Target USMLE

STEP 2 CS HANDBOOK

DISCLAIMER

All content in Target Step 2 CS handbook is for education purposes designed to help students pass USMLE Step 2 Clinical Skills (STEP 2 CS) by giving them an organized format for history taking and physical examination in order to enable them to perform on the real exam in a time constrained manner with standardized patients who are actors and not real patients. We are not responsible for the use of any knowledge, information or facts gained from this book in the practice of medicine on real life patients (or harm done to anybody thereof), medical research or any related medical or science applications.

Though the materials available in this book may be useful for strategies needed for passing examination like the USMLE Step 2 CS, it is not a substitute for the medical knowledge and acumen gathered in medical school from standard text books and clinical rotations. Please do understand that Target USMLE is not affiliated with any other third party and does not (directly or by implication) make any guarantees that the materials provided by us will be tested on the USMLE Step 2 CS exam.

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FOREWORD

Few experiences in the journey to becoming a physician spark more terror in the hearts of students than the USMLE Step 2-CS, and the fact that you are reading this book suggests that you yourself are one of these terror-stricken students. By this point in your training, you have decades of experience with exams, but Step 2-CS is a different type of exam. It requires that you abandon the comfort and safety of the multiple choice question, where one of the answers is always right, and leap into the unpredictable chaos of human interaction. It requires that you demonstrate the ability to act and think like a doctor at a point in your career when you are likely still questioning your right to wear the white coat. It requires that you earn the confidence of strangers at a time when you lack confidence in yourself.

However, I am here to assure you that this terror is misplaced. Unlike other exams you've taken, Step 2-CS does not demand encyclopedic knowledge of pharmacology or memorization of the intricacies of the Krebs cycle. Other exams require mastery of concepts that bear little relation to your daily life as a budding clinician, and that are not intuitive. Step 2-CS, on the other hand, simply demands that you do what you do every day in clinic and in the hospital: take care of patients. Unlike other exams you've taken, Step 2-CS allows you to actually do what you've spent all these years learning to do – what could be more natural?

This is not to say that you can just bumble through Step 2-CS without preparation. Quite the contrary – passing Step 2-CS requires that you elicit specific key information from each patient in a very limited time frame, rapidly synthesize it into an assessment and plan, and demonstrate effective communication and compassion in the process. This requires an organized strategy – one that ensures that you ask the right questions and perform the right exam maneuvers in an efficient manner without losing sight of the human dimensions of each encounter. These are the skills you will learn in this book.

Dr. Mary June has enabled many students to pass Step 2-CS, and now she is making her years of experience and success available to students around the world. In this book, you will learn the skills you need to pass all dimensions of the exam, and in doing so you will gain confidence and control. In acquiring this book, you have already taken an important step towards passing the exam, and I wish you every success in this and all your endeavors!

Julianna Jung, MD, FACEP
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Director, Comprehensive Clinical Skills Exam
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DEDICATION

I dedicate this book to my dear son Rohit Vinay, who has been a source of strength and courage to help me believe in myself - to never give up on whatever little difference we can make in this world with the gifts that our Maker has entrusted us with by His Grace.

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PREFACE

USMLE Step 2 CS exam is a very easy exam to pass. It is also a very easy exam to fail especially since it is conducted in a time pressured capsule. You meet 12 strangers consecutively as Standardized Patients, who assess you for English Proficiency, Communication and Interpersonal Skills as well as Physical Examination. Even though you might have excelled in Step 1 and Step 2 CK, Step 2 CS is a very different exam. Since the material to be covered is comparatively lesser than Step 1/CK many students assume that they can cram the material in a short period of time and reproduce in the real exam. Not quite true!

Target USMLE Step 2 CS Handbook is a compilation of lecture notes which are given to our students along with the coaching classes offered by Target USMLE. These lecture notes have taken the form of a book at the request of many of my students who found the notes immensely helpful to pass Step 2 CS the first time around!

Personally, I like to assess my students when they register for our courses as many of them come from varied backgrounds: different countries, different medical education systems, varied interpersonal skills/ English proficiency and more importantly a wide range of variation in medical knowledge and clinical skills acumen. Though many of them have already been reading various resources I still find them unable to conduct an organized encounter. After I share the CS handbook that you are now holding in your hands, I have seen a remarkable improvement in their presentation in the very next assessment. More importantly, they are more confident and in control of their 15 minute encounter.

Target USMLE Step 2 CS handbook is a simple yet comprehensive compilation of the essentials you need to pass Step 2 CS. It is not only easy to read but also remember in the real exam as it gives you an organized flow of thought. The online video tutorial that accompanies the notes help you experience a didactic classroom like setting with lectures and demos, especially for students who do well with audio and visual tools. The Step 2 CS handbook is a perfect complement for the '7 Easy Steps 2 CS' online video tutorial, which also includes an interactive program of how to go about deriving the differential diagnosis for each chief complaint that the patient may present with. For more information visit our website http://www.targetusmle.com/video.php

I had only one thing in mind when I wrote this book – to take 'YOU' one step closer to your dreams by contributing my part to your success in the Step 2 CS exam. Good luck and God bless!

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Director Target USMLE
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ACKNOWLEDGEMENTS

I am very grateful to my parents Carmela and Iruthayanathan for their love and invaluable sacrifice in raising me to be who I am today. I thank my brother Gerald who always infuses me with words of encouragement. I am eternally grateful to Rev. Fr. Arputhasamy who believed in me to become a doctor when I myself did not!

I would like to thank all my students and friends who encouraged me to write this book especially Ashley Sarasan MD, RajeshGopalarathinam MD and Preethi Jackson MD, for their contribution and help with the Step 2 CS handbook and online video tutorials.

Last but not the least, I reminisce with a heart of gratitude all my wonderful teachers at high school (Ms. Regina M.Sc, Zoology) and medical college, my mentors Geetha Haripriya MD, Gwen Childs PhD and Joseph Dillon MD for having sowed into me their knowledge and wisdom from years of experience without expecting anything in return!

STEP 2 CS EXAM OVERVIEW

INTRODUCTION TO STEP 2 CS

Hello there! If you are getting started on USMLE Step 2 CS you have come to the right place. Step 2 Clinical Skills exam is a simple exam which expects you to behave and think like a doctor which you already are or going to be soon.

Whether Step 2 CS is your first or last exam before you get ECFMG certified, the key is to first know what is expected of you in the limited time they give you in the real exam. That is exactly the goal of this book – to provide you with all the information in one place!

I am sure you have a lot of questions about the Step 2 CS exam per se and the following questions and answers will answer most of them.

What is STEP 2 CS?

Step 2 Clinical Skills (Step 2 CS) is one of the USMLE exams required as a pre requisite for getting ECFMG certified in the United States. Passing the Step 2 CS along with Step 1 (Basic Sciences) and Step 2 CK (Clinical Knowledge) gets your ECFMG Certified which allows you to be recognized as a physician in the USA. Most residency programs require it as a pre-requisite before getting into residency. You also need to be ECFMG certified for taking the USMLE Step 3.

When is it offered?

Step 2 CS is offered throughout the year except for a few days. Two sessions are available for you to pick in a day a.m. or p.m.

Where is it offered?

It is offered in 5 cities in the USA. Chicago, Philadelphia, Houston, Atlanta and California.

How long is the Step 2 CS exam?

The step 2 CS exam lasts for about 8 hours

What's the passing score? Who grades each component?

There is no passing score on this exam. The results are displayed as Pass OR Fail. There is no numerical score. There are 3 components that you need to pass individually to pass the Step 2 CS.

1) SEP – Spoken English Proficiency (graded by SP)
2) CIS – Communication Interpersonal Skills (graded by SP)
3) ICE – Integrated clinical encounter (graded by SP and Physician)
   ICE includes Data Gathering & Patient note

You will be graded 10 out of 12 cases and the average of 10 evaluations will be calculated.

How long do I have to study for Step 2 CS?

Typically medical students take 2 - 4 weeks for preparation. Depending on whether you are an American Medical Graduate (AMG) or an International Medical graduate (IMG) the timing of preparation will vary as you will have to factor in, training yourself to interact with a patient the American way! You also need to consider travel time to and fro from your country. Some students need 2-3 months to improve their Spoken English proficiency and/or typing speed as the patient note has to be typed and not hand written.

What resources do I use for Step 2 CS preparation?

There are a lot of resources and methodologies that students use to prepare for CS.
There are books that provide a lot of information but each student has to filter the numerous inputs and create a system that works for them. Some videos online show how physical examination is done in a detailed manner but the student has to know how to edit it to fit it into the 15 min encounter that the Step 2 CS exam allows for a clinical encounter. Target USMLE video tutorials '7 Easy Step 2 CS' shows how to do the PE manoeuvres within time.

What am I expected do during the CS exam?

You are asked to examine a standardized patient in a clinical setting for 15 minutes and type patient note for 10 min. There will be 12 cases overall. Information about each case will be displayed outside the door (Doorway information). You will have breaks after a couple of cases in a row. For example 5 - break - 4 - break - 3 cases (or) 3-3-3-3 cases

What are the details provided in the Doorway information?

The name, age, sex, vital signs (BP, Pulse, Respiratory Rate and Temperature in both Celsius and Fahrenheit) are displayed along with instructions of do's and don't's during the encounter. You are requested to take a focused history and do a focused physical examination but not allowed to do any internal exams like pelvic, rectal or breast exam. If it is minor patient information regarding consent is also written in the doorway information.

All information outlined above regarding STEP 2 Clinical Skills Exam are extracted from the ECFMG bulletin. Please read the current bulletin for up to date information: www.ecfmg.org

HOW TO PREPARE FOR STEP 2 CS?

In my years of experience training students across the globe, Step 2 CS preparation falls under the following 4 stages

Stage 1) Initially, it is knowing what the Step 2 CS exam is all about.

Stage 2) How to conduct an organized encounter by asking relevant questions to the case at hand and not just going through a bunch of mnemonics or irrelevant questions. Basically knowing the flow of the case encounter from start to finish, how much time to allot mentally for each section and getting absolutely familiar with the format so that you are on autopilot for most parts of the encounter. This is where the CS handbook comes in – to become confident that you are presenting cases in a right and organized way!

Stage 3) Knowing how to write a good patient note. The physician (who is not in the encounter room) corrects your patient note which forms the bulk of your ICE component. No matter how well you do inside the room with your Standardized patient (SP) if it doesn't get translated into the patient note unfortunately you don't score on ICE. On the other hand, even if you are a fast typist, if you did not ask the relevant questions inside the encounter room there is nothing you can make up to type on your patient note. If you missed to ask rash, neck stiffness, photophobia to r/o meningitis in a case of fever inside the room, it is too late to remember when you type the patient note because you will not have the substantial evidence to support your diagnosis even if you list it . I have outlined in the CS handbook precisely how to write an organized patient note and also written 3 sample patient notes for your reference.

Stage 4) Practice! Practice! Practice! It is one thing to know how to do it the right way but it is another thing to put it into action in a given time frame under pressure. It is a good idea to do multiple cases in a row under timed conditions just like the real exam. Again there is no point doing a mock exam if you really aren't ready (i.e completed the first 3 stages mentioned above). Sitting in coaching classes for 4-5 days can give you insights and strategies about the exam but does not get YOU exam ready! There are a lot of things you got to work on by yourself before you take the mock exam or assessment! To take an assessment with Target USMLE click on the link below http://www.targetusmle.com/assesmyprep.php

TIME FRAME FOR A GOOD PREPARATION

The time frame depends on your previous training and whether you are an AMG or IMG. For most AMG's from good schools this exam is a cake walk, although I have also seen some who have failed because they took it too lightly. The IMG's need to focus on the 'American way' of seeing the patient, work on their spoken English proficiency if it is not their primary medium of instruction, practice on their typing speed and plan travel/accommodation for their stay to and fro to the United States. Both AMG's and IMG's need to focus on their basic medical knowledge, the differential diagnosis, analysis of symptoms and signs as the case presents. This not only requires the knowledge but practice. It is not a good idea to take the exam without practicing a good number of cases and timing yourself whether you are an AMG or IMG.

In my experience with both AMG's and IMGS I believe it would take about 2- 6 weeks to get fully prepared for this exam for an average student in medical school. The most important things is to first find and collect all the right tools to study for the exam – this is what I have compiled in the Step 2 CS handbook to save you time instead of hunting for different resource materials and separating the useful info from the useless details. Everything in this handbook is something you should know to score well on the exam. When you read through the handbook and master these notes you can be rest assured that you are on the right track before practicing with your colleagues/SP's!

SECTION I: INTRODUCTION TO PATIENT ENCOUNTER

10 KICK STARTERS FORTHE CS ROBOT

REMEMBER TWO AT A TIME!
BEFORE KNOCKING - **TAKE A DEEP BREATH**
Do not undermine the value of its relaxing power!

1. **Knock Knock**(Recall patient name before knocking) 2. Enter **Smiling**

3. **Mz/Mr**….(last name) example..Mr. Jones?....(Patient responds).4. Hi/hello, I am **Dr**. (last name)....I am the physician on duty today. Nice to meet you (first patient's name then your name)

5. **Shake hands** and 6. Make **Eye contact** with patient

7. When you hear the **Chief complaints** (after you have asked How can I help you?)……I have a headache doctor…….8. Oh, I am so **sorry to hear that** (sympathy!) but let me try to help you here

9. **Drape** (as you say "Can I make you more comfortable"). Sometimes patient may already be draped. 10. **Sit down** on the Stool (as you say "Do you mind if I sit down and **takesome notes**")

Following 10 kick starters start with open ended questions like -

- Can you tell me more about this ……(chief complaint)?.
- How is this affecting your life?

All 10 come with practice – in the real exam they should come natural while your mind is racing on the questions for history of present illness i.e even without thinking after knocking you should realize you are sitting on the stool! In case of emergency you would be standing while taking history. When the patient is in acute pain you probably would avoid a hand shake.

Watch sample lecture & also a demo of 10 kick starters here
Video 1 & Video 2

HISTORY – BLUE SHEET- QUESTIONNAIRE

(You may substitute with sentences you are comfortable with)

O- Onset	When did it start? Was it sudden or gradual?
P- Progression	Is it better, worse or same since the pain started?
D- Duration	How long does it last? / How long have you had this problem?
S- Setting	What were you doing when it first started?
C-Constant	Is it constant or intermittent?
F- Frequency	How often does it come?
A-Aggravating	What makes it worse?
A-Alleviating	What makes it better?
A-Associated	Anything else that occurs while you have …(symptom)..? Ask relevant symptoms related to chief complaint
L- Location	Can you show me exactly where the pain is?
I-Intensity	On a scale from 1 to 10, being 1 the mildest and 10 the worst pain, how would you rate this pain?
Q-Quality	Can you please describe the pain? Is the pain it sharp? Dull? Stabbing? Throbbing? Crampy? Squeezing? Burning?
O-Onset, Progression, Duration	When did it start? How did it progress? How long did it last?
R-Radiation	Does your pain go/travel to any other part of your body?
A-Aggravating	What makes your pain worse?
A-Alleviating	What makes it better?
A-Associated	Does it change with your daily activities, like postures, exertion, rest, sleeping, eating, coughing, walking etc
A- Amount	How much do you vomit/cough up – a cup, a teaspoon, tablespoon?
B- Blood	Did you notice any blood in it?
C-Consistency, color	What is the consistency of the phlegm? /thin/thick/frothy, color?
O-Odor	Any foul smell/odor?
Transition sentence: I am now going to ask some questions regarding your past medical history? Is that alright with you?	
P- Past History	Have you ever had a similar problem before? If "Yes" When? Did you take any medication? Are you currently having any medical illnesses like Diabetes? Hypertension? If "Yes" – How long? Is your blood sugar/BP under control? When was you last check up with your physician? (counsel if necessary) Do you have any inherited diseases?
A- Allergy	Any allergies that you know of? If positive say for a particular drug – ask what happens when they take it.
M- Medication	Are you on any medication for the current complaint? Any other prescribed medicine or over the counter (OTC) drugs?
H- Hospitalization/trauma	Have you ever been hospitalized? Any surgeries in the past? Any injuries or accidents?
U- Urinary	Any changes in your urinary habits? Any burning sensation?
G-Gastrointestinal	What about your bowel habits? Any alteration in your bowel habits?
S-Sleep	Are you sleeping well?
F-Family History	Does anybody in your family have the same problem? Are your parents alive? Are they healthy? How did she/he die? (I'm sorry to hear that on getting an answer). Are there any medical conditions that run in your family?.. like Diabetes, High blood pressure, Cancer?

O-Obstetric/Gynaec	**Gynaec** - Menarche? When was your last menstrual period (LMP)? Are your periods regular? How many days does it last? Any pain? How is the flow – regular or heavy? Any spotting? **Obstetrics** - How many times have you been pregnant? Any miscarriages? How many children do you have? Are they full term delivery? Normal or C-section? Any abnormalities or complications? Are they healthy? Are you on any birth control measure/contraception? When was your last Pap Smear? Mammogram?
Alright… now I am going to ask you some very personal questions, but let me re-assure you that everything we talk will be kept confidential okay?	
S-Sexual History	Are you sexually active? If No – ask why? If Yes – May I know with whom? (with one partner – no more questions) If multiple partners – Are your partners men, women or both? In the last year how many sexual partners have you had? Do you always use condoms? Have you ever had any Sexual transmitted disease (STD)? Were you treated? Do you know your HIV status?
I would like to ask you about your life style and social life in general? Is that alright with you?	
S-Social history	**S**-Do you smoke?" How many cigarettes per day? For how long have you been smoking? Have you ever thought of cutting down or quitting? **A**- "Do you drink alcohol? If Yes - CAGE questions (**c**ut down, **a**nnoyed, **g**uilty, **e**ye opener). How often do you drink? What do you drink? **D**-"Do you use any recreational drugs? What do you use? How long have you been using it? When was the last time you had it?
W-Weight changes	Have you lost or gained any weight recently? Over a period of…….?
A-Apetite changes	How is your appetite?
D- Diet	Are you on any special diet?
E- Exercise	How often do you exercise?
S-Stress	Are you stressed out work /home?
F- Fatigue	Are you tired all/most of the time?
T-Travel/Thyroid	Have you traveled recently? Do you feel cold/hot when others don't?
LW- Live with	Whom do you live with? If patient lives alone, ask if they have social support around.
	Is there anything else you would like to add, Mr. Jones?
Mr. Jones, I appreciate you for patiently answering all my questions. You may summarize at this juncture or after physical exam is done. Please excuse me while I wash my hands before I begin my physical examination. Is that alright with you? …….(after washing hands while asking occupation to avoid a long silence)…..Okay I am going to begin by examining your eyes….can you look down for me?	

PHYSICAL EXAM: GENERAL & FOCUSED SYSTEM EXAM

(Please refer Section III)

CLOSURE

Use a transition sentence when physical exam is done

"Thank you Mr. Jones ……. I have finished my examination. Now I'd like to take a moment and discuss with you about what I think so far."

CLOSURE HAS THE FOLLOWING 6 PARTS

1. Summary History
2. Summary Physical Exam
3. Differential Diagnosis
4. Work Up
5. Challenging Questions
6. Counselling

1. Summary of History

(chief complaint, duration, associated symptoms and any relevant positive history)

To summarize, you told me that you have had (chief complaint) ….……over a … (period of time), and that you also had … (other symptoms – salient positive and important negatives if time permits)…….. You also have a family Hx of ……cancer …… because you mentioned your father died from a ……"(if present)

2. Summary of Physical Exam

"From the physical exam, I observed that you do have a ……(some redness around your knee joint) and also have severe pain on flexing and extending the joint ……."

3. Diagnostic Impression

Hence based on the above observation, I think the problem you are having could be because of a couple of possibilities. It could be a problem/infection with your colon (explain in simple layman language, which in medical terms we call it……gastroenteritis/ulcerative colitis…….. …….Or it could be an infection or obstruction to an appendage of the small intestine which we call……appendicitis. Alternatively, it could be……this ……or …that… (2-3 Differential diagnosis as time permits).

4. Lab tests and Investigations

Hence, to be completely sure of your diagnosis, I would like to do a pelvic/rectal/breast exam and also need to do/run a few tests like and

- Blood test
- Urine test
- Stool test
- Ultrasound
- Xray
- CT
- MRI

We have a certain imaging tests using X rays/sound waves/magnetic waves where we can get a very accurate picture of what's happening inside your….(i.e. any organ you consider affected). We call this exam CT Scan, USG, MRI, etc. (explain any test you mention in layman language)

5. Challenging question

So, as soon as we get the results we are going to meet up again and discuss your diagnosis and take it from there. Does that sound good to you? Do you have any questions for me? (Address any challenging question/s if they have not yet been asked in the clinical encounter- *If the SP already asked you the challenging question, he probably won't ask you anything else)*

6. Counsel for bad habits /lifestyle

As your physician, I am a little concerned about your smoking/ alcohol or illicit drug use (whichever applicable). As you probably know, they can be very damaging to many internal organs in your body and affect their function. If you ever plan on quitting, we have a great support team of social workers that can help you do that. Also, regarding your sexual habits, it is important that you use condoms for protecting yourself and your partner against sexually transmitted diseases and unwanted pregnancies. You may also counsel for weight loss, diet and exercise if appropriate to that particular patient. If there are no bad habits express your appreciation for maintaining a healthy lifestyle. *(When there is lack of time just counsel on just one or two)*

Alright/Okay then… It was nice meeting you (shake hands). I'll see you with the results. You take care. Bye!

SECTION II: SPECIFIC SYTEMS HISTORY

CARDIOVASCULAR HISTORY

CHEST PAIN

1. Do you have chest pain?

- ask for OPDS CF
- ask for LIQORAAA

When he shows the location, ask him if it hurts when he touches the spot (costochondritis/muscular pain). Ask him if he experienced these symptoms at rest or with activity before? (Angina)

SHORTNESS OF BREATH (SOB)

2. Do have breathlessness (or) are you short of breath?

If "yes"→ then ask "when do you get breathless"?

- on walking or at rest? (how many minutes of walk?)
- climbing stairs? (how many flights of stairs)
- on lying down flat? (orthopnoea)
- sleeping with how many pillows? (severity of orthopnea)
- Do you ever have to wake up feeling SOB or having to get up from bed to catch a breath of fresh air? (Paroxysmal nocturnal dyspnea)

TO RULE OUT MYOCARDIAL INFARCTION/ANGINA

(additional symptoms)

3. Any sweating?
4. Any nausea?
5. Any vomiting?

TO RULE OUT ARRYTHMIAS/HEART BLOCK

6. Any palpitations (racing of your heart)?
7. Do you sense any skipped beats?

TO RULE OUT OTHER CARDIAC PATHOLOGIES

(VALVULAR, CARDIOMYOPATHIES, CCF)

7. Do you feel dizzy at times? (Describe 'dizzy'- objects spinning around/sensation of falling or losing consciousness (vertigo vs syncopal causes)
8. Have you lost your consciousness anytime? (hypotension)
9. Any swelling of your leg (Congestive heart failure)
10. Did you notice any bluish discoloration of the skin, nails?

TO RULE OUT ACID PEPTIC DISEASE WHICH MAY MIMIC CHEST PAIN

11. Any past history of heart burn or peptic ulcer?

RESPIRATORY HISTORY

COUGH

1. Do you have any cough?

If "yes→" OPDS FC (Onset, progression, duration setting frequency constant/intermittent)
If "no"→ dry cough

PHLEGM

2. Do you have any phlegm when you cough?

If "yes"→ ask ABCO
a) **A**mount (how much?)
b) **B**lood (any blood in it?)
c) **C**olor, **C**onsistency
(What color is the phlegm? Is it thick, frothy or slimy)
d) **O**dor
(Does the phlegm have any distinct smell to it?)

PAIN

3. Do you have any pain associated with your cough?- If "yes"→LIQORAAA
(Location, Intensity, Quality etc)

(Make sure you rule out if pain gets aggravated on deep inspiration or associated with cough → suggestive of pleuritic pain)

BREATHLESSNESS

4. Do you get short of breath sometimes?

OTHER SYMPTOMS

5. Any wheeze/ musical sound when you breathe ? (asthma)
6. Any fever? (pneumonia, high fever; tuberculosis – low grade, evening rise of temperature)
7. Any chills? (pneumonia, bronchiectasis)

TO RULE OUT UPPER RESPIRATORY INFECTION

8. Do you have a running nose? Watery eyes?
9. Do you have a sore throat?
10. Any ear pain? Fullness in the ears?
10. Any pain around your eyes, cheek (sinusitis)?
11. Do you feel that you have to keep swallowing the secretions from the back of your throat? (post nasal drip- sinusitis)

TO RULE OUT TUBERCULOSIS/MALIGNANCY

11. Do you get any night sweats?
12. Any loss of weight?
13. Any loss of appetite?
14. Do you feel tired most of the time? (fatigue)
15. Any history of recent travel?

16. Any contact with someone with tuberculosis?
17. Have you ever had any skin injections for testing for tuberculosis (PPD)?

TO RULE OUT TICK-ASSOCIATED RESPIRATORY INFECTION

18. Have you gone hiking recently?
19. Any history of tick bite?
20. Do you have any rash anywhere?

ABDOMEN HISTORY

ABDOMINAL PAIN

1. Do you have pain in your belly?
   If "Yes"→

   - ask for OPDS CF
   - ask for LIQORAAA

   Location of the pain is very important as it gives you clues to the differential diagnosis eg. Epigastric pain could be gastric ulcer, pancreatitis etc

Aggravating and Alleviating factors:

- Find out if *food* aggravates or relieves the pain
  Gastric ulcer – aggravated by food, alleviated by antacids, Duodenal ulcer– relieved by food, Cholecystitis – aggravated by fatty food

- Pain in right hypopochondrium on *deep inspiration* suggests cholecystitis.

Radiation of pain is also important history.

- Radiation from umbilicus to right iliac fossa suggests appendicitis.
- Pancreatitis radiates to the back.
- Aortic dissection presents as tearing pain down the spine.

SYMPTOMS FROM MOUTH TO ANUS

2. Do you have any problems swallowing food?
   If "Yes"→ is it for solids or liquids?

   - Dysphagia to *solids* or *food sticking to throat* is suggestive of oesophageal cancer.
   - Dysphagia to *liquids* occurs with achalasia cardia.
3. Do you have any regurgitation of food?
4. Do you have any heart burn?
5. Any nausea?
6. Vomiting? If "Yes" – ask ABCO (amount, blood, color, consistency, content, odor) and ask for signs of dehydration (sunken fontanelles, dry tongue, dry skin, lack of urination etc)
7. Do you have any swelling in your abdomen that increases in size when you cough or strain? (hernias)
8. You do you feel your abdomen is distended/bloated?
9. Are there any changes in your bowel habits recently?

If there is h/o **constipation** –

- How *often* do you pass stools?
- Is there any *pain* while passing stools?
- Any change in *color* of stools eg.dark brown/ black stools as in a upper GI bleed (or) streaks of fresh blood as in anal fissure, splash of blood as in haemorrhoids)

Note: Also think of *hypothyroidism* if there is h/o constipation – so ask associated symptoms like dryness of skin, lethargy, intolerance to cold, weight gain, loss of hair, swelling in the neck

If there is h/o **diarrhea** –

- Ask for ABCO (amount, blood, color, consistency, content, odor, how many times a day, any pain while passing stools, any mucus or blood as in dysentery etc)
- Ask for signs of dehydration

10) What type of *diet* you take?

Does it include lots of vegetables and fruits (fibre) – if not advise them to take a fibre rich food during counsel

SYSTEMIC CHANGES

11. Any fever?
12. Any recent changes in appetite?
13. Any changes in your weight recently? (weight loss can occur in malignancy, gastric ulcer)
14. Do you feel tired most of the time? (fatigue in malignancy, anemia due to vitamin malabsorption)
15. Any swelling in the neck or groin (supraclavicular node/Virchow's node in GI malignancy); infection of a fissure/haemorhoids in anal canal can cause swelling of the inguinal lymph nodes.

OBSTETRICS & GYNAECOLOGY HISTORY

GYNAEC HISTORY

- When was your last menstrual period LMP?
- At what age did you have your first period?
- How often do you get your periods usually?
- Are your periods regular?
- How many days does it last?
- How many pads?
- How is the flow – regular or heavy?
- Any clots?
- Any spotting in between your periods?
- Any pain?

OBSTETRIC HISTORY

- Have you been pregnant before?
- How many times have you being pregnant?
- Any miscarriages?
- How many children do you have?
- Are they full term delivery?
- Normal or C- section?
- Any complications at birth?
- Are the children healthy?
- Are you currently on any birth control measure/contraception?
- When was your last Pap smear?
- Did you get a mammogram done recently?

JOINT HISTORY

JOINT PAIN

1. Do you have pain in any of your joints?
   - Then ask for OPDFSC
   - Then ask for LIQORAAA
   - For multiple joint involvement ask for order of involvement
2. Did you fall or injure yourself? How? (trauma, accident, vigorous exercise, substance abuse, factitious, abusive relationship)

LOCAL AREA

2. Is there any redness?
3. Any swelling?
4. Any warmth?

SPECIFIC JOINT SYMPTOMS

5. Any restriction in moving the joint actively?
6. Any clicking sound in the joint during movement /walking? (Osteoarthritis (OA)-crepitus in knee joint)
7. Any stiffness in the joint? When (? Early morning stiffness – Rheumatoid Arthritis along with metacarpophalangeal joint involvement, OA presents with stiffness at the end of day)
8. Any locking of the joint?
9. Any deformity?

GENERAL

10. Any fever?
11. Any history of loss of appetite?
12. Any weight loss?
13. Any fatigue?
14. Any nodules under the skin? (Rheumatoid nodules)
15. Any history of easy bruising? (Bleeding disorders, haemarthrosis)

TO RULE OUT SLE/PSORIATIC ARTHRITIS

16. Are you sensitive to sunlight? (photosensitivity in SLE)
17. Any rash on the body or face (malar rash in SLE, extensor scaly salmon pink lesions in Psoriasis)

TO RULE OUT REITER'S DISEASE

18. Any history of red eye?
19. Any oral or genital ulceration?
20. Any burning micturition?

TO RULE OUT SEPTIC ARTHRITIS

Males

- Any purulent discharge in the urethra?
- Any swelling in the groin?
- Any burning micturition?

Females

- Ask for history of purulent vaginal discharge, pelvic pain, past history of STD, recurrent miscarriages, abortions
- Any burning micturition
- In menopausal age group – history of fractures associated with falls, h/o of hormone replacement therapy, calcium supplements if any

OTHER CAUSES

21. Any family history of joint diseases eg. RA, cancer, DM?
22. Any history of hiking? Tick bites?
23. Whom do you live with? Have you been in an abusive relationship?

TO RULE OUT MUSCULOSKELETAL AND NEUROVASCULAR SYMPTOMS

24. Have you noticed any decrease in size of the (distal /proximal) muscles? Any weakness?
25. Any discoloration of skin distal to the joint involvement? (vascular compression)
26. Any tingling? Numbness? Altered sensation? Any shooting pain? distal to the joint (neural compression)

Watch video on Joint History lecture

NERVOUS HISTORY

HEAD TO TOE

1. Do you have **headache**? (high intracranial tension, hemorrhage, tumor)
2. Do you have any problems in vision? Any **blurred vision**? Changes in visual field?
3. Any problems with **hearing**? Any **ear discharge**? **Fullness** of ear?
4. Any **Nausea**? **Vomiting** ?(projectile in case of high intracranial tension)
5. Any difficulties with **speech**?
6. Any difficulty **swallowing**?
7. Any stiffness in your **neck (meningeal irritation)**?
8. Any **weakness** in your limbs?
9. Any tingling **sensation**? Numbness? Altered sensation?
10. Any difficulty in **walking**? (gait)
11. Any difficulty in **balancing** yourself? (cerebellar disorders)
12. Any **abnormal movements** of limbs (seizures, chorea)?
13. Any difficulty in controlling your **bowel**? (autonomic)
14. Any difficulty in controlling your **bladder**? (autonomic)
15. Any problems during **sexual** activity? (autonomic)

- **Alzheimer's/Vascular Dementia:** Do you have any problems doing your **daily routine** like shopping, paying bills, making phone calls, bathing, driving etc
- **Hypothyroidism:** Do you feel cold when other's don't? Lethargy? Constipation? Dry skin? Fatigue? Weight gain? (to rule out **hypothyroidism**)
- **Schizophrenia:** Do you see or hear things that other's don't?
- **Depression/Mania:** How is your **mood** lately? Do you feel tired/excited all the time? Do you feel like hurting yourself?

SEIZURE

1) **Frequency**–how often do you have seizures?
2) **Duration**–how long does it last?
3) **Aura**–any premonition that you are going to get a seizure? (like flashes of light, alterered taste)
4) **Partial or General seizure**–Do all four limbs move or only upper or lower limbs shake during the seizure?
5) **Tongue biting**–any episode of tongue biting or swallowing of tongue?
6) **Mouth frothing**–any frothing from the mouth?
7) **Incontinence of bowel orbladder**–have you ever lost control of your bladder or bowel during an episode of seizure?
8) **Consciousness during seizure**–are you fully aware of your surroundings when you have a seizure?
9) **Post ictal drowsiness/weakness/confusion** – how do you feel after the seizure – Drowsy? Weak? Confused?

PSYCHIATRY HISTORY

Scenarios

Depression, Hearing voices,Strange writings on the wall, Anxiety attack

- Chief complaint
- Onset
- Progression
- Duration
- Setting
- Constant /Intermittent
- Frequency

Content of the voices/strange writing?
Do you see anything that others don't?
Are there any warning signs before these symptoms arise?
Do you have any feeling of bugs crawling under your skin?

SAFETY OF PATIENT AND OTHERS

Does it instruct you to harm yourself?
Do you feel it instructs to harm others?
Do you have any thoughts of harming yourself (or) others?
Have you physically tried to harm yourself in the past?

HISTORY TO RULE OUT ANY ORGANIC DISORDER

EAR: Any hearing problem? Any ringing in your ears? Any fullness? Any discharge?
BRAIN: Any seizures? Any headache? Any loss of memory? Concentration?
VISUAL: Any blurry vision? Any changes in the field of vision?

GENERAL WELL BEING

How is your appetite?
Any changes in your weight?
How is your energy level?
Are you able to do your day to day activities?

SLEEP

Are you able to sleep well at night?
DO you have problems falling asleep? Staying asleep?
Do you wake up early in the morning?
Do you feel refreshed after resting?
Do you nap or feel sleepy at work?

MOOD/GUILT:

Do you feel sad all the time? Does it alternate with periods of being normal or elated?
Do you feel guilty about anything?

HOME
Who do you live with?
Any guns in the house?
Do you feel safe at home?

WORK/SCHOOL
Are you able to concentrate at work /school?
Are you able to perform well on your day to day activities?
Do you enjoy your hobbies?

SOCIAL
Do you have friends/family member you can to talk to?

STRESS
Are you stressed at work / school / home?

NOTE:
SPECIAL ATTENTION TO THE FOLLOWING DURING HISTORY TAKING

PAST HISTORY/MEDICATIONS:
Any mental illness in the past? Depression? Treated? Any medications currently on?

FAMILY HISTORY
Any mental illness in family? (Any Schizophrenia?, Depression)

SOCIAL
Any illicit drugs?
Alcohol?

GENITOURINARY HISTORY

- Did you notice any changes in your urinary habits?
- Do you have any pain or burning during urination?
- Have you noticed any change in the color of your urine?
- Did you notice any blood in your urine?
- How often do you have to urinate?
- Do you wake up at night to urinate?
- Did you notice any changes in the volume of urine you produce?
- Do you have any difficulty urinating?
- Do you have to push/strain during urination?
- Have you noticed any changes in your urinary stream?
- Have you noticed that you need to stop and start again while urinating?
- Do you feel that you haven't completely emptied your bladder after urination?
- Did you notice any dribbling after urination?
- Do you feel need to urinate, but very little comes out?
- Do you feel as though you have very little time to make it to the bathroom once you feel urge to urinate?

Questions for hematuria:

- Describe what do you mean by dark urine?
- Was there any bright red-color/any clots, in your urine?
- Is there any pain with urination?
- Is there any abdominal/back pain?
- Any h/o of urinary stones in the past?
- Is there any fever/chills?
- Any nausea, vomiting?
- Have you had diarrhea recently?
- Have you had any recent trauma/injury to your back/pelvis?
- Do you do heavy exercise?
- Have you eaten anything (berries, colored candy or beets) recently, that could cause this change in the color of your urine?
- Have you had any recent infections such as sore throat?
- Did you notice any muscle pain? Are you taking any meds for high cholesterol?
- Other meds: cyclophosphamide?

HEENT HISTORY

HEAD and NECK

1. Do you have headache? (sinusitis, vision problems)
2. Can you show me with one finger where it hurts?
3. Any previous head injury?
4. Any swelling/swollen glands in your neck?
5. Any stiff neck?

EYES

1. Do you have any problems in vision?
2. Any blurred vision?
3. Changes in visual field?
4. Any runny eyes?
5. Any discharge from eyes?

NOSE

1. Any runny nose? Any discharge from the nose?
2. Have you had any bleeding from your nose?
3. Are you able to smell well?
4. Any pain around your eyes or cheek bones? (sinusitis)
5. Do you have secretions at the back of your throat that requires constant swallowing?

EARS

1. Any fullness of the ears?
2. Any itching?
3. Any discharge from the ears?
4. Do you hear well? (deafness)
5. Any ringing sensation? (tinnitus)
6. Any dizziness?(vertigo)
7. Any nausea?
8. Any vomiting?

MOUTH

1. Any altered taste sensation? Red tongue? (glossitis)
2. Any ulcers in your mouth?
3. Any decayed tooth?
4. Any bad breath?
5. Any secretions at the back of your throat that requires constant swallowing? (sinusitis)
6. Any sorethroat?
7. Any difficulty/pain while swallowing? (tonsillitis, pharyngitis)

THROAT

8. Any hoarseness of voice? (laryngitis, chronic smoking)
9. Do you snore at night?
10. Any noisy breathing? (stridor)

PAEDIATRIC HISTORY

Scenarios:

- **Mother of 7 year old male child Jack White comes to clinic concerned that her child is sick.**
- **Grandfather of 7 year old male child Jack White calls the clinic that the child has fever y**
- **Father of 18 month old female child Matilda Rose is in the clinic to discuss about his daughter's fever. The mother of the child is the ER as the child has high fever.**
- **Mother of 6 years old female child Matilda Rose is in the clinic concerned about her daughter's fever. The child is in the triage with the nurse.**

Opening Conversation

KNOCK KNOCK

- Hello, are you the mother of Jack White? → Yes
- Is it okay if I address you as Mz. White?→ Yes
- Well, Mz. White I am Dr. Willis, the doctor on duty today. (Shake hands, maintaining eye contact)
- How can I help you?

→ My child is sick doctor
→ I am so sorry to hear that. *(No draping!)*

- May I sit down and take a few notes while we talk →Yes please.
- Let me clarify a few details before I go on, Mz White
  Can you clarify the age of the child? → 7 years
  Boy or girl? → boy
  Thank you!
- Now, tell me what exactly is the problem with your child, Mz. White?

→ He is running a temperature since last night doctor
→ I am really sorry to hear that. I'll do my best to help him get better.

History of Present Illness

- When did the fever start? (**O**nset)
- Suddenly or gradually?
- How high is the fever?
- How did you measure his temperature? (Thermometer in mouth, axilla, anal)
- Any chills?
- Ay night sweats?

OPDS CF

- Since it started, how has it progressed? is it getting better or worse? (**P**rogression)
- Is it constant or comes and goes? (**C**onstant/intermittent)
- If intermittent→ How long does it last? (**D**uration)
- Do you have an idea what might have caused your child's fever to start? (**S**etting)
- How often does it come on in a day? (**F**requency)
- Does anything make it worse? (**A**ggravating factors)
- Does anything make it better? (**A**lleviating factors)
- Have you tried any treatment?

ASSOCIATED SYMPTOMS

General

Does your child's fever affect his activities?
Is he active/playful like before?
Any rash anywhere in his body? (exanthematous fevers, meningitis)

- When did it start?
- Where did it start first?
- Can you describe the rash for me?
- What size is it?
- How about the color?
- Flat or swollen?

HEENT

Does he have any discharge from his eyes?
Any red eye?
Any ulcers in the mouth?
Does your child pull his ears?
Does he complain of fullness in his ears (older kids)?

Respiratory system

Does he have running nose?
Does he have any sore throat / difficulty swallowing?
Any pain around his cheek bones or forehead? (older kids)
Any cough?
Breathlessness?
How about wheezing?

Nervous system

Do you think he is sensitive to light /or is avoiding light?
Is Josh holding his neck stiff?
Any abnormal jerks/ movements of limbs?

Gastrointestinal system

Does he have nausea?
Any vomiting?
Any changes in apetite?
Any changes in his weight?
Do you think the stomach is distended/bloated?
Does he cry when he passes stools?
Any changes in his bowel habits ? (Diarrhea/ Constipation)
Can you describe his stool for me ? Any foul smell? Any blood? Any mucus?

Urinary System
Does he cry when he passes urine?
Any change in your child's urinary habits?
How many diapers do you need to change?
Can you describe your child's urine for me?Is the urine dark colored than usual?
Any foul smell in his diapers?
Any blood?
When was the last time he peed? (rule out dehydration)
Do you think is mouth is dry?
Now I am going to ask you some questions about your child's birth history. Is that okay with you? Thank you!

ANTENATAL HISTORY
Did you have any problems when you carried Josh?
Did you have regular antenatal visits?
Did you use alcohol?
Any illicit drugs?
Did you smoke?
Was there steady weight gain?
Did you get regular ultrasounds during your visits?

BIRTH HISTORY
Was Josh born at full term?
Was it a vaginal delivery or C-section?
(If C section, ask for indication. "Do you know why they opted for a C section?"
Any complications?

POST NATAL HISTORY
Did he cry immediately after birth?
When was your child's first bowel movement?
How long did you stay at the hospital after the delivery? Any complications?

DIET
Did you breast feed you child? How long?
Can you please tell me about his diet?
Is he feeding well?

PAEDIATRICIAN VISITS & IMMUNIZATIONS
Did Josh have regular visits with his paediatrician?
When was the last visit?
Are his immunizations up to date?

DEVELOPMENTAL MILESTONES
Is Josh meeting his developmental milestones compared to his peers?
(alternatively Weight? Height? Language skills? When did he smile? Sit up? Stand? Talk? etc)

DAY CARE & SICK CONTACTS
Does your child go to day care?
Have you heard of any sick contacts there?

Does Josh have other siblings?
Anybody else sick at home?
Any recent hiking/ travel?

I am going to ask you a few questions regarding his past medical health. Is that okay?

PAMH~~UG~~SF~~OSS~~
P- Did you your child have any major medical disorders before?
A-Is your child allergic to anything? Like pets, or foods, or plants?
M -Is he taking any medications on a regular basis?
H-Has your child been hospitalized before?
-Any surgery before?
-Any injury or trauma before?
S-How is his sleep?
F-Who does Josh live with?
-Is the environment safe for Josh at home?
-Who takes care of him after daycare?
-Any inherited diseases in the family?

MENTAL HEALTH
Was there any traumatic event that happened recently? (eg. Moving, separation from caretaker etc)

Is there anything else you would like to tell me?

SUMMARIZE
Let me summarize what you have told me thus far…..

P.S. No physical exam for Paediatric case

SECTION III: PHYSICAL EXAMINATION

A.GENERAL EXAMINATION

Do the following very quickly so that the Standardized patient notices you looked for them

- Eyes – Look up (anemia), look down (icterus)
- Nose – any discharge/deviation of septum/mass*
- Mouth – oral cavity, tonsillar fossa, erythema/exudates*
- Neck –Thyroid (inspect the neck as you ask patient to swallow), Lymph, nodes (palpate)
- Hands – Radial pulse (both sides compare), Koilonykia, Clubbing, moist/dry palms, tremors (if pertinent)
- Feet - Dorsalis pedis pulse, post tibial (both sides to compare only if pertinent), pedal edema (all cases)
- Skin – Rash, Scar, Petichae, Bruise

*Use otoscope to shine light

B. FOCUSED SPECIFIC SYSTEM EXAM
CARDIOVASCULAR EXAMINATION

GENERAL EXAMINATION

(Pertinent to Cardiac Diseases)

- Breathlessness at rest
- Dilated veins in neck/chest
- Peripheral Pulses
- BP
- Pedal Edema

INSPECTION

- Pulsations on the chest wall (apical, suprasternal etc)
- Dilated veins (Jugular venous dilatation (JVD) at 45 degree inclination)
- Scars (previous surgeries, injuries)
- Rib cage deformities-kyphosis, scoliosis

PALPATION

- Local tenderness
- PMI/Apical Impulse
- Thrills- all 4 areas
- Heave

AUSCULTATION

- Heart Sounds – S1 S2 (4 heart areas)
- Mitral area – left side lateral position (lying down)
- 5^{th} carotid bruit (auscultation)
- Murmurs/rubs gallops

OTHER SYSTEMS: PERTINENT SIGNS TO A CARDIAC CASE

ABDOMEN:

-Hepatosplenomegaly -Right heart failure (RHF)
- Free fluid (RHF)

RESPIRATORY:

- Basal crepitations on auscultation (CCF)

RESPIRATORY EXAM

ENT & SINUSES

(to rule out Upper Respiratory Tract Diseases)

EAR:

Inspect ear canal under flash light for any discharge, foreign body

NOSE

Inspect nasal cavity for any polyps, bleeding, discharge

THROAT:

Inspect oral cavity for any mouth ulcers, swollen gums, tonsils, tonsillar fossa and posterior pharyngeal wall (Say ‘ah”)

SINUSES:

Check for sinus tenderness (frontal – press medial end of eyebrows, maxillary- press over cheek bones asking if there is pain)

INSPECTION

- Trachea (note if in midline)
- Scars (previous surgeries, injuries)
- Rib cage deformities - kyphosis, scoliosis
- Spine
- Symmetrical movement of chest wall with each deep breath
- Any accessory muscles of respiration used (Sternomastoid, Trapezius)

PALPATION

- Local tenderness
- Tracheal position-
  (Gently insinuate a finger between sternomastoid and trachea on either side and assess if the gap is similar -narrowed gap in case of tracheal shift towards the side of lung collapse)
- Chest expansion –symmetrical
- Tactile fremitus
  Touch each side of the chest (as patient repeats 99) and feel if the resonance is equal on both sides with ulnar border

PERCUSSION

Percuss on both sides of the midline and compare sides for similar resonance

- 4 areas in the front of the chest
- 4 areas at the back of the chest

AUSCULTATION

1) Breath Sounds

(Instruct patient "Please take a deep breath in and out everytime my stethoscope touches your chest)

- Auscultate 4 or more areas in the front of the chest
- Auscultate 4 or more areas at the back of the chest

2) Added Sounds (if any)

- Any crepitations (rales- pneumonia, bronchiectasis, heart failure etc)?
- Any rhonchi (wheeze –asthma, chronic bronchitis etc)?
- Any rubs (pleural rub- pleurisy)?

3) Vocal fremitus

Instruct patient to "Please say 99 everytime my stethescope touches the chest"

- Auscultate 4 or more areas in the front of the chest comparing sides
- Auscultate 4 or more areas at the back of the chest comparing sides

ABDOMEN EXAMINATION

INSPECTION

- Is the abdomen distended?
- Are all quadrants moving equally with respiration?
- Any Scars?
- Any abnormal pulsations?
- Hernia (umbilical hernia – ask them to cough/ lift head up while lying down)
- Peristalsis

AUSCULTATION (before palpation)

- Bowel sounds (4 quadrants – hyperactive? hypoactive?)
- Bruit
  - 1" above umbilicus (aortic aneurysm)
  - 1" lateral to umbilicus (?renal stenosis)

PALPATION

Patient is in supine position with hip and knees flexed

1. Superficial palpation – pulsating masses, subcutaneous masses
2. Deep palpation – two hands on top of one another and press gently deeper to feel for

- Organomegaly(spleen, liver kidney)
- Tenderness (appendicitis, pancreatitis, gastric/duodenal ulcer etc)
- Rebound tenderness (all 4 quadrants)
  - Murphy'sign (if needed)
  - Obturator sign (if needed)
  - Psoas sign (if needed)

3. CVA (costovertebral angle) tenderness

PERCUSSION

- Liver span
- Free fluid

SPECIAL TESTS

Murphy's Sign

(Cholecystitis)

Press on the right side of abdomen below the ribs and ask the patient to take a deep breath. If patient catches his breath and is unable to complete a full deep breath due to pain, it suggests positive Murphy's sign.

