



MCM Peshawar



Budni Road, Yaseen Abad, Peshawar



091-2614151 / 091-2614174



4th Professional MBBS (2026)

ENT Logbook

STUDENT DETAILS					
Student Name:	Gender:	M		F	
Email address:					
Roll No:					
Batch:					

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

History Of Present Illness: (HPE)

Past History: *(Medications, Hospitalization, Surgical procedures, Blood transfusion, etc)*

Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
Competencies		EXPECTED LEVEL OF COMPETENCE 1. Below Expectation 2. Adequate 3. Excellent			Teacher to sign & date	
History / Exam / Management Plan		Below expectation	Adequate	Excellent	Sign	Date
1	Obtain comprehensive history after introduction and informed consent, asking relevant questions in order to reach a history based differential diagnosis.					
2	Perform complete physical examination, with detailed examination of the involved organ System					
3	Skillfully present patient history, physical examination findings in a systematic, coherent and concise manner, which addresses the chief complaint/problem, identifies pertinent positive and negative findings and reach a logical conclusion.					
4	Arrange a focused list of differential diagnosis					
5	Prepare a diagnostic plan, selecting investigations appropriate for the Patient.					
Good points						
Suggestions for improvement						
Sign/ Date						

ENT DEPARTMENT

S. No	Date	Competencies	Level					HOD/Focal Person Signature
			A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					
			A	B	C	D	E	
1.		History taking from a patient in medical unit						
2.		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
3.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
4.		Pulse Oximeter placement						
5.		Nasogastric tube insertion						
6.		Foley`s catheter insertion						
7.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

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Duration of Marriage: _____

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Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

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Posterior rhinoscopy: _____

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Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

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Suggestions for improvement						
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		• Temperature						
		• Respiratory rate						
		• Others (specify)						
10.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
11.		Pulse Oximeter placement						
12.		Nasogastric tube insertion						
13.		Foley`s catheter insertion						
14.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

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Patient Age: _____

Gender: M ☐ F ☐

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Drug history:

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Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

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Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

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Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

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Suggestions for improvement						
Sign/ Date						

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16.		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
17.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
18.		Pulse Oximeter placement						
19.		Nasogastric tube insertion						
20.		Foley`s catheter insertion						
21.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

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Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ *Buccal mucosa:* _____

Gums and teeth: _____ *Hard palate:* _____

Tongue: _____ *Posterior pharyngeal wall:* _____

Examination of Larynx

External laryngeal examination: _____ *Indirect laryngoscopy:* _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
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History / Exam / Management Plan		Below expectation	Adequate	Excellent	Sign	Date
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Good points						
Suggestions for improvement						
Sign/ Date						

ENT DEPARTMENT

S. No	Date	Competencies	Level					HOD/Focal Person Signature
			A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					
			A	B	C	D	E	
22.		History taking from a patient in medical unit						
23.		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
24.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
25.		Pulse Oximeter placement						
26.		Nasogastric tube insertion						
27.		Foley`s catheter insertion						
28.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

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Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
Competencies		EXPECTED LEVEL OF COMPETENCE 1. Below Expectation 2. Adequate 3. Excellent			Teacher to sign & date	
History / Exam / Management Plan		Below expectation	Adequate	Excellent	Sign	Date
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Good points						
Suggestions for improvement						
Sign/ Date						

ENT DEPARTMENT

S. No	Date	Competencies	Level					HOD/Focal Person Signature
			A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					
			A	B	C	D	E	
29.		History taking from a patient in medical unit						
30.		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
31.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
32.		Pulse Oximeter placement						
33.		Nasogastric tube insertion						
34.		Foley`s catheter insertion						
35.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

History Of Present Illness: (HPE)

Past History: *(Medications, Hospitalization, Surgical procedures, Blood transfusion, etc)*

Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

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Nasal patency test: _____

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What pre-Operative patient Investigations performed/ordered;

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Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
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36.		History taking from a patient in medical unit						
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		• Temperature						
		• Respiratory rate						
		• Others (specify)						
38.		Systemic examination						
		• GIT						
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		• Respiratory system						
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Doctor's Signature:.....

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ENT

4th Year MBBS

Date:

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Patient Age: _____

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Patient Name: _____

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Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

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Suggestions for improvement						
Sign/ Date						

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45.		Systemic examination						
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49.		Fluid aspirations						
		• Ascitic:						
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Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

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Date of admission:

Time of admission:

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Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

History Of Present Illness: (HPE)

Past History: *(Medications, Hospitalization, Surgical procedures, Blood transfusion, etc)*

Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth: _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
Competencies		EXPECTED LEVEL OF COMPETENCE 1. Below Expectation 2. Adequate 3. Excellent			Teacher to sign & date	
History / Exam / Management Plan		Below expectation	Adequate	Excellent	Sign	Date
1	Obtain comprehensive history after introduction and informed consent, asking relevant questions in order to reach a history based differential diagnosis.					
2	Perform complete physical examination, with detailed examination of the involved organ System					
3	Skillfully present patient history, physical examination findings in a systematic, coherent and concise manner, which addresses the chief complaint/problem, identifies pertinent positive and negative findings and reach a logical conclusion.					
4	Arrange a focused list of differential diagnosis					
5	Prepare a diagnostic plan, selecting investigations appropriate for the Patient.					
Good points						
Suggestions for improvement						
Sign/ Date						

ENT DEPARTMENT

S. No	Date	Competencies	Level					HOD/Focal Person Signature
			A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					
			A	B	C	D	E	
50.		History taking from a patient in medical unit						
51.		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
52.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
53.		Pulse Oximeter placement						
54.		Nasogastric tube insertion						
55.		Foley`s catheter insertion						
56.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

History Of Present Illness: (HPE)

Past History: *(Medications, Hospitalization, Surgical procedures, Blood transfusion, etc)*

Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
Competencies		EXPECTED LEVEL OF COMPETENCE 1. Below Expectation 2. Adequate 3. Excellent			Teacher to sign & date	
History / Exam / Management Plan		Below expectation	Adequate	Excellent	Sign	Date
1	Obtain comprehensive history after introduction and informed consent, asking relevant questions in order to reach a history based differential diagnosis.					
2	Perform complete physical examination, with detailed examination of the involved organ System					
3	Skillfully present patient history, physical examination findings in a systematic, coherent and concise manner, which addresses the chief complaint/problem, identifies pertinent positive and negative findings and reach a logical conclusion.					
4	Arrange a focused list of differential diagnosis					
5	Prepare a diagnostic plan, selecting investigations appropriate for the Patient.					
Good points						
Suggestions for improvement						
Sign/ Date						

ENT DEPARTMENT

S. No	Date	Competencies	Level					HOD/Focal Person Signature
			A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					
			A	B	C	D	E	
57.		History taking from a patient in medical unit						
58.		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
59.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
60.		Pulse Oximeter placement						
61.		Nasogastric tube insertion						
62.		Foley`s catheter insertion						
63.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

History Of Present Illness: (HPE)

Past History: *(Medications, Hospitalization, Surgical procedures, Blood transfusion, etc)*

Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
Competencies		EXPECTED LEVEL OF COMPETENCE 1. Below Expectation 2. Adequate 3. Excellent			Teacher to sign & date	
History / Exam / Management Plan		Below expectation	Adequate	Excellent	Sign	Date
1	Obtain comprehensive history after introduction and informed consent, asking relevant questions in order to reach a history based differential diagnosis.					
2	Perform complete physical examination, with detailed examination of the involved organ System					
3	Skillfully present patient history, physical examination findings in a systematic, coherent and concise manner, which addresses the chief complaint/problem, identifies pertinent positive and negative findings and reach a logical conclusion.					
4	Arrange a focused list of differential diagnosis					
5	Prepare a diagnostic plan, selecting investigations appropriate for the Patient.					
Good points						
Suggestions for improvement						
Sign/ Date						

ENT DEPARTMENT

S. No	Date	Competencies	Level					HOD/Focal Person Signature
			A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					
			A	B	C	D	E	
64.		History taking from a patient in medical unit						
65.		General physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
66.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
67.		Pulse Oximeter placement						
68.		Nasogastric tube insertion						
69.		Foley`s catheter insertion						
70.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

