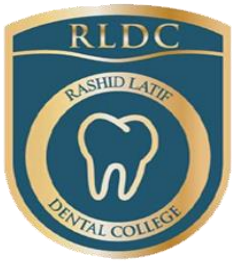

THIRD YEAR BDS
CLINICAL CLERKSHIP LOGBOOK
DEPARTMENT OF MEDICINE.

Department: _____

Student Name: _____

Registration No: _____

Session: _____

Rotation Duration: From _____ To _____

INTRODUCTION

This Clinical Clerkship Logbook is a mandatory academic and assessment document for Final Year MBBS students, developed in accordance with the UHS Model Curriculum. It serves as verifiable evidence of clinical exposure, competency development, reflective learning, and workplace-based assessment.

OBJECTIVES OF THE LOGBOOK

- To document supervised clinical encounters
- To ensure structured exposure to core clinical conditions
- To promote case-based discussion (CBD) and reflective learning
- To facilitate formative and summative assessment (Mini-CEX, DOPS)

GENERAL INSTRUCTIONS

- All entries must be **legible, complete, and signed** by the supervisor
- Patient **confidentiality** must be maintained (initials / ID only)
- Incomplete logbooks will **not be accepted** for final assessment

CFRC log book V

Medicine CLERKSHIP

Learning Outcomes
By the end of the Surgery clerkship, a student will be able to: • • Identify characteristic signs, symptoms, and clinical patterns, and formulate accurate differential diagnoses of common medical diseases. • Take a comprehensive and focused medical history from adult patients and caregivers. • Perform a system based and clinically relevant physical examination for major medical presentations. • Interpret essential laboratory and imaging investigations to support diagnostic decision-making. • Develop and outline management plans for acute and chronic medical conditions. • Communicate effectively and empathetically with patients, families, and the healthcare team. • Demonstrate professionalism, ethical conduct, and collaborative teamwork in medical care settings.

Medicine -I

Clinical Skills		
Code	**Topic**	**Clinical Methods/Skills**
HISTORY TAKING AND GENERAL PHYSICAL EXAMINATION		
M1-001	History taking skills	**Demonstrate history-taking skills covering:** • Patient biodata, rapport building, identity confirmation, and consent. • Presenting complaints including onset, duration, severity, and associated factors. • Structured history of the present illness with relevant characteristics and contextual details. • Brief review of systems using focused screening questions • Past medical and surgical history including previous illnesses, hospitalizations, and procedures. • Drug history including prescribed medications, herbal supplements, and allergies. • Family history. • Social history including occupation, lifestyle habits, exposure risks, socioeconomic history, and psychosocial factors.
M1-002	General Physical Examination	**Perform general physical examination:** • Preparation of the patient, maintaining privacy, comfort, proper exposure, and hand hygiene • Assess for build, nourishment, level of consciousness, posture, distress, facies, body movements, and hygiene • Measurement of vital signs • Pulse for rate, rhythm, volume, character, radio-radial delay, and radio-femoral delay • Head and face for pallor, icterus, cyanosis, xanthelasma, corneal arcus, rash, and facial symmetry

		• Eye for conjunctival pallor, scleral icterus, pupillary responses, and ocular movements • Oral cavity for mucosal color, hydration, tongue changes, and dental hygiene • Neck examination including thyroid inspection, tracheal position, and assessment of jugular venous pressure • Lymph node examination of cervical, axillary, epitrochlear, and inguinal regions for size, tenderness, mobility, consistency, and fixation • Skin for color changes, pallor, cyanosis, jaundice, pigmentation, rashes, scars, edema, and dehydration signs • Nails for clubbing, koilonychia, leukonychia, and capillary refill time • Hands for tremors, palmar erythema, asterixis, warmth, and peripheral perfusion • Assessment of the chest for shape, symmetry, deformities, tracheal alignment, respiratory rate, breathing pattern, and use of accessory muscles • Cardiovascular screening for peripheral pulses, peripheral perfusion, and peripheral edema. • Respiratory screening through observation of chest expansion and symmetry • Abdominal screening including inspection and light palpation for tenderness, organomegaly, or masses. • Basic neurological screening including mental status, orientation, gait, muscle bulk, and gross motor function. • Leg examination including edema. • Appropriate documentation and communication of findings while maintaining patient dignity and comfort throughout the examination

