OSCE History Taking – Notes for Actor Template

Patient demographics:
55-year-old presenting with knee pain
Location: GP practice

Presenting Complaint:
Left knee pain

History of Presenting Complaint:
S – Left knee
Q – dull achy pain
I – 7 out of 10
T – started 3 weeks ago and progressively got worse
A – walking around
R – sitting down and resting
S – fatigue

No trauma
Worse during the day and better at night

Other history:
No red flags such as fever, swelling or sudden onset
Had the flu about 4 weeks ago but other than that not much changed

ICE
Concerned because affecting job and doesn't know what it is. Wants an x-ray.

PMH + Surgical History
Had gall bladder removed couple of years ago – laparoscopic due to ascending cholangitis
Hypertension
Diabetes mellitus type 2
GORD

Drug History
Atorvastatin
Lisinopril
Omeprazole
Vitamin tablets
No allergies

Family History
No significant

Social History
Smoker for last 30 years – 20 a day
Never had alcohol
Lives with wife and works as waiter which has him up on his feet a lot
Has 4 children that all live abroad

Diagnosis
OA

OSCE History Taking – Notes for Candidate Template

Role: FY1 in GP
Presenting complaint: Knee pain

Please take a history in 8 minutes

There will be 2-minute further questions from examiner at the end

OSCE History Taking – Examiner marksheet

Opening:

- Introduces themselves
- Confirms Patient demographics
- Explains and gains consent from patient about consultation

Presenting complaint and History of presenting complaint:

- Open questioning to begin
- Structured approach e.g. SQITARS
- Red flags
- ICE
- Uses clear language and avoids jargon

Systemic enquiry:

- Screens for relevant symptoms in other body systems

PMH/Surgical history

- Asks about any medical conditions
- Asks about relevant surgical procedures

Drug History, Social and Family History:

- Asks about both prescribed and over the counter medication
- Allergies and what happens during allergy
- Substance misuse
- Alcohol and Smoking history
- Occupation
- Support at home/mobility
- Relevant Family History

Ending consultation:

- Summaries and clarifies any points
- Thanks Patient
- Signposting

EXAMINER FOLLOW UP QUESTIONS:

1. **What is your top differential diagnosis and why?**
   OA – reasonably explanation

2. **What initial investigations/examinations would you order for this patient?**
   None required clinical diagnosis but can order x-ray

3. **What is your initial management plan?**
   Lifestyle
   Physio
   Analgesics

Global Impression:

- Excellent
- Good
- Pass
- Borderline
- Fail

Patient Impression/comments: