How will a student-doctor document a case in e-logbook after collecting the information from history-taking?

**Part 1**

(This part will be based on the information that a student-doctor will collect from a simulated student-patient)

Patient’s particulars

Chief complaints/presenting complaints with duration
1. 
2. 
3. 

History of present illness

History of past illness

Other aspects of the history in detail (e.g., occupational hx, psychosocial hx, menstrual hx, family hx, etc.)

Confirmatory diagnosis

Or,

Provisional diagnosis
1. 
2. 

Part 2

(This part will be prepared hypothetically by the students from their own rational ideas as to what findings they may get from physical examination or what investigations might be necessary (etc.) with reference to their diagnosis. Students may like to focus on a single or more than one diagnoses and thus, describe the relevant features accordingly)

Expected physical findings

This could be supplemented by suitable and appropriate images, diagrams/ drawings etc. that they may collect from one or more reliable sources and should be well-referenced.

General/ ear/ nose/ throat/ neck/ chest/ abdomen/ cranial nerves etc.

Suggested investigations expected abnormalities.

1. Blood
2. X-ray
3. CT scan

Further management plan including treatment outline

• If the students get any real workplace posting subsequently, they may write their logbook in their traditional way and can attach that document as an annex to this e-logbook.