CENTRAL NERVOUS SYSTEM DISEASES		
M1-018	History taking	• **Take** a comprehensive neurological history, including onset, progression, associated symptoms, risk factors, and functional impact.
M1-019	Clinical Examination	• **Perform** clinical examination of I–XII cranial nerves, motor and sensory systems, cerebellar tests, higher mental functions, meningeal irritation signs, and raised intracranial pressure. • **Demonstrate** approach to assessing and stabilizing an acute stroke patient. • **Interpret** common lab investigations (CBC, electrolytes, renal and liver function tests, coagulation profile, CSF analysis and CNS imaging (CT, MRI), correlating findings with clinical presentation to support diagnosis and management.
M1-020	Counselling	• **Counsel** patients and families with professionalism, empathy, and cultural sensitivity.
CARDIOVASCULAR DISEASES		
M1-035	History Taking	• **Take** a focused history of chest pain, dyspnea, palpitations, syncope, edema, and functional limitations. • **Record** past medical, surgical, drug, allergy, personal, and social history relevant to cardiovascular conditions.
M1-036	Clinical examination	• **Assess** general appearance, hands (color, temperature, clubbing, splinter hemorrhages, Janeway lesions, Osler's nodes, and tendon xanthomas). • **Measure** and interpret pulse, blood pressure, and JVP • **Inspect** the precordium for scars, pacemaker sites, and visible pulsations. • **Palpate** apex beat, parasternal heave, and thrills. • **Auscultate** heart sounds and murmurs, pericardial rub, lungs for fine crackles or pleural effusion at bases.

		• **Palpate** abdomen for hepatospleenomegaly or pulsatile liver and check for ascites, ankle, and sacral edema. • **Auscultate** for bruits over the abdomen and femoral arteries. • **Inspect** lower limbs for temperature, color, capillary refill, ulceration, varicosities, and scars. • **Perform** ECG with correct lead placement and interpret the findings. • **Observe and assist** in echocardiography and interpret the report. • **Interpret** laboratory investigations, including cardiac enzymes, lipid profile, coagulation profile, electrolytes, renal function tests, thyroid function tests, and inflammatory markers, in relation to common CVS conditions.
M1-037	Counselling	• **Counse**l patients and families with professionalism, empathy, and cultural sensitivity.
RESPIRATORY DISEASES		
M1-051	History taking	• Obtain focused respiratory history (symptom analysis: cough, sputum, dyspnea, chest pain, hemoptysis).
M1-052	Clinical examination	• **Perform** inspection, palpation, percussion, and auscultation of chest. • **Identify and interpret** abnormal breath sounds (rhonchi, crackles, bronchial breathing). • **Interpret** examination findings in pleural effusion, consolidation, pneumothorax, COPD, asthma. • **Demonstrate** correct use of a peak flow meter and incentive spirometer. • **Interpret** spirometry graphs (normal, obstructive, restrictive patterns). • **Interpre**t basic chest X-rays (effusion, consolidation, collapse, pneumothorax). • **Demonstrate** steps of oxygen therapy administration and nebulization.