History Of Present Illness: (HPE)

Past History: *(Medications, Hospitalization, Surgical procedures, Blood transfusion, etc)*

Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

ENT

4th Year MBBS

Date:

Time:

Patient Age: _____

Gender: M ☐ F ☐

Patient Name: _____

Date of Birth: ____/____/____

CAP Number: _____

PR #:

Admission Details

Date of admission:

Time of admission:

Source of Admission: Emergency Dept. ☐ Clinic ☐ Other: _____

Patient Details

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Duration of Marriage: _____

Occupation of Patient: _____ Occupation of Husband: _____

Address: _____

Postcode: _____

CHIEF COMPLAINTS:

History Of Present Illness: (HPE)

Past History: *(Medications, Hospitalization, Surgical procedures, Blood transfusion, etc)*

Personal History: *(Allergies, Smoking, Alcohol, Bowel habits Married/Unmarried)*

Comorbidities: *(hypertension, diabetes, IHD etc)*

Drug history:

Social history: *(Joint family, living conditions etc)*

Family History: *(Diabetes, Hypertension, Heart Disease, etc)*

Examination of ENT

Examination of nose:

Inspection: _____

Palpation of paranasal sinuses: _____

Per speculum examination (anterior rhinoscopy): _____

Posterior rhinoscopy: _____

Nasal patency test: _____

Examination of Ear:

Inspection: _____

Speculum examination: _____

Examination with otoscope: _____

Tuning fork tests:

Oral Cavity

Lips: _____ Buccal mucosa: _____

Gums and teeth; _____ Hard palate: _____

Tongue: _____ Posterior pharyngeal wall: _____

Examination of Larynx

External laryngeal examination: _____ Indirect laryngoscopy: _____

Examination of Head and Neck lymph nodes:

What pre-Operative patient Investigations performed/ordered;

What post-operative, care was provided:

Confirmed diagnosis after ENT procedure;

4th Year ENT : Mini-Cex

Patient Name:		Diagnosis:			Date:	
Competencies		EXPECTED LEVEL OF COMPETENCE 1. Below Expectation 2. Adequate 3. Excellent			Teacher to sign & date	
History / Exam / Management Plan		Below expectation	Adequate	Excellent	Sign	Date
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4	Arrange a focused list of differential diagnosis					
5	Prepare a diagnostic plan, selecting investigations appropriate for the Patient.					
Good points						
Suggestions for improvement						
Sign/ Date						

ENT DEPARTMENT

S. No	Date	Competencies	Level					HOD/Focal Person Signature
			A: Observer status B: Assistant status C: Performed part of the procedure under supervision D: Performed whole procedure under supervision E: Independent performance					
			A	B	C	D	E	
71.		History taking from a patient in medical unit						
72.		physical examination						
		• Pulse						
		• BP						
		• Temperature						
		• Respiratory rate						
		• Others (specify)						
73.		Systemic examination						
		• GIT						
		• CVS						
		• Respiratory system						
		• Nervous system						
		• Other (specify)						
74.		Pulse Oximeter placement						
75.		Nasogastric tube insertion						
76.		Foley`s catheter insertion						
77.		Fluid aspirations						
		• Ascitic:						
		• Pleural:						
		• CSF:						
		• Joint fluid:						
		• Others (specify						

Doctor's Signature:.....

Name:.....

