Interactive history and exam session

<table>
<thead>
<tr>
<th>Administrative goals:</th>
<th>Practical goals:</th>
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<tbody>
<tr>
<td>• Direct observation of history taking</td>
<td>• During the session: Take a history on a patient with an eye complaint and obtain physical exam information</td>
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<tr>
<td>• Patient note #2</td>
<td>• After the session: Write a patient note based on your interaction</td>
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For this session, students will be paired. One student will act as a patient, and their history and physical exam will be provided to them.

The other student will act as the examiner, and start by taking a history. Then, the examiner will ask the patient for physical exam information in oral boards style. For example:

Examiner: "I will check the patient's visual acuity with a near card, by asking him to cover one eye with the palm of his hand, wear his habitual glasses and hold the near card at 14 inches away,"

Patient: “The visual acuity in my right eye is 20/20, and in the left eye is 20/40.”

Examiner: "I will now check the confrontation visual fields by...." etc.

Then, students will switch roles. The history and physical exam provided to the next student will be a different case.

After this is completed, students will each write a note with the information they obtained and submit as Patient Note 2.
Chief Complaint
81-year-old with sudden, painless vision loss OS.

History of Present Illness
• Sudden black spot in the vision that spread out over the complete visual field OS over a 15-minute time frame. No pain, no diplopia, no problems in the right eye.
• Drove directly to the ER.

POHx
• No history of ocular surgeries or trauma
• Mild myopia and presbyopia

PMHx
• Coronary artery disease s/p CABG & balloon angioplasty
• Right carotid endarterectomy (1990s)
• Left carotid stenting (endovascular) recently with transient right hemiparesis (resolved).

FHx
• Father had poor vision from cataracts, died of heart disease
• Mother and brother had glaucoma

SHx: Retired school teacher, lives alone

Meds: ASA, Plavix, nitroglycerine PRN and alfalfa pills

Allergies: None

ROS: denied headaches, jaw claudication, scalp tenderness, weight loss, and loss of appetite, otherwise as in HPI or negative

EXAM
• Visual acuity with glasses: 20/30 OD and HM OS.
• Confrontation visual fields: Normal OD, able to see hand motions in all four quadrants OS
• Pupils: pupils equal in light and dark, reactive, large RAPD OS
• EOM: full OU
• Hirschberg: Symmetric corneal light reflexes
• Penlight exam of anterior segment: mild nuclear sclerosis cataracts OU
• Fundus: normal OD, see photo OS (share screen with the examining student and show only the image below)
**Chief Complaint**

34-year-old with watery, red, irritated eyes; left more than right

**History of Present Illness**

- 6-day history of watery, irritated eyes
- Noted that the left eye was tearing, slightly blurry, and starting to get red six days ago
- The eye gradually became increasingly red and irritated over the ensuing 2 days and the with increased crusting in the mornings.
- There is a mild "scratchy" sensation.
- Given antibiotic drops 3 days ago, but no improvement in symptoms
- Left eye continued to worsen
- 2 days ago, right eye started to get red and watery
- One week prior to any ocular symptoms, had an upper respiratory infection which had subsided spontaneously.

**POHx**: Former contact lens wearer (five years ago), now only wears glasses for myopia. No eye surgery or trauma

**PMHx**: Healthy

**PSHx**: Tonsillectomy in childhood

**FHx**: Maternal grandmother with macular degeneration (in her 80s), paternal grandfather with recent cataract surgery

**SHx**: Married, works as an accountant

**Meds**: Daily multivitamin

**Allergies**: None

**ROS**: As in HPI, otherwise negative

**EXAM**

- Visual acuity with glasses: 20/20 OD and 20/30 OS
- Confrontation visual fields: Normal OD and OS
- Pupils: pupils equal in light and dark, reactive, no RAPD
- EOM: full OU
- Hirschberg: Symmetric corneal light reflexes

- Penlight exam of anterior segment: Evident crusting on lashes and watery discharge, OU. The conjunctiva is injected OS>OD. There is mild swelling of the eyelids, again L>R.

- Palpable pre-auricular lymphadenopathy (LAD), L>R

  *(share screen with the examining student and show only the images below when asked about penlight exam or lymphadenopathy exam)*

- Direct ophthalmoscopy: normal OD and OS
### Clerkship Direct Observation Form

**History Taking and Communication Skills**

**Ophthalmology**

<table>
<thead>
<tr>
<th>Skill</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Not Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluates reasons for visit in organized manner</td>
<td>many disjointed unorganized questions</td>
<td>most but not all questions followed logical order</td>
<td>questions followed clear logical order</td>
<td></td>
</tr>
<tr>
<td>Explores symptoms in sufficient detail to generate a logical DDx</td>
<td>level of detail insufficient to generate logical DDx</td>
<td>level of detail allows some but not fully developed DDx</td>
<td>Level of detail allows a logical well-developed DDx</td>
<td></td>
</tr>
<tr>
<td>Elicits PMH, FH and SH as applicable to the case</td>
<td>did not obtain any relevant PMH, SH or FH</td>
<td>addressed some but not all relevant domains</td>
<td>addressed all relevant domains</td>
<td></td>
</tr>
<tr>
<td>Elicits pertinent ROS (positive, negative)</td>
<td>did not obtain a ROS</td>
<td>obtained ROS, omitting some important details</td>
<td>obtained relevant ROS with all important details</td>
<td></td>
</tr>
<tr>
<td>Uses appropriate combination of open and closed questions</td>
<td>rare use of open questions; most questions were closed</td>
<td>open questions with some but not all major lines of inquiry; heavy use of closed questions</td>
<td>open questions with all major lines of inquiry, followed by appropriate number of closed questions</td>
<td></td>
</tr>
<tr>
<td>Demonstrates active listening</td>
<td>frequent interruption of patient; lack of facilitative skills to encourage patient to tell their story</td>
<td>occasional inappropriate interruption of patient; some but inconsistent use of facilitative and guiding skills</td>
<td>No inappropriate interruption of patient; consistent use of facilitative and guiding skills</td>
<td></td>
</tr>
<tr>
<td>Responds to patient’s concerns with appropriate verbal and non-verbal behavior</td>
<td>negative/closed body language; no eye contact; no expression of empathy</td>
<td>open body language; some but inconsistent eye contact and expression of empathy</td>
<td>open body language; effective eye contact and expression of empathy</td>
<td></td>
</tr>
</tbody>
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Describe 1-2 effective skills that the student performed:

Suggest ways to help student move 1-2 skills to the next level: