**Instructions:** Use to document OSCE patient appointment data

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Occupation:</th>
</tr>
</thead>
</table>

**Chief Complaint:**

**History of Present Illness – OPQRST**

<table>
<thead>
<tr>
<th>O - Onset</th>
<th>When did this happen? How many times has this happened? How long did it occur each time?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P – Provoke</td>
<td>What causes the problem/symptoms? Can you point to the area of the symptoms? Can you point to the area where it is the worst?</td>
</tr>
<tr>
<td>Q - Quality</td>
<td>Can you describe to me the symptoms/pain? What is the quality of the pain, sharp stabbing-like or a dull ache?</td>
</tr>
<tr>
<td>R - Radiating</td>
<td>Do the symptoms radiate? Does the pain shoot or transfer to other parts of the body?</td>
</tr>
<tr>
<td>S - Setting</td>
<td>Where do the symptoms occur? Work or Home? Where are the symptoms worse, early in the day, or late? When you awake?</td>
</tr>
<tr>
<td>S - Severity</td>
<td>How bad are the symptoms? How painful are they? From a scale of 0-10, with 10 being the worse pain</td>
</tr>
<tr>
<td>T - Timing</td>
<td>Are the symptoms constant or intermittent? Does the pain/symptoms fluctuate?</td>
</tr>
</tbody>
</table>

**Past Medical History (HITS)**

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>Illnesses</th>
<th>Trauma</th>
<th>Surgeries</th>
</tr>
</thead>
</table>

**Medications**

**Allergies**

**Social History**

<table>
<thead>
<tr>
<th>Smoking (pack hx)</th>
<th>Alcohol (CAGE)</th>
<th>Drugs</th>
<th>Coffee / Tea</th>
</tr>
</thead>
</table>

**Family History – Circle if Positive (Indicate Mother / Father / Both)**

<table>
<thead>
<tr>
<th>Arthritis</th>
<th>Asthma</th>
<th>Diabetes</th>
<th>Heart Disease</th>
<th>Cancer</th>
</tr>
</thead>
</table>

**General Review**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Nausea, Vomiting (bilious, feculent, blood), Diarrhea?</td>
<td>Any Headaches, Dizziness, Lightheadedness, Fainting spells, Life stresses?</td>
<td>Any Muscle or Joint Pains? Any Pain at all?</td>
</tr>
</tbody>
</table>

**Prevention – Circle (document dates and details)**

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Seat belt</th>
<th>Helmet</th>
<th>Physical</th>
<th>Pap/PSA</th>
<th>Mammogram</th>
<th>Colonoscopy</th>
<th>B/T self-exam</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N</td>
<td>Y N</td>
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<td>Y N</td>
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</tbody>
</table>
### Section-2 Review of Systems

<table>
<thead>
<tr>
<th>General/skin/sleep</th>
<th>Respiratory</th>
<th>Blood?</th>
<th>Musculoskeletal</th>
<th>Endocrine</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ △ weight</td>
<td>□ Cough</td>
<td>□</td>
<td>□ Joint pain/back ache</td>
<td></td>
</tr>
<tr>
<td>□ Fatigue</td>
<td>□ Dyspnea</td>
<td>□</td>
<td>□ Swelling</td>
<td></td>
</tr>
<tr>
<td>□ Weakness</td>
<td>□ Wheezing</td>
<td>□</td>
<td>□ AM stiffness</td>
<td></td>
</tr>
<tr>
<td>□ Fevers</td>
<td>□ Asthma</td>
<td>□</td>
<td>□ Arthritis</td>
<td></td>
</tr>
<tr>
<td>□ Chills</td>
<td>□ Bronchitis</td>
<td>□</td>
<td>□ Gout</td>
<td></td>
</tr>
<tr>
<td>□ Rash/itching/dryness</td>
<td>□ Emphysema</td>
<td>□</td>
<td>□ Cramps</td>
<td></td>
</tr>
<tr>
<td>□ △ hair</td>
<td>□ Pneumonia</td>
<td>□</td>
<td>□ Prox. weakness</td>
<td></td>
</tr>
<tr>
<td>□ △ nails</td>
<td>□ TB</td>
<td>□</td>
<td>□ Functional limit</td>
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<table>
<thead>
<tr>
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<th>□ △ nails</th>
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</thead>
<tbody>
<tr>
<td>□ High/low BP</td>
<td>□ Murmurs</td>
<td>□ Orthopnea</td>
<td>□ Nocturnal dyspnea</td>
<td>□ Edema</td>
<td>□ Chest pain</td>
<td>□ Palpitations (rapid/skip)</td>
<td>□ Claudication</td>
<td>□ Varicose veins</td>
</tr>
<tr>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>□ △ appetite</td>
<td>□ Heartburn</td>
<td>□ Nausea</td>
<td>□ Vomiting</td>
<td>□ Abd. Pain</td>
<td>□ Bloating</td>
<td>□ Lactose intoler.</td>
<td>□ Diarrhea</td>
<td>□ Constipation</td>
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</tr>
</thead>
<tbody>
<tr>
<td>□ Heat/cold intolerance</td>
<td>□ Polydypisia</td>
<td>□ Polyphagia</td>
<td>□ Diaphoresis</td>
<td>□ Thyroid problems</td>
<td>□ Diabetes</td>
<td>□ Skin color change</td>
<td>□ Excess hair growth</td>
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### HEENT