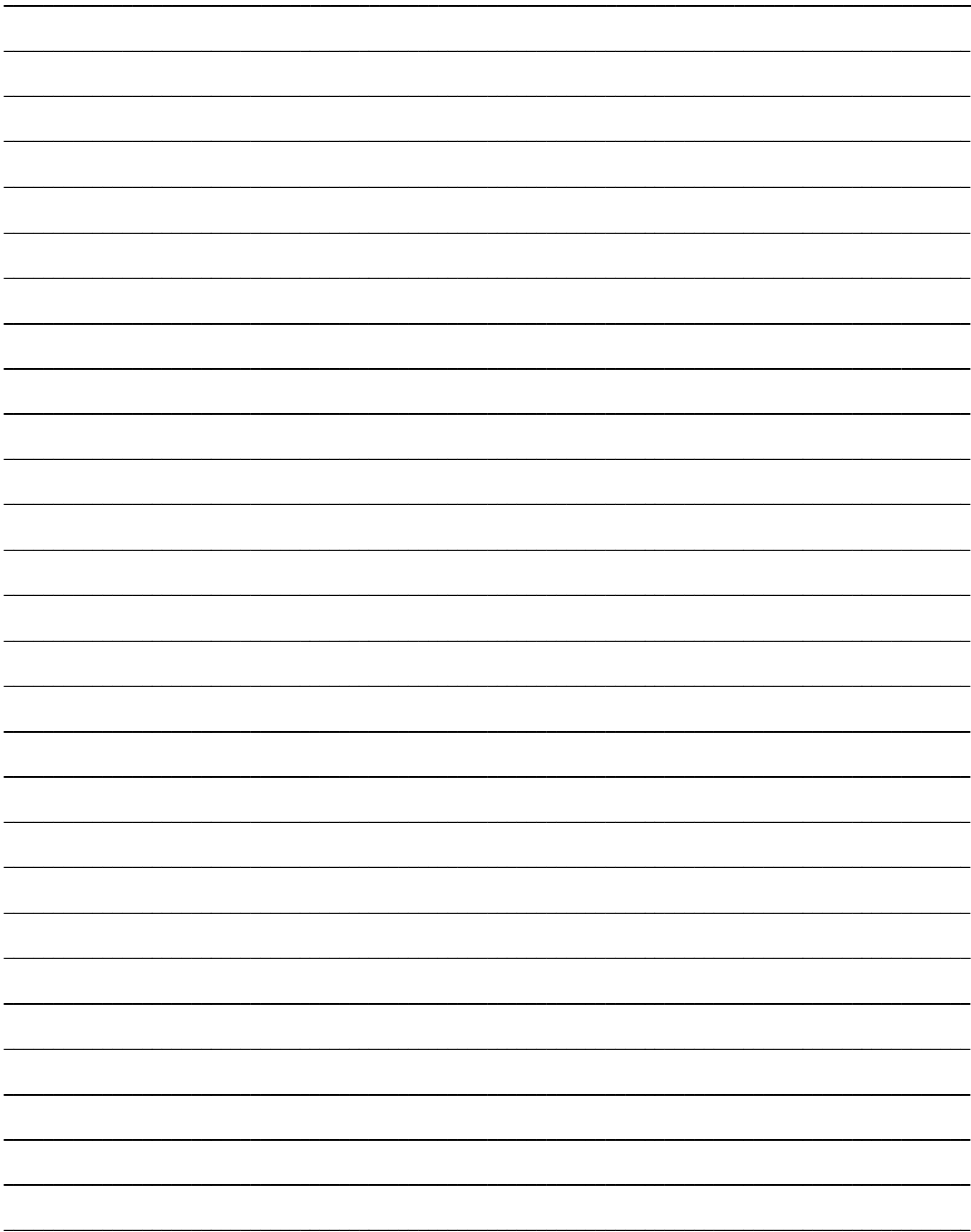
ENT CLINICAL PLACEMENT REFLECTION

1. Description of what happened.)

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

2. What are your reflections & Learning from the experience?

[illegible]



3. Action plan? when I visit a ward again?

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Clinical Placement Feedback

(To be filled by specified departmental personnel)

Name of student: _____

Professional attitude on placement? Y ☐ N ☐

Maintaining Dress Code on placement? Y ☐ N ☐

Progress seen during placement? Y ☐ N ☐

Any feedback, comments, concerns:

HAS STUDENT ATTENDANCE BEEN SATISFACTORY ? YES NO

Supervisor Name:

Signature:

Stamp:

For DME Use;

Name of Student _____

Date of submission of Portfolio _____

Attendance record certificate signed; **Yes/No**

Daily Logs complete: **Yes / No**

Signature of Assistant Professor DME _____