OSCE History Taking – Notes for Actor

Patient demographics:
You are Jackson Marshall a 16-year-old Male. You have come to the GP because you feel Breathless

Presenting Complaint: Breathlessness

History of Presenting Complaint:

- Breathlessness + Cough for past few months
- Mainly after Exercise, but also when walking around in the Cold and at Night and in the Mornings
- Last week he tried using his friend's blue inhaler and it helped to alleviate the symptoms

Other symptoms + Negative history (ONLY IF ASKED)

- No Pain, No Sputum, Not progressive, No Weight loss/ Difficulty gaining weight
- No issues with Urine frequency/ appearance, Normal bowel movements, No recent travel history

ICE
I: None
C: None
E: Wants to stop feeling out of breath

PMH + Surgical History:

- Eczema

Drug History

- Peanut allergy

Family History

- Asthma in Grandfather

Social History

- Doesn't smoke or drink, has a healthy diet, lives with Parents. No Pets

Diagnosis: Asthma

OSCE History Taking – Notes for Candidate

Role: GP Trainee
Presenting complaint: Breathlessness

This is Jackson Marshall, a 16-year-old Male who has presented to the GP with Breathlessness

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
- ***Demonstrates relevant and spontaneous empathy at APPROPRIATE times***

Presenting complaint and History of presenting complaint:

- Open questioning to begin
- Structured approach
- 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 or 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, Relevant Family History

Ending consultation:

- Summarises and clarifies any points
- Thanks Patient
- Signposting

EXAMINER FOLLOW UP QUESTIONS:

Q1: What is your top differential diagnosis and why?
Asthma: Inhaler works, Family Hx, Atopy, Dry cough + SoB worse on Exercise, Diurnal variation

Q2: What initial investigations would you order for this patient?
PEFR, Spirometry with Bronchodilator reversibility

Q3: How would you manage this patient?
Start on a Short-acting Beta Agonist (Salbutamol)

Q4: How would you manage this patient if Salbutamol alone was insufficient?
Add Low dose Inhaled Corticosteroid

Global Impression:

- **Excellent**
- **Good**
- **Pass**
- **Borderline**
- **Fail**

Patient Impression/comments: