History OSCE

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1- leg swelling
2- pleuritic chest pain
3- vomiting of blood
4- Hemoptysis
5- Joint pain
6- Loin pain
7- Skin rash
8- Weight loss
9- Cough
Etc…

1

A 41 years old male patient who presents to your clinic for **legs swelling** for 2 months.

Professionalism		
Introduce name, role and takes permission	0	0.25
Student has an identifying badge	0	0.25
Analysis of Chief complaint		
Onset (gradual or sudden)?	0	0.5
Unilateral or bilateral?	0	0.5
Painful or painless?	0	0.25
Severity (feet, legs, thighs)?	0	0.25
Other sites of edema (periorbital, face)?	0	0.5
Frothy urine?	0	0.25
Hematuria, hypertension?	0	0.5
Timing (worse in the morning or nighttime)?	0	0.25
Associated symptoms		
Shortness of breath or chest pain?	0	0.25
Orthopnea, PNDs?	0	0.25
Abdominal distension, jaundice, confusion?	0	0.5
Melena, hematemesis?	0	0.25
Abdominal pain?	0	0.25
Malnutrition? Or decreased calorie/protein intake?	0	0.25
Diarrhea? Chronic?	0	0.25
Varicose veins?	0	0.25
Uremic symptoms (nausea, vomiting, sleep disturbances, muscle spasms)	0	0.25
Fever, chills, malaise, hypotension?	0	0.25
Past Medical history		
Previous history of medical illnesses	0	0.25

Previous history of medical illnesses		
Past Surgical History		
Surgeries or procedures	0	0.25
Drug history		
Home medications	0	0.25
Allergies	0	0.25
Family history		
Family history of medical conditions	0	0.25
Social history		
Smoking history?	0	0.25
Global assessment (Overall understanding and orientation to a differential diagnosis list)	0	1
Total mark	/9	

- **On Physical examination, the patient has bilateral leg edema, No JVP elevation, what is your top differential diagnosis?** (0.5 mark)
    - Hypoalbuminemic states/Third-spacing (liver, nephrotic syndrome)

- **What blood tests would you like to order NEXT?**
  - Urinalysis, Urine spot Protein/Creatinine, Liver function tests (albumin, PT/INR, AST/ALT, bilirubin)

2

25 years old man presented in ER with chest pain, cough-greenish sputum and fever few days duration. Take a focused history:

Introduce him/her self	0.5
site	0.25
Onset (sudden vs gradual), duration , continuous vs intermittent	0.25-0.5-0.75
character	0.25
radiation	0.25
Severity (scale /10)	0.25
Relieving factors/ exacerbating factors(exertion, breathing , drugs like nitrates or analgesics) Relation to position Relation to food	0.25 0.5 0.5
Associated symptoms	
Fever, cough, sputum	0.5
nausea, vomiting, sweating, feeling of impending death palpitations , syncope, SOB, orthopnea , PNDs Skin rash (varicella zoster infection)	0.5 0.5
<u>Risk factors :</u>	
Contact with ill patient	0.5
<u>Family history</u>	
<u>Past medical history</u> DM, HTN	0.5
Previous similar chest infection	0.5
Vaccination	0.5
Social history: Smoking , alcohol intake , illicit drug use	0.25
Drug history	0.25
Global assessment	0.5

What is your top differential diagnosis? (1 mark)

Pleurisy from community acquired pneumonia, complicated pneumonia (empyema)

What blood tests would you like to order NEXT?

CXR, CBC (1)

3

A 65 years old male patient who presents to ER complaining of vomiting of blood.

Professionalism		
Introduce himself and takes permission	0	0.5
Student has an identifying badge	0	0.5
Analysis of Chief complaint		
Amount?	0	0.5
Frequency (how many times)?	0	0.5
Aggravating/ Relieving factors(PPI, Antacids)	0	0.5
Associated symptoms/ Diseases		
Abdominal pain, GERD	0	0.5
Liver diseases, CKD, IHD	0	0.5
Recurrent vomiting followed by blood ?	0	0.5
Melena/ tarry stool, ‘coffee ground" emesis, Lower GI bleeding.	0	0.5
Feeling of palpitation/ postural dizziness/ postural palpitation	0	0.5
Constitutional symptoms (loss of appetite, weight loss)	0	0.5
Past Medical history		
Previous similar episodes, cardiac diseases?	0	0.5
Past Surgical History		
Previous GI surgeries Gastric bypass, recent AAA repair	0	0.5
Drug history		
Aspirin, Anticoagulants, NSAID, Steroids.	0	1

Family history		
Family history of GI diseases/ Malignancies, Bleeding tendency?	0	0.5
Social history		
Smoking history? Drinking alcohol?	0	1
Global assessment (Overall understanding and orientation to a differential diagnosis list)	0	1
Total mark	/10	

4

Case: A 40 year old man presented with Hemoptysis

Item	Score		
• Introduce him/her self	0	0.5	
• Onset, frequency	0	0.25	
• Amount	0	0.25	
• Progression	0	0.25	
• Fever, Night sweats	0	0.5	
• Weight loss (significant or not)	0	0.25	
• Cough (onset, duration, contacts, etc), sputum amount, color, etc) • Chest pain (character, etc)	0	0.5	1
• Smoking history	0	0.25	
• Previous similar symptoms	0	0.25	
• Other Associated symptoms and other relevant symptoms: SOB, leg swelling, bony pain, bleeding from orifices, fever, prior medical procedures, symptoms of connective tissue disease	0	0.5	1 1.5 2
• PMH: Prior PPD tests, Any underlying lung disease, bleeding disorders	0	0.5	

• FH: FH of Lung cancer, TB, exposure to TB risk factors, similar conditions	0	0.5
• Medications: Antiplatelet and anticoagulants.	0	0.25
• Social History other than smoking: IVDA, Home conditions, etc	0	0.25
• Total History Mark	/ 7	

What is your differential diagnosis? **(1 marks)**

What investigations would you send for? **(1 marks)**

5

32y old male who is previously healthy presented with multiple joints pain.

Professionalism		
Introduce himself and takes permission	0	0.25
Student has an identifying badge	0	0.25
Analysis of Chief complaint		
Onset, duration (acute/ chronic)	0	0.25
Which joints involved, migratory or additive, asymmetrical	0	0.25
Morning stiffness > 1 hour	0	0.5
Swelling of the joints	0	0.5
Severity (pain score 0-10)	0	0.25
Relieved with analgesia like NSAID	0	0.25
Tendonitis/enthesitis of the lower limbs (achilles' tendonitis/ plantar fasciitis)	0	0.25
History of trauma	0	0.25
Associated symptoms		
oral ulcer, genital ulcer	0	0.5
Dysuria, frequency, urgency, urethral discharge?	0	0.5
Nail changes	0	0.5
Eye redness	0	0.5
Skin rash, Reynaud's phenomena	0	0.5
Neurological symptoms	0	0.5
Constitutional symptoms (loss of appetite, weight loss)?	0	0.25
Chest pain- pleura-pericarditis- aortic valve incompetence.	0	0.25
Diarrhea or GU infection symptoms	0	0.25
Past Medical history		
Previous history of musculoskeletal diseases/ gout	0	0.25
Past Surgical History		

Surgeries or procedures	0	0.25
Drug history		
NSAIDs	0	0.25
Allergies	0	0.25
Family history		
Family history of musculoskeletal conditions?	0	0.25
Social history		
Occupation/ sport	0	0.25
Smoking history?	0	0.25
Global assessment (Overall understanding and orientation to a differential diagnosis list)	0	0.5
Total mark	/9	

- **What is your top two differential diagnosis?** (0.5 mark)

1- - REITERS DISEASE 2- REACTIVE ARTHRITIS

- **Mention 3 laboratory test which are mandatory to confirm your diagnosis?** (0.5 mark)

6

A 43-year old female patient with a history of loin pain of two days duration.

Initiation Greet the patient and introduce himself	**0**	**0.5**	**1**
SYMPTOM ANALYSIS (SOCRATES)			
Site	0	0.5	
Onset	0	0.5	
Character	0	0.5	
Radiation	0	0.5	
Timing	0	0.5	
Exacerbating/relieving factors/ related to food	0	0.5	1
Severity	0	0.5	
SYSTEM REVIEW (urogenital ,GI)			
Voiding: Hesitancy, Dribbling, Poor stream, Incontinence	0	0.5	1
Storage: Volume of urine, Frequency, Urgency, Nocturia, Retention	0	0.5	1
Infection: Dysuria, Hematuria, Discharge	0	0.5	1
Catheter use	0	0.5	
Menstrual irregularities, dysmenorrhea	0	0.5	
Nausea & vomiting	0	0.5	
Change in bowel habits	0	0.5	
Constitutional			
Fever, shivering, weight loss, anorexia	0	0.5	1
BACKGROUND INFORMATION			
Past medical history •any medical conditions: DM • Ask about previous UTIs, STIs	0 0	0.5 0.5	1 1
Past surgical history: Renal calculi, DJ catheters, renal tract injury, and recent hospitalization	0	0.5	
Family history • Any conditions run in the family? Ask about any renal/urinary tract problems	0	0.5	1

Social history • smoking, drinking alcohol • Her job and whether her problem affects her job or home life in any way?	0	0.5	1
marital status (sexual activity)	0	0.5	
Global Assessment • Starting history with open questions • CLARITY (organization, appropriate confidence) • WARMTH (engagement, compassion, care for patient)	0	1	2
Total mark			

What is the most likely diagnosis? (0 / 1)

Which tests you would do for this lady? (0 / 1)

7

41 y old male who is previously healthy presented with lower limb skin rash.

Professionalism		
Introduce himself and takes permission	0	0.5
Student has an identifying badge	0	0.5
Analysis of Chief complaint		
Onset (when did you notice these lesion?)	0	0.5
Area of distribution	0	0.5
Shape and characteristics (What shape are the skin lesions?)	0	1
itching or bleeding	0	1
Time course (change over time)	0	0.5
Previous similar episodes	0	0.5
Contact with ill patients	0	0.5
	0	0.5
Associated symptoms		
Systemic symptoms (fever, malaise)	0	1
Any bleeding (hematuria, epistaxis, hematemesis)	0	1
Join pain	0	1
Neurological symptoms (numbness, focal weakness, diplopia)	0	1
Abdominal pain/SOB	0	1
Digital gangrene	0	1
Decrease urine output	0	0.5

Past Medical history		
Recent cardiac catheterization	0	0.5
History of hepatitis B, C		
History of bronchial asthma, sinusitis, sclreritis		
History of hematological disease (low platelets)		
Past Surgical History		
Surgeries or procedures	0	0.5
Drug history		
Thyroid disorders, Allopurinol	0	0.5
Anticoagulant	0	0.5
Allergy		
Family history		
Family history of connective tissue disease?	0	0.5
Social history		
Recent travel	0	0.5
Smoking history?	0	0.5
Global assessment (Overall understanding and orientation to a differential diagnosis list)	0	1
Total mark	/18	

- **What is your top two differential diagnosis?** (1 mark)
- **What investigations would you send for him ?**(1 mark)

8 weight loss

1. Duration.
2. Documented or not? And how much kg?
3. Course? Progressive or what?
4. Intentional weight loss?
5. Diet and calorie intake?
6. Change in appetite?
7. Physical activity?
8. Change in bowel habit?
9. Blood in stool or melena?
10. Difficulty swallowing?
11. Palpitations?
12. SOB/ Orthopnea/ PNDs?
13. Nausea and vomiting?
14. Abdominal pain?
15. Fever or chills?
16. Night sweats?
17. Palpable lumps anywhere?
18. Energy level?
19. Polyurea?
20. Polydypsia?
21. Mood?
22. Heat intolerance?
23. Lack of interest in life/ sleep disturbances?
24. Tremor?
25. Any drugs or herbal medications? / smoking?
26. PMHx: history of DM or thyroid problems?
27. PMHx of HTN?
28. Family history of thyroid problems?
29. Family Hx of depression?
30. Family Hx of Malignancy?
31. Menstrual cycle history? Heavy or frequent menses?

Q1: what is the most likely etiology of this patient's weight loss? (3pts)

1) Thyrotoxicosis.

2) Drug abuse.

3) Pheochromocytoma.

4) Depression.

Q2: Blood work up that you would like to obtain in this patient? (3pts)

1) CBC.

2) Thyroid function test.

3) LFT.

4) Urine VMA metanephrine.

5) Urine Drug Screen.

9 Cough

25 y/o female presented to you with **cough**

1. Duration
2. Presence of sputum
3. Presence of wheezing
4. SOB /Relation to exertion
5. Orthopnea/PND/ lower limb swelling
6. Aggravating factors
7. Relieving factors
8. Similar episode in the past
9. History of smoking
10. Family history of asthma/ similar symptoms
11. Chest pain
12. Medication (ACE inhibitor)
13. Past medical History
14. Hemoptysis
15. Hematuria
16. Fever/Chills
17. GERD
18. Sinus congestion/Runny nose