<table>
<thead>
<tr>
<th>Ears:</th>
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<tbody>
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<td>□ Hearing</td>
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<table>
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<tbody>
<tr>
<td>□ Colds</td>
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<td>□ Hay fever</td>
<td>□ Nose bleed</td>
<td>□ Sinus</td>
<td>□ Anosmia</td>
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<td>□ Fatigue</td>
<td>□ Weakness</td>
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<table>
<thead>
<tr>
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<td>□ Excess hair growth</td>
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</table>

### Gynecological

<table>
<thead>
<tr>
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<th>□ △ weight</th>
<th>□ Fatigue</th>
<th>□ Weakness</th>
<th>□ Fevers</th>
<th>□ Chills</th>
<th>□ Rash/itching/dryness</th>
<th>□ △ hair</th>
<th>□ △ nails</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Menarche age</td>
<td>□ Irregular period</td>
<td>□ Period freq</td>
<td>□ Period duration</td>
<td>□ Bleed between</td>
<td>□ Last period</td>
<td>□ Menopause age</td>
<td>□ Symptoms</td>
<td>□ △ weight</td>
</tr>
<tr>
<td>□ △ weight</td>
<td>□ Fatigue</td>
<td>□ Weakness</td>
<td>□ Fevers</td>
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<td>□ △ hair</td>
<td>□ △ nails</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Neuro/psych</th>
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<th>□ Fatigue</th>
<th>□ Weakness</th>
<th>□ Fevers</th>
<th>□ Chills</th>
<th>□ Rash/itching/dryness</th>
<th>□ △ hair</th>
<th>□ △ nails</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Headache</td>
<td>□ Fainting</td>
<td>□ Blackouts</td>
<td>□ Seizures</td>
<td>□ Paralysis</td>
<td>□ Numbness/tingling</td>
<td>□ Vertigo/dizziness/difficulty</td>
<td>□ walking</td>
<td>□ Confusion</td>
</tr>
<tr>
<td>□ △ weight</td>
<td>□ Fatigue</td>
<td>□ Weakness</td>
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<td>□ △ hair</td>
<td>□ △ nails</td>
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</tbody>
</table>

### Section-3 Physical Exam

<table>
<thead>
<tr>
<th>Skin</th>
<th>Eyes</th>
<th>Ears</th>
<th>Nose</th>
<th>Mouth / Throat</th>
<th>Heart</th>
<th>Lungs</th>
<th>Abdomen</th>
<th>Neurological</th>
<th>Diagnosis / Plan</th>
</tr>
</thead>
</table>

Notes

- □ Headache
- □ Fainting
- □ Blackouts
- □ Seizures
- □ Paralysis
- □ Numbness/tingling
- □ Vertigo/dizziness/difficulty
- □ walking
- □ Confusion
- □ Memory loss
- □ Tremor/coordination
- □ Anxiety/tension/stress
- □ Depression/tearfulness
- □ Suicide attempts

- □ Transfusions
- □ Menarche age
- □ Irregular period
- □ Period freq
- □ Period duration
- □ Bleed between
- □ Last period
- □ Menopause age
- □ Symptoms
- □ △ weight
- □ △ appetite
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Abd. Pain
- □ Bloating
- □ Lactose intoler.
- □ Diarrhea
- □ Constipation
- □ Gas
- □ △ appetite
- □ Blood?
- □ Sputum?
- □ - Color?
- □ - Quantity?