Mc Burney Point tenderness

(Appendicitis)

Pain at the Mc Burney's point (junction of lateral 1/3 with medial 2/3 of the line drawn between umbilicus and Rt. anterior superior iliac spine

Rebound Tenderness

(Ipsilateral pain, Peritonitis)

Pain on removing the pressure on deep palpation at the site of tenderness

Rovsing's Sign

(contralateral pain)

When you press in the Left iliac fossa there is pain in the right iliac fossa (appenditicitis)

Psoas sign

Make patient lie down on left lateral position. Extend the right thigh backwards (maintaining extension at the knee joint) while pressing on the right hip. Eliciting pain suggests a positive Psoas sign . Psoas spasm can occur as a sign of irritation of the psoas muscle as in appendicitis

Obturator sign

Patient in supine position. Flex the right hip and internally rotate. Pain suggests a positive obturator sign – suggesting obturator spasm/irritation due to local pathology.

OBSTETRICS/GYNAECOLOGICAL EXAMINATION

In the step 2 CS exam you are not allowed to do a pelvic or genital examination. Hence following a general examination, examination of the abdomen (especially the hypogastric/suprapubic region) for any mass or tenderness should be sufficient.

For cases where you are considering a specific diagnosis relevant physical exam can be included. For example in a case of amenorrhea if prolactinoma is suspected then funduscopic examination and checking the field of vision for bilateral hemianopia will be relevant.
If you are suspecting thyroid hyper/hypo function then include examination of the neck for thyroid swelling by asking patient to swallow other than checking for dry/moist skin and tremors in general exam.

JOINT EXAMINATION

GENERAL EXAMINATION
(Pertinent to Joint Disease)

- Rash
- Oral Ulcers
- Tick bite
- Purpuric spots, ecchymosis (bleeding disorders)
- Dry skin (hypothyroidism)

INSPECTION

- Swelling – compare with the other side
- Redness
- Range of movement (patient moves the joint)
- Muscle wasting (proximal and distal to joint)

PALPATION

1. Involved Joint

- Warmth
- Tenderness a) joint line b) bony points
- Crepitus
- Bony points
- Range of motion (doctor moves the joint)

2. Neurovascular exam

- Motor deficit (strength, reflexes, atrophy)
- Sensory deficit: touch, pain, vibration, position sense
- Vascular deficit: pulse bilateral, skin/nail color

3. Other Joints

- Observe if movement at other joints are full and non painful

SPECIAL TESTS:

Drawer's Sign

A diagnostic sign of a ruptured or torn anterior cruciate or posterior cruciate ligament of the knee. Testing involves having the patient flex the knee at a right angle while the lower leg is grasped just below the knee and moved first toward, then away from the examiner. The test result is positive for the knee injury if the head of the tibia can be moved more than a half inc h from the joint.

For the **anterior Drawer test**, with the subject's knee flexed to 90°, the hamstrings relaxed andthe foot stabilized, the examiner firmly grasps the leg below the knee and pulls it so as to movethe tibia forward; for the **posterior Drawer test**, with the knee flexed to 80° and the foot stabilize, the examiner attempts to move the tibia backwards. Excessive movement, compared to the other knee, indicates rupture of the ligament.

McMurray's Sign

The test is done with the patient in a relaxed supine position. To perform the test, the knee is held by one hand, which is placed along the joint line, and flexed to completely while the foot is held by the sole of the foot with the other hand. You then place one hand on the medial side of the knee to provide a varus stress, pushing the knee laterally. The other hand rotates the leg internally extending the knee. If pain or a "click" is felt, this constitutes a "positive McMurray test" for a tear in the *lateral* meniscus.

Likewise, valgus pressure on the lateral knee can be applied in a fully flexed position and the leg at the sole of the foot externally rotated as the leg is extended. A tag, caused by a tear will cause a palpable or even audible click on extension of the knee. A positive test indicates a tear of the *medial* meniscus.

Drop Test

The patient is asked to raise his/her arm to 90 degrees of abduction and slowly lower it to his sides. A sudden dropped arm is considered positive and suggestive of a rotator cuff tear.

Tinel's sign

Tap over the median nerve as it passes through the carpal tunnel in the wrist. Positive test shows a sensation of tingling in the distribution of the median nerve over the hand

Phalen's sign

The patient is asked to hold their wrist in complete and forced flexion (pushing the dorsal surfaces of both hands together at 90 degrees to the wrist) for 30–60 seconds. A sensation of tingling in the distribution of the median nerve over the hand suggests a positive test.

Movements at each joint:

Shoulder: Flexion, extension, adduction, abduction, rotation, circumduction
Elbow: Flexion, extension
Wrist: Flexion, extension, adduction, abduction, circumduction
Hip: Flexion, extension, adduction, abduction, rotation, circumduction
Knee: Flexion, extension, slight rotation when flexed
Ankle: Dorsiflexion, plantar flexion, slight circumduction
Spine: lumbar flexion, extension and lateral flexion

NERVOUS SYSTEM EXAMINATION

1. MINI MENTAL EXAM

O	M	C	J
Orientation	**Memory**	**Concentration**	**Judgement**

O- Orientation
-Name
-Age
-Plac
-Time of year/week

M - Memory
- Repeat 3 things
(immediate recall)
eg. Chair- bed- pen

-President of the USA
(long term)

-Repeat 3 things later
(short term)

C- Concentration
-Spell WORLD/CAT backwards
-Keep subtracting 7 from 100

J- Judgement
-Fire comes out of dustbin
What would you do?

Alert?
Sad?

Watch video on Mini Mental Exam

2. CRANIAL NERVES

II – Optic N.

1. Pupils equally Reacting to light and accommodation (PERLA)
2. Visual Acuity – Finger counting (one eye closed) or Snellen's chart
3. Visual Field –one eye closed (one eye closed)
4. EOM- (extra occular movement) Right, Left, Right up, Right.down, Left up, Left down (wiggle finger, both eyes open) **(TESTS FOR III Occulomotor, IV Trochlear, VI Abducens)**
5. Fundoscopy

V – Trigeminal N.

- Clench Teeth (feel the masseter both sides)
- Fascial sensation

VII – Fascial N.

- Lift Eye Brows/Frown
- Shut eyes tight -Don't let me open your eyes
- Smile
- Puff Cheeks

VIII – Vestibulocochlear N.

- Rinne's Test
- Weber's Test

(Rub fingers near each ear and ask patient if he can hear)

IX – Glossopharyngeal N.
X – Vagus N.

- Please open your mouth and say "ah" (shine light inside open mouth to check for uveal deviation)

XI – Accessary N.

- Shrug shoulders against resistance
- Move neck right and left against resistance

XII – Hypoglossal N.

- Stick your tongue out and move it in all directions

3. MOTOR NERVOUS SYSTEM

A. Strength

Upper Limb :

	Arm:	"pull in"- "push out" (elbow)
	Forearm:	"push down"- "push up" (wrist)
	Hands:	"spread out your fingers"
		"make a fist"/ "grasp my finger"
Lower Limb:	Thigh:	"lift up" "push down" (hip)
	Legs:	"kick out' "kick in" (knee)
	Feet:	"hit the gas pedal" (ankle)
		"do it in opposite direction"

Strength :

0-no movt
1-wiggle
2-against gravity
3-against 1 finger resistance
4-against 2 finger resistance
5-full strength

B. Tone

Passively extend and flex each joint in upper and lower limbs. Note the tone.
Tone : Hypertonia, Normal, Hypotonia/Atonia

C. Reflexes

Upper Limb

Biceps
Brachioradialis
Triceps

Lower Limb

Knee Jerk
Ankle Jerk
Babinski's *(in upper motor neuron lesion)*

Reflexes:

0- areflexive
1- hyporeflexive
2 - normal
3 - hyperreflexive
4 - hyperreflexive + clonus

4. SENSORY NERVOUS SYSTEM

1. Sharp stimulus
2. Dull stimulus
3. Two point discrimination
4. Vibration – base of big toe, maleoli, tibial plateau
5. Position – toe up and down

5. CEREBELLUM

1. Rapid alternating movement (demonstrate it to patient)
2. Finger nose test (demonstrate it to patient)
3. Knee to heel
   Romberg's sign – to test for proprioception which requires posterior column of spinal cord. It is NOT a cerebellar test but this test can be done after cerebellar signs.

6. GAIT

Walk normally
Walk in a straight line

7. MENINGEAL SIGNS

Check if patient is able to touch their chin to the chest (sternum) without any pain/discomfort

SPECIAL TESTS

Signs of Meningeal irritation

(tests are done in supine position)

1) Kernig's sign: You flex knee and flex hip and then extend the leg at the knee joint (stimulus). Then ask patient if there is pain in the neck (response). If response is "yes" then it is a positive Kernig's sign.

2)Brudzinki's sign: You flex the neck (chin to chest- stimulus) and check if the hip or the knee flexes (response). If any of the joint flexes then it is a positive Brudzinki's sign.

Rinne's and Weber's Test (VIII Cranial N.)

(Test done in sitting position)
*Large **128Hz** tuning fork is used for testing vibration (sensory system)*
***256Hz (or) 512Hz fork** is used for Rinne's & Weber's (auditory system)*

1) Rinne test: Place a vibrating tuning fork (256 or 512 Hz) against the patient's mastoid bone (bone conduction) and ask the patient to tell you when the sound is no longer heard. Then the tuning fork is held in front of the ear canal and the patient should be able to hear (air

conduction). In a person with intact hearing sensation, air conduction (AC) is better than bone conduction (BC)

2) Weber test:Place a vibrating tuning fork (256 or 512 Hz) in the middle of the forehead, chin, or head equidistant from the patient's ears. The patient is asked to report in which ear the sound is heard louder. In a normal person, the sound is heard equally loud in both ears (no lateralization). In an abnormal person, the sound is heard louder in one ear (lateralization to the deafer ear).

PSYCHIATRIC CASE EXAMINATION

Depending on the chief complaint you will need to examine the relevant system to rule out any organic lesion. For example if the patient is seeing things you may want to examine the eyes: pupillary reflexes, visual acuity, field of vision, extra ocular movements and funduscopic examination. If the patient is hearing voices you may want to examine the ears: the pinna, external auditory meatus with a speculum inserted on the otoscope (change speculum for each ear), tympanic membrane. If you suspect hearing problems you might want to do Rinne's and Weber's test.

The main thing is to do a Mini Mental State Examination (MMSE) and do a relevant neurological exam (example check sensation if patient c/o of bugs crawling under skin). MMSE is also done in a suspected case of dementia.

GENITOURINARY EXAMINATION

In the step 2 CS exam you are not allowed to do a pelvic or genital examination. Hence only examination of the abdomen (especially the hypogastric/suprapublic region) following a general examination for any mass or tenderness will suffice.

If you suspect nephrolithiasis/pyelonephritis in the specific case you are encountering then you will check for renal angle tenderness bilaterally.

HEENT EXAM

(Head, Eyes, Ear, Nose & Throat)

HEAD/FACE

Cranial shape and size
Hair distribution
Symmetry of eyes, ears, corners of mouth, nasolabial fold
TM joint – any tenderness, crepitus, audible clicks on opening the mouth

EYES

Any redness/discharge/swelling
Pupils: Size, shape, and reaction to light
Visual acuity
Visual field
Extraoccular movements
Fundoscopy

EARS

Examination of the pinna for swelling/redness/tenderness
Otoscopic examination: auditory canal and tympanic membrane
Mastoid tenderness

NOSE

Examine for any nasal discharge/mass
Septal deviation
Sinus Tenderness – Frontal, Maxillary

THROAT

Examine if trachea is midline
Any swelling of thyroid/salivary glands/lymph nodes
Oropharynx
Examine tongue, oral mucosa, soft & hard palate, post nasal drip
Tonsillar fossa: any enlargement, erythema, exudate and peritonsillar fullness

SECTION IV: PATIENT NOTES

HOW TO WRITE PATIENT NOTES IN 10 MINUTES?

Patient Note writing has been a challenge to many test takers. Some of them are used to writing patient notes manually and hence the transition to typing may be difficult without practice. Others who are used to typing have difficulties organizing everything that needs to be written for a particular case in 10 minutes. There are many reasons to not finishing the patient note in a time namely a) They are not fast enough (typing speed) b) No proper blue sheet organization – some students find it difficult to read their own handwriting on the blue sheet and waste time in searching for information. c) Data gathering – sometimes relevant data (focused history and PE) is not gathered while the student is inside the room for 15 minutes. Obviously if you did not ask about phlegm/sputum in a case of cough you will not have anything to write about it in the patient note. d) Students practice on laptop but the real exam they give you a keyboard to type. The differences in key board can present problems while typing and spelling errors. e) The organization of the patient note is not a mechanical typing act but a translation of your thoughts into sentences/bullet points on the computer screen. Hence if you don't have a good strategy in your mind you will be facing a lot of hiccups which slow down your typing!

Organization of your mind is more important for your performance inside and outside the room. As doctors and medical grads in the final year of medical school you do have all the knowledge to see patients, mull over the differential diagnosis and ask relevant questions and may even come to a reasonable diagnosis. The only difference in the Step 2 CS exam is that you are expected to display it all in a 15 minute encounter, in front of a stranger with the clock ticking as fast as your heart beat, under pressure and also in a 10 min patient note in the midst of a rapid fire keyboard clicks from your co test takers! Watch patient note typing demo here.

4 SECTIONS IN A PATIENT NOTE

1) The 4 major sections of a patient note are
    1. **History**
    2. **Physical Exam**
    3. **Diagnosis # 1, 2 & 3**
    4. **Diagnostic study/studies**

1) History

History is listed under the following headings

- HPI: History of present Illness
- OBS/GYN (female patients): Obstetric/Gynaecology
- ROS:Review of Systems
- ALLERGIES: Allergy to food, substances or drugs
- MEDICATIONS: Current meds including over the counter medications
- PMH: Past Medical History

- PSH: Past Surgical History
- SH: This includes Social and Sexual history
- FH: Family history

The first sentence of the HPI should include the a) age, b) sex, c)chief complaint (in the same words of the patient which is usually the door way information – for example Don't write palpitation when the patient complained of racing of the heart and d) duration . This is followed by the positive and negative history you found out from the patient in the context of the chief complaint. You will also include a note of the review of systems (other systems than the system of the chief complaint) and constitutional symptoms. Then under ROS you will write negative except as above (since you have written it already under HPI), unless the patient has a positive ROS which may not be pertinent to the HPI. You can list all the findings under each subheading (OBS/GYN, ROS, ALLERGIES etc) as you have noted in your blue sheet from the Standardized Patient**.**

2) Physical Exam

The PE starts with a note on the General Exam and Vital signs. General Exam should be relevant to the case . For example in a case of amenorrhea, hyperthyroidism being one of the differentials you are expected to check for the any neck swelling by asking patient to swallow and also check for any moist palms and tremors on outstretched hands. Prolactinoma being another differential you are expected to check for visual field to r/o bitemporal hemianopia. Vital signs: you can write it as WNL except the (abnormal vital). For example: WNL except RR 28/min.

Then comes the focused PE headings according the system that the chief complaint revolves around. Think of the most relevant system your history suggests and then having examined that system in detail (inspection, palpation, percussion, auscultation) you will write it down in the patient note PE section. You may also want to include any relevant system that needs to be examined in conjunction with the main system. For example in a case of chest pain it is relevant to do a detailed examination of the cardiovascular system and in conjunction examine the respiratory system and abdomen for any epigastric tenderness (GERD that might mimic chest pain)

3) Diagnosis:

You are expected to come up with 3 differential diagnoses (in some cases there might be just 2 diagnoses) based on your history and physical exam during the patient encounter. Important thing is to list these Differential Diagnosis in the order of priority. For prioritizing you will take into consideration the age, sex, the presentation of the case in the context of setting, aggravating/alleviating factors, other associated symptoms and history revealed in the form of social /sexual/past history etc. It is important to train yourself in knowing the relevant questions to rule out or rule in the differential diagnosis as the exam requires you to write pertinent positive and negative history in support of the diagnosis. Watch sample Interactive Differential Diagnosis for all chief complaints (Mini Cases) here. While writing the PE findings under each diagnosis remember that these are standardized patients. They can only mimic a real patient to a certain extent. For example the standardized patient can c/o of warmth, redness and swelling of a joint (history findings) but when you examine he/she can only show redness (PE finding) by painting red on the respective part. They can mimic tenderness but not mass abdomen. If they are so sick they probably won't be acting!

Having said this, the SP's can talk in short sentences, mimicking shortness of breath. Remember sometimes you need to acknowledge these symptoms they pretend as "findings" for PE column of the Diagnosis for the purpose of this exam. Step 2 CS is unique in that not only is the SP acting – you are too! When SP says "Ah" when you press on his belly, you do pose considerate enough to empathize "Oh! I am so sorry you are having to go through this pain".

4) Diagnostic Study/Studies:

You may add any restricted internal examination in the exam under your diagnostic studies on the first row For example: pelvic, rectal or breast exam. You may list tests that you cannot do in the test for lack of time or technical requirements or forgot to do but feel is essential. For example: tilt test, MMSE (Mini Mental State examination), orthostatic vitals. You may then list the workup you plan to do for the patient. It may be a good idea to start off with a test that helps you differentiate between the differential diagnoses you enlisted especially with a most cost effective test. For example chest X ray in a case of cough rather than CT scan. Though tests like CBC is a routine workup in normal practice you may want to list it low in the order of priority list unless it is going to be diagnostic for the case presented.

PATIENT NOTE SAMPLE OUTLINE

HISTORY: Include significant positives and negative history in each of the following subheadings: HPI, Obs/Gyn, RAM (ROS, allergies, Medications), PMH-PSH, SH-FH.
HPI: 48 yr old M/F c/o …(complaint)……for the past (duration) Describe all positive history in OPDSC FAAA and LIQORAAA. ABCO …….Positive and Negative history pertaining to the case ……
…….. Review of other systems :
……
…….
OBG/GYN (if relevant): Gravida, Para, abortion/miscarriage, surgery/LSCS/vaginal delivery. Menarche at age 14, has regular periods 4-5/30 days. LMP: …., last pap smear was taken 8 months ago and was normal. No H/O STD. Patient is on OCP for contraception
ROS: negative except as above (U-G-S) occasional cough/pain **Allergies:** NKDA
Medications : Tylenol, Advil
PMH: Previous similar problems: other conditions. Hypertension for the past 5 yrs treated with atenolol, Hypercholesterolemia for past 1 year managed by diet, GERD treated with antacids
PSH: Haemorrhoids operated 2 years back. Appendectomy 6 months back (or)
PSH :none
SH: Habits (tobacco, alcohol, recreational drugs), work situation, home life ex. Two PPD for 10 years; drinks whiskey on weekends x 5 years (CAGE 1/4), no illicit drugs Works as clerk. Married and lives with wife and two kids. Sexually active with wife. Feels safe at home. Exercises occasionally. Vegetarian diet.
FH:same/similar complaint, related illnesses/conditions, eg father diabetic died of heart attack. Mom alive and healthy

PHYSICAL EXAMINATION: Indicate only pertinent positive and negative findings related to patient's chief complaint.

General appearance: Patient apparently comfortable/in severe pain (or) in /not in acute distress.Not anaemic/icteric /clubbing (pick by system relevance to the case – example anemia important in menorrhagia)
HEENT: Normocephalic, Atraumatic (NCAT), PERLA, no funduscopic abnormalities
Neck: Supple, no carotid bruits, no JVD, 2+ carotid pulses, thyroid normal, no lymphadenopathy
Chest: Clear breath sounds bilaterally. No rales or rhonchi
Heart: RRR, normal S1/S2; no murmurs, rubs or gallops.
Abdomen: Scars? BS +, non-distended, soft, non-tender, no rebound tenderness, no hepatosplenomegaly, no palpable masses.
Neuro:Mental Status: Alert and oriented x 3 (person, place and time), spells backward, can recall 3 objects.
Cranial nerves: 2-12 grossly intact. **Motor:** Strength 5/5 throughout. **DTRs:** Symmetric 2+ in upper and lower extremities, Babinski negative bilaterally **Sensation:** Intact to sharp and dull sensation bilaterally **Cerebellar** Romberg, finger to nose test

Extremities: Symmetric 2+ brachial, radial, and dorsalis pedis pulses bilaterally. Sensation intact. No wasting of proximal and distal muscles. (Warmth ,edema, erythema, tenderness, pain and restricted range of motion on flexion and extension of … (limb) compared to ….. (R/L limb). Other joints WNL bilaterally.
Back: No obvious deformities or signs of trauma. No spinous process or paraspinous tenderness. **Range of motion** normal anteriorly. Normal gait. Reflexes 2+ patellar, Achilles)

DATA INTERPRETATION :

Diagnosis # 1	**xxxxxx**

	History	**PE**
1.		
2.		
3.		

Diagnosis #2	**xxxxxxx**

	History	**PE**
1.		
2.		
3.		

Diagnosis # 3	**xxxxxxx**

	History	**PE**
1.		
2.		
3.		

Diagnostic Study/Studies	
1.	Internal exams example pelvic/rectal/breast
2.	relevant test 1
3.	relevant test 2
4.	relevant test 3

DIAGNOSTIC STUDY/STUDIES

Dermatology	(Fungal) Wood's light – Fungal culture (Allergy) Patch test (Any colored lesion): Skin biopsy
Anemia	CBC with differential, Serum iron level, TIBC, ferritin,B12 level
Pyschiatry	Mental status exam - Urine toxicology – TSH – CBC, Electrolytes, calcium, glucose - BUN/Cr
Drug abuse	Urine toxicology - Mental Status Exam
AIDS	HIV antibody and viral load
Abuse	Skeletal survey

Sepsis	CBC with differential, blood culture, UA and urine culture *In Children- add Titers for CMV, toxoplasmosis, and rubella if required*
Meningitis	CBC, Electrolytes –ESR - LP,CSF analysis / CT head or MRI brain
Sleep	Ambulatory nocturnal pulse oximetry – Polysomnography
Ear Infection	Audiometry- Tympanometry - Brain stem auditory evoked potentials – Dix-Hallpike maneuver(BPPV) – VDRL/RPR *In Children-Pneumatic otoscopy – Tympanometry*
Eye Infection	Tonometry - Slit lamp examination-discharge culture
Sinusitis	CT sinus
Throat	Throat swab for culture& ASOT - Monospot test & Anti-EBV Abs
Thyroid	TSH / US
Chest	ABGs – CXR (PA and lateral) – CT chest– Sputum exam microscopy, Gram stain, AFB smear, Culture, Cytology – PPD – Direct laryngoscopy (FB) – Bronchoscopy with BAL (hemoptysis-cancer-ILD) - Spirometry (Asthma/COPD/GBS/ Neuromuscular disorders) - PFTs For PE: Doppler U/S legs – D-dimer
Heart	ECG – Stress test – ECHO (TEE/TTE) – Cardiac enzymes (CPK-MB, troponin) - Cardiac catheterization (MI) +/- Cholesterol &TGs levels

Abdomen & Pelvis	**General:** AXR - US–CT abdomen& pelvis –Rectal exam, Anoscopy. **Esophagus& Stomach:** 24 hour pH monitoring - Upper endoscopy Noninvasive H. pylori testing=urea breath test (for peptic ulcer disease) **Bowel:** FOBT - (Stool leukocytes, culture, ova and parasitology,and pH - Electrolytes(esp. in diarrhea) – Colonoscopy - Procto-sigmoidoscopy *In Children- Rotavirus enzyme immunoassay (important)* **Liver:**AST,ALT, ALP, bilirubin -Viral hepatitis serologies – PT/PTT-MRCP/ERCP- esp.for PSC *In Children- Blood type + Direct Coombs' test* **Pancreas:** (Amylase, lipase) / D-xylose **DM:** Serum glucose - UA, urine microalbumin – HbA1c - Islet cell Abs **Kidneys:** UA/ Urine "culture-cytology"/ BUN,Cr / USG / Cystoscopy **Adrenal:** Dexamethasone suppression test – 24h urine free cortisol/US **Genital organs:** Urine hCG / "Genital or Pelvic or Breast" exam ***STDs:*** (Wet mount, KOH prep"whiff" test) / Cervical GC DNA testing/Pap ***PCOD:*** LH/FSH ,Testosterone/DHEA ***Ectopic pregnancy –PID-Endometriosis -Pelvic cyst***: Laparoscopy ***Impotence:***Testosterone, Prolactin level-TSH-Doppler US penis

SAMPLE PATIENT NOTES

OBSTETRICS/GYNAEC
SAMPLE PATIENT NOTE-1

History:
HPI-35 yo F comes to clinic c/o absence of periods for 2months. She had regular periods before that every 28 days. No h/o of prior excess flow or passage of clots. No dysmenorrhea. LMP- 2 months back. She is sexually active with her partner. No protection or OCP's. H/o of rigorous training for a marathon for past 4 months. She has tremors, weight loss of 8 pounds, heat intolerance and excessive sweating. Occasional nausea no h/o headache, vomiting, vision changes, breast swelling or discharge , chest/abdominal/joint pain, fever or headache OBS/GYN- Has been pregnant once. 1child normal delivery. No gynec procedures done before. ROS- none except above ALLERGIES:NKDA;NKA Medication- none PMH- none PSH- none SH- not a smoker/alcoholic. Takes weed sometimes. Last intake was 1 week back FH- mother is a hyperthyroid pt. No other family members suffer from any problems.
Physical Examination:
GE- comfortable. anxious. VS- WNL except for PR 102/min. HEENT-NCAT.EYES-normal.ENT-normal No thyroid swelling. HEART –S1S2+No murmurs/gallops/rubs CHEST- clear breath sounds both sides ABDOMEN- soft, no organomegaly.

DATA INTERPRETATION:

Diagnosis # 1	Hyperthyroidism

	History	**PE**
1.	absent period for 2 months	Tremors
2.	weight loss of 8 pounds	moist palms
3.	Tremors/ excessive sweating	Tachycardia
4.	Family h/o thyroid disease	

Diagnosis #2	Pregnancy

	History	**PE**
1.	absent period for 2 months	
2.	unprotected sex	
3.	H/o nausea	

Diagnosis # 3	Anorexia nervosa

	History	**PE**
1.	absent period for 2 months	
2.	marathon training intense	
3.	loss of weight 8 lbs	

Diagnostic Study/Studies	
1.	Pelvic /Breast exam
2.	Urine pregnancy test
3.	USG pelvis
4.	TSH, T3,T4

RESPIRATORY/CARDIAC
SAMPLE PATIENT NOTE-2

History :
60 yo M c/o SOB X 4 m, gradual, worsening, present all the day, exacerbated by walking 3-4 blocks, asstd. with PND, orthopnea, uses 3 pillows. .H/o ankle swelling end of day , fever without chills, cough with sputum, yellow, non bloody, no pus, no bad odor, 1-2 tsp in amount. He denies weight loss, nausea, vomiting, headache, palpitations, chest pain, sweating, wheezing, ill contact, travel recently. Normal sleep, appetite, bowel and urinary habits.ROS: Negative except as above. Allergies: NKA NKDA PMHx: COPD X 5 yrs, HTN X 10 yrs. PSHx: None Medications: Lopressor, HCTZ, . SH: Smokes 1 PPD X 40 yrs, No drugs, EtOH socially, monogamous with wife. FH: Father died of MI at the age 60.
Physical Examination :
Patient is in no acute distress. Mild dysnoea+ V/S: WNL except temp 100'F RR 28/min Neck: Supple, no JVD, No thyromegaly Chest: Breath sounds B/L, TVF NL, No added sounds.CVS: RRR, S1/S2 , no murmurs, rubs or gallops..Extremities: Pulses 2 equal B/L, no clubbing/pitting edema.

DATA INTERPRETATION:

Diagnosis # 1	CCF/Cor Pulmonale

	History	**PE**
1.	SOB – PND/Orthopnea	Orthopnea
2.	Ankle swelling end of day	
3.	Known case of COPD	

Diagnosis #2	COPD exacerbation

	History	**PE**
1.	SOB	Temp 100 F
2.	Fever	RR increased
3.	Known case of COPD	
	Cough with sputum	

Diagnosis # 3	Pneumonia

	History	**PE**
1.	SOB	Temp 100 F
2.	Fever	RR increased
3.	Cough with sputum	

Diagnostic Study/Studies	
1.	CXR
2.	SPUTUM C/S
3.	ECG, ECHO
4.	CT CHEST

NERVOUS SYSTEM
SAMPLE PATIENT NOTE-3

HPI - 65 yo M comes to clinic with c/o confusion x 3months. started insidiously and is progressively increasing, intermittent. occurs 5 to 6 times a day, no aggravating or relieving factors. Sleep disturbed. H/o loss of interest in activities, inability to concentrate and reduced appetite. Difficulty finding way home, making telephone calls and remembering names No h/o head trauma, seizures, weakness/tingling/numbness of ext., visual or gait disturbance. No bowel or bladder disturbances. No h/o excessive sweating/tremors/skin dryness/heat or cold intolerance or neck stiffness. No suicidal ideation. No chest pain/SOB/palpitations. ROS- none except above ALLERGIES-NKDA MEDICATION-none PMH-HTN on Atenelol for 10 years Not a known Diabetic PSH-none SH-lives with wife .No interest in sex. Smokes cig 2ppd X 10years. 2 pints of beer everyday x 5years. CAGE 0/4. no illicit drugs. FH- no similar complaints

Physical Examination:

GE-comfortable. VS- WNL. HEENT- atraumatic, normocephalic. Eyes- normal. ENT- normal. MMSE - not oriented to place. memory 2/3 , short term and recent impaired. Concentration and judgement impaired. CN 2-12 clinically intact. strength 5/5 in all ext. DTR 2 in all Ext. Sensation equal on both sides. Gait -normal. No cerebellar signs. No meningeal irritation. Heart- S1/S2 no murmur, rubs, gallop Chest- clear breath sounds. No added sounds

DATA INTERPRETATION:

Diagnosis #1	Alzheimers disease

	History	**PE**
1.	Confusion x 3months	orientation 2/3- not oriented to place
2.	Not able to do activities of daily life	short and recent memory impaired
3.	Memory disturbances	concentration impaired
	Age	judgement impaired

Diagnosis #2	Multi infarct dementia

	History	**PE**
1.	confusion and forgetfulness x 3m	orientation 2/3- not oriented to place
2.	Known hypertensive on atenolol	short and recent memory impaired
3.	Age.	concentration and judgement impaired

Diagnosis #3	Pseudo dementia

	History	**PE**
1.	Confusion and forgetfulness x 3months	Apathy
2.	Sleep disturbance, loss of interest, not able to concentrate	poor grooming
3.	Elderly	orientation 2/3, impaired memory, concentration and judgement

Diagnostic Study/Studies	
1.	TSH,T3,T4
2.	serum B12 levels
3.	CT brain
4.	Blood glucose, HbA1c

SECTION V: COMMUNICATION AND INTERPERSONAL SKILLS (CIS) & SPOKEN ENGLISH PROFICIENCY (SEP)

CIS

Some IMG's find the CIS and SEP components of Step 2 CS challenging to pass. Make sure you keep your focus on the patient and his needs/gestures. The following are some of the "must do's and don'ts".

- Knock on the door before you enter
- Enter smiling unless the patient is in acute distress
- Shake hands with the patient – a gentle yet firm professional handshake
- Address patient by last name or ask him how he/she would like to be addressed
- Show empathy when you hear about the chief complaint (10 Kickstarters) and assure him/her that you are going to help him/her regarding their problem
- Ensure patient is comfortably seated – drape them (drape is a sheet of cloth which is folded and left on the stool that you sit. You may unfold it and place it on the patients lap if he is sitting or cover from hip below if he/she is lying down. Sometimes patient may be sitting on the exam table already draped when you enter the room. You may then ask them if they are comfortable and if the room temperature is okay.
- Start with an open ended question? – "Tell me more about your problem". This allows the patient to talk freely about their problem. This should be your opening sentence after you have asked about the chief complaint of course. They might say "I have been having this sharp belly pain constantly for the past 3 days ever since I ate outside and it is getting worse doctor". They just answered 5 questions you might have had to follow up with in one sentence– Duration, Constant/intermittent, Quality of Pain, Setting, Progression.
- Ask permission from the patient to jot down a few points on the blue sheet as you talk and also if they don't mind you sitting down as you interview. In an emergency setting (chest pain, acute abdominal pain etc.) it is better to stand than sit.
- Maintain eye contact with the patient while briefly looking down at your clip board to note down the answers on the blue sheet.
- **Paraphrasing:** A couple of times in the encounter rephrase what the patient said in your own words to ensure that you understood it right. Example: After enquiring about setting 'Do you know of anything that might have caused this belly pain?' Patient response: "I did eat at a restaurant last night doctor". You may paraphrase this as "So you are telling me that this pain started only after you ate at the restaurant and prior to that you were fine. Am I correct? " Watch sample paraphrasing video here
- **Transitional Sentences:** Please use transitions when you move from present to past history – "Thank you very much, Mr. Jones for answering my questions patiently. Now I would like to ask you a few questions about your past history. Would that be alright?" You may also use transitions before family history, social and sexual history as noted in Section I. Watch demo
- **Avoid leading questions (where the answer is just a 'Yes' or 'No')** Example:Is your pain sharp in nature? Instead you might ask "How would you describe your pain? Sharp, dull, burning, throbbing?"

- **Building rapport:** Find out how the current complaint of the patient is affecting his life? Be genuinely concerned and encourage him/her as you address this issue. Assure him that you are there to help. Addressing the patient by his/her name a couple of times during the encounter also gives a personal touch to build rapport between you and the patient.
- **Empathize:** There are couple of places you can empathize including a) When you hear about the chief complaint b) When the pain is severe on the pain scale c) When you hear that their parents/ patient himself has been in an accident/trauma – " I am really sorry to hear that"
- **Summarize:** Give a brief summary of the salient history that you elicited and not each and every positive and negative history that you collected. As sample is given in Section I under Closure. It is important to ask the patient if there is anything else they would like to add to your summary.
- **Responding to gestures:** If patient is showing discomfort with room light you might ask him if he/she would like for you to dim it. If patient is looking at his wrist watch a couple of times, you might want to ask if he is hard-pressed for time or need to be somewhere else soon. Everything the patient does is for a reason – for you to note and respond!
- **Offering assistance:** Help the patient to stand up to his feet by putting the foot stool, help him lay down by holding his/her shoulder and pull the foot rest when you need him to stretch out his/her legs.
- **Keep the patient informed:** It is a good idea to inform the patient what you are planning to do next. Example: "Now that I have finished taking history I would like to wash my hands and do a brief physical exam."
- **Washing hands:** You may wash hands with a little soap and wash thoroughly with water and pat it dry with a towel before you touch the patient. Alternatively you may use gloves or sanitizer that is kept in the room. It is a good idea not to entirely turn your back to the patient. Stand at an angle, briefly glancing at him/her at times and keep the conversation going regarding his/her exercise regime or occupation or stress in his/her life. Some small talk regarding general topics is also fine during this time. If you happen to touch the table or wipe the sweat off your brow or pull the stool aside, you might have to wash your hands again. After washing hands go straight to the patient for doing the physical exam without touching anywhere else.
- **Patient gown:** Most patients wear a gown which is like an apron. It covers the upper body, abdomen and down to the knee or just below depending on the height of the patient. It is tied around at the back right around the neck region and back region. Please inform the patient before untying the gown (ask permission) and offer to help them untie. Only expose appropriate areas for examination and keep the remaining parts of the body covered, respecting their modesty. For example if you need to examine the heart and lungs expose the chest by untying the knot from behind the neck and pull the gown down to expose the chest area. If you plan to palpate the abdomen next, do not just make the patient lie down just like that, exposing the chest and abdomen but rather tie his/her gown back and lift the bottom of the gown till it is rolled up around the lower border of the rib cage exposing only the abdomen. Ensure the drape covers the pelvic area and below. Usually, a physical examination may not be warranted in an SP who is not wearing a gown.

- Avoid repeating painful manoeuvres! For example, you need not press twice on an area of abdominal pain for tenderness and rebound tenderness. Rather, you can give instruction to elicit the same. “I am going to gently press on the area that you complain of pain. Please let me know if it hurts while I press in or when I let go.” Please notice the fascial expression if the patient winces with pain and not look at the area where you palpate!
- Make sure your hands /stethoscope is warm before you place it on the patient
- Never disregard anything that the patient might be saying. Be patient and listen to them. If it is not related to what you are dealing with politely remind him/her “And you were saying regarding your abdominal pain that…” and draw him/her back to the relevant conversation.
- To reiterate, explaining the diagnostic possibilities and workup in layman language, answering one or more challenging question/s the patient might have and counselling him/her on relevant unhealthy practices is very important in *every* case especially for the CIS component. Strive to close every case before you run out of time.
- Supposing the time runs out before you finish, politely and calmly wind up by saying “I have got to attend to an emergency situation right now but I will be back to talk to you again. Please excuse me for now. It was a pleasure meeting you, Mrs. Parker”
- Overall you have to behave professionally as a doctor, show genuine care and concern, address any questions or doubts they may have, treat them with respect and courtesy, making sure they understand what condition they could possibly be suffering from and what your plan of action is going to be regarding deciphering the correct diagnosis.
- Remember the patient is an actor but you are a real doctor! Just be yourself and pretend you just opened your very own private clinic and this SP happens to be your first patient. You sure would want him to come back to you again, isn’t it? Behave accordingly.
- However, sometimes you have to act too! When the patient winces in pain even though you know he/she is acting, you go along with the flow and empathize “I am so sorry you are going through such severe pain”.
- You should be aware of the clock ticking towards the 15 minute deadline and may be you are anxious but the SP need not know that! Even if you don’t feel like it, act confident. Dress modestly, stand /sit tall, maintain eye contact and be a professional that you really are! The patient should feel confident that he/she is in good hands (This goes for real life practice too!).

CHALLENGING QUESTIONS: These may be asked anywhere during the encounter or maybe at the end. Sometimes there might me more than one question. Patiently answer the patient and ask "Does that answer your question Mr. Johnson". These are just questions that patients can come up with even in real life practice. They can be answered using just good old "common sense. Watch Sample video challenging question regarding insurance

My husband is out of town doctor and I don't have a car to bring my baby to the hospital.
Ms. Anderson, I understand your situation. We have very good social workers here at our hospital who can arrange for transportation. Would you like me to talk to them for you?

Are you saying that I could be pregnant doctor? Oh my God! My husband would be mad – we did not plan on having another baby.
Oh! I understand your concern about this unplanned pregnancy. Again I would like to state that pregnancy is only a possibility at this point and I have to confirm with pregnancy tests. So let us not get ahead of ourselves. Once the results are back and if it is positive I'll be happy to discuss your options. You may also bring your husband to the clinic and we can sort it out together.

Do you think I will be able to walk like before after this knee injury?
I certainly hope so, Ms. Patterson and I will do everything in my capacity to help you get back to your feet again. We have a very good and experienced team of doctors here that can help you. I am glad you came to the hospital as soon as you got yourself injured.

Can you give me an injection for the pain doctor? (Patient asks in the middle of history taking)
I most certainly can but let me ask a few more questions and examine you briefly so that I can understand your problem better and treat the cause of the pain appropriately. Would that be okay? Thank you for your patience.

What is an endoscopy doctor?
Well, it is a procedure where we insert a narrow tube down your throat which has a camera at the end. This will help us visualize if there is any bleeding or ulcer in the food pipe or the stomach.

Doctor, am I going to die?
Mr. Jones, I know you are anxious but it is a little premature for me to comment on the severity of the problem. I am glad you came to the hospital and you are in good hands. Do not worry.

Doctor, are you going to draw blood for the tests? I usually pass out when I see blood.
I understand Mr. Parker…. some of my patients are scared too. But remember we have about 5 litres of blood circulating in our blood and a small prick to draw a couple of mls will not hurt you at all. I will make sure you have a good phlebotomist. So I want you to be brave and relaxed this time. Can you do that for me?

Doctor, are you planning to do an MRI? I had a friend who underwent this. She said they injected some dye into the veins. Is that true?
Not necessarily, unless a contrast study is required. We have very good radiologists and supporting technical team in this hospital. I assure you, you are in good hands nd will be well taken care of.

CHALLENGING SITUATIONS: Below are some sample challenging situations that you might have to handle in the real exam –

SAD/DISTINTERESTED/ DEPRESSED PATIENT
Patient doesn't want to talk and looks sad
Mr/Ms. Jones, I understand that you are very upset/sad. But I want to assure you that I am here to help you. I would like to tell you that anything you say will be kept confidential.
If patient does not respond still…….
Mr/Ms. Jones, only if you open up to me and tell me your problems, I will be able to find out the cause for your problem and we will be able to sort it out together. So tell me what is bothering you/making you sad?

CRYING PATIENT
Mr/Ms Jones….I understand that you are very upset. I am here to help you with whatever situation you are in right now. Would you like a tissue?
(Still crying)…. Please understand that I can only help you if you tell me what your problem is. I am sure we can sort it out together. Please tell me what is causing you this distress.

ANGRY PATIENT
Mr./Mz Jones…. I apologize for being late. We had an emergency that had to be attended to immediately. I hope you will understand. Now that I am here, I want you to be assured that I am here for you, to sort out the cause for your problem and give the best treatment possible Can you tell me more about the pain that you have ?.....(Watch sample video demo)

ANY PATIENT WHO IS NOT ON THE EXAMINATION TABLE (maybe walking around room pretending to be looking at writings on wall /listening to voices)
Hello Mr. Jones …. I m Dr. ……. Go shake hands and tell him "I understand you have been hearing strange voices lately……Would you like to take a seat on this exam table and tell me more about it. Walk with him to the exam table and after he is seated (with you helping him to get onto the table by putting a foot stool)…..Do you mind if I sit down and take some notes while we talk.
Okay then……please tell me more about your problem…

PATIENT IN SEVERE PAIN
(rolling side to side on the exam table)
Hello Mr. Williams…….I' m Dr. ….. (DON'T HAVE TO SHAKE HANDS). You can keep your hands on his shoulder and say "I understand you are in a lot of pain. I am here to help you. Can you tell me more about the pain"

PATIENT WITH SHOULDER PAIN
Same as above ……after introduction DON'T SHAKE hands

PATIENT WHO IS COUGHING
After introduction ……"Can I get you a glass of water" or "Can I get you a tissue"……don't forget to ask him to show his tissue even if he is not having one in hand ……..(He might just pull it out of his gown …don't be surprised if it has a red spot or pinkish stain!)

SP KEEPS LOOKING AT THE CLOCK DURING YOUR CONVERSATION. WHAT SHOULD YOU SAY?
Looks like you have another appointment after this. I just have a couple of questions more and will try to be as quick as possible and you can be on your way.

SP TALKS WITH MOBILE PHONE WHEN YOU ENTER THE ROOM. HOW WOULD YOU HANDLE THE SITUATION?
Wait for a few secs (15 - 30 secs). Pardon me, Mr Gordon for interrupting (or I apologize for interrupting Mr Gordon). I would appreciate if you can continue the conversation after I examine you. There are other patients waiting for my attention. I hope you understand.

PATIENT TALKS IRRELEVANT STUFF (EXAMPLE: ABOUT HIS DAUGHTER)
Pretend to listen for a few seconds. "That's good to hear. Oh! You were saying…. (that you had cough) . Bring him back to the topic and your line of questioning

PATIENT IS READING A BOOK/MAGAZINE AND CLOSES WHEN HE SEES YOU ENTERING
Offer to put it on the table/ask him with a smile "May I know what are you reading? Anything interesting?"

WHEN YOU COUNSEL FOR SMOKING/ALCOHOL PATIENT RETORTS THAT HE DID NOT COME FOR THAT BUT FOR HIS COMPLAINT
Oh! I do understand Mr. Jones that you did not come for cessation of alcohol/smoking. However I would like you to understand that some of the problems you are facing currently maybe linked to alcohol/smoking. So this is good time for you to consider making some changes in your lifestyle.

SEP

Spoken English is sometimes the only component students fail this exam and is not to be taken lightly. Either you speak English or you don't! However I have noticed during my years of experience training students from different countries whose first language is not English, still pass the SEP component. They accomplish this by taking extra effort and planning to prepare for this exam for a longer duration than others. It is especially difficult for these IMG's because in addition to remembering a ton of questions to ask they have to translate the questions in their brain before they utter it correctly. Writing down the questions, especially the common ones that are to be asked for all cases (Section I - Blue sheet questionnaire) and practicing them multiple times till you develop fluency and confidence is key to passing the SEP. Again, you don't have to ask all the questions outlined – just what is relevant to the case at hand.

The common template for possible questions that are given in this hand book in addition to the specific system-wise questions has helped many students to master them by-heart and perform on the real exam with ease. Another issue is that, even though a student may speak English sometimes the accent is difficult to understand. Ensure you articulate loud and clear, looking directly at the patient so that he/she could figure out certain words by at least looking at your lip movements. Some students take separate English classes other than our personalized coaching (Click link for more info http://www.targetusmle.com/coach.php) to get their pronunciation and grammar corrected. Some students practice speaking to patients in English during their clerkship rotations in the United States if they happen to have these rotations before their Step 2 CS exam. Listening to audio tapes, movies in English can help. If you happen to be an IMG living in the United States, take efforts to talk to Americans at the grocery store, fast foods, to teachers at school where your children study. Be patient with yourself. Listen and learn. It might take longer but don't give up on Step 2 CS exam just because of the spoken English component! Nothing is impossible. It's doable. Remember, students have done it before you. Believe in yourself!

You also need to be articulate, loud and clear for the SP to understand your spoken English. Just like you take on 12 SP's during the exam, each SP is faced with doctors from different parts of the world and you can imagine their plight in understanding different accents and trying to answer the doctors appropriately for their questions without wasting much of their time. Listening skills are also important so that you don't repeat the questions you already asked. Please pay attention to what the patient is saying. Most students are intently thinking on what question to ask next but forget the fact that they need to be processing the answers from the patient as well, to come to a reasonable diagnosis by the end of the encounter. Give them your undivided attention for the few minutes you spend with them. Isn't that also what patients in real life practice want from you as well, having picked YOU amongst many others as their trusted physician!

Note from the author

Hope this short CS handbook has given you useful tools not only to pass USMLE Step 2 CS but also insights into everyday practice in the future as a compassionate, knowledgeable and caring physician to the sick and the hurting who co-habit this world with us. Always remember, you did not choose your patient but the patient chose 'you' to be their doctor – it is an honor and a privilege to serve them and restore them back to health and vitality. Personally, I learned more about being a doctor when I was a patient myself. You get a totally different perspective from the other end of the doctor's table! For the brief period that you meet your patient, you get to heal them not just physically but emotionally, instil hope and courage to fight their disease, not just palpate but make a palpable difference in their lives by showing love from one human being to another! Be mindful, because everything matters – your smile, your touch, your words, your decisions, your eye contact, your undivided attention and above all your care, concern and love. Your last patient of the day deserves no less than your first!

Keep shining at YOUR best!

Dr. Mary June

P.S. I would love to hear back from you – your insights on the book - constructive criticisms or how it helped you in your exam prep Reach me at dr.maryjune@targetusmle.com Skype ID: mjjune1

Other resources from Target USMLE for Step 2 CS Preparation

- We also encourage you to enrol in our **online self-study video tutorial'7 Easy Step 2 CS'**(30 day access, 24/7) (http://www.targetusmle.com/video.php) which has been designed for YOU to ace this exam with lectures and practical video demos within the time restraints of the Step 2 CS exam. It goes hand in hand with this CS handbook!
- Personal coaching is also available for those who would like to ensure that they are doing it right by presenting cases to our MD tutors who will act as SP's while simultaneously assessing you and correcting your mistakes before going for the real exam – Click here to enrol http://www.targetusmle.com/rapid-cs-review-course.php).
- If you would like to contribute to the next edition to help many more doctors like you pass this tricky exam please reach us at dr.maryjune@targetusmle.com
- If you have found this book beneficial for your CS preparation please take a few minutes to visit http://www.amazon.com/dp/B01B0TYXNY#customerReviews and give a brief review. It could help other students find this resource material from Amazon bookstore. Thank you for trusting us with your CS preparation.