		• **Demonstrate** use of inhalers and spacers to patients. • **Observe/assist** in initial management of respiratory emergencies (asthma attack, pneumothorax).
M1-053	Counselling	• **Counsel** patients on smoking cessation and lifestyle modifications.
RHEUMATIC DISEASES		
M1-066	History taking	• **Take** a detailed history of joint pain, stiffness, swelling, and systemic symptoms
M1-067	Clinical examination	• **Perform** general examination with focus on musculoskeletal system. • **Conduct** systematic examination of small and large joints for tenderness, swelling, and deformity. • **Assess** range of motion and functional status of joints. • **Identify** clinical signs of rheumatoid arthritis, SLE, gout, and osteoarthritis. • **Interpre**t basic rheumatologic investigations such as ESR, CRP, ANA, RF, anti-CCP.
M1-068	Counselling	**Counsel** patients empathetically and professionally on following points: • chronic and relapsing nature of rheumatic diseases in layman language to patients. • importance of medication adherence, expected benefits, and potential side effects. • lifestyle modifications. • impact of disease on daily activities, work, and mental health, offering appropriate support and referrals. • need for periodic follow-up, laboratory monitoring, and screening for drug toxicity.
RENAL DISEASES		
M1-077	History taking	• **Take** a structured renal history, focusing on urinary output changes, hematuria, edema, flank pain, dysuria, and relevant systemic or constitutional symptoms.

M1-078	Clinical examination	• **Perform** a general physical examination with emphasis on assessing volume status, pallor, and edema. • **Examine** the abdomen for renal masses, tenderness, and bladder distension. • **Identify** clinical signs of chronic kidney disease such as pallor, scratch marks, and edema. • **Interpret** urinalysis results, renal function tests (RFTs), and electrolyte profiles, and renal imaging studies, including ultrasound of kidneys, ureters, and bladder (KUB). • **Observe/assist** in dialysis procedures and indications for initiation.
M1-079	Counselling	**Counsel** patients and caregivers on following points: • chronic nature of renal diseases. • importance of medication adherence, diet, fluid management, and lifestyle modifications. • need for regular follow-up, laboratory monitoring, and timely reporting of warning signs. • understanding dialysis or transplantation options, including indications and expectations.

FORMAT OF HISTORY TAKING

Personal Particulars:

- Name
- Age
- Sex
- Religion
- Occupation
- Address
- Marital Status
- Date & Mode of Admission

Presenting Complaints:

- Primary complaints with duration
- in patient's own words,
- in chronological order.

History of Present Illness:

Detailed history including ODPARA

- Onset
- Duration
- Progression
- Association
- Relieving and aggravating factors.
- Associated symptoms.
- Include treatment provided during hospital stay.
- systemic review.

History of Past illness:

- Previous admissions,
- medical and surgical illnesses.

Drug, Allergies & Vaccination History.

- OCPs, Anticoagulation (in all patients)
- EPI status known or unknown, any other vaccinations.

Personal History:

- Level of Education
- smoking, alcohol, addictions
- physical activity.

Family History:

- Immediate family members; parents, grandparents & siblings.
- Chronic illnesses, malignancy, TB, hereditary conditions.
- Similar symptoms in family

Socioeconomic History:

- Socioeconomic status
- Living conditions and water supply.

Menstrual / Obstetric History (Females).

- Menarche, menopause, pregnancies, deliveries.

Developmental & Vaccination History (Pediatrics).

- Milestones of development. Fronto-occipital circumference, length, height and weight

PATIENT PROFILE:

Name_____ Age_____ Sex_____ Religion_____

Occupation_____ Address_____

Date & Mode of Admission _____

PRESENTING COMPLAINTS:

_____

_____

_____

HISTORY OF PRESENTING ILLNESS;

_____
_____
_____
_____
_____
_____
_____
_____

HISTORY OF PAST ILLNESS:

_____
_____
_____

OTHER ACTIVE PROBLEMS:

Hypertension ☐ Diabetes ☐ Tuberculosis ☐ Covid Infection ☐

Heart Disease ☐ Respiratory Disease ☐ Jaundice ☐

Hepatitis B ☐ Prolong Medications ☐ Hepatitis C ☐

Details (if applicable) _____

GYNAECOLOGICAL/OBSTETRICS HISTORY (IF APPLICABLE).:

Age of Menarche_____ Cycle _____ LMP _____

EDD _____ Conception used _____ Children _____

FAMILY HISTORY:

Hypertension ☐ Diabetes ☐ Heart Disease ☐ Respiratory Disease ☐

Joint Pains ☐ Tuberculosis ☐ Malignancies ☐ Mental Illnesses ☐

PERSONAL & SOCIOECONOMIC HISTORY:

