quality Improvement:

1.Safe：避免意圖幫助病患的醫療行為反而傷害病患。
2.Timely：減少等候時間，避免具傷害性的延遲。
3. Effective：根據醫學知識提供適當(不過當亦無不足)的服務。
4. Efficient：避免設備、材料、人力意見或能力等資源的浪費。
5. Equitable：不因性別、種族、地域或社經階層而不同，提供同樣品質的服務。
6. Patient-Centered：依病患個別偏好及需求，提供尊重及負責任的照護，並參考其價值觀決定臨床決策。

用藥安全

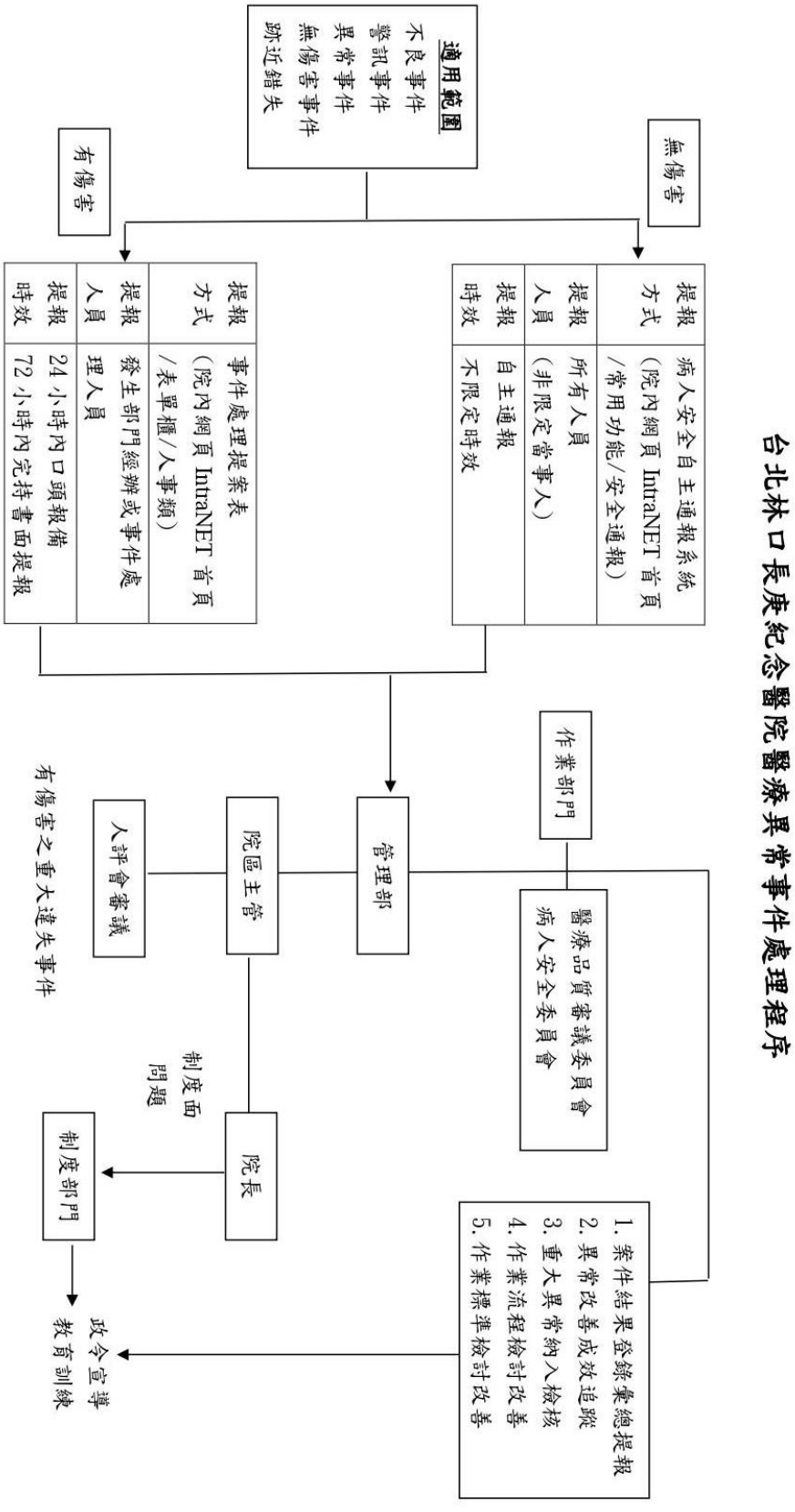
一、本院處方的醫令系統上有避免錯誤用藥或不當之警示機制，包括重覆、交互作用、過敏、極量管制、懷孕等級之警示畫面。例如針對腎功能不佳的病人，電腦醫囑系統增設提示功能，提醒醫師需要調整用藥，以降低因腎功能不佳而導致的治療禁忌。以降血糖藥物 Metfomin 為指標，分析提示功能上線前後異常處方筆數差異。單一劑量作業系統自動提示病患肌苷酸清除率，藥師於處方審核時能很且正確掌握病患腎功能之變化給予適當的處方、劑量建議。建置經腎排除藥品監測系統(Renal drug excretion monitoring)。隨時掌握病人病情變化，並及時調整藥物處方。

二、建立藥物血中濃度監測系統：監測品項 phenytoin, valproic acid, digoxin, theophylline, vancomycin, gentamicin, amilacin, carbamazepine 等藥品。由專責藥師根據每日抽血結果並評估病患臨床狀況給予適當劑量調整建義且紀錄於藥物血中濃度監測表及藥事服務紀錄系統。臨床服務醫療系統設定 vancomycin, gentamicin, digoxin 等藥物血中濃度監測提示供醫師參考，並由系統主動提示醫師監測血中濃度，降低抽血錯誤率。

三、全院住院醫囑系統及 HIS 系統：門診醫囑、護理作業、單一劑量等建置 ADR 通報路徑。

安全暨國際病安目標簡介

一、病人安全事件處理流程圖：



二、通報事件類別：

1. 藥物事件
2. 跌倒事件
3. 手術事件
4. 輸血事件
5. 醫療照護事件
6. 公共意外事件
7. 治安事件
8. 傷害事件行為
9. 管路事件
10. 麻醉事件
11. 院內不預期心跳停止事件
12. 檢查/檢驗/病理切片事件
13. 其他事件

三、病人安全相關政策與程序：

1. IPSG（國際病人安全目標）

-正確辨識病人政策與程序

-有效溝通政策與程序

-高警訊藥品安全政策與程序

-侵入性處置病人辨識與確認安全政策與程序

-減少醫療相關感染風險之基本政策與程序

-預防病人跌倒政策與程序

2. COP3 弱勢或高風險病人照護與高風險醫療服務政策

-明確規範保護弱勢病人、照護高風險病人與提供高風險醫療服務，確保病人之安全及醫療服務之品質。

四、病人的權利：

1. 公平醫療
2. 安全照護
3. 告知說明
4. 知情同意
5. 持續照護
6. 安寧療護
7. 尊重隱私
8. 資訊提供
9. 申訴服務
10. 專業服務