***Sheet 1***

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**(Information for student)**

**Patient Brief Record / Brief Scenario:**

**Patient Name: Ahmad**

**Age: 50 years**

**Occupation Teacher, Primary School.**

**No frequent visit to clinic**

**Ahmad is a 50-year old, came with complaint of abdominal pain and indigestion.**

**TASK: (What is expected from a student)**

* **Take a focus history, to reach a probable diagnosis.**
* **Explain to the patient possible diagnoses and the management plan.**

**No need of physical examination.**

***Sheet 2***

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**Patient’s Scenario/ Instructions to Patient**

**A 50-year-old man, who works as a teacher for long time, has presented to the clinic today with the complaint of indigestion and upper abdominal pain.**

**These complaints initiated for last 3 months. Pain and indigestion are usually felt after heavy meals.**

**Bowel movements are normal.**

**He uses paracetamol and Brufen for aches and pain.**

**He is smoker, 10-20 cigarettes per day.**

**No history of hematemesis or melena.**

**No history recent weight loss or generalized weakness.**

**He is not known to have any other chronic illness.**

**Initially, he could manage this problem taking antacid brought over the counter.**

**During the last week he could not get relief by the antacid and has vomited 2-3 times.**

**Idea: could be some serious problem.**

**Concern: not specific**

**Expectation: Relief of symptoms.**

***Sheet3***

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**Candidates Name:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Professional behavior (for all cases)**
 | **0** | **1** | **2** |
| 1. **Data Gathering (If Hx Taking to be tested)**
 |  |  |  |
| 1. **Examination (If Clinical examination to be tested)**
 |  |  |  |
| 1. **Management ((If Mgx plan to be tested)**
 |  |  |  |
| **Total****Grades %** |  |  |  |
| **Passed Borderline Failed**  |  |  |  |

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**Candidates Name:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Professional behavior (for all cases)**

Introduces himself, and get the permission to take historyStarts with open ended question.Develops the rapport with patient. | **0** | **1** | **2****10** |
| 1. **Data Gathering (If Hx Taking to be tested)**

Onset, duration, character of pain, relieving and aggravating factors………..Bowel movement, character of stoolALARM symptoms (recent wt loss, hematemesis, malena,….)SmokingMedications (NSAID, or other gastric irritant medication)Social history (home or work stree…)Ongoing problem**Summarizes to the patient about the history taken from him.**Differentiating symptoms for GERD.and other causes of dyspepsia.Patient idea, concern and expectation |  |  | **60** |
| 1. **Examination (If Clinical examination to be tested)**

**NOT NEEDED** |  |  |  |
| 1. **Management ((If Mgx plan to be tested)**

Explains the problem to the patient in simple way.Informs that could be NUD or GERDDietary advice and other non-pharmacological advice.PPI medication / H2 blockerFollow up advised Possibility of Urea Breath test request.Arrive at shared understanding.**Summarize at the end of consultation** **Invite questions from patient** |  |  | **30** |
| **Total****Grades %** |  |  |  |
| **Passed Borderline Failed**  |  |  |  |