Smoking _____ Alcohol _____ _ Huka/Niswar _____ Any other addiction _____

Monthly Income _____ Social class _____ Allergic Reaction _____

Water / sanitation _____ Housing _____

EXAMINATION:

GENERAL APPEARANCE:

_____

GENERAL PHYSICAL EXAMINATION:

Height: _____ Weight _____ BMI _____ Gait _____

Pulse _____ Blood Pressure _____ Temperature _____ Resp. Rate _____

Pallor ☐ Clubbing ☐ Koilonychia ☐ Jaundice ☐ Edema ☐ Cyanosis ☐

Skin: _____ Oral Hygiene: _____ Thyroid _____

Lymph nodes _____

ABDOMINAL EXAMINATION:

Inspection:

Palpation:

Percussion:

Auscultation:

Genitalia:

Rectal Examination:

Inspection:

Digital Rectal Examination:

RESPIRATORY EXAMINATION:

Inspection:

Palpation:

Percussion:

Auscultation:

CARDIOVASCULAR SYSTEM:

Inspection:

Palpation:

Percussion:

Auscultation:

CENTRAL NERVOUS SYSTEM:

Speech examination;

Sensory system examination:

Motor system examination:

Cranial nerves examination:

Gait:

MUSCULOSKELETAL SYSTEM EXAMINATION:

LOCAL EXAMINATION:

PROVISIONAL DIAGNOSIS:

INVESTIGATIONS:

Laboratory investigations

Radiological Investigations

Other investigations

FINAL DIAGNOSIS:

MANAGEMENT PLAN:

FOLLOW UP:

Indoor Rotations:

Morning Shifts:

- Minimum 10 mandatory cases to be completed during the rotation.
- Each case must include:
    - Patient history
    - Physical examination findings
    - Differential diagnosis (D/D)
    - Management plan o Discussion with supervisor

Sr #	Date	Patient Initials / ID	Diagnosis/ Code	History & Exam Summary	Differential Diagnosis	Management Plan	Supervisor's Signature & Stamp

Sr #	Date	Patient Initials / ID	Diagnosis/Code	History & Exam Summary	Differential Diagnosis	Management Plan	Supervisor's Signature & Stamp

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Sr #	Date	Patient Initials / ID	Diagnosis/Code	History & Exam Summary	Differential Diagnosis	Management Plan	Supervisor's Signature & Stamp
Remarks:							

Outdoor (OPD) Rotations:

- Minimum 12 cases to be documented.
- For each case following must be recorded:
    - Short history
    - Management plan
    - Follow-up review

Sr. #	Date	Patient Initials / ID	Diagnosis/ Code	Short History	Management Plan	Follow up Review / Remarks	Supervisor's Signature

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Sr. #	Date	Patient Initials / ID	Diagnosis/ Code	Short History	Management Plan	Follow up Review / Remarks	Supervisor's Signature
Remarks:							

Emergency Duties:

- Each student must complete a minimum of ten (10) emergency duties.
- During emergency duties, students are expected to:
    - Attend to patients presenting in the emergency or casualty department.
    - Assist in the initial assessment, stabilization, and management of acute and critical cases under supervision.
    - Participate in the documentation, follow-up, and handover of cases as per hospital protocol.
    - Students should demonstrate professional conduct, effective communication, and teamwork during all emergency encounters.
    - Attendance and performance during emergency duties will be verified by the supervising faculty through logbook entries.
- Each department will plan and schedule emergency duties to ensure equitable exposure and learning opportunities for all students.
- Departments must ensure that students experience a range of clinical scenarios covering both medical and surgical emergencies, in alignment with the learning outcomes defined by the University of Health Sciences (UHS).

