Department of Primary Health Care, University of Pécs, Hungary

Family Medicine Practice, 6th year

EVALUATION FORM FOR STUDENS

Name of family doctor: …….....

Place of praxis: ……..

Date of practice: …….

Please, mark the numbers that express your opinion the statements.

	No at all	Partly	Yes	Absolutely
1. The practice fulfilled my expectations	1	2	3	4
2. The practice was very useful	1	2	3	4
3. My professional plans are influenced by the practice	1	2	3	4
4. The teaching work of the family doctor was similar to my ideas	1	2	3	4
5. The medical practice of the family doctor was an example for me	1	2	3	4
6. The circumstances of the practice were good	1	2	3	4
7. I have got acquainted with the specificity of family medicine	1	2	3	4

	Not acceptable	Acceptable	Average	Good	Excellent
8. The whole practice evaluation	1	2	3	4	5

Notice and recommendation:.....

.....

Date:.....

.....

Student Signature's

Department of Primary Health Care, University of Pécs, Hungary

Family Medicine Practice 6th year

EVALUATION FORM FOR MENTRORS

EVALUATION OF THE PROGRAM

Please, mark the numbers that expresses your opinion about the question/ statements.

	Yes	No
1. Was the date of the practice appropriate for you?	1	2
2. Was the length of period (two weeks) convenient	1	2
If no, the ideal duration (weeks) …..…….		
3. Did you teach besides the consulting hours?	1	2

EVALUATION OF THE STUDENTS WORK

Name of student: ……..……..

Date of practice: ……..

	Unsatisfactory	Satisfactory	Average	Good	Excellent
5. Motivation of student	1	2	3	4	5
6. Communication skills of student	1	2	3	4	5
7. Practical skills of student	1	2	3	4	5
8. Acceptance of the practice (Please tick)			Yes		No

OVERALL EVALUTAION OF THE STUDENT'S PERFORMANCE DURING THE PRACTICE

1 (failed) 2 (satisfactory) 3 (average) 4 (good) 5 (excellent)

Notice/Remarks……...……

……..

Date: ……..

……
Signature

INTERVIEW

6th year Medical Student

Patient's data

Monogram: ..... Age: ..... Occupation: .....

Marital status: .....

Present complaints

Past medical history

Actual therapy

Family history

Quality of life/Risks

Body weight (kg): ..... Body height (cm): ..... Consumption:…….

Alcohol: ..... Smoking: ..... Caffeine: .....

Drug abuse: .....

Alimentation habits: .....

Physical activities/sports: .....**Allergy**: .....

Physical examination
List of the problems **Aktíve** **(needs to be done)** **Inactíve**
The main diagnosis
Additional diagnostic procedures **(i.e., Lab, Rtg)**
Therapy (life style, diet, medication)
Summary

Date:……. …… ……

Student Mentor