Scenario:

A 22 year old women presents because she is concerned about her irregular periods. Please take a history.

Mark scheme:

Introduces self

Confirms patient's details

Gains permission to take a history

Asks about patient's pain and comfort

Presenting Complaint (PC): Asks about and establishes presenting complaint using an open question

History of PC:

- **Asks about onset, time course (when her last period was), associated factors**
- **Asks about key related symptoms: hirsutism, weight loss or gain, greasy skin, acne, headaches, visual problems**

Gynaecological history:

- **Menstrual history: last menstrual period and regularity**
- **Contraception history**
- **Cervical smears, previous disease & treatments**

Sexual history: unprotected sex

Obstetric history: has pt taken pregnancy test, previous pregnancy (gravidity, parity)

Past Medical History: diabetes, operations

Drug History: allergies, over the counter, prescribed medications

Family History: diabetes

Social History: occupation, smoking, alcohol, recreational drug use, living situation, activities of daily living, especially:

- **Stress**
- **Exercise level (eg training for marathon)**
- **Diet**

Review of Systems: BMI, thyroid symptoms, skin and hair abnormalities

Asks about ideas, concerns, expectations

Thanks patient

Communication skills: active listening, summarising, signposting