Sr. #	Date	Duration / Shift	Type of Emergency Case	Role of Student (Observer / Assistant / Performer)	Procedures Assisted / Performed	Learning Points

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Remarks:						

Medicine -II

Clinical Skills		
Code	**Topic**	**Clinical Methods/Skills**
ENDOCRINE DISORDERS		
M2-011	History taking	• **Take** a focused endocrine history for Diabetes mellitus, Hypothyroidism, Hyperthyroidism, Thyroid nodules, Pituitary adenomas, Cushing's syndrome, Adrenal insufficiency, and Hypogonadism.
M2-012	Clinical Examination	**Perform** general physical examination. **Examine:** • Neck for goiter, nodules, or thyroid enlargement (Thyroid disorders). • Skin for pigmentation changes, stretch marks, hirsutism, edema (Adrenal disorders, Cushing's syndrome, Polycystic Ovary Syndrome). • Musculoskeletal system for bone deformities, muscle weakness, or skeletal abnormalities (Vitamin D disorders, Osteoporosis, Paget's disease of bone). • Genitalia and secondary sexual characteristics (Hypogonadism, Disorders of puberty). **Observe/assist** in management of acute endocrine emergencies including diabetic ketoacidosis and severe hypoglycemia. • **Interpret** thyroid function tests, thyroid antibodies, and relevant imaging, blood glucose, electrolytes, renal function, and ketones for acute diabetic complications, adrenal function tests, cortisol, and imaging studies, reproductive endocrine investigations, bone metabolism markers, calcium, phosphate, vitamin D, and imaging studies.
M2-013	Counselling	• **Demonstrate** effective patient counselling skills, including explaining the diagnosis, treatment options, lifestyle

		modifications, medication adherence, and follow-up plans for patients with endocrine disorders.
GASTROINTESTINAL DISEASES		
M2-025	History taking	• **Take** focused gastrointestinal history, including pain, diarrhea, dyspepsia, reflux, dysphagia, bleeding, weight loss, chronic illness, and red-flag symptoms.
M2-026	Clinical Examination	• **Examine** oral cavity. • **Assess** hydration status using capillary refill time, skin turgor, pulse, and blood pressure, particularly in acute gastroenteritis and chronic diarrhea. • **Perform** a complete abdominal examination (inspection, palpation, percussion, and auscultation). • **Demonstrate** per rectal examination where indicated, including assessment for bleeding, masses, and tenderness. • **Identify** clinical signs of anemia, malnutrition, and vitamin deficiencies during general and gastrointestinal examination. • **Interpret** diagnostic investigations relevant to gastrointestinal diseases, including CBC, stool examination, occult blood testing, and relevant biochemical tests, ultrasound abdomen, and X-ray abdomen.
M2-027	Counselling	• **Counsel** patients regarding disease nature, lifestyle modification, dietary advice, medication adherence, red-flag symptoms, and follow-up care.
HEPATOBILIARY DISEASES		
M2-048	History taking	• **Take** a focused hepatobiliary history, including jaundice, abdominal pain, pruritus, nausea, vomiting, dyspepsia, weight loss, bleeding tendencies, risk factors, chronic liver disease symptoms, and red-flag features.
M2-049	Clinical examination	• **Perform** abdominal examination including inspection, palpation,

		percussion, auscultation and document the findings. • **Interpret** relevant tests including LFTs, INR/PT, viral markers, ceruloplasmin, serum ferritin, ultrasound abdomen, Doppler, CT/MRI, MRCP, and liver biopsy where indicated. Communicate disease nature, treatment plan, lifestyle advice, and follow-up requirements to patients and caregivers.
INFECTIOUS DISEASES		
M2-059	History taking	• **Take** history in patients with suspected infectious diseases (fever, malaria, dengue fever, enteric fever, amebiasis, COVID-19, HIV/AIDS, rabies).
M2-060	Clinical examination and investigation Counselling	• **Perform** a thorough general physical examination and system-focused examination relevant to infectious diseases, including assessment of vital signs, hydration status, respiratory distress, abdominal findings, neurological status, and identification of red-flag signs (severe malaria, dengue warning signs, septic features). • **Interpret** relevant laboratory and diagnostic investigations such as complete blood count, peripheral smear and rapid tests for malaria, platelet trends, liver function tests, blood cultures, stool examination, oxygen saturation, imaging, and HIV diagnostic tests, and monitor disease severity and response to treatment. • **Counsel** patients and attendants empathetically and professionally on the following points: • nature and expected course of infectious diseases in simple language. • importance of treatment adherence, completion of prescribed therapy, and potential adverse effects.

		• preventive measures including hygiene, sanitation, vector control, vaccination, and infection control practices. • indications for urgent review, follow-up planning, and referral when required.
HEMATOLOGIC DISORDERS		
M2-071	History taking	• **Take** history of patients with suspected hematological • disorders (iron deficiency anemia, megaloblastic anemia, • hemolytic anemia, aplastic anemia, leukemias, Hodgkin • lymphoma, non-Hodgkin lymphoma, bleeding disorders, • platelet disorders, plasma cell disorders).
M2-072	Clinical examination and investigation Counselling	• **Perform** general physical and system-focused examination, including assessment of pallor, jaundice, lymphadenopathy, hepatosplenomegaly, bone tenderness, petechiae, purpura, and signs of infection or bleeding. Interpret hematological investigations such as complete blood count, peripheral blood smear, reticulocyte count, iron studies, vitamin B12 and folate levels, hemolysis profile, coagulation tests, bone marrow examination, and relevant imaging, to assess disease severity and guide management. • **Counsel** patients empathetically and professionally on the following points: • nature, chronicity, and prognosis of hematological disorders in simple, layman language. • importance of medication adherence, transfusion safety, and monitoring for treatment-related adverse effects. • dietary advice, infection prevention, bleeding precautions, and lifestyle modifications where relevant. • need for regular follow-up, laboratory monitoring, and timely referral to hematology services when indicated.

POISONING		
M2-077	History taking	• **Take** history in patients with suspected poisoning (general poisoning, aluminum phosphide, organophosphate, opioid poisoning).
M2-078	Clinical examination Counselling	• **Perform** a rapid survey and physical examination, including assessment of airway, breathing, circulation, level of consciousness, pupil size, secretions, vital signs, and identification of characteristic toxidromes. • **Interpret** relevant investigations such as arterial blood gases, serum electrolytes, ECG, cholinesterase levels, toxicology screens, and other baseline tests to assess severity, guide antidotal therapy, and monitor response to treatment. • **Counsel** patients and attendants empathetically and professionally.
M2-079	Medico-legal aspect of poisoning *(integrate with forensic medicine)*	• **Identify** routes of poison administration. • **Examine** teeth for the effects of poisoning. • **Examine** body orifices for sample collection for traces of poison. • **Apply** law relevant to poisoning.

Indoor Rotations:

Morning Shifts:

- Minimum 10 mandatory cases to be completed during the rotation.
- Each case must include:
    - Patient history
    - Physical examination findings
    - Differential diagnosis (D/D)
    - Management plan o Discussion with supervisor

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    - Management plan
    - Follow-up review

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Remarks:						

Assessment.

(A) Mini -CEX

Sr. No	Date	Case/ procedure	Assessors name & signature	Remarks/ Feedback
1				
2				
3				
4				
5				

(B) DOPS.

Sr. No	Date	Case/ procedure	Assessors name & signature	Remarks/ Feedback
1				
2				
3				
4				
5				

Procedures.

Sr. No.	Procedure	Competency O/A/P	Date	Diagnosis	Supervisor
1	NG insertion				
2	Foleys catheterization				
3	ECG technique				
4	Nebulization technique				
5	IV cannulation and infusion rate				
6	Insulin administration technique				
7	Ascitic Tap				
8	LP technique.				

Skill Acquisition Workshop.

Sr. No	Course Name	Date	Instructor
1	Basic Life support		

BLOCK ASSESSMENT.

Sr. No.	Clinical skill	Max Marks	Obtained Marks	Remarks
1	OSCE	50		
2	OSVE	20		
3	Short Case	60		
4	Long Case	70		

_____

Signature of Instructor/ Unit Head