TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER™

School *of* Medicine

Third-Year Clerkship OSCE Manual

Content Description and General Information

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Introduction

The OSCE (Objective Standardized Clinical Encounter) Experience in your Third-Year Clerkships is designed to assess your ability via simulated patient encounters, to create a patient-centered encounter, address the diagnostic challenges posed, to prepare the patient for next steps, and lastly, to document the encounter appropriately. The USMLE has identified 72 common signs and symptoms that form the basis for the Step 2CS Exam which is designed to "assess a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills that are important in health and disease management and that constitute the basis of safe and effective patient care." These common presenting signs and symptoms are listed in Appendix A. Appendix B provide a screenshot depicting the note format. A link to the USMLE Step 2CS practice note site will allow writing notes with character and line limits and a ten-minute time limit.

Your OSCE score will represent 15% of your Final Clerkship Grade.

Note: The contents of this manual are based closely on the instructions provided by the NBME for students preparing to take USMLE Step 2CS. This relationship is intentional as a goal of both our Clerkship OSCE program and the Longitudinal Clinical Skills Examination (LCSE) is to assist learners as they prepare for the Step 2CS Examination.

OSCE Structure

In a standardized patient encounter, you will determine the patient's presenting symptom, perform a focused History and (usually) Physical examination, develop a working differential diagnosis, and create a list of the next steps in the patient's work-up. The standardized patients (SP) will evaluate you using a checklist. The SP's checklist is an evaluation of your communication and interpersonal skills (CIS), one of the grading components of Step 2CS. After the encounter, you will document your patient's History, Physical Examination, Differential Diagnoses, and the next steps in your patient's Work-up. Your written note will serve as a second component of the grading of an OSCE, which corresponds to the integrated clinical encounter (ICE) component of Step 2CS. Your OSCE occurs during week eight of your Third-Year Clerkship except for Psychiatry, which occurs on Friday during week seven. You have a total of fifteen (15) minutes for the patient encounter. You have ten (10) minutes for the written note. If you finish the patient encounter before the fifteen-minute time limit, you may apply the additional time on your note. You will go through a transition during each of the first three Clerkship OSCEs. You will have character and line limits as follows for the History:

Clerkship Period #	Character Limit	Line Limit
1	1150 characters	25 lines
2	1050 characters	20 lines
3-6	950 characters	15 lines

The OSCE character and line limits for the Physical Exam will be:

Clerkship Period #	Character Limit	Line Limit
1	1150 characters	25 lines
2	1050 characters	20 lines
3-6	950 characters	15 lines

The rationale for character and line limits is to allow you to adjust to the character and line limits for the USMLE Step 2CS Exam.

You are required to successfully pass the STEP 2CS (Clinical Skills) Exam for graduation. The Step 2CS exam has three graded components, Spoken English-Proficiency (SEP), Communication and Interpersonal Skills (CIS), and the Integrated Clinical Encounter (ICE). You must pass each component to pass the exam. It is required that on-cycle students take USMLE Step 2CS prior to October 31 of their fourth year and, in practice, most students take the exam between June and September. The character and line limits for Step 2CS are:

Character Limit	Line Limit
950 characters	15 lines

During the Spring semester of Year 3 (February for FMAT students; May for everyone else) the Longitudinal Clinical Simulation Encounter (LCSE) will occur as practice for USMLE Step 2CS. The LCSE is a six-station OSCE that is designed to simulate the twelve-station USMLE Step 2CS. The LCSE has identical character and line limits as those used in Clerkship Period 3,4,5, and 6 OSCEs.

Description of the Examination

Timing

You should arrive at least 15 minutes early at the Simulation Center on your home campus. Your Clerkship Coordinator will advise you as to the start time of the examination. The OSCE encounters are timed events, so do not arrive late for your exam. OSCEs occur at the same time on each campus for each clerkship according to the schedule listed below

Clerkship	Time
Family Medicine	Week 8, Wed am
Internal Medicine	Week 8, Wed pm
Obstetrics and Gynecology	Week 8, Tues pm
Pediatrics	Week 8, Mon am
Psychiatry	Week 7, Friday am
Surgery	Week 8, Tues am

Location

Your OSCE encounter will occur in the designated Testing Area. Your Clerkship Coordinator will instruct you regarding campus-specific information.

Policies and Procedures

The Clerkship OSCEs and LCSE are conducted under the SOM OP 30.01, Grading Policy, SOM OP 30.01, Appendix F, SOM OP 30.03, Electronic Devices, and SOM OP 30.09, Educational Record and Grade Appeal Policy. All OSCEs are graded on a 100-point scale (30% contributed by the Communication and Interpersonal Skills (CIS) component, 70% by the Integrated Clinical Encounter (ICE) component) and final scores are converted to a 15-point scale. No electronic devices are allowed during the OSCE, including the Patient Encounter and Note Writing tasks of the OSCE. A score of 70% is required for passing the OSCE. SOM OP 30.01, provides guidelines for actions in MSIII Clerkships for the failure of an OSCE.

Table 1: Guidelines for Actions in MSIII Clerkships

Academic Condition	Course of Action
Failure of single component other than clinical performance (i.e., NBME exam or OSCE)	Repeat component. A four-week elective for credit in Year 4 concluded by repeat of component is recommended. Failure to remediate a failed component will result in assignment of a final grade of FA and referral to the SPPCC.
Failure of clinical performance OR failure of two or more components (including failing the same subject exam on two separate occasions)	Assign clerkship grade of FA and refer for review by campus SPPCC Year 3/4 subcommittee with options for courses of action as described in SOM OP 40.04, Student Promotion.
Failure of overall clerkship	Assign clerkship grade of FA and refer for review by campus SPPCC Year 3/4 subcommittee with options for courses of action as described in SOM OP 40.04, Student Promotion

Clothing

Wear comfortable, professional attire with a clean, white lab coat. Men should have a necktie, and women should have closed toe shoes. (**taken from the Step 2 CS manual**)

Equipment

The only required medical equipment is your stethoscope. The Sim Center provides all other necessary medical equipment.

Onsite Equipment and Examinee Instructions

The Testing Area of the Sim Center will consist of a standardized exam room. An examination table, chair, BP cuffs, otoscopes and ophthalmoscopes, gloves, sinks, towels, and antibiotic foam dispensers are in the standardized room. You may need to adjust the table for your patient's comfort during the examination. You are expected to use any drapes as necessary to protect your patient's modesty.

Outside the exam room, you are provided a clipboard with a blank paper for taking notes. You are expected to bring your pen for taking notes during the encounter. A note detailing the patient's name, age, gender, and reason for visiting the doctor will be facing away from you at the doorway. It also indicates his or her vital signs, including heart rate, blood pressure, temperature (Celsius and Fahrenheit), and respiratory rate, unless instructions indicate otherwise. You may not look at the note in advance of the announcement that the patient encounter has begun. You can accept the vital signs on the examinee instruction sheet as accurate, and do not need to repeat them unless you believe the case specifically requires it. You may encounter a case in which the examinee instructions include the results of a lab test. In this type of patient encounter, the patient is returning for a follow-up appointment after undergoing testing. The doorway instructions will indicate whether, in these instances, you must perform a physical examination.

The Patient Encounter

You will have 15 minutes for each SP encounter. Once the announcement "Students, you may begin" is given, you may look at the information sheet and begin your encounter. You must knock on the door before entering. You should introduce yourself and begin your conversation after closing the exam door. You should treat each SP as you would an actual patient. The SP will be evaluating you based on the

encounter using the Communication and Interpersonal Skills (CIS) Checklist. The CIS Checklist is found in Appendix C. Communicate in a professional and empathetic manner, being responsive to the patient's needs. You should respond appropriately to the patient's needs and ask the patient questions and communicate using nonmedical jargon. You will need to communicate the working diagnoses and next steps in the workup of the patient's problem. You should determine the patient's willingness to participate in the next steps and gauge their understanding of their present illness.

Physical Examination

You should perform a directed physical examination based on your patient's history and potential differential diagnoses. You should wash your hand or use antimicrobial foam before examining the patient. It is important that you respect the patient's comfort and modesty. You will need to move their drapes to avoid unnecessary exposure. It is an expectation that you listen with a stethoscope directly on the skin and not on the gown or through clothing. It is critical that you apply no more pressure than the amount of pressure that is appropriate when performing tasks such as the abdominal exam, examination for Murphy's sign, Obturator or Psoas sign, eliciting CVA tenderness, and examination of the ears with an otoscope.

You should interact with the standardized patients as you would with any patients you may see with similar problems. Do **not** perform the following: rectal, pelvic, genitourinary, inguinal hernia, female breast, or corneal reflex examinations. If indicated, you should include them in your proposed diagnostic work-up. Do not perform a throat swab for a throat culture; include it in your workup. All other examination maneuvers are completely acceptable, including femoral pulse exam, inguinal node exam, and axillary exam.

The overhead speaker will make announcements when to begin the patient encounter, when 5 minutes remain, and when the patient encounter is over.

If you complete the patient encounter in fewer than 15 minutes, you may leave the examination room early to begin your note. Be certain that you have obtained all necessary information before leaving the examination room. You are not permitted to re-enter the examination room. Re-entering an examination room after leaving will be considered misconduct.

Telephone/Video Patient Encounters

Telephone/video patient encounters may occur during the Pediatric OSCE, LCSE, and even Step 2 CS. These encounters begin like all encounters with a case-specific doorway instruction sheet. Once the announcement "Students, you may now begin," you make notes about the case before entering the exam room. Upon entering the room, sit at the desk in the front of the room. You should conduct the encounter via phone or via video link and take a history and ask pertinent questions. Because no physical exam is possible, leave that section of the note blank.

Immediately after each patient encounter, you will have 10 minutes to complete a patient note. If you leave the patient encounter early, you may use the additional time for the note. You will be asked to type (on a computer) a patient note similar to the medical record you would compose after seeing a patient in a clinic, office, or emergency department.

You should record pertinent medical history and physical examination findings obtained during the encounter, and your initial differential diagnoses (maximum of three). List your diagnoses in order of likelihood. You should also indicate the pertinent positive and negative findings obtained from the history and physical examination to support each potential diagnosis. Do not list information or findings not documented in the History or Physical Exam! You will lose points in Step 2 CS for failure to document supporting evidence in the History or Physical Exam.

Finally, you will list the diagnostic studies you should order for that particular patient. If you think a rectal, pelvic, inguinal hernia, genitourinary, female breast, or corneal reflex examination, or a throat swab, would have been indicated and performed during the encounter, list it as part of the diagnostic studies. **Treatment, consultations, or referrals should not be part of the OSCE, LCSE, or Step 2 CS. You will lose points on the Step 2 CS if you include treatments!**

You will not receive credit for listing examination procedures you **should** have performed or questions you **should** have asked had the encounter been longer. Write **ONLY** information you elicited from the patient through either physical examination or your history taking.

Scoring of Your OSCE

You are assessed for your Communication and Interpersonal Skills (CIS) by the Standardized Patient (SP). The CIS portion of your Clerkship OSCE counts 30%. The remaining 70% is your performance in the Integrated Clinical Encounter (ICE). Your ICE is evaluated by a Clerkship Director using a grading rubric. Typically the rubric is based on written documentation, required pertinent positives and negatives determined by the History and a focused Physical Exam. The grading rubric uses a Does, Partially Does, and Does Not Do grading system. Thus "enough documentation" (i.e., 3 out of 5 items) results in a does checkmark, partial documentation (i.e., 1-2 items), no documentation (i.e., 0 items) results in a does not do.

A grade of 70 is the minimum passing score for the OSCE.

Rules of Conduct and Testing Regulations

The SOM OP 30.03 Electronic Devices in the Classroom and SOM OP 40.03 Student Conduct outline the duties of our students. No smartphones or other electronic "smart device" is permitted in the testing area. The Medical Student Honor Code of Professional and Academic Conduct prohibits your discussing the case at any time. Your Clerkship Coordinator and Sim Center staff will conduct the OSCE testing. You must follow the instructions of your Clerkship Coordinator and Sim Center, Staff.

APPENDIX A

Common Presentations on USMLE Step 2CS

(this list is used to guide the cases presented on clerkship OSCEs)

Please note that this list shows examples, and does not represent all possible presenting signs and symptoms that may be encountered during a Step 2 Clinical Skills examination.

Abdominal distension
Abdominal pain
Abnormal menses
Abnormal movements
Altered bowel habits
(e.g., constipation, diarrhea, fecal incontinence)
Back pain
Bloody stools/melena
Breast-related complaints
Chest pain/discomfort
Child and adolescent behavior concerns
Confusion
Cough
Decreased sensation in extremities
Dental pain
Difficulty walking
Dyspareunia
Dysphagia
Ear-related complaints
(e.g., pain, tinnitus, hearing loss)
Easy bruising
Epistaxis
Evaluation after a fall
Extremity pain
Eye complaints (e.g., pain, visual changes)
Fatigue
Fevers, chills and/or night sweats
Flank pain
Genital complaints (e.g., discharge, lesions, pain)
Hallucinations
Headache
Hematemesis
Hemoptysis
High blood pressure
Hot flashes
Indigestion
Infant spitting up
Irritable infant/child
Jaundice
Jaw pain
Joint pain
Joint swelling
Leg swelling
Loss of appetite
Mass/lump
Memory loss
Mood disorder
Mouth and lip changes
Muscle pain
Nasal discharge
Nausea/vomiting
Neck pain
Palpitations
Post-operative complications
Postpartum concerns/complications
Pregnancy-related concerns/complications
Pruritus
Rash
Seizure
Sexual dysfunction
Shortness of breath
Sinus pain/pressure
Sleep issues
Sore throat
Substance use
Syncope
Trouble concentrating
Urinary complaints
(e.g., frequency, dysuria, retention, incontinence)
Vertigo/dizziness/lightheadedness
Weakness
Weight gain
Weight loss
Wheezing

APPENDIX B

Communication and Interpersonal Skills Checklist

This is the exact checklist used by SPs to evaluate your patient-centered interviewing skills. The same checklist is used in all clerkships, with slight modifications for phone/video interview formats.

Standardized Patient Checklist – Information for students and standardized patients

Note: The N/A designation should only be selected for items that cannot be assessed on a particular case, for example, a case involving a phone call, where items related to knocking on door, closing the door, shaking hands, making eye contact, washing their hands cannot be assessed. (Note that the text in red is directed to the student and should be used by the SP to gauge what is expected of the student)

Interview Skills		Yes	No	N/A
1	Did the student knock on the door before entering? This maintains respect for the privacy of the patient. Note that encounters using phone interchanges require informing the student to enter without waiting for an answer			
2	Did the student close the door before beginning to talk to you? Closing the door before talking maintains patient confidentiality			
3	Did the student introduce themselves to you? For example: I am a third year medical student			
4	Did the student explain their role in your care? For example: I have been asked by your attending physician to collect information from you as part of your care			
5	Did the student verify your identity? You should confirm that the patient's identity matches that on your documentation. It is best to start with a formal address (Mr., Ms., etc)			
6	Did the student ask you how you wish to be addressed? This shows respect for the individual and cultural awareness			
7	Did the student shake hands with you? In general, shaking hands is an accepted means of greeting your patient. You (the student) may choose to shake hands before you wash your hands			
8	Did the student sit down? It is considered good practice to sit in the presence of your patient to be closer to their eye level and has been shown to enhance patient's feeling that you have spent more time with them (ie you do not appear to be rushing to the next patient)			
9	Did the student establish eye contact with you? Maintaining eye contact provides a sense of connection and comfort for the patient			
10	Did the student inquire about the reason for your visit using open ended questions? You should avoid leading questions and allow the patient to describe the reason for their visit in their own words. Asking leading questions can prevent collection of vital information from the patient.			
11	Did the student listen attentively to you? Sitting quietly and listening to the patient will provide evidence of your engagement and interest in helping the patient			
12	Did the student show genuine interest in you? Showing interest will assist in the development of rapport with the patient. Taking short notes with important keywords will allow you to maintain contact without long interruptions as you write long notes			
13	Did the student wash (or sanitize) their hands before examining you? Depending on the room set-up, you may choose to wash with water and soap in the sink or use an alcohol-based hand sanitizer if that is more convenient			
14	Did the student ask or comment on how this health issue is affecting your life? This is a key part of the process for developing rapport, an affirmation that ill health affects the patient's QOL, if that is appropriate			
15	Did the student explain clearly (without medical jargon) what is happening with you medically? It is important to provide sufficient feedback to the patient in words that they can understand			
16	Did the student explain clearly (without medical jargon) the next steps in your care? As above, you should make sure that the patient understands the plan as this will improve compliance			
17	Did the student ask specific questions to confirm your understanding of the findings? It is good practice to have the patient summarize what they have heard and to clarify any information that may seem unclear.			
18	Did the student assess your ability and/or willingness to carry out the next steps?			

	This is a component of the motivational interviewing procedure, obtaining a commitment that the patient understands and can comply with your plan			
19	Did the student demonstrate an understanding of the reason for your visit? Although you may have seen other patients with similar presentations, you should demonstrate your understanding of the uniqueness of each specific patient encounter			
20	Did the student demonstrate an understanding of any concerns you had? Displaying compassion and deep understanding of issues being faced by the patient will enhance rapport and trust			
21	Did the student use statements of understanding and support to acknowledge your emotions? You can enhance your connection with the patient by frequently confirming information being provided and the impact on the patient.			

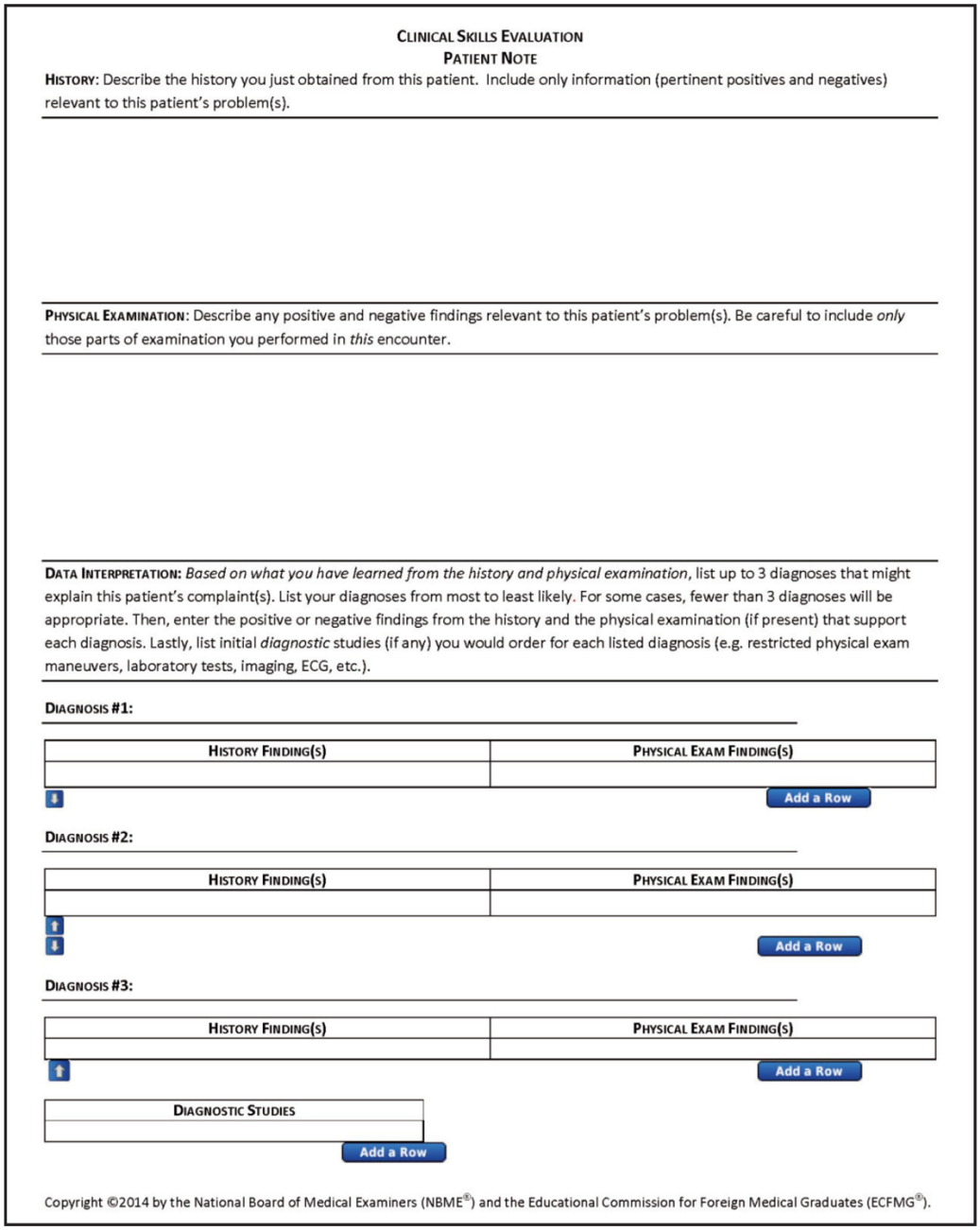
How comfortable would you be with this student as your health care provider? (5 point Likert scale)

Not comfortable at all Very comfortable

APPENDIX C

Patient Note Screen

When you type the patient note, you will use a program similar to the one pictured below. You can practice using the patient note software by using the program provided at the USMLE website (www.usmle.org). The patient note screen that appears during the actual examination will have a status bar for each field, indicating how much space remains.



CLINICAL SKILLS EVALUATION
PATIENT NOTE

HISTORY: Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives) relevant to this patient's problem(s).

PHYSICAL EXAMINATION: Describe any positive and negative findings relevant to this patient's problem(s). Be careful to include *only* those parts of examination you performed in *this* encounter.

DATA INTERPRETATION: *Based on what you have learned from the history and physical examination*, list up to 3 diagnoses that might explain this patient's complaint(s). List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive or negative findings from the history and the physical examination (if present) that support each diagnosis. Lastly, list initial *diagnostic* studies (if any) you would order for each listed diagnosis (e.g. restricted physical exam maneuvers, laboratory tests, imaging, ECG, etc.).

DIAGNOSIS #1:

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)

Add a Row

DIAGNOSIS #2:

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)

Add a Row

DIAGNOSIS #3:

HISTORY FINDING(S)	PHYSICAL EXAM FINDING(S)

Add a Row

DIAGNOSTIC STUDIES

Add a Row

The systems used at TTUHSC mimic the note format used by USMLE Step 2CS. You may access the STEP 2 CS practice note section to check on character and line limits.

The address is: https://www.usmle.org/practice-materials/step-2-cs/patient-note-practice2.html

APPENDIX D

Common abbreviations for the Patient Note (courtesy of USMLE Step 2CS exam description)

UNITS OF MEASURE	
C	Celsius
cm	Centimeter
F	Fahrenheit
hr	Hour
kg	Kilogram
lbs	Pounds
mcg	Microgram
mg	Milligram
min	Minute
oz	Ounces
VITAL SIGNS	
BP	Blood pressure
HR	Heart rate
R	Respirations
T	Temperature
ROUTES OF DRUG ADMINISTRATION	
IM	Intramuscularly
IV	Intravenously
po	Orally
MEDICAL ABBREVIATIONS	
ø	Without or no
+ or pos	Positive
- or neg	Negative
Abd	Abdomen
AIDS	Acquired Immune Deficiency Syndrome
AP	Anteroposterior
CABG	Coronary artery bypass grafting
CBC	Complete blood count
CHF	Congestive heart failure
COPD	Chronic obstructive pulmonary disease
CPR	Cardiopulmonary resuscitation
CT	Computed tomography
CVA	Cerebrovascular accident
CVP	Central venous pressure
CXR	Chest X-ray
DM	Diabetes mellitus
DTR	Deep tendon reflexes
ECG or EKG	Electrocardiogram
ED	Emergency department
EMT	Emergency medical technician
ENT	Ears, nose, and throat
EOM	Extraocular muscles

MEDICAL ABBREVIATIONS CONTINUED	
EtOH	Alcohol
Ext	Extremities
f or ♀	Female
FH or FHx	Family history
GI	Gastrointestinal
GU	Genitourinary
h/o	History of
HEENT	Head, eyes, ears, nose, and throat
HIV	Human immunodeficiency virus
HRT	Hormone replacement therapy
HTN	Hypertension
Hx	History
JVD	Jugular venous distention
L	Left
LMP	Last menstrual period
LP	Lumbar puncture
m or ♂	Male
Meds	Medications
MI	Myocardial infarction
MRI	Magnetic resonance imaging
MVA	Motor vehicle accident
Neuro	Neurologic
NIDDM	Non insulin-dependent diabetes mellitus
NKA	No known allergies
NKDA	No known drug allergy
nl	Normal/Normal limits
PA	Posteroanterior
PERRLA	Pupils equal, round and reactive to light and accommodation
PMH or PMHx	Past medical history
PT	Prothrombin time
PTT	Partial thromboplastin time
R	Right
RBC	Red blood cells
ROM	Range of motion
SH or SHx	Social history
SOB	Shortness of breath
TIA	Transient ischemic attack
U/A	Urinalysis
URI	Upper respiratory tract infection
WBC	White blood cells
wnl	Within normal limits
yo	Year-old

Note: This is not intended to be a complete list of acceptable abbreviations, but rather represents the types of common abbreviations that may be used on the patient note. There is no need to use abbreviations on the patient note; if you are in doubt about the correct abbreviation, write it out.

APPENDIX E

Guidelines for writing a patient note in CS format

These guidelines are intended to provide you with guidance in structuring your note to permit documentation of important information within the character constraints of the Step 2CS exam. As mentioned above, you will be able to use more characters and lines in Periods 1 and 2 but you will be expected to meet Step 2CS character limits by Period 3.

1. Chief Complaint (Hint: Use simple abbreviations (CC, etc) to organize your note)

2 choices are available: Direct quote from patient or inclusion in first sentence

Examples:

A. CC: "I'm having trouble breathing" (34 characters)
B. Mr. X is a 58 yo Hispanic male complaining of (or "presenting with") shortness of breath (or SOB) for past 2 months. (85 characters)

Note: if you choose option A, make sure this is a direct quote from the patient, it is not acceptable to simply write the presentation in quotation marks (eg. "SOB"). If you choose option 2, you can use qualifiers (eg, severe shortness of breath) to add detail using fewer characters.

Special cases: Obstetrics and Gynecology
Although not a universal requirement, at TTUHSC Ob/Gyn OSCE notes must use a specific format for the first sentence as follows:

XX y/o G0 (use appropriate descriptor (GXPX) for patient) LMP [WHEN, best if specific date, ok if "x days/weeks/months ago"), using [details about contraceptive use] who complains of [INSERT chief complaint]

2. History of Present Illness (HPI)

This section is best presented as a short paragraph that presents the information you collect form the patient in a logically organized manner. The best strategy is to use one of the common mnemonics (OPPQRST or OLD CARTS, for example) to organize your response. Although these mnemonics are most commonly associated with acute events, such as pain, they provide useful guides for any presentation.
Remember that ONSET and DURATION/CHRONOLOGY can often seem to be the same (for example, if pain is constant since onset) but in many cases the pain is only felt for specific periods or began after a specific event, such as a fall. Information about LOCATION should include any radiation. QUALITY should include descriptors of the nature of the presenting condition and the severity of the presentation (including pain or discomfort) should be QUANTIFIED. Relevant ALLEVIATING/PALLIATIVE or AGGRAVATING/PROVOCATIVE events should be documented along with any associated clinical information (eg febrility, etc). TIME characteristics, including any similar prior events are important to document.

Once this paragraph is complete, it is useful to present supporting information as a series of combined labeled responses as follows:

3. Past Medical/Surgical/Psychiatric/Neurological History. Use appropriate abbreviations (PMH/PMHx; PSH/PSHx) from approved list where appropriate. It is best not to include prior history before this point to avoid unnecessary biasing of your decision-making. If a patient has a prior history that would normally involve medication, make sure that you inquire about this medication and note it below. In most cases other than psychiatric patients, the first two items will suffice.

4. Allergies and Medications: These items, even if negative, should always be included. Allergies could include both drug allergies and other allergies depending on their relevance to the case.
Medications includes OTC meds, such as Tylenol, as well as prescription drugs. It is critical that prescription drugs related to prior history are included here.

5. Family History: Include relevant information about family members that informs decisions about the presentation.

6. Social History: You will need to decide which information is relevant her. At the very least, you should list occupation, living condition, and substance use.

7. Review of Systems: It is OK to state that ROS is "negative except as in HPI" so long as the important information has already been presented. A common reason for loss of credit in this area is the omission of critical pertinent positives of negatives based on a general statement such as the "negative except as in HPI" version, which can often lead to the omission of pertinent negatives, in particular. An organized method for listing the systems in the head to toe direction can be useful to avoid missing an important system. Here is a method for organizing your ROS:

a) General/constitutional: how does the patient appear, are they feeling weak, tired, have they lost or gained weight without trying, any fever.
b) HEENT: visual changes, eye pain, eye redness, hearing change, earache, tinnitus, nosebleeds, dry mouth, hoarseness, oral ulcers, sore throat)
c) Neck: neck pain or swollen glands
d) Pulmonary/Respiratory: chronic cough, decreased exercise tolerance, difficulty breathing, coughing up blood (hemoptysis), sputum production, wheezing
e) Breast: breast mass, breast pain/tenderness, nipple discharge, skin changes
f) Cardiovascular: chest pain, leg pain when walking, leg swelling, night awakening due to trouble breathing, palpitations, SOB
g) Gastrointestinal: abdominal pain, change in bowel habits, constipation, diarrhea, nausea, vomiting, rectal bleeding, trouble swallowing
h) Genitourinary: vaginal discharge, menstrual irregularities, difficulty starting/stopping urinary stream, dysuria, change in urinary stream, increased frequency, blood in urine, loss of bladder control, urinary retention, urethral discharge, impotence, penile lesion, testicular mass, testicular pain
i) Musculoskeletal: decreased range of motion, joint pain, joint redness, joint swelling, joint stiffness, muscle wasting, muscle weakness, muscle aches, muscle pain
j) Neurological: Loss of bowel control, dizziness/vertigo, headaches, numbness/tingling, passing out, seizures, tremor
k) Psychiatric: Anxiety, change in sleep pattern, depression, hallucinations, suicidal ideation

l) l: Endocrine: change in appetite, cold intolerance, increased thirst, increased urination, hair changes, sexual dysfunction
m) Hematology: easy bruising, enlarged lymph nodes, prolonged bleeding

Special cases: Pediatrics
Birth history, developmental progress, dietary history and immunization status will often be needed for pediatric patients.

8. Physical Exam: This is the area that probably needs more of your attention as the data we receive from the USMLE on our students' performance on Step 2CS identifies the PE as the one area of underperformance. It is worthwhile noting that the standard form used on Step 2CS allocates the same maximum number of characters for the PE section as the History section (950 characters on Step 2CS), yet we consistently observe on clerkship OSCEs that the actual number of characters used for the PE section is around 50% of the number used for the History section.

Organize your PE, for example like this list:

a) Vital Signs (with comments) – always list the VS and comment whether within normal limits or not for each.
b) General: describe patient including level of distress
c) HEENT
d) Neck
e) CV
f) Lungs
g) Abdomen
h) Genitourinary (in OSCEs, you will not be expected to perform these exams, include as part of your diagnostic follow-up, if appropriate)
i) Extremities
j) Neurological
k) Psychiatric
l) Skin
m) Lymphatic

9. Diagnostic Impression: You will be expected to list up to three potential diagnoses in order of priority. If you have trouble coming up with three diagnoses, this can be because you are deciding too quickly, which can result in an inability to come up with a reasonable list of choices. A useful mnemonic to help to consider a broad set of possible causes is VINDICATE.

Mnemonic letter	System/cause	Alternative
V	Vascular	
I	Infectious	
N	Neoplastic	
D	Degenerative	
I	Iatrogenic	Intoxication
C	Congenital	
A	Autoimmune	
T	Traumatic	
E	Endocrine	Metabolic

After documenting your diagnoses, you will then be expected to list supporting information from your History and/or physical examination. You can list up to eight items from each prior section. It is critical that there is no disconnect between the supporting information and prior documentation and the chief complaint should be one piece of supporting information from the history.

10. Diagnostic Workup/Studies: List laboratory tests, imaging, follow-up exams (eg pelvic/breast) along with a rationale for each test (such as to rule in/rule out one of the diagnoses). Your diagnostic workup should include items related to each of your listed diagnoses.

DO NOT list treatments for clerkship OSCEs or USMLE Step 2CS.

Resources: The USMLE Step 2CS site has practice materials for your note, including an interactive site in which you can write a note (this will give you a sense of how much you can include in 950 characters) and some sample notes. This site also has sample videos top help you to prepare for the communications component.

AMBOSS and USMLE World also have sections dedicated to Step 2CS for your ultimate preparation for that exam.