College of Nursing

# OSCE Exam Documentation Form

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

| Name: | Age: | Occupation: |
|---|---|---|
| Chief Complaint: | | |

## History of Present Illness – OPQRST

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

## Past Medical History (HITS)

| Hospitalizations | Illnesses | Trauma | Surgeries |
|---|---|---|---|
| Medications | | | |
| Allergies | | | |

## Social History

| Smoking (pack hx) | Alcohol (CAGE) | Drugs | Coffee / Tea |
|---|---|---|---|

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

| Arthritis | Asthma | Diabetes | Heart Disease | Cancer |
|---|---|---|---|---|

## General Review

| | | |
|---|---|---|
| General health – good, bad, stable etc. | Any changes in your Sleep? Energy level/Fatigue? Appetite? Weight? | Any Chills, Fevers, Sweats? |
| Any Nausea, Vomiting (bilious, feculent, blood), Diarrhea? | Any Headaches, Dizziness, Lightheadedness, Fainting spells, Life stresses? | Any Muscle or Joint Pains? Any Pain at all? |

## Prevention – Circle (document dates and details)

| | | | | |
|---|---|---|---|---|
| Vaccines | Y N | Pap/PSA | Y N | **Notes:** |
| Seat belt | Y N | Mammogram | Y N | |
| Helmet | Y N | Colonoscopy | Y N | |
| Physical | Y N | B/T self-exam | Y N | |

## Section-2 Review of Systems

**General/skin/sleep**
- □ Δ weight
- □ Fatigue
- □ Weakness
- □ Fevers
- □ Chills
- □ Rash/itching/dryness
- □ Δ hair
- □ Δ nails

**Respiratory**
- □ Cough → Blood? Sputum? - Color? - Quantity?
- □ Dyspnea
- □ Wheezing
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Pneumonia
- □ TB

**Musculoskeletal**
- □ Joint pain/back ache
- □ Swelling
- □ AM stiffness
- □ Arthritis
- □ Gout
- □ Cramps
- □ Prox. weakness
- □ Functional limit

**Endocrine**
- □ Heat/cold intolerance
- □ Polydypsia
- □ Polyphagia
- □ Diaphoresis
- □ Thyroid problems
- □ Diabetes
- □ Skin color change
- □ Excess hair growth

**HEENT**

Eyes:
- □ Vision
- □ Pain
- □ Redness
- □ Tearing
- □ Double vision

Ears:
- □ Hearing
- □ Tinnitus
- □ Vertigo
- □ Earache
- □ Discharge

Nose:
- □ Colds
- □ Stuffiness
- □ Hay fever
- □ Nose bleed
- □ Sinus
- □ Anosmia

• Mouth:
- □ Teeth
- □ Bleeding gums
- □ Sore throat
- □ Hoarseness

• Throat:
- □ Dysphagia
- □ Lumps
- □ Goiter
- □ Pain
- □ Stiffness

**Cardiovascular**
- □ High/low BP
- □ Murmurs
- □ Orthopnea
- □ Nocturnal dyspnea
- □ Edema
- □ Chest pain
- □ Palpitations (rapid/skip)
- □ Claudication
- □ Varicose veins
- □ Thrombophlebitis
- □ Easy bruise/bleed
- □ Anemia
- □ Transfusions

**GI**
- □ Δ appetite
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Abd. Pain
- □ Bloating
- □ Lactose intol.
- □ Diarrhea
- □ Constipation
- □ Gas
- □ Hemorrhoids/**r**ectal bleed
- □ Liver/gallbladder
- □ Jaundice/hepatitis

**GU**
- □ Dysuria
- □ Nocturia
- □ Polyuria
- □ Hematuria
- □ Urgency
- □ Hesitancy
- □ Incontinence
- □ UTI
- □ Stones
- □ Δ stream

**Genital/sexual**
- □ Discharge
- □ Itching
- □ Sores
- □ STD
- □ Hernias
- □ Test/vag pain
- □ Testicular mass
- □ Interest
- □ Function
- □ Satisfaction
- □ Problems

**Gynecological**
- □ Menarche age _____
- □ Irregular period
- □ Period freq _____
- □ Period duration ____
- □ Bleed between
- □ Last period _____
- □ Menopause age ____
- □ Symptoms
- □ Post-men bleed
- □ Breast lumps
- □ Breast pain
- □ Breast discharge
- □ G___P___A___
- □ Preg complications

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

Suicide attempts

**Notes**

## Section-3 Physical Exam

| | |
|---|---|
| Skin | |
| Eyes | |
| Ears | |
| Nose | |
| Mouth / Throat | |
| Heart | |
| Lungs | |
| Abdomen | |
| Neurological | |
| Diagnosis